Turning the Key

Appendices

Mental Health Commission of Canada

Commission de la santé mentale du Canada

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APPENDIX ONE: DETAILED RESEARCH METHODOLOGY

OVERVIEW

The research design of the project was tailored to adequately address the scope of the project in terms of both its aims, as well as the fact that this was a national level study that looked at housing and related supports across Canada. This necessitated a design involving multiple approaches that could reach out to various respondent and stakeholder groups in all provinces and territories.

The **project aims** were as follows:

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

The project employed a mixed design using qualitative and quantitative methodologies, with multi-stakeholder participation. The multi-stakeholder participation ensured a comparative element to the design. The design was also participatory in that it had inbuilt processes for stakeholder participation and feedback in facilitating representation; refining the tools of data collection; informing data analysis; and ensuring knowledge development, exchange, and transfer.

The quantitative element of the project comprised a survey design with comparable questionnaires as the tool of data collection. The survey sample was stratified into five different stakeholder groups and the survey was administered across Canada using a snowball method. The qualitative elements of the study comprised of teleconferences and consultations with reference groups, key informant interviews with national and international experts, consumer webinars, and site visits of housing programs across Canada.

SPSS 15.0 was the program of choice for data 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 in that it added to existing knowledge, as well as shed light on less explored areas, leading to the emergence of new categories and themes. Triangulation was possible as more than one approach was used to investigate research questions. This enhanced the confidence in the ensuing findings.

This research project underwent an expedited review process through the Centre for Addictions and Mental Health Research Ethics Board. In addition, the research team completed the Alberta Research Ethics Community Consensus Initiative (ARECCI) Ethics Decisions Support Tool to capture the ethical processes that are incorporated in the project. Also, as a best practice to promote ethics in research projects, each member of the research team

completed the Interagency Advisory Panel on Research Ethics' (PRE) on-line Introductory Tutorial for the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS). Where students have been involved, they have also completed the Tri-Council tutorial and are being supervised by seasoned researchers.

DETAILED METHODOLOGY

This section of the methodology section will present a detailed review of the range of methods utilized in the project.

The project consisted of a multi-pronged approach to assessing housing and related supports across Canada, utilizing the following methods:

1. The development of provincial/territorial and national reference groups.
2. A comprehensive search and review of grey and published literature.
3. Interviews with key stakeholders.
4. Interviews with international key informants.
5. Development and distribution of surveys to people living with mental illness, family members, community mental health service providers, housing providers, and hospital administrators and clinical leads.
6. Webinar consultations with people living with mental illness.
7. Site visits to housing programs across Canada.

PROVINCIAL/TERRITORIAL AND NATIONAL REFERENCE GROUPS

The participation of provincial/territorial and national reference groups was a process that was used by the research team to formally and consistently validate study findings. The key system stakeholders that participated in the reference groups played a critical role in informing all aspects of the project, from planning phases to data collection and analysis.

There were numerous benefits to utilizing reference groups in all aspects of the project. First, the process allowed the research team to consistently present and assess the adequacy of preliminary findings. In addition, erroneous and/or misinterpreted findings were identified early, and findings were challenged through open discourse. The process also presented the researchers with the opportunity to work closely with key system stakeholders across Canada.

The research team recruited provincial/territorial and national reference groups to inform the design and implementation of the environmental scan and analysis of housing and related supports for adults living with mental health problems and illnesses. These groups would also identify emerging better practices in the development and provision of secure and stable housing for this population across Canada.

The research team underwent an extensive process to select each reference group member and develop groups so that they reflected a well-balanced group of stakeholders. Specifically, in selecting potential reference group members, the research team conducted an iterative process of background searches on key stakeholders and leaders in the field through internet searches, contacting stakeholders directly for recommendations, and collaborating with other housing project investigators within the Mental Health Commission of Canada.

- To ensure true representation of stakeholder groups a matrix was developed:

- Provide subject matter expertise.
- Inform the Research Team (Centre for Addiction and Mental Health and Canadian Council on Social Development) as to key partners and champions within the field.
- Assist in identifying promising models of housing and supports from their jurisdictions.
- Review proposed methodology for the environmental scan process.
- Review and assist in analysis of findings from the national assessment.
- Share project information with key partners within their jurisdiction.
- Promote the project with key partners within their jurisdictions.

In addition, a national reference group was created that met via teleconference three times during the study to:

- Provide insight into how the systems for mental health related housing and supports in Canada compare to those that exist in other regions.
- Provide subject matter expertise.
- Review and assist in analysis of findings from the national assessment.
- Promote the project to key partners nationally and internationally.

Reference group members played a critical role in each data collection phase. The research team received valuable feedback on each of the questionnaires and interview questions, contact names of key informants for interviewing, and provincial networks for questionnaire distribution. In addition, reference groups provided recommendations for innovative programs that could be considered for site visits, as well as high level assessments of current housing and community support challenges. Reference group members also distributed surveys within their networks to mental health service providers, housing providers, hospital representatives, people living with mental illness, and family members.

DATA

As mixed-methods approach to data collection was used, multiple sets of data were collected and included:

- Literature search and review.
- Semi-structured qualitative interviews with key system stakeholders (e.g., government representatives, regional health authorities, provincial/territorial housing corporations, and municipal housing providers).
- Qualitative interviews with international key informants.
- Surveys from five stakeholder groups including people living with mental illness, family members of individuals with lived experience, community mental health service providers, housing providers, and hospital administrator and clinical leads.
- Webinars with people living with mental illness.
- Notes from site visits with housing programs with a focus on innovative practices.
- Notes from consultations with reference groups across Canada.

LITERATURE SEARCH AND REVIEW

The literature review included academic literature (e.g., published research studies, reviews of literature, theoretical papers) and grey literature (e.g., unpublished reports and government documents). The research team developed a list of key search terms to identify papers exploring housing for individuals with mental illness together with other housing options including social housing, residential care, emergency shelters, and transitional housing. Key words included, but were not limited to the following (either alone, or in combination):

- housing
- mental illness
- mental disorder
- mental health
- mentally ill
- addictions
- housing supports
- supported housing
- supportive housing
- dedicated housing
- homes for special care
- domiciliary hostels
- Residential Treatment Facilities
- custodial housing
- Housing First
- Pathways to Housing
- continuum of care housing
- treatment first housing
- boarding home
- unregulated housing
- foster homes
- group homes
- congregate housing
- shared housing
- supervised apartments
- rooming house
- single room occupancy
- alternative housing
- transitional housing
- psychiatric patients
- housing outcomes

- housing stability

The search was limited to English-language articles published from 1990 to 2010.

In addition to considering models of housing and support that are dedicated to people living with mental illness and/or mental health problems[1], the research team identified the need to consider the broader array of affordable housing programs across Canada. The goal of this exercise was to provide relevant background information to root any future national strategy in better practices with respect to determinants of health, human rights, and relevant policy directions. While there is no doubt that the continuum of housing and supports includes these dedicated models, the reality is that people with mental illness live in many different types of housing arrangements, as does any person in Canada. These include:

- Owning a home
- Living with parents, living with friends
- Renting an apartment in the private rental market
- Living in social housing (including public, non-profits and co-operatives, and other affordable housing initiatives)
- Living in dedicated housing[2] (including 'scattered site' housing where a rent supplement enables rental in the private rental market, dedicated buildings with self-contained apartments, dedicated homes with private, or shared bedrooms) with a variety of housing and/or clinical supports where intensity of supports can range from low to high.

Key objectives were to:

- Synthesize the history and current status of social housing in Canada.
- Understand housing's role in health and the "fit" within the social policy context.
- Discuss housing as a basic human right and the implications this has for government.
- Review how other countries have addressed affordable housing needs.
- Provide additional information on the economic, social, and personal costs
- Summarize considerations for policy and long-term strategies for affordable housing.

Multiple activities were undertaken to address these objectives:

- Interviews with key contacts and government sources with a focus on mapping existing housing and mental health supports, together with existing policy frameworks relating to housing, mental health, poverty reduction, and prosperity promotion.
- Review of existing provincial/territorial, national, and international reports that synthesize issues that impact affordable housing, policy directions that support affordable housing and people with special needs, and effective planning for affordable housing and people in core need of housing.
- Review of provincial, territorial, and federal government websites on existing policies and practices related to affordable housing.

[1] 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).

[2] 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.

- Review of research related to better practices in fostering the creation of affordable housing, with a particular emphasis on social housing and people with special needs.
- Review of publications issued by key organizations in Canada, including Canada Mortgage and Housing Corporation, Statistics Canada, Canadian Policy Research Networks, Canada Housing and Renewal Association, Wellesley Institute, Caledon Institute of Social Policy, National Council on Welfare, Canadian Centre for Policy Alternatives, National Housing Research Committee (chaired by CMHC), National Aboriginal Housing Organization, together with past work from the project lead organizations (Canadian Council on Social Development and the Centre for Addiction and Mental Health).

Key words used in searches include:

- affordable housing
- social housing
- public housing
- mental health
- mental illness
- policy
- social policy
- core housing need
- better practice
- inclusionary housing
- housing benefit
- housing supplement
- zoning
- supportive housing
- supported housing
- green housing
- determinants of health
- income
- human rights
- health
- homeless

A series of electronic databases were consulted to retrieve the published literature[3]. A web-based search was also conducted for non-indexed published and unpublished reports on housing and related supports for individuals

[3] The following electronic databases were used to access published literature: Age line, AMED, ASSIA, Bibliography of Native North Americans, CIHAHL, Criminal Justice Abstracts, Criminology: A SAGE Full-Text Collection, Digital Dissertations @ Scholars, EconLit, E-Journals@Scholars, EMBASE (Ovid), Expanded Academic ASAP @ Scholars, Family Studies Abstracts, Health Sciences: A SAGE Full-Text Collection, OVID/ HEALTHSTAR, Medline, PAIS Archive, PAIS International, Political Science: A SAGE Full-Text Collection, PsychARTICLES, PsychCRITIQUES, Psychology: A SAGE Full-Text Collection, PsychINFO, Public Administration Abstracts, PubMed, Scholars Portal, Scopus, Social Sciences Abstracts@Scholars, Social Sciences Citation Index, Social Services

with mental illness. Numerous search engines and knowledge exchange portals were used including: Google Scholar, the Homeless Hub, the Wellesley Institute, the Substance Abuse and Mental Health Services, and the Ontario Mental Health and Addiction Knowledge Exchange Network (OMHAKEN). In addition, a website search was conducted of various mental health organizations and housing provider organizations in Canada and internationally. Some specific websites were: the Canadian Mental Health Association, Ontario Non-Profit Housing Association, and the Mental Health Commission of Canada.

WEBINARS

As part of the multi-method approach to understanding the firsthand experiences of people living with mental illness with regard to housing and related supports, the research team partnered with the National Network of Mental Health (NNMH), the largest national organization run by and for people with mental illness in Canada that focuses on activities such as advocacy, education, resource sharing, and information distribution on issues which impact persons living with mental illness. The NNMH assisted the research team in hosting a series of online consultations with people living with mental illness (e.g., webinars). The webinars were hosted using Adobe Acrobat Connect Pro Meeting software which enabled participants to attend via teleconference or webcast. Six English webinars were facilitated by the project's consumer consultant, Mr. David Reville, and were held between February 23rd and February 26th, 2010 for various regions across Canada. Provinces and territories were grouped into five larger regions (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; and Ontario) with one webinar designated for residents in each region. Due to large levels of interest in Alberta and British Columbia, a second webinar was hosted for these provinces.

Participants were asked to share their thoughts and experiences with the mental health and housing system, best practices, governance issues, preferences, as well as facilitators and/or barriers regarding housing and related supports. One additional French webinar, facilitated by Mr. Alfred Cormier, was held on June 3rd, 2010 for francophone residents in Quebec and New Brunswick. Another webinar was scheduled for francophone residents from the rest of Canada; however, this was cancelled due to low participation.

Participants were recruited via an electronic invitation that was distributed through e-mail to reference group members, and posted on the NNMH and MHCC websites. Reference group members were asked to circulate the invitation through their respective networks in order to utilize a snowball sampling methodology. Overall, there was a strong level of interest in the webinars, with 83 registrants (including waitlist participants) and 60 participants across all six webinars. Participants received a $30.00 honorarium for their participation.

INTERVIEWS WITH KEY SYSTEM STAKEHOLDERS

Interviews with key system stakeholders for the purpose of obtaining current information on housing/support stock in Canada[4] began in January 2010 and were completed by the end of April 2010.

The research team identified representatives from Regional Health Authorities, provincial housing corporations, municipal housing providers, and government ministries in each province and territory (and nationally) who had

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Abstracts, Social Work Abstracts, Sociological Abstracts, Sociology: A SAGE Full-Text Collection, Urban Studies Abstracts, and Worldwide Political Science Abstracts.

[4] In addition to an interview methodology, the research team reviewed published reports, site visits, and questionnaire data to obtain information on the current housing/support stock across Canada.

expertise that enabled them to report current information on housing/support models in their respective areas. Provincial and territorial reference group members and the project's advisory board were also consulted.

Interviews with system experts were approximately 1-2 hours in length and were used to collect information on the categories/themes, including models of support; capacity, funding, and regulation; and, historical and current trends in housing and supports investments. A sample of questions utilized to guide the interviews is listed below[5]:

1. **Models of Support**:
    - Can you characterize the models of housing/support that are on the ground (e.g., size of average site, clustered/scattered, type of support and how it's provided, "typical" characteristics of each model)?
    - What is the nature of the operation that typically provides the various models (e.g., private, for profit; non-profit; community NGO versus hospital)?

2. **Capacity, Funding, and Regulation**:
    - What are the round numbers of each housing model at the provincial or territorial level?
    - What are the funding levels in each model?
    - How are each of the models funded (funding mechanism) and regulated?

3. **Historical and Current Trends in Housing/Support Investment**:
    - What is the nature of investment in housing models over the last decade (e.g., has there been a particular trend in the types of models being funded)?
    - Who has funded these specific investments (e.g., municipal government, provincial government, federal government, other)?
    - How does this more current investment compare to investments made historically?
    - What is the nature of the investment over the last few years?

INTERNATIONAL KEY INFORMANTS

The research team identified international experts with knowledge of housing models unique to regions outside of Canada. The research team identified international experts in the field of housing and related supports through various processes including: scans of both published and grey literature, recommendations made by reference group members, and via other international informants.

Seven interviews were conducted with international key informants from April 2010 to June 2010. Interviewees were asked to share their thoughts and knowledge of the mental health and housing system in the areas of best practices, policy development, funding models, creative partnerships, and innovations in the provision of housing programs.

Initial correspondence with the majority of the informants was made by e-mail. This approach was intended to probe interest, introduce the project, and allow the prospective informants to recommend other experts in the field.

[5] The listed questions were used as a general interview guideline.

Interviews were held with seven international key informants from three different countries. In total, five informants were from the United States, one was from Portugal, and one was from Ireland.

An analysis of verbatim transcripts was conducted to identify common themes.

SURVEY USING QUESTIONNAIRES

To understand specific issues around housing and related supports from the perspectives of diverse stakeholders, questionnaires were developed for the following stakeholder groups:

- persons living with mental health issues/mental illness
- family members of persons living with mental health issues/mental illness
- housing providers
- community-based mental health service providers
- hospital administrators and clinical leads

In summary, questionnaires asked stakeholders about barriers/enablers regarding housing and related supports in their regions, challenges around access and tenure of housing and supports, and recommendations.

Questionnaire Distribution

Questionnaires were uploaded into SNAP Surveys Professional 10, a program used for online survey distribution. PDF versions of questionnaires were also created and distributed along with online survey links. An invitation was created for all stakeholder groups and a snowball methodology was employed to distribute questionnaires across Canada[6].

The research team created databases containing contact information of mental health service provider networks, social and dedicated housing provider networks, and hospitals with specialized mental health beds. These lists were vetted through reference group members for further input.

Invitations letters and questionnaire links were sent to reference group members for further distribution to associated networks (refer to section on reference groups for a detailed description), and directly to contacts listed in all databases. In addition, the invitation letter and links were posted on websites such as The National Network for Mental Health, the Mental Health Commission of Canada, the Homelessness Hub, and various other network sites. Study notices and links were also featured in numerous community mental health agency and housing provider newsletters across Canada.

All questionnaires underwent a pilot phase. The piloting of the questionnaires occurred during a three-week period. Invitations to participate in the pilot were distributed through reference group members with a request to return completed questionnaires by a set deadline. Based on feedback from the questionnaires, numerous revisions were made to each of the questionnaires.

Questionnaire Analysis

Both quantitative and qualitative components were included in the questionnaires. A content analysis was undertaken to identify common themes within qualitative responses. A primary researcher repeated this process until all responses were accounted for and synthesized into themes and sub themes. Once theoretical saturation was achieved, findings were reviewed and agreed upon by additional members of the research team.

[6] Copies of questionnaires and associated materials are available on request.

Quantitative data were analyzed using the Statistical Package for the Social Sciences (SPSS) Version 15.0. A variety of statistical tests were conducted during the data analysis phase, which included the following tests: descriptive statistics, crosstab analyses with chi-square tests of association, independent-sample t-tests, one-way analyses of variance, Pearson r correlations, and linear regression analyses. In addition, some basic mean and summation calculations were carried out using Microsoft Office Excel 2003.

SITE VISITS

Through the research process, efforts were made to identify innovations in housing and supports that address challenges and/or lead to positive change. There were extensive consultations with reference group members in each province or territory to identify innovation and promising practices. Through this process, a tentative list of innovative services were identified for each province, following which site visits were undertaken to most of the services to gain an in-depth understanding of the innovation. Site visits included visiting the actual sites and services, consultations with staff and people living with mental illness and/or tenants. More than 30 sites were visited across the different provinces and territories. In addition, extensive consultation with multiple stakeholders including hospital representatives, people living with mental illness, housing providers, ministries, peer support groups, and mental health service providers were undertaken during these site visits.

KNOWLEDGE EXCHANGE STRATEGY

The process of engaging multiple stakeholders at various levels and through multiple modalities, in different aspects of the study created a fertile ground for knowledge exchange (KE). KE activities like sharing and consultations through webinars, site visits, reference group teleconferences, and web based information sharing have occurred. The research team and the Mental Health Commission of Canada also worked on creating a long-term plan for KE, which will be supported beyond the life of the project by a CIHR grant awarded to facilitate KE pertaining to the outcomes and the results of the study.

The knowledge exchange strategy focuses on creating meaningful dialogues between multiple stakeholder groups and to impart information in creative ways, such that the momentum created through such exchange will result in ongoing, nationwide, proactive collaboration, intervention, and advocacy in the field of housing and related supports in mental health.

Aims of the Knowledge Exchange Initiative:

- Create an active, sustainable platform for ongoing collaboration and KE.
- 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 made available through multiple channels.
- Establish an expert resource base with an interactive, real-time component.

At this point, strategies to operationalize these aims have been developed. An online innovations template has been developed and piloted with reference group members. Through the research and consultation process, some key areas of common interest have been identified and reference group members have been invited to indicate their areas of interest. This will lead to the development of cross-cutting interest groups across Canada. In collaboration with the Knowledge Exchange Division of the Mental Health Commission, the innovations template will be made available online and will serve to inform stakeholders of ongoing innovations in the field. The cross-cutting interest groups will also find a sustainable platform for ongoing collaboration through the Commission's KE website and other modalities. The knowledge exchange strategy will also arrive at creative ways of presenting information and findings from the project to target audiences. Existing websites and portals will be used

effectively to post reports and other information. These next steps will be undertaken as part of the CIHR knowledge translation project.

LIMITATIONS OF THE STUDY

The surveys reached a national audience, and were stratified in terms of stakeholders. Given the scope of the study and the fact that this study was limited to a brief time period, a random sampling methodology could not be employed. This has inadvertently resulted in over/under representation of some groups, and some provinces and territories over others. However, this has analytical value in terms of understanding levels of engagement, the concentration or lack of services in different geographic areas, and the need for specific qualitative methodologies to be employed in understanding issues of certain stakeholders/provinces and territories that have been underrepresented. This is particularly true of the North West Territories, Yukon, and Prince Edward Island. With the stakeholder groups, the participation of hospital representatives was lower than that of other stakeholders. Also there was greater participation of people living with mental illness from independent settings than from congregate settings. This could have been due to access issues, though specific efforts were made to reach out to people in all type of housing settings through service providers and by encouraging the provision of hard copies.

In spite of these limitations, the multi-methods employed neutralized many of the limitations of a specific method. It also ensured that as comprehensive a picture of housing and supports was captured within the constraints of time and budget.

APPENDIX TWO: WEBINARS

Consumers from across Canada were invited to participate in six webinars held between February 23 and February 26, 2010 (two for the Alberta and British Columbia region, and one for each of the following geographic areas: Manitoba and Saskatchewan; the Northwest Territories, Nunavut, and the Yukon; New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island; and Ontario) and one francophone webinar on June 3, 2010. A total of 70 individuals participated in the webinars. The majority of these were people living with mental illness, but participants also included service providers, family members, a provincial government member, and a landlord. Participants living with mental illness reported living in a wide range of housing situations.

WEBINARS OVERVIEW

Housing was seen as fundamental to recovery. A range of consumer preferences were expressed regarding housing, including a need for community integration through both scattered and non-scattered housing models, mechanisms to facilitate connections to the communities in which consumers live, and a continuum of housing options. Identified issues included the lack of safe and affordable housing, vulnerability to slumlords, and NIMBY-related barriers. Participants also expressed a desire for people living with mental illness to play a real role in the planning and decision-making process.

SYSTEM BARRIERS

Themes raised by participants included the need for increased financial supports and subsidies and enhanced social assistance structures. Poverty and threat of loss of housing or supports were identified as barriers to aiding recovery, in addition to systemic disincentives to employment and homeownership.

Other factors participants viewed as anti-recovery were the difficulty of navigating the current fragmented housing system, lack of equitable access and system transparency, and issues with navigating and accessing services outside of the mental health system, such as dental or legal services.

TAILORED SUPPORTS BEYOND THE TRADITIONAL BASKET OF SERVICES

Participants noted that the effects of mental illness are different for each person, and thus there is a need for a range of individually tailored supports beyond the typical “basket of services.” Participants reported the need for, and positive impact of, supportive services in accessing and maintaining housing. They also reported the need for other, related supports, such as assistance with activities of daily life, and supports to allow people to maintain their housing during periods of crisis or hospitalization. Together with recovery-oriented education and employment**,** these tailored supports would enable people to focus on and advance their recovery.

PEER SUPPORT

Feedbacks from participants identified peer support, including peer organizations, as important in helping people living with mental illness to access and navigate the system and programs.

STIGMA

People living with mental illness consistently reported experiencing stigmatization in interactions with landlords, employers, the community, police, etc. They voiced the need for public education to change society’s views of individuals with mental illness.

PEOPLE WITH MULTIPLE NEEDS

Persons with concurrent disorders were identified as a population particularly lacking in adequate supports, services, and housing options. The need for tailored housing and supports and services for the youth and elderly, in particular, for the large aging population with mental illness, was also regularly mentioned. 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, were noted. Concern was also expressed for aging caregivers with dependants who are in the mental health care system or have mental health issues, and the lack of planning for this population.

It was also raised that many groups tend to "fall through the cracks" due to lack of, or inability to access services. These groups include people with cognitive issues, autism, personality disorders, forensic clients, and those who remain undiagnosed. Particular emphasis was placed on individuals who are undiagnosed and have difficulty accessing or are unable to access the mental health system.

RURAL/REMOTE ISSUES

Participants spoke to the challenges faced by those living in rural/remote areas, including a 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 for expanding limited road access. The negative effects of having to leave one's community to travel to large urban centres to access needed care or supports were also mentioned. The issues faced by those in rural/remote areas were identified as being unique and need to be addressed as such.

ISSUES SPECIFIC TO ABORIGINAL COMMUNITIES

Several issues specific to Aboriginal communities were raised by participants, including a lack of housing options; the need for self-governance, ownership, and involvement in program planning for their communities; 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 levels of drug and alcohol abuse by this population, and the tailoring of services around these issues, to the exclusion of others. Also identified were the lack of cultural awareness and of the variety of Aboriginal cultures, and the influence of culture on the needs of people with mental illness, all of which must be considered in program planning.

In summary, the following are the highlights from the analysis of webinar data:

- Housing is fundamental to recovery, and a recovery-oriented system must provide a range of housing options.
- Enhanced social assistance structures and increased financial supports and subsidies are integral to recovery.
- System fragmentation, inequitable access, and lack of transparency make it difficult to navigate the housing system.
- Supports need to move beyond the typical basket of services to include support for activities of daily living, housekeeping, maintaining housing during periods of crisis or hospitalization, employment, and education.
- Stigma is a significant barrier to recovery. Landlords need to be educated about mental illnesses to create a more supportive housing environment.
- The current housing system has significant gaps in serving people with concurrent disorders, youth with mental health issues, and seniors with mental health issues.
- The future of dependants with mental health issues living with aging caregivers was a significant source of concern.

- There are unique issues relating to housing and supports in rural/remote communities, including lack of resources, transportation issues, and the need to leave one's community to access supports.
- The Aboriginal community deals with a very inadequate housing system for people with mental health issues, lack of culturally competent services, lack of involvement in decision making, and a skew in the services provided due to assumptions that this population is particularly vulnerable to issues of substance abuse.

ALBERTA AND BRITISH COLUMBIA

PARTICIPANT PROFILE

The webinar in Alberta and British Columbia was held on Tuesday, February 23rd, 2010, and involved eight participants, the majority of whom were people living with mental illness. Four participants were from Lethbridge, AB, and at least two participants were family members.

Due to extensive interest, a second Alberta and British Columbia webinar was held on Thursday, February 25th, 2010. The second webinar involved 11 participants, the majority of whom were people with mental illness.

HOUSING STOCK

Participants agreed that housing was the first priority and "fundamental" for recovery. Throughout the webinars, they noted the shortage of housing stock; in particular, of housing that is both safe and affordable.

> "When I finally moved to my apartment, it was tremendous to my recovery."
> - webinar participant

The need for sustainable housing options was particularly identified in British Columbia, especially in Vancouver, where the housing stock consists mainly of single-family homes that are not affordable. This removes the option for low-income people to live in the interior of the city, where the bulk of supports and services are located. Participants further expressed concern about the lack of housing geared towards seniors, youth, and Aboriginals, as well as the shortage of housing options in rural/remote areas. A unique issue mentioned in the webinars was the situation of homeless individuals, many of whom likely suffer from some form of mental illness; these individuals often live in the woods on the outskirts of urban areas, viewing this as a safer and preferable alternative to shelters or alleyways in the cities.

CONSUMER HOUSING PREFERENCES

The issues of consumer choice and the need for a continuum of housing options to meet the diverse needs of individuals in various stages of recovery were prominent in the webinar discussions. In the February 25th webinar, the scattered site model and market housing were frequently mentioned, particularly because these models offer the ability to choose the area where one wishes to live. The need for additional supportive housing, as well as housing for seniors and youth, was raised throughout the webinars. Several webinar participants lived at home with their families and reported mixed experiences; one participant noted being satisfied with the living arrangement, while another felt "bad living at home as an adult" when "sick."

SUPPORTS AND SERVICES

Access to Housing

The lack of safe and affordable housing stock was a prominent theme throughout the webinars. This constitutes a major challenge to accessing housing, which was noted to be crucial for recovery.

"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

Lack of housing, and subsequent access issues, were identified specifically for Aboriginals, seniors, and youth. Discrimination, stigma, and NIMBY issues were also noted as challenges to accessing housing in certain areas.

Youth and Seniors
The need for housing and programs specifically for youth and for seniors was a definite theme throughout the webinars. It was noted these populations require tailored supports and services and housing to aid in their recovery, including supports for daily living skills for youth. The gap in services and supports for youths between the ages of 18 and 19 years was also noted. In particular, it was mentioned that in British Columbia, the education system is not required to fill out supportive pension papers for children who are physically disabled or have a low I.Q. until they are 19 years old, which is an access and system issue for youth. The impact on income and financial supports for the elderly population transitioning from disability to old age security at age 65 was also raised.

People with Concurrent Disorders
Participants noted a gap in services and programs for the large population with substance abuse or addiction issues in this area; one participant specifically noted the lack of daytime programs and services. Participants also noted that some populations tend to "fall through the cracks" due to access issues, such as those with cognitive issues, autism, personality disorders, forensic clients, and those who are undiagnosed.

Income and Policy Issues
An important theme raised by participants was lack of adequate financial supports to access safe and affordable housing. Housing subsidies and social and disability assistance do not keep up with market costs and inflation or discretionary rent increases by landlords. One participant noted that it could be necessary to choose between paying for housing or food. People often live in groups out of necessity rather than desire, possibly creating anti-recovery situations.

Rental subsidies were described as extremely important for accessing and maintaining housing; however, participants noted that there are not enough subsidies available, and that the subsidies that do exist are not adequate to access decent and safe housing. Lack of supports to access housing translates into a large and possibly hidden homeless population. *Housing First* type initiatives were viewed as positive and needed in many areas.

Participants' responses were mixed regarding involvement in the management or **governance** of their housing, although a few indicated they had opportunities to do so.

Rural/Remote Issues
Rural/remote areas were described as particularly lacking in resources and support to access services. It was also identified that rural issues are unique and must be addressed as such. People often must leave their communities to seek supports and services elsewhere, which may be anti-recovery. **Transportation** in rural/remote areas was noted as a major barrier to accessing supports and services.

Peer Support
The level of peer support was noted as being variable, and an increase in access to this type of is needed. In North Vancouver, peer support workers are restricted to mental health clients, thus creating an access barrier for non-clients. Receiving support from peer support workers often leads to participants becoming peer support workers

in turn, and in some cases, they get jobs in the "outside environment". Support groups were also noted as beneficial to recovery.

Maintaining Housing and Program Eligibility
Participants expressed that supports and services tailored to the individual are extremely important in maintaining housing, and that the varying levels of services by location may negatively impact recovery.

> "Here in Victoria we have a real problem with services. I tried to get a case manager for years… I am on ODSP, but… they say "we have too many patients, you have to go to a family physician."
> -webinar participant

The issue of being able to maintain housing during hospitalizations arose. One participant received several eviction notices while hospitalized, due to non-payment of rent on account of inadequate disability income. Difficulty maintaining housing when transitioning from disability assistance to old age security income was also reported as an issue. The current system in which "the better you get, the less likely you are to be housed" was viewed as a disincentive to recovery.

Education and Employment Supports and Policies
Supports for education, employment, and volunteering were noted as important, particularly for youth. Volunteer opportunities lead to increased self-esteem and aid in recovery; participants felt that supports to promote such opportunities are important to consumers.

> "When I've got a volunteer job, my mental health improves a lot."
> -webinar participant

Disincentives to work, which are also not conducive to recovery, include claw-backs and workplace discrimination. A participant reported that in Victoria, B.C., when one secures a job, the housing subsidy is withdrawn.

> "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

Aging Caregivers
Participants raised the issue of aging caregivers to dependents with mental health issues who live at home. There is lack of planning for this issue and inadequate support for this population.

OTHER SYSTEM LEVEL ISSUES

Participants viewed the system as fragmented, "barrier-oriented," anti-recovery, and lacking in transparency. They noted that the aid of an advocate to assist with navigating the system and accessing programs and services would be beneficial. Accessing services outside of the mental health system, such as dental and legal services, were also noted as challenges, particularly for those with mental illness.

Participants voiced the need for safe and affordable housing and available and accessible supports. Supports and services should be tailored, client-centered, and recovery-oriented; they must also include things outside of the typical "basket of services," such as supports for employment, education, and daily living.

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

Another major theme was the need for more funding and resources to increase availability of and access to housing and related supports and services, instead of budget cuts. Systemic disincentives to working must also be addressed. The need to enhance the knowledge of people living with mental illness about their rights as tenants was identified, as well as the need to address various eviction experiences.

Participants expressed the need for a lobbying or advocacy group to campaign for change and to ensure that the voice of mental health consumers is heard in the political arena.

"When you have a mental illness a lot of times you don't have the energy or 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

MANITOBA AND SASKATCHEWAN

PARTICIPANT PROFILE

Of the 17 participants, the majority were people living with mental illness. One family member, two staff members from a mental health centre, and a landlord also participated in the webinar.

HOUSING STOCK

Housing was described by participants as very important to recovery. They noted a marked housing shortage and affordability issue, with typical rents higher than the supplements provided. Landlords avoid the rent control in Manitoba by carrying out complete renovations, exacerbating the shortage of affordable housing options. There are long wait times for housing clients being discharged from mental health centres in Selkirk, as well as in the much larger city of Winnipeg.

HOUSING PREFERENCES AMONG PEOPLE LIVING WITH MENTAL ILLNESS

Preferred housing options included living in a house, private apartment, and group or dedicated homes. A portable housing benefit, provided through the Manitoba government, was very beneficial in allowing one participant to live independently.

SUPPORTS AND SERVICES

Accessing Programs and Housing
Participants expressed a definite need for supports to access programs and housing. Participants reported that the system was not user-friendly or recovery-oriented, and that issues of inequitable access, lack of transparency, and disincentives to work resulted in negative mental health outcomes. Navigating the system and associated paperwork was described as creating barriers to accessing and maintaining program eligibility. The system was also described as arbitrary – it was noted that programs were not implemented in a standardized fashion, and that there is a lack of uniformity in the benefits offered by workers to clients. Peer support was described as important for learning about programs and opportunities and how to navigate the system.

"To have to prove how disabled you are, it's ridiculous. In recovery you are supposed to think of yourself as healthy, and yet we have to keep proving how sick we are."
-webinar participant

An important issue raised was the limiting definition of serious mental illness. This prevents many people from accessing support and programs, including supports that would enable them to maintain housing.

Another issue was the lack of services in rural/remote locations, which necessitates travel to an urban centre, often far from home, to access needed services.

Maintaining Housing and Program Eligibility

Participants expressed a need for support and services to maintain their housing. They described situations in which people lose their housing on admission to hospital, or lose their place in programs due to their inability to participate in a program audit. Disincentives to working were noted as non-recovery-oriented practices – people with mental illness who work beyond a certain threshold risk being terminated from programs and jeopardizing needed supports, benefits, etc.

"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 can I afford to keep housing in the future. I need government support to finish school."
-webinar participant

Another major theme of support in maintaining housing was around rent supplements and assistance, and the issue of a **rental gap**. Participants noted that welfare, disability assistance, benefits, and rent supplements were not high enough to maintain adequate housing and meet the costs of daily living, and thus failed to support their recovery.

"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

Participants reported positive outcomes from support groups, as well as a need for increased mental health supportive services to maintain their housing and assist them in their recovery.

"It's very important, those connections and a network of people. I've had the same one for five years and am applying for a community mental health worker, which is another stage for me in my growth…it's very helpful for me personally"
-webinar participant

Peer support in maintaining housing was also noted as a positive and helpful for recovery.

OTHER SYSTEM LEVEL ISSUES

Broader system structure or governance issues included the need to move away from a "one-size-fits-all" approach, and to emphasize helping consumers find meaningful full-time employment through supportive education. The example cited was the need to provide financial and other support services rather than limiting client eligibility and moving clients out of services as quickly as possible.

Consumers expressed the desire for equal representation in decision making and planning – to have a voice and mechanisms in place to ensure meaningful participation. The need for consumer-based language and for consumers' perspective to be taken into account with a more "bottom-up" approach was expressed.

THE MARITIMES

PARTICIPANT PROFILE

There were 10 participants in this webinar, all of whom were people living with mental illness.

HOUSING STOCK

Housing was agreed upon as a top priority and the number one requirement for recovery. Issues of safety, affordability, and choice were noted to be universally valued, irrespective of mental illness.

> "People with mental illness have special needs, but they don't need to stand out in the community. They need affordable housing, safe housing, a crisis house – there needs to be decent landlords and good support agencies that understand the needs [of this population]… We're not all the same, our needs are unique."
> -webinar participant

> "Decent affordable housing is a need for everybody."
> -webinar participant

Clear themes that emerged from the discussion were inadequate housing stock and the need for housing that is safe and affordable. In Charlottetown, P.E.I. there is a lack of one-bedroom apartments. Low incomes and inadequate subsidies make it difficult to secure accommodation in private buildings. Participants noted the need for more public housing to address these affordability and accessibility issues. Additionally, it was mentioned that lack of housing stock and options for this population have given rise to slum-type living situations, where social services make rent payments directly to landlords without consideration for the condition of the housing.

HOUSING PREFERENCES AMONG PEOPLE LIVING WITH MENTAL ILLNESS

In general, participants expressed the need for more housing stock to enable consumer choice. Housing preferences included market rent, public housing, and a scattered model to promote anonymity and decrease stigma. Some participants identified a specific need for one-bedroom units for those aged 18-30 years.

SUPPORTS AND SERVICES

Access to Housing
Issues of access focused on the lack of housing stock, the need for more subsidies, and increased options and choice for people living with mental illness. It was noted that even with subsidies, there was a lack of safe and affordable housing options.

The lack of one-bedroom apartments in Charlottetown, P.E.I. was noted as a gap in housing options, particularly for people aged 18 to 30 years. The attitude of staff, who at times encourage rooming-style living situations despite the housing preferences of consumers, may be viewed as anti-recovery.

Participants reported a gap in housing options for the elderly and aging population of people with mental illness. The stigma in some nursing homes, apparent in their reluctance to accept persons with mental illness, makes it even more problematic for this population to access housing.

The lack of affordable and safe housing stock increases people's vulnerability to exploitation by slumlords. The system must be accountable for the type of housing available to individuals and guard against potential exploitation.

Access to Services/Supports

Equitable access and system transparency were described as issues. The availability of supports is dependent on one's location, and individual workers may interpret or implement policies in different ways.

The issue of transportation was rated second in importance after housing, and was noted to be particularly challenging for those in rural/remote areas. Transportation choice was also noted as a challenge for those in urban areas.

Financial Supports and Policy Issues

A major theme that arose from the webinar was the inadequacy of financial supports. It was noted that social assistance did not increase in line with inflation. Also, those on a rent-geared-to-income model of social assistance or a pension plan do not receive an increase in income in conjunction with rent increases, thus putting a strain on budgets and making it increasingly difficult for those individuals to make rent payments. Participants further highlighted the fact that social assistance does not cover necessary expenses such as laundry or moving costs.

One participant noted a systemic gap in that when youth turn 18 years old, the social assistance income of their parents/guardians is decreased and the youth are considered boarders, whether or not they can or do pay for board. The imposed financial strain is sustained until dependents turn 19 years old and are eligible to apply for social assistance.

Another participant identified social assistance policies that are disincentives to homeownership and contrary to recovery-oriented practice – if a mortgage is paid off, the recipient's income might be decreased to the point of having to consider selling the home and return to renting.

The rental subsidy program was noted as important and recovery-oriented; it increases the amount of income that people living with mental illness receive, and affords both "self-esteem" and a "happy place to live."

Employment Supports and Policies

Recipients of social assistance jeopardize needed support, programs, benefits, etc. if they work beyond a certain threshold, which reflects anti-recovery practices and disincentives to work.

> "There's such a disincentive to… get better… to become employable."
> -webinar participant

Support Service Models, Practices, and Policies

Wraparound supports that are tailored and client-centered were noted to be essential to maintain housing, as well as the inclusion of supports beyond the typical basket of services, such as supports for daily and independent living, and for continuing education and employment.

Community development and peer support were identified as important resources; for example, many clubhouse members reside in the same public housing building and "act as a community and support each other." Peer

advocates, through a clubhouse model that is no longer available in Halifax, were a useful service, as the advocates helped with issues such as housing and tenant's rights.

The clubhouse model, which is recovery-oriented, was specifically noted by participants as beneficial; it helps to support education and volunteer opportunities, increases self-esteem and community integration, helps keep people out of the hospital, and views them as "people, not as mental illnesses."

> "A lot of people with mental illness are very bright people - they just need an opportunity to spread [their] wings."
> -webinar participant

Community integration was also noted as important, both within the larger community and smaller neighbourhood or building communities or peer groups.

Equitable access and system transparency issues were raised by participants with respect to the variance among social workers in the application of rules and relaying information to clients. There was an expressed need to move towards more recovery-oriented practices and attitudes.

> "I didn't ask for my illnesses and when I did my yearly review with my social worker I wanted to go back to school, but because it says on my chart that I may not ever be able to work, they don't want to waste that money. Even if you feel fine about yourself but your social worker tells you you're wasting our money if you want to go back to school, then what's the use?"
> -webinar participant

> "I think so much of it is the individual social worker; my worker has let me get away with murder. But man, there are some social workers out there that wouldn't give you a dime."
> -webinar participant

Participants noted the importance of having supports in place to maintain their housing during hospitalizations.

> "If you have to go back to the hospital it's good to know that when you get out of the hospital you do have a place to go. You don't have to worry about what am I going to do, where am I going to live?"
> -webinar participant

Another issue raised was care for pets during hospitalization. A variety of experiences were shared, ranging from no supports to securing care from a social worker or a clubhouse.

> "I have a cat - he's my best support, he's my buddy."
> -webinar participant

Participants described a gap in service in that some areas lack a crisis or safe house, or a **respite care** facility to be used in place of hospitalization. A participant noted that "not everybody needs to be hospitalized." Brief stints of support for a day or two may be all that are needed, and respite care is preferable to a shelter or hospitalization. Twenty-four hour **crisis services** were noted as essential, though lacking in some areas, with police often the first and only responders. The type and effectiveness of these services, where they are available, varies depending upon location, funding, and staff.

Rural/Remote Issues

Several issues specific to rural/remote areas were raised throughout the webinar. Crisis services were noted as challenging, especially due to the geography, but it was noted that a mobile unit and phone line would be very helpful. The issues of an aging population, migration of young and skilled workers, and transportation were challenges specifically associated with rural/remote areas.

OTHER SYSTEM LEVEL ISSUES

Broader system structure or governance issues included the need for more system transparency, equitable access for consumers, and recovery-oriented, client-centered practices. Inadequate financial and housing supports, and gaps such as those in services for the elderly and youth, need to be addressed. Partnerships between the public and private sector, and a **mixed funding** structure that does not rely solely on government funding, were noted as having the potential to create a safer, cleaner, and more affordable array of housing options. The need to change the current governance and structure of the social assistance program to combat slumlord issues and exploitation was raised as a concern.

THE NORTH

PARTICIPANT PROFILE

There were five participants in the North region webinar, the majority of who were service providers from Yellowknife, Northwest Territories. Other participants included a member of the homelessness coalition, a representative of provincial government, and a provider of a variety of services that were not specifically mental health oriented but included a trauma-recovery service for women. None of the participants were consumers of the mental health system.

HOUSING STOCK

Housing with 24/7 on-site staff consists of approximately five 3- or 4-bedroom homes with four beds per room. Of these, at least two were for persons with psychiatric disabilities. The YWCA is the only supportive housing provider that participants were aware of, though the number of units it contains was unknown. There is some social housing and a shelter system. The hospital in Yellowknife has approximately 30 dedicated psychiatric beds, a significant improvement since the 1970s, when there were no dedicated psychiatric beds.

HOUSING CHALLENGES

Challenges included the very high cost of living, a general population that is under-housed, which worsens the situation for those with mental health issues, and the extremely high cost of building new stock in the North. The many logistical challenges faced in the North are worsened by limited road access (noted for both the Northwest Territories and Nunavut). In the North, participants identified a critical need for ownership, or at least involvement, in the process of designing programs, services, and housing. The North region was viewed as marginalized, and housing was described as a major issue for all of the territories. A participant identified weather conditions as another challenge for the homeless population.

SUPPORTS AND SERVICES

Some housing options provide 24/7 on-site support, while others do not. A worker visits the YWCA to dispense medication; support is very limited, and there are no ACT teams. There are at least two homes (3- or 4-bedroom houses with four beds per room) that are dedicated to psychiatric disabilities, which offer more intense supports with full-time staff. There is also income support, through which rent is paid. It was noted that in the North, there is more psychiatric support for men than for women, and a greater focus on addictions. There was general

consensus that the current systems and programs lack Aboriginal cultural awareness; however, one participant noted that at the grassroots level in some regions, programs and services are attempting to support the culture, language, and practices of communities. The government has replaced non-mental health counsellors in the community with mental health workers.

Needs

Though individuals referred from remote communities typically have intellectual disabilities as opposed to psychiatric disabilities, neither group has access to a range of medical services. The issue of lack of local service and supports in remote areas means that people often have to travel to urban areas such as Edmonton or Winnipeg to seek treatment.

A key challenge faced in the North is the difficulty of recruiting professional services to remote communities, resulting in the need to rely less on the professional system. Participants identified a clear gender bias and noted that women face greater challenges in accessing care. A potential class and age bias in mental health services was also noted by one participant. It was noted that the Euro-based and traditional Aboriginal approaches to mental health are very different, often conflict with one another, and could pose a barrier to women and others in accessing needed care. The stereotyping by health care professionals who assume that the issues of Aboriginal community members are primarily drug or alcohol related was also a concern.

> "When we go to the hospitals, hospitals always put it down to drug and alcohol abuse. It 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

Another issue raised was cultural differences among Aboriginal groups, which could lead to inaccurate pathology of persons who do not respond as expected to programs. A major theme that emerged from the webinar was the need for communities, especially Aboriginal communities, to be involved in program design. The lack of fit between services provided and the cultural context of Aboriginal communities, as well as a general disconnect from the community and government, were identified as concerns.

UNIQUE ISSUES TO THE REGION

Unique issues faced in the North include the Aboriginal population, the need for community involvement in and ownership of planning processes, and rural/remote issues. The rural context and the distribution of the population give rise to unique challenges that require policies specific to that context. The North has limited or non-existent road access; high costs for building housing, specifically housing for those with mental health issues; high costs in general (e.g., fuel, electricity, etc.); and a complex logistical environment. Due to the challenges of the rural context, there is also a need for less reliance on the professional system. It was noted that there are no universities in the North, which decreases the number of funded projects and studies conducted by the Commission. Although there have been many studies in the North, none have translated into changes on the ground.

> "There have been so many studies over the years… and none of them have contributed to services. In 1970 we were saying the same thing as [we are in] 2010."
> -webinar participant

The only new research being done is through the Commission, involving a study on homelessness and mental health in the North. It was noted that, due to the relatively small population in the North, concerns are often viewed holistically instead of individually, and that the population in the North is often marginalized. Any planning

for the North needs to take into account and respond to the unique challenges and context, and ensure community involvement and ownership regarding programs and planning.

OTHER SYSTEM LEVEL ISSUES

Overall, it was noted that the system in the North is very "government directed." Congregate living is typical in mental health, and imposed by the system. There is a need for more self-governance and less top-down approaches to planning and program delivery. The government's mental health strategy does not include a housing strategy; it was suggested it would be helpful if the government would "get out of the way to some extent." Following a study on addictions in the North, the government replaced all community and non-mental health counsellor positions with mental health workers. This was viewed as a mistake and as a "disconnect between the community and government." It was also noted that the government does not contribute to addressing issues of mental health or housing. The existence of Aboriginal self-government in the North was noted, and the need for community ownership of programs, services, and housing was stressed as a major theme.

ONTARIO

PARTICIPANT PROFILE

There were 14 participants in the Ontario webinar, the majority of who were people with lived experience. A case manager, a peer specialist, and a member of a rights coalition also participated.

HOUSING STOCK

Participants agreed that there is a definite housing shortage in Ontario, which exacerbates the housing situation for those with mental health issues. Affordability was also an issue. Lodging homes throughout Ontario were viewed as substandard, providing low quality of life for tenants, and in discord with recovery-oriented practices. A positive example was cited of a peer run housing model with communal living and shared facilities, support from ACT team members, and assistance from housing staff for activities of daily living (e.g., cooking).

HOUSING PREFERENCES AMONG PEOPLE LIVING WITH MENTAL ILLNESS

A range of housing preferences was expressed by participants, including housing that enabled community integration.

SUPPORTS AND SERVICES

Peer Support

> "[We are] a group of people with mental health issues. We have a woodworking shop. We make lawn chairs. We have a café and car wash… We make our own money and we have a lot of fun. **It does keep me out of the hospital.**"
> -webinar participant

Peer support plays an important role in the lives of people with mental illness. Peer-run initiatives located throughout Ontario provide various supports, including assistance with navigating the system, advocacy, and even employment. Peer support and peer-run initiatives were deemed very important to recovery.

Recovery-Oriented Practices

> "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

While most participants agreed that housing is critical to recovery, others considered education and employment also to be essential and to enhance self-esteem. Education is often interrupted with the onset of mental illness, and this negatively impacts the stability and outcomes for that person. Another theme was disincentives built into the system that are anti-recovery.

Accessing Programs and Housing

Participants raised the need for equitable access and a transparent system. Long wait times for services and programs, as well as bureaucracy barriers, were identified as challenges people with mental illness face when accessing the system. A key issue was landlords' stigmatization of people with mental health issues, and "slumlords" who prey on this population. Participants felt that there was a need for more programs and options for people living with mental illness.

MAINTAINING HOUSING AND PROGRAM ELIGIBILITY

The theme of a transparent system and equitable access was also raised with regard to maintaining eligibility for programs and the complex administrative and bureaucratic "hoops" people must "jump through" to access or remain in programs. With respect to people living independently in the community, the programs were "falling short." Accommodations are often located in bad neighbourhoods and in need of support. The issue of financial assistance, which is inadequate to secure affordable, safe, and quality housing and to promote a good quality of life, was viewed as counter to recovery.

OTHER SYSTEM LEVEL ISSUES

Participants expressed the need for the system to be flexible and for services to be tailored to individuals.

Another key theme was "violent" areas, described by a participant as a place where "no one [the police] shows up when someone calls." The police stigmatize these communities and are often not responsive to calls for help. The mentally ill population must often reside in these areas due to low levels of financial support.

> "I called the police and had a police officer say to me, 'you're probably more used to this than me, you go over and deal with it and call us if you can't.'"
> -webinar participant

> "I lived in a building with a lot of violence that went on. Mental health survivors got the blame when it wasn't them at all. A lot of people were not helped…"
> -webinar participant

Also noted was stigmatization by the larger community following negative occurrences. The need for community integration was raised as a solution to this problem.

Another issue that arose was the need for an increase in services available to persons with concurrent disorders, and increased ability of agencies to make referrals from one area to another. The lack of rehabilitation facilities was noted to be reflective of the need for more services, and a source of discouragement for those with concurrent disorders.

The need for early intervention and social change was identified. Early intervention strategies and the promotion of public awareness and de-stigmatization efforts may help mitigate the effects of interrupted education, housing, and income instability. This up-stream approach necessitates wider system change.

QUÉBEC

PARTICIPANT PROFILE

There were five participants in the Québec webinar, all of whom were people living with mental illness. One service provider was also present as an observer only, and did not participate in the webinar.

HOUSING STOCK

A shortage of housing stock was a theme throughout the webinar, as well as a lack of stock that is both affordable and clean. There are low vacancy rates; one participant reported that only eight people per year from the waiting list are placed in supervised apartments.

HOUSING PREFERENCES AMONG PEOPLE LIVING WITH MENTAL ILLNESS

Participants of the webinar reported living in a variety of housing situations, including a foster home, a supervised apartment, HLM (low rent) housing, and private housing. Participants did not express a preference for any particular housing type, though the one participant in foster care expressed a desire to live more independently, specifically, in a supervised apartment. Another participant noted that the government should concentrate more on social housing as an aid to recovery, while another suggested that housing that supports integration back into the community is important for those in crisis and those who have lost their housing.

SUPPORTS AND SERVICES

Peer Support
A theme that emerged was the importance of peer support in the form of an informal network of peers. It was noted that self-esteem, confidence, and self-worth can be negatively impacted by mental illness, and that close friends who are peers help to ameliorate this issue. Supports noted as beneficial included both tangible supports, such as helping with housing maintenance or financial assistance, and emotional supports, such as promoting self-confidence and serving as a confidante.

Family Support
Participants noted that support from family members is sometimes lacking or challenging when family involvement is not supportive of, or conducive to, recovery. Further, there exist certain expectations around the support that a person should receive from family, but it is important to consider that this might not always be provided.

> "My family is closed and against the idea that I would go live in a supervised apartment. My social worker needed to go talk to them to tell them that it would be good for me to go live in an apartment."
> -webinar participant

Recovery-Oriented Practices

Participants emphasized that recovery-oriented practices must be improved upon, especially regarding assistance in finding and maintaining housing, supports for daily living and recovery, and long-term work and education. Several participants reported positive experiences with service providers who were recovery-oriented in their practices and attitudes.

> "I felt supported by mental health organizations; they are the resource-people who help us to see ourselves more positively."
> -webinar participant

> "I met a therapist… He hadn't used the psychiatric approach where they want to put things in your head. He told me that it was possible and he dove down into the dark with me. It's important to have someone who believes in you and believes what you're living through."
> -webinar participant

> "Together these service providers [pharmacy, nurse, social worker, etc.] with me coordinate my treatment plan. The service provider asked me what I wanted, what my dreams were. This is a supportive and hopeful approach, it's not perfect but it works 80-90% of the time."
> -webinar participant

Accessing Programs and Housing

Some participants noted the need for support in accessing housing, while others reported positive experiences with service providers who offer this type of support. Lack of available housing was also noted.

> "It is [the social worker] who showed me my supervised apartment; it's the social worker who helped me find this resource affiliated with transitional housing."
> -webinar participant

There were mixed reports of the availability of supports for entering and staying in the workforce, including educational supports; a few participants reported the availability of some supports, and others reported no supports at all in these areas. One participant identified the need for financial supports to access some of these resources.

> "You have to make contacts for yourself with organizations. It takes patience and we have to be careful with our budgets, we learn despite all the restrictions we have with our illness."
> -webinar participant

> "I'm in a work reintegration program twice a week… educational supports do exist, but I can't afford it."
> -webinar participant

MAINTAINING HOUSING AND PROGRAM ELIGIBILITY

Some participants received help with daily living and maintenance or upkeep of their housing, including housekeeping; the majority did not, and they expressed the need for increased supports which would aid in their recovery.

"HLM housing helps me but there's not enough for upkeep and maintenance. It's okay to get a housing subsidy, but if the person is too sick to take care of it, it can become unhealthy."
-webinar participant

"It would be good for me if there would be a volunteer who would help me with spring cleaning, cleaning the windows and floors, painting, help me to know how to do different tasks to maintain my apartment."
-webinar participant

Participants voiced the need for more long-term supports, not only to maintain housing, but for all aspects of their recovery to help get them "back on track."

"I see a service provider once a week; she helps me manage my emotions, my budget, and my affairs."
-webinar participant

The need for support for people to maintain their housing during difficult or crisis periods, as well as more rehabilitation housing specifically designed for this purpose, was expressed.

OTHER SYSTEM LEVEL ISSUES

The issue of stigma arose, as experienced by a participant during a volunteer placement, and fear in general of being perceived as a "mental case." A participant suggested public education to sensitize people to mental health issues and to decrease stigma and prejudice towards persons experiencing them.

Another issue is the current structure of the system for those with concurrent disorders (both addictions and mental health issues), where the system, far from being recovery-oriented, creates barriers to accessing care. Program restrictions, such as requirements to be working or have an apartment, were noted to pose barriers to accessing or maintaining care.

"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

A participant suggested that financial incentives, in the form of tax credits, for persons with mental health problems, would be beneficial. Another suggested that the government should concentrate on social housing and social intervention budgets to aid people's recovery paths.

Participants also mentioned that participation in governance and on committees is often beneficial and conducive to recovery; it increases self-respect, confidence, and skills, as well as the opportunities to gain experience. The importance of allowing full participation and not just tokenism was noted.

"I was part of a committee where we needed a user. That didn't go well, I didn't feel listened to … It was just for appearances; they didn't want me to open my mouth."
-webinar participant

APPENDIX THREE: SURVEY FINDINGS

PEOPLE LIVING WITH MENTAL HEALTH PROBLEMS AND/OR MENTAL ILLNESS

DESCRIPTION OF SAMPLE

- 330 people living with mental health problems and/or mental illness completed the survey.
- 71% had mental health problems/illnesses, and around 25% had a concurrent disorder.
- All territories and provinces except for the Northwest Territories and Nunavut were represented (See Table 1).
- The greatest representation was from Ontario, followed by British Columbia, Alberta, and Nova Scotia.
- The majority of participants lived in their own apartments, with most living in housing stock that was not solely dedicated to people living with mental health problems and/or addictions (37.8%); see Figure 1 for an expanded listing of housing arrangements.
- 20 respondents identified as Aboriginal, 12 of whom lived in housing that was not dedicated solely to people living with mental health problems and/or addictions.

SATISFACTION WITH LIVING ARRANGEMENT

- Satisfaction was significantly higher among individuals who rent a room (73%) or an apartment (68%) dedicated to people with mental health problems/illnesses or who own their own home (77%). ($\chi^2 = 45.93$, $p = .05$)
- The highest rates of dissatisfaction were among those living with their families, renting a room or an apartment not dedicated to people with mental health problems, those in shelters, and the homeless.
- Primary causes for concern regarding housing arrangement included affordability (29%), maintenance of the physical site (17%), fear of eviction (16.5%), safety (13.5%), and distance from services (13.5%).
- Motivators for people who indicated that they would want to move (50.2%) from their current housing arrangement included more independence (41.5%), less distance from family and friends (34%), more mental health services (33%), more physical health supports (24.5%), and less distance to public transportation (21%).
- There were significant associations by province and territory with the reasons that motivated people to move. In Québec and Ontario, the desire to be closer to friends and family, and to public transportation, were significant factors, while these were non-issues in Prince Edward Island and Saskatchewan. The need for on-site support workers was a significant motivator in Saskatchewan, Québec, and the Yukon.

CHALLENGES AND SUPPORTS INFLUENCING FINDING, ACCESSING, AND MAINTAINING HOUSING

- Affordability (68%), quality (45%), safety (42%), access (39%), and necessary supports (26%) were cited most frequently as challenges to appropriate housing.
- Responses to open-ended questions revealed additional challenges such as house cleaning, long waiting lists to access housing, and accessing financial assistance.

- Though not statistically significant, trends 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 were reported by this sub-population.
- Affordability was a major issue in many provinces: more than 68% of the respondents in Quebec, British Columbia, Saskatchewan, Ontario, Nova Scotia, and Alberta cited this as a challenge.
- A series of independent sample t-tests revealed that, among those who used the following services – housing support services, mental health services, and services of a community nurse – there was greater agreement with the statement that the services they used helped them maintain housing when compared to those who did not avail themselves of these services. Further analyses using multiple regression showed that receipt of housing support services was the strongest predictor of success in maintaining housing (on its own, $R^2 = .32$)[7].
- Housing supports, as identified by respondents in response to an open-ended question, included support workers, case managers, peer support, income and employment support, housekeeping, community outreach, budgeting guidance, assistance with healthy living, and availability of on-site counselling.
- Income support was cited most frequently as one of the most important support services that should be offered by housing programs. This was followed by access to healthy, affordable food, mental health services, a family doctor, and employment support (see Figure 2 for complete list).
- Identification of assistance with dealing with landlords as an important support need was significantly associated with housing arrangements where people living with mental illness were renting a subsidized apartment (frequency 93.8%; $\chi^2 = 14.14$, $p = .02$).

RECOMMENDATIONS FOR IMPROVING HOUSING

- 82% of respondents agreed with the statement that housing and supports need to be adequately funded to help people keep their housing.
- 81% agreed with the statement that increasing housing support options with subsidies based on income are needed.
- 80% agreed with the statement that more housing for single people is required (for a complete listing of the most embraced recommendations, see Table 2).
- Aboriginal participants echoed the above recommendations.
- The recommendation that more housing for single people is needed was significantly associated with Aboriginal status ($\chi^2 = 5.39$, $p = .02$); all Aboriginal participants were in agreement with this recommendation.

[7] $F(1, 124) = 57.04$, $p < .001$

Table 1. *Consumer representation by province/territory.*

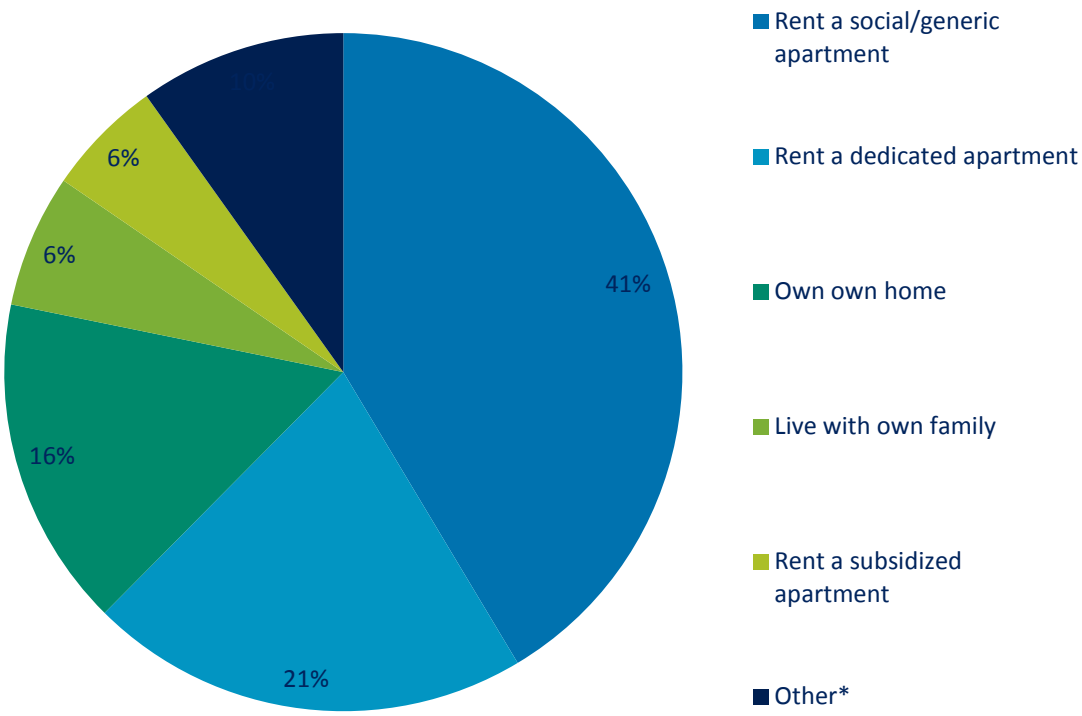
Province	Frequency (n)	Percentage (%)
Alberta	22	6.7
British Columbia	73	22.1
Manitoba	4	1.2
New Brunswick	3	0.9
Newfoundland and Labrador	11	3.3
Nova Scotia	19	5.8
Ontario	154	46.7
Prince Edward Island	5	1.5
Quebec	15	4.5
Saskatchewan	16	4.8
Yukon	3	0.9

Table 2. *Consensus with list of recommendations presented.*

Recommendations	Percentage (%)
Supports are needed to help prevent eviction of people with mental health or addictions issues	76.7
More home ownership options are needed for people living with mental health problems.	63
More housing for single people is needed.	79.1
Increase housing options (rent and owned) where the rent or mortgage is subsidized based on your income.	80.9
Put more effort into building new housing instead of research and planning.	68.8*
Power needs to be shared between tenants/residents of the housing and the operators of the housing	51.8*
People should have choice and freedom about if they want treatment - it should not be a condition of having the housing.	55.2*
People need to be empowered by staff, not directed by them.	67.6
People need access to peer support.	72.7
Housing and supports need to be adequately funded to help people keep their housing.	81.5
Have housing options specifically for people that aren't stable	67.9
Respite options are needed to give people short-term support instead of only hospitals.	70.3
Supports are needed to help build a sense of community	74.2
Social/recreation opportunities are needed to help build a sense of community	70.6
Rapid access to disability and income replacement programs are needed.	73.3

* Significant difference between consumers and family members (please see Findings from Family Member surveys)

Figure 1. *Percentage of participants that lived in the various housing arrangements*[8].

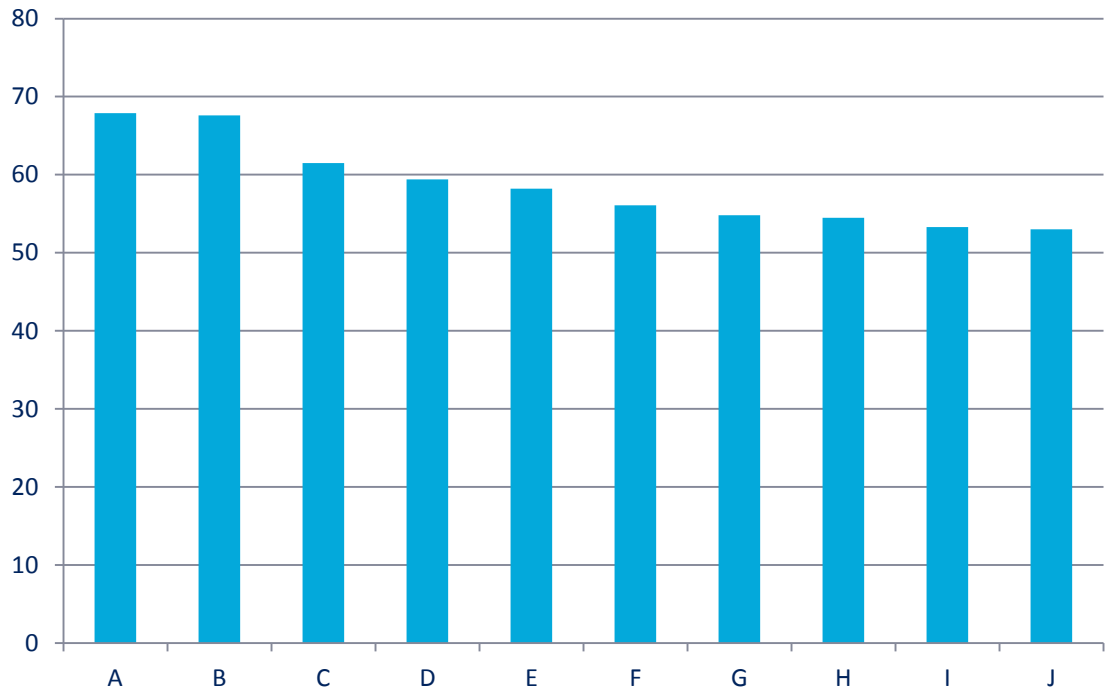


***** "Other" includes: senior's home, co-operative housing, living with a family outside their own, friend's place, shelter, care facility, live with extended family, transitional housing, clubhouse, and homeless.

** each "Other" subcategory equals ≤1.3%.

[8] Not all arrangements of housing are exclusive categories; some were raised by participants and not part of the original questionnaire.

Figure 2. *Essential support services rank ordered by frequency (n = 330).*



A – income supports; **B** – access to healthy, affordable food; **C** – mental health services; **D** – family doctor; **E** – employment support; **F** – life skills training; **G** – education support; **H** – recreational activities; **I** – access to supports that help people find housing, including a central point where you can apply for housing; **J** – assistance in dealing with landlords

FAMILY MEMBERS

DESCRIPTION OF SAMPLE

- 183 family members completed the survey.
- The majority were family members of persons with a mental health problem/illness only (61%), while 34% were family members of persons with a concurrent disorder.
- All territories and provinces except for Northwest Territories and Prince Edward Island were represented (See Table 3).
- The greatest representation was from Ontario, followed by British Columbia, Saskatchewan, and Alberta.
- More than 31% of the respondents had a family member with mental illness living with them or someone in their family (see Figure 3), and around 30% had family members renting an apartment that was not meant only for people living with mental health problems and/or addictions.
- Nine respondents identified as Aboriginal.

SATISFACTION WITH LIVING ARRANGEMENT

- The most widely held reasons for dissatisfaction with a family member's living situation were affordability (21%), lack of safety (16.5%), fear of eviction (16.5%), maintenance of physical site (14%), and distance from family and friends (13%).
- Affordability, fear of eviction, and lack of safety were the most important concerns in British Columbia and Saskatchewan.
- Motivators for people who indicated that their family members would move to a different setting if available included more mental health services (36%), on-site support workers (31%), more independence (29%), less distance to friends and family (22%), and less distance to public transportation (13%).
- The need for more mental health services was most often indicated by respondents whose family members were living in a place not meant for people with mental health problems and by respondents whose family members were living with them.
- Independence was more frequently reported as a need by respondents who had family members living with them or with other family members, as was the need for on-site support workers[9].
- Provincially and territorially, the need for more mental health services was most reported by respondents with family members living in Saskatchewan (6 of 8 respondents) and British Columbia (70.8%).
- The desire for more independence was most highlighted by respondents for their family members who live in Ontario (48%) and Saskatchewan (5 of 8).
- There was a significant association between the need for on-site support workers and province/territory (χ^2 = 16.87, $p < .03$), with respondents from Alberta and Saskatchewan noting that it would be an important support for their family members.

CHALLENGES AND SUPPORTS INFLUENCING FINDING, ACCESSING, AND MAINTAINING HOUSING

- Lack of affordable housing (57%), supports needed to stay in a home (48%), safety concerns (42%), quality of housing (40%), access to transportation and shopping (28%), and discrimination when trying to find/keep housing (26%) were cited as the most important challenges.
- There was a significant association between affordable housing and province/territory, with those in British Columbia and Saskatchewan finding it a significant problem, followed by Québec and Ontario (χ^2 = 19.38, p = .04).
- Analysis of open-ended items revealed other challenges that included housing for minors, long waiting lists for low-income/subsidized housing, access to high support housing, stable housing to prevent relocation, and self-confidence to live on one's own.
- In terms of services and supports, participants reported that health-related services (family doctor, mental health services, and community nurse) were most utilized by their family members, while housing-related services (housing support, meal preparation, and housekeeping services) were the most difficult to access.
- A series of independent sample t-tests revealed that among those who used the following services – housing support services, mental health services, and services of a community nurse – there was greater concurrence with the statement that the services they used helped them maintain housing when compared with those who

[9] This indicates that living with family members is not the most ideal in terms of independence. It also denotes that there are specific supports like mental health supports and more housing with on-site supports that could address the needs of families who currently have their family members with mental illness living with them. The needs of this caregiver group need to be addressed.

did not avail themselves of these services. Further analyses using multiple regression showed that housing support services were the strongest predictor of success in maintaining housing (on its own, $R^2 = .15$)[10].

- Income support was cited most frequently as one of the most important supports that should be offered by housing programs. This was followed by medication management, mental health services, and access to healthy, affordable food (see Figure 4 for a complete list).
- There were significant provincial differences in support service needs, with respondents from Manitoba and New Brunswick underscoring a significant need with regards to meal preparation services, which was a non-issue in Newfoundland and Labrador and Québec. Nova Scotia, Manitoba, and British Columbia underscored the need for access to healthy, affordable food.

RECOMMENDATIONS FOR IMPROVING HOUSING

- 80% of respondents agreed with the statement that supports are needed to help prevent eviction.
- 77% agreed with the statement that housing and supports need to be adequately funded to help people keep their housing.
- 76% agreed with the statement that social/recreational opportunities are needed to help build a sense of community.
- 75% agreed with the statement that increasing housing support options with subsidies based on income is needed.
- 75% concurred that respite options, rather than just hospitals, are needed to give people short-term support (for a complete list of recommendations, see Table 4).

Table 3. *Participant representation by province/territory.*

Province	Frequency (n)	Percentage (%)
Alberta	14	7.7
British Columbia	34	18.6
Manitoba	2	1.1
New Brunswick	6	3.3
Newfoundland and Labrador	7	3.8
Nova Scotia	5	2.7
Nunavut	2	1.1
Ontario	88	48.1
Quebec	5	2.7
Saskatchewan	16	8.7
Yukon	1	0.5

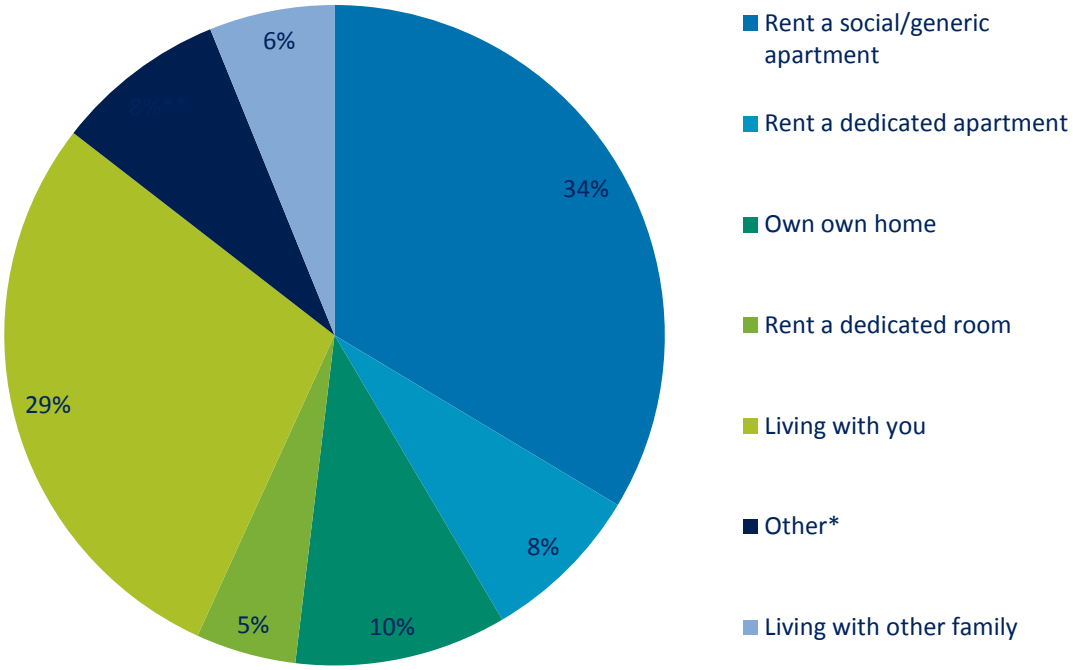
[10] $F(1, 54) = 9.65$, $p < .01$.

Table 4. *Consensus with list of recommendations presented.*

Recommendations	Percentage (%)
Supports are needed to help prevent eviction of people with mental health or addictions issues.	79.8
More home ownership options are needed for people living with mental health problems.	57.4
More housing for single people is needed.	73.8
Increase housing options (rent and owned) where the rent or mortgage is subsidized based on your income.	75.4
Put more effort into building new housing instead of research and planning.	60.1*
Power needs to be shared between tenants/residents of the housing and the operators of the housing	38.8*
People should have choice and freedom about if they want treatment - it should not be a condition of having the housing.	33.9*
People need to be empowered by staff, not directed by them.	61.7
People need access to peer support.	68.3
Have housing options specifically for people that aren't stable	69.9
Housing and supports need to be adequately funded to help people keep their housing.	76.5
Supports are needed to help build a sense of community	73.8
Social/recreation opportunities are needed to help build a sense of community	76
Respite options are needed to give people short-term support instead of only hospitals.	74.9
Rapid access to disability and income replacement programs are needed.	70.5

*Significant difference between consumers and family members

Figure 3. *Percentage of participants' family members that lived in the various housing arrangements*[11].

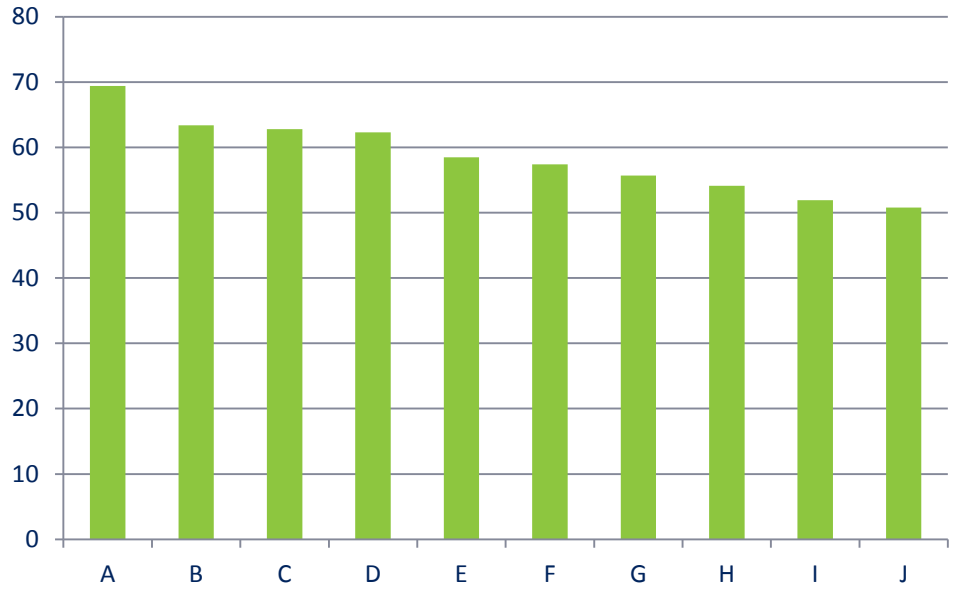


***** "Other" includes: homeless, friend's place, living with family outside their own, living with parents, hospital, group home, respite home, and shelter.

** each "Other" subcategory equals ≤1.6%.

[11] Not all arrangements of housing are exclusive categories; some were raised by participants and not part of the original questionnaire.

Figure 4. *Essential support services rank ordered by frequency (n = 183).*



A – income supports; **B** – medication management; **C** – mental health services; **D** – access to healthy, affordable food; **E** – life skills training; **F** – employment support; **G** – access to supports that help people find housing, including a central point where you can apply for housing; **H** – recreational activities; **I** – community activities; **J** – meal preparation services

HOSPITALS

DESCRIPTION OF SAMPLE

- 35 hospital administrators and/or clinical leads completed the questionnaire.
- The majority of the participants were from Ontario. There were no participants from the territories or from Prince Edward Island (see Table 5 for participation by province).
- 22 participants were from general hospitals with designated inpatient mental health services, nine worked for a dedicated mental health hospital, and one belonged to a Health Authority.
- Communities served ranged from large metropolitan communities to small towns. Though none of the hospitals that participated were located in rural areas, 14.3% of participants indicated that their hospital served rural/remote communities (see Table 6).

CHALLENGES AND GAPS

- 61.3% of respondents considered high support housing a priority that needs to be addressed. This was followed by supports for people with dual diagnoses, concurrent disorders, complex mental health and acute care issues, and transitional-aged youth services.
- Transitional-aged youth: the gap between the needs of transitional youth and the available community supports was highest in Nova Scotia (3 of 3 respondents), Ontario (74%), and New Brunswick; the provincial association was significant ($\chi^2 = 16.35$, $p < .04$).

- There was a significant association between need for supports for the aging population and the provincial location of the hospital, with all participants from Alberta, British Columbia, Newfoundland and Labrador, and Québec, along with 84% of participants from Ontario, highlighting this as a concern.
- Integrated mental health and housing services, treatment and support for people with dual diagnoses, assertive community treatment, treatment for people with concurrent disorders, drug or alcohol treatment, and housing support are among the top support needs that are not being met (for a complete listing see Table 7 and Figure 5).

BARRIERS IN DISCHARGING CLIENTS

The ten most prevalent barriers reported based on frequency are as follows:

1. Existing service capacity is not adequate to meet demand (91.4%)
2. Funding levels do not support provision of additional supports (82.9%)
3. Integrated mental health and housing services (68.6%)
4. Support needs are not quantified (68.6%)
5. Existing service models do not meet criminal justice sector support needs (62.9%)
6. Existing service models do not meet youth-specific support needs (62.9%)
7. Staff skill level and/or staff training is not sufficient to meet all support needs (62.9%)
8. Exclusionary criteria acts as a barrier to meeting needs (62.9%)
9. Staff skill level in private accommodations (e.g., lodging homes) is insufficient to meet people's needs (62.9%)
10. Fragmented/uncoordinated service delivery systems (57.1%)

KEY FEATURES IN DISCHARGE PLANNING THAT FACILITATE ACCESS TO HOUSING AND RELATED MENTAL HEALTH SERVICES

- Relationships between the hospital and community providers (85.7%)
- Engagement of clients in discharge planning (77.1%)
- Engagement of providers in discharge planning (74.3%)
- Engagement of family in discharge planning (74.3%)
- Adequate funding of housing and supports (68.6%)

Additional factors noted in open-ended responses were clearly defined roles and responsibilities between partners and long-term relationships with staff at community agencies.

RECOMMENDATIONS

The following recommendations were most endorsed by the respondents:

1. Development of a housing strategy (91%)
2. Adequate funding of a full continuum of housing and supports (89%)
3. Adequate income for clients in order to afford housing options (89%)
4. Cross-ministerial partnerships for planning and funding purposes (86%)

5. Availability of high support housing such as 24/7 onsite capacity (86%)
6. Change government policy of how existing funds can be used to increase flexibility (83%)
7. Availability of off hour supports to clients in the community (83%)
8. Increase subsidized housing stock (77%)
9. Adequate training of staff (74%)

Table 5. *Participants by province.*

Province	Frequency (n)	Percentage (%)
Alberta	1	2.9
British Columbia	3	8.6
Manitoba	2	5.7
New Brunswick	1	2.9
Newfoundland and Labrador	1	2.9
Nova Scotia	3	8.6
Ontario	19	54.3
Quebec	2	5.7
Saskatchewan	2	5.7

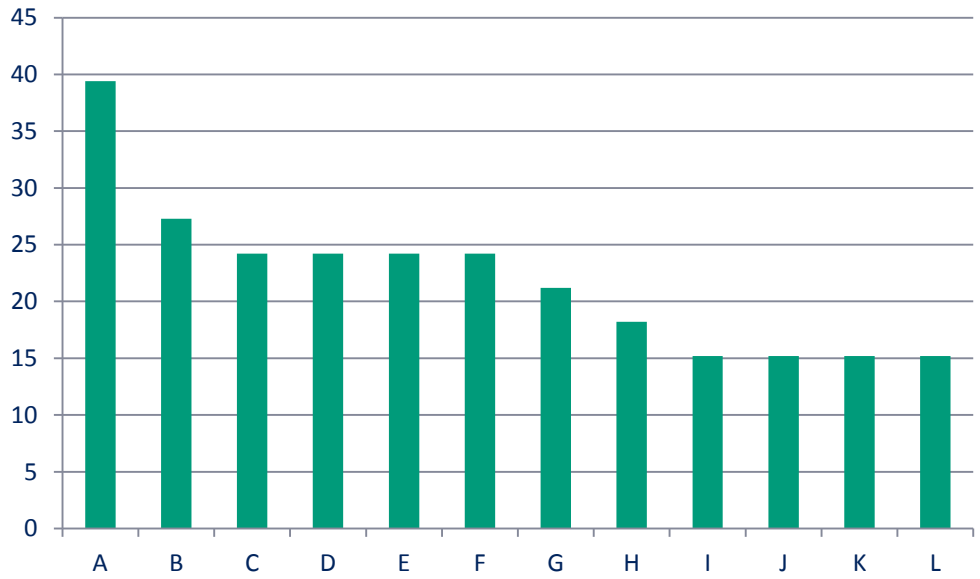
Table 6. *Communities served.*

Community	Frequency (n)	Percentage (%)
Large metropolitan (1,000,000+)	7	20.0
Medium metropolitan (250,000 – 999,999)	5	14.3
Small metropolitan (50,000 – 249,999)	15	42.9
Small city (20,000 – 49,999) adjacent to metropolitan area	2	5.7
Small city (20,000 – 49,999) not adjacent to metropolitan area	1	2.9
Small town (2,500 – 19,999) adjacent to metropolitan area	1	2.9
Small town (2,500 – 19,999) not adjacent to metropolitan area	3	8.6

Table 7. *Support needs that are not being met in order of importance*[12] *(n = 35).*

	Support Need	Score	Number of "most important" selections
1	Integrated mental health and housing services	13	3
2	Treatment/support for people with dual diagnoses	9	3
3	Assertive Community Treatment (ACT)	8	4
3	Treatment/support for people with concurrent disorders	8	1
3	Drug or alcohol treatment – residential model	8	1
3	Housing support	8	1
7	Short-term case management/Transition/Discharge planning	7	3
8	24-hour on-site support	6	1
10	Crisis beds/Safe beds/Respite beds	5	3
10	Mobile crisis services	5	1
10	Employment support	5	1
10	Service/supports related to aging	5	0

Figure 5. *The most important support needs not being met*[13] *(n = 35).*



A – integrated mental health and housing services; **B** – treatment/support for people with dual diagnosis; **C** – assertive community treatment; **D** – treatment/support for people with concurrent disorders; **E** – drug or alcohol treatment: residential model; **F** – housing support; **G** – short-term case management/transition/discharge planning; **H** – 24-hour on-site support drug or alcohol treatment: community-based; **I** - crisis beds/safe beds/respite beds; **J** – mobile crisis services; **K** – employment support; **L** – services/supports related to aging

[12] Score indicates the number of times an item was selected as one of the five most important support needs not being met
[13] Scores indicate the percentage of participants that selected the item as one of the five most important support needs not being met

HOUSING PROVIDERS

DESCRIPTION OF SAMPLE

- 96 housing providers completed the questionnaire. One-third of the sample indicated that they were mental health service providers as well.
- While all provinces were represented in the sample, the Yukon and Nunavut were not represented among the territories (see Table 8).
- Most housing providers had a municipal (46%) or regional mandate (35%), while 11.5% had a provincial mandate and 3% a national mandate.
- Communities served ranged from large metropolitan communities to rural/remote communities, with 17 housing providers serving rural/remote communities[14] (see Table 9). Many housing providers were from agencies that served more than one community.
- 58.3% of the housing providers reported that all of their housing was dedicated, 27.1% said that some or most of their housing was dedicated, and 12.5% reported none of their housing stock was dedicated to people with mental illnesses, concurrent disorders, or substance use issues. The three available categories were 1) dedicated housing; 2) mixed models; and 3) social housing.
- Funding was from territorial or provincial governments for 60% of the housing providers, while almost 40% reported that rents were a budgetary source (see Table 10 for complete list of funding sources; see Figure 7 for percentages of funding from the most common sources).

CHALLENGES AND GAPS

- Both access and fit were highlighted as challenges by housing providers, as 78% reported that there was not enough housing stock while 71% reported that the models available were limited.
- More than half the housing providers indicated that extended stays in acute care beds was an issue.
- Support needs identified as crucial by housing providers were supports for complex mental health and acute care issues, dual diagnoses, high support housing, a social determinants of health approach to treatment and support, and stigma reduction work targeting landlords.
- Social providers reported the least integration between mental health services and housing providers (M = 1.67). Mixed model providers reported slightly more integration (M = 2.09) while dedicated providers indicated the most integration (M = 2.35)[15].
- Insufficient funding (79%); lack of safe, affordable housing (74%); and inadequate supports for aging individuals aging (62.5%) were the top concerns with long-term implications.
- 50% of housing providers reported that they have inadequate funding to maintain the housing they provide. This was because funding models do not incorporate sufficient dollars for maintenance (58%), maintenance costs exceed budget availability (54%), and buildings are run-down and capital dollars for repairs are inadequate (44%).

[14] Please note that this is not a group that exclusively services the rural/remote communities. In most cases the mandate also covers rural/remote communities.

[15] Integration was measured using a 4-point scale with higher scores reflecting greater integration. A one-way ANOVA, which was conducted on the level of integration by the dedication of housing providers, revealed a significant difference between the three dedications, $F(2, 84) = 3.85$, $p = .03$. The strength of the relationship, as assessed by η^2, was small, with dedication accounting for 8% of the variance in the level of integration.

- 35% of the respondents cited lack of transitional housing options as a concern.
- 24-hour on-site support, crisis beds, integrated mental health and housing services, housing supports, and support for people with concurrent disorders were among the top five support needs reported by housing providers as not being met with regards to the clients that they serve (see Table 11 and Figure 6).
- For remote providers, transition-aged youth services was a significant support need that was not being met (67%).
- There was a significant association between one barrier, support needs are not part of organizational mandates, and housing model ($\chi^2 = 18.51$, $p < .001$). Social housing providers indicated that this was a great barrier.
- There were significant agency and regional gaps identified for a number of populations/services. The highest agency gaps existed for people with concurrent disorders, mental health problems, and seniors. Regional gaps were also highest for individuals with mental health problems and concurrent disorders; however, they were also exponentially high among homeless persons (see Figure 8 for a listing of the existing agency and regional gaps by population).
- An issue that was more prevalent in remote communities was that of youth-specific needs (not met by existing service models). 83.3% of remote providers reported this as a barrier preventing people from meeting support needs that would assist them in retaining housing, as compared to 35.6% of non-remote providers ($\chi^2 = 5.42$, $p = .02$).

CULTURE-SPECIFIC CHALLENGES

- Only 26% of the housing providers indicated that they were able to meet the cultural needs of their clients, while 61% indicated that they were able to partially meet cultural needs and 8% reported an inability to meet cultural needs.
- 34% reported that there were inadequate staff and/or skill levels to provide culturally competent services.

POPULATION-SPECIFIC CHALLENGES

- **Concurrent Disorders**: There was a significant association between the provinces and territories and the gap identified with regards to the needs of people with concurrent disorders and services available to them. All of the housing providers from Alberta, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Québec, and the North West Territories identified this as a significant gap ($\chi^2 = 18.18$, $p = .05$).
- Support for people with concurrent disorders was cited as the most crucial new and emerging support need by 56% of the housing providers.
- **Diverse populations**: Dedicated housing providers reported higher rates in gaps between client needs and their agency's services for services for Aboriginal persons ($\chi^2 = 8.20$, $p = .02$) and Lesbian, Gay, Bisexual, and Transgender populations ($\chi^2 = 5.61$, $p = .06$). This indicates that dedication needs to take into account diversity and the needs of sub-populations who are further marginalized.
- **Lack of supports for individuals aging in place**: 83% of housing providers from Ontario reported this as a concern, and this was also reflected in Saskatchewan, Manitoba, and Alberta.
- **Transitional-Aged Youth**: There was a significant association between housing model and the mental health support needs of transitional-aged youth, with more social providers citing this as a need than other providers.

STAFF TRAINING NEEDS

Housing providers prioritized the following training and learning needs:

- Community-based management of mental illness (56.3%)
- Support for concurrent disorders (54.2%)
- Behaviour management and modification (49.0%)
- Better practice models (44.8%)
- Cultural Competence (32.3%)

Eight out of the 12 social housing providers indicated that orientation to better practice models was a significant training need; this was the only training need that had a significant association with type of housing model (i.e., dedicated, mixed, social housing).

KEY FEATURES OF HOUSING AND RELATED SUPPORT MODELS THAT FACILITATE ACCESSING AND MAINTAINING HOUSING

- Subsidized/rent-geared to income housing (80.2%)
- Flexible and adaptable supports (76.0%)
- Continuum of housing options (67.7%)
- Transitional housing (47.9%)
- 24/7 high support housing (46.9%)
- Off-site supports (44.8%)
- Harm reduction housing models (42.7%)
- Low barrier (on-site substance use allowed within housing) (30.2%)

RECOMMENDATIONS

The following recommendations were most endorsed by the housing providers:

1. Adequate funding of a full continuum of housing and supports (83.3%)
2. Development of a housing strategy (75.0%)
3. Increase subsidized housing stock (74.0%)
4. Change government policy of how existing funds can be used to increase flexibility (71.9%)
5. Funding for community-based services (66.7%)
6. Cross-ministerial partnerships for planning and funding purposes (54.2%)
7. Development of supports for the aging population (52.1%)
8. High degree of consumer involvement in decision-making (42.7%)
9. Development of partnerships with funders (40.6%)

Remote providers were more accepting of two recommendations than were non-remote providers:

- Adequate training of staff (support from 83.3% of remote providers and 34.4% of non-remote providers; $\chi^2 = 5.74$, $p = .02$)
- Identifying lead agencies to address housing and support needs (support from 83.3% of remote providers and 36.7% of non-remote providers; $\chi^2 = 5.12$, $p = .02$)

Table 8. *Housing provider responses by province/territory.*

Province	Frequency (n)	Percentage (%)
Alberta	4	4.2
British Columbia	17	17.7
Manitoba	4	4.2
New Brunswick	2	2.1
Newfoundland and Labrador	4	4.2
Northwest Territories	1	1.0
Nova Scotia	2	2.1
Ontario	53	55.2
Prince Edward Island	2	2.1
Quebec	2	2.1
Saskatchewan	1	1.0

Table 9. *Communities served by the housing providers.*

Community	Frequency (n)	Percentage (%)
Large metropolitan (1,000,000+)	27	28.1
Medium metropolitan (250,000 – 999,999)	29	30.2
Small metropolitan (50,000 – 249,999)	19	19.8
Small city (20,000 – 49,999) adjacent to metropolitan area	10	10.4
Small city (20,000 – 49,999) not adjacent to metropolitan area	17	17.7
Small town (2,500 – 19,999) adjacent to metropolitan area	3	3.1
Small town (2,500 – 19,999) not adjacent to metropolitan area	9	9.4
Rural (less than 2,500) adjacent to metropolitan area	2	2.1
Rural (less than 2,500) not adjacent to metropolitan area	6	6.3
Predominantly rural (no urban settlements in area)	2	2.1
Remote (less than 2,500 with minimal or no road access)	4	4.2
Northern Hinterland	3	3.1

Table 10. *Percentage of housing providers that receive funding from various sources.*

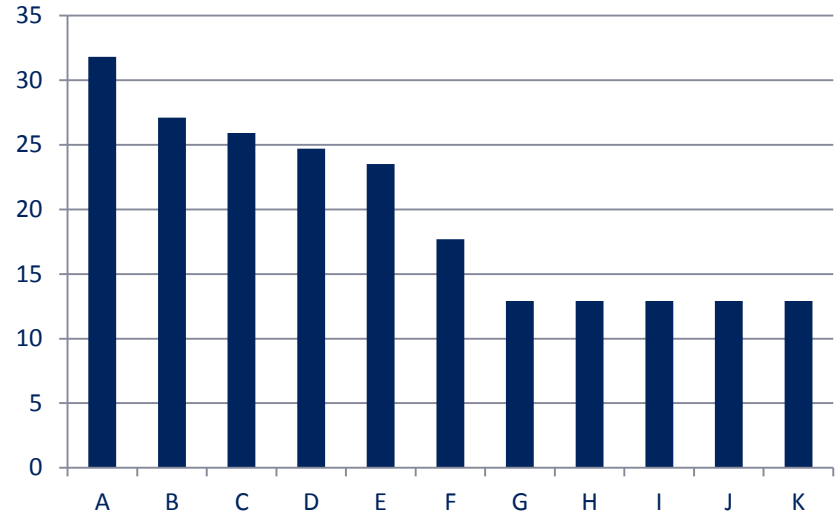
	Housing Model Type		
Funding Source	**Social**	**Mixed Model**	**Dedicated**
Federal government	30.0	40.0	22.0
Provincial or territorial government	40.0	68.0	78.7
Regional health funding	9.1	28.0	32.7
Regional housing funding	0	4.0	4.0
Municipal government	30.0	0	17.4
Private donations	8.3	16.0	12.5
Foundations	0	28.0	15.4
Social enterprise	0	16.0	5.8
Rents	36.4	50.0	38.0
General fundraising	16.7	24.0	20.0

Table 11. *The ten, most important support needs not being met by housing providers*[16] *(n = 96).*

	Support Need	**Score**	**Number of "most important" selections**
1	24-hour on-site support	27	7
2	Crisis beds/Safe beds/Respite beds	23	7
3	Integrated mental health and housing services	22	5
4	Housing support	21	9
5	Treatment/support for people with concurrent disorders	20	8
6	Intensive Case Management (ICM)	15	3
10	Drug or alcohol treatment – residential model	11	4
10	Treatment/support for people with dual diagnoses	11	4
10	Intensive mental health treatment (i.e., options instead of ACT teams)	11	2
10	Transition-aged youth services (i.e., aged 16 to 24)	11	1
10	Drug or alcohol treatment – community based	11	0

[16] The score indicates the number of times an item was selected as one of the five most important support needs not being met.

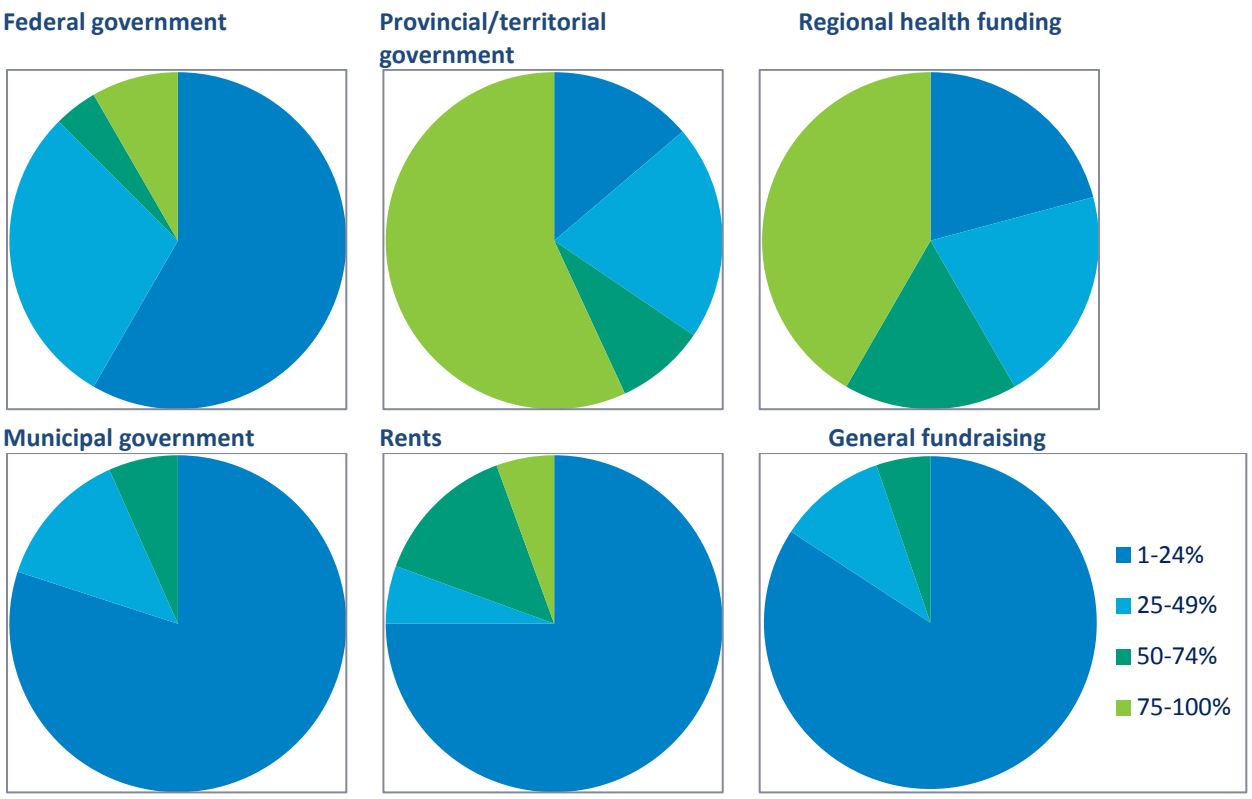
Figure 6. *The most important support needs not being met by the housing providers*[17] *(n = 96).*



A – 24-hour on-site support; **B** – crisis beds/safe beds/respite beds; **C** – integrated mental health and housing services; **D** – housing support; **E** – treatment/support for people with concurrent disorders; **F** – intensive case management; **G** – drug or alcohol treatment: residential model; **H** – treatment/support for people with dual diagnosis; **I** - intensive mental health treatment (i.e., options instead of ACT teams); **J** – transition-aged youth services (i.e., aged 16 to 24); **K** – drug or alcohol treatment: community-based

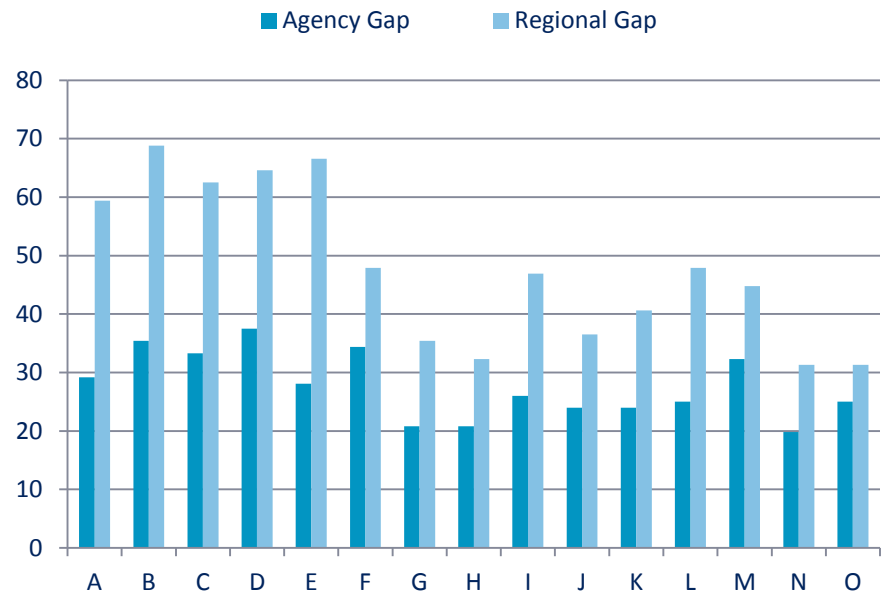
[17] Scores indicate the percentage of participants that selected the item as one of the five most important support needs not being met.

Figure 7. *Percentage contributions to total budget from various funding sources.*



Clockwise from top left: federal government funding (n = 24); provincial/territorial funding (n = 58); regional health funding (n = 24); municipal government funding (n = 15); rents (n = 36); and general fundraising (n = 19)

Figure 8. *Percentage of housing providers that indicated a regional or agency gap between the available mental health services and the population.*



A – people living on low income; **B** – people with mental health problems; **C** – people with mental illness; **D** – people with concurrent disorders; **E** – people who are homeless; **F** – seniors; **G** – gender-specific services for women; **H** – gender-specific services for men; **I** – transition-aged youth (i.e., aged 16-24); **J** – families; **K** – Aboriginals; **L** – people with involvement in the criminal justice system and who have mental health problems; **M** – people with dual diagnoses; **N** – LGBT population; **O** – immigrants and newcomers to Canada

MENTAL HEALTH SERVICE PROVIDERS

DESCRIPTION OF SAMPLE

- 216 mental health service providers completed the questionnaire. Of this sample, 21 indicated that they were housing providers as well.
- While most provinces and territories were represented in the sample, there was no representation from Nunavut or Prince Edward Island (see Table 12 for representation by province).
- Most providers had a municipal (32%) or regional mandate (46%), while 11.6% had a provincial mandate and 2.3% a national mandate.
- Communities served ranged from large metropolitan communities to rural/remote communities, with 87 mental health service providers serving rural or remote communities[18] (see Table 13). Many service providers were from agencies that served more than one community. 25 providers indicated that they served a remote community and/or a community that was situated in the Northern Hinterland.

[18] Please note that this is not a group that exclusively services the rural/remote communities. In most cases the mandate also covers rural/remote communities.

- The agencies were dedicated to serving a number of different populations including those with mental illness, mental health problems, concurrent disorders, and substance use issues (see Table 14).
- Almost 42% of service providers reported that funding was from provincial or territorial governments.

CHALLENGES AND GAPS

- Funding levels that do not support the provision of additional support (72%) and the inadequacy of the existing service capacity (59%) were seen as the greatest barriers to assisting people with regards to retaining their housing. Lack of adequate income and/or financial support was also identified as a significant barrier in response to an open-ended item.
- Lack of safe, affordable housing (83%), insufficient funding (72%), lack of transitional housing (59%), insufficient staff availability to support individuals in their homes (50%), insufficient outreach teams/off-site services (48%), and supports for individuals aging in place (47%) were identified as the topmost concerns with long-term implications.
- Accommodating a transition from one housing context to another based on needs was considered difficult by 47% of service providers. Smaller agencies reported significantly greater rates of difficulty than did larger agencies.
- The need for transitional housing was a significant concern in a number of provinces, most notably in Saskatchewan, Québec, Nova Scotia, and Newfoundland and Labrador ($\chi^2 = 20.95$, $p = .02$).
- Insufficient outreach teams and off-site services were cited as a concern in Nova Scotia, the Yukon, Saskatchewan, and Québec ($\chi^2 = 30.10$, $p = .001$).
- Housing and related mental health support needs identified as crucial by service providers were supports for people with concurrent disorders, holistic determinants of health approach to treatment and support, high support housing, support for people with dual diagnoses, and transition-aged youth services.
- Crisis beds, integrated mental health and housing services, housing supports and support for people with concurrent disorders, and 24-hour onsite supports were among the top five support needs reported by mental health service providers as not being met with regards to the clients that they serve (see Table 15 and Figure 9 for complete listing).
- Consistent with reports from housing providers, a divide existed between remote and non-remote mental health service providers regarding the need for transition-aged youth services ($\chi^2 = 4.06$, $p = .04$). The issue more frequently resonated with remote providers (48.0%) than non-remote providers (28.3%). 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.
- Peer support, which was ranked 16th from the 60-item support need list, was significantly associated with provinces and territories ($\chi^2 = 21.78$, $p = .02$). The majority of respondents from New Brunswick (3 of 4 respondents), Québec (3 of 4), Nova Scotia (6 of 10), and Saskatchewan (3 of 5) reported that the need for peer support was not being met. Service providers from British Columbia and Ontario reported the gap at a lesser rate, with 27.0% and 25.7% of respondents from each province, respectively, indicating a gap.
- 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 reported significantly more by remote providers than non-remote providers. Issues related to existing service models not meeting aging needs, criminal justice support needs, culture-specific needs, and gender-specific needs; the non-existence of inter-agency partnerships; a lack of sufficient staff training and/or skill level; and the fragmentation of service delivery systems were all more frequently reported as barriers by remote providers ($p \leq .05$).

CULTURE-SPECIFIC CHALLENGES

- Only 15% of mental health service providers indicated that they were able to meet the cultural needs of their clients, while 74% indicated that they were able to partially meet cultural needs and 7% reported an inability to meet cultural needs.
- 22% reported that there were inadequate staff and/or skill levels to provide culturally competent services.
- 21% reported that their organization is unable to meet the language needs of their clients.

POPULATION-SPECIFIC CHALLENGES

- **Concurrent Disorders**: There was a strong association between agency size and gaps in specific services. Smaller agencies reported the greatest gaps with regards to their ability to serve people with concurrent disorders ($\chi^2 = 5.94$, $p = .05$).
- **Forensic Clients**: There was a strong association between agency size and gaps in serving forensic clients, with smaller agencies reporting the greatest gaps ($\chi^2 = 6.38$, $p = .04$).
- **Transitional-Aged Youth**: The gap between the needs of transitional youth and mental health services was highest in Nova Scotia (8 of 10 respondents) and Ontario (65%). The provincial association was significant ($\chi^2 = 25.26$, $p < .01$).

STAFF TRAINING NEEDS

Mental Health Service Providers prioritized the following training and learning needs:

1. Support for concurrent disorders (61.6%)
2. Community-based management of mental illness (53.7%)
3. Behaviour management and modification (46.3%)
4. Better practice models (43.5%)

- Remote service providers (68.0%) more frequently reported the need for behaviour management and modification training than did non-remote providers (43.5%); $\chi^2 = 5.36$, $p = .02$.
- Community-based management of mental illness was significantly associated with province, with the need being most reported in Nova Scotia, Québec, New Brunswick, Newfoundland and Labrador, British Columbia, and Alberta.

KEY FEATURES OF HOUSING AND RELATED SUPPORT MODELS THAT FACILITATE ACCESSING AND MAINTAINING HOUSING

- Subsidized/rent-geared to income housing (62.0%)
- Continuum of housing options (61.6%)
- Flexible and adaptable supports (57.4%)
- 24/7 high support housing (55.1%)
- Transitional housing (50.9%)
- Harm reduction housing models (48.6%)
- Off-site supports (33.3%)

- Low barrier (on-site substance use allowed within housing) (29.6%)

Also, certain practices currently being undertaken by mental health service providers facilitate accessing and maintaining housing:

- Partnerships between mental health services and housing providers (60.6%)
- Off-site housing supports (53.7%)
- On-site housing supports (e.g., hygiene support, crisis services, eviction prevention programs, etc.) (51.9%)
- Development of relationships with landlords (48.1%)

RECOMMENDATIONS

The following recommendations were most endorsed by the housing providers:

1. Adequate funding of a full continuum of housing and supports (76%)
2. Change government policy of how existing funds can be used to increase flexibility (74%)
3. Development of a Housing Strategy (68.5%)
4. Funding for community-based services (65.7%)
5. Increase subsidized housing stock (65.7%)
6. Cross-ministerial partnerships for planning and funding purposes (53.2%)
7. Adequate training of staff (49.5%)
8. High degree of consumer involvement in decision-making (49.1%)
9. Development of supports for the aging population (47.7%)

The high level of support for the recommendation of funding a full continuum of housing and supports was strongly backed by remote service providers (92.0%). Nearly 75% of non-remote providers also endorsed this recommendation.

Table 12. Mental Health Service Provider responses by province/territory.

Province	Frequency (n)	Percentage (%)
Alberta	8	3.7
British Columbia	37	17.1
Manitoba	13	6.0
New Brunswick	4	1.9
Newfoundland and Labrador	26	12.0
Northwest Territories	1	0.5
Nova Scotia	10	4.6
Ontario	105	48.6
Quebec	4	1.9
Saskatchewan	5	2.3
Yukon	1	0.5

Table 13. Communities served by the agencies of mental health service providers.

Community	Frequency (n)	Percentage (%)
Large metropolitan (1,000,000+)	42	19.4
Medium metropolitan (250,000 – 999,999)	39	18.1
Small metropolitan (50,000 – 249,999)	60	27.8
Small city (20,000 – 49,999) adjacent to metropolitan area	23	10.6
Small city (20,000 – 49,999) not adjacent to metropolitan area	29	13.4
Small town (2,500 – 19,999) adjacent to metropolitan area	21	9.7
Small town (2,500 – 19,999) not adjacent to metropolitan area	41	19.0
Rural (less than 2,500) adjacent to metropolitan area	22	10.2
Rural (less than 2,500) not adjacent to metropolitan area	27	12.5
Predominantly rural (no urban settlements in area)	10	4.6
Remote (less than 2,500 with minimal or no road access)	13	6.0
Northern Hinterland	15	6.9

Table 14. Type of provider and populations served.

	People with mental illness (%)	People with concurrent disorders (%)	People with mental health problems (%)	People with substance use issues (%)
Dedicated	47.7	16.2	35.6	9.7
Mixed (most or some services dedicated)	47.7	75.5	56.5	44.9
Social	3.2	6.5	5.1	43.1

Table 15. *The ten most important support needs not being met by the service providers[19] (n = 216).*

	Support Need	Score	Number of "most important" selections
1	Crisis beds/Safe beds/Respite beds	67	31
2	Integrated mental health and housing services	57	22
3	Housing support	53	18
4	Treatment/support for people with concurrent disorders	50	13
5	24-hour on-site support	45	8
6	Drug or alcohol treatment – residential model	37	3
6	Treatment/support for people with dual diagnosis	37	6
8	Drug or alcohol treatment – community-based	27	10
10	Housing	25	6
10	Intensive Case Management (ICM)	25	3
10	Intensive mental health treatment (i.e., options instead of ACT teams)	25	2

[19] The score indicates the number of times an item was selected as one of the five most important support needs not being met

Figure 9. *The most important support needs not being met by the service providers*[20] (n = 216).

A – crisis beds/safe beds/respite beds; **B** – integrated mental health and housing services; **C** – housing support; **D** – treatment/support for people with concurrent disorders; **E** – 24-hour on-site support; **F** – drug or alcohol treatment: residential model; **G** – treatment/support for people with dual diagnosis; **H** – drug or alcohol treatment: community-based; **I** - assertive community treatment; **J** – housing; **K** – intensive case management; **L** – intensive mental health treatment (i.e., options instead of ACT teams)

[20] Scores indicate the percentage of participants that selected the item as one of the five most important support needs not being met

APPENDIX FOUR: LITERATURE REVIEW – HOUSING AND SUPPORTS

INTENSIVE CASE MANAGEMENT (ICM)

Keyword Searches
Intensive case management, ICM, mental health, mental* ill*, homeless*, housing, housing program*, peer support, peer*, consumer, satisfaction, standard*, cost effective*

Databases
Francis, PsycINFO, Social Sciences Citation Index ® (1956 to present), Google, Google Scholar, professional networks

Intensive Case Management (ICM) proposes to promote independence and quality of life for persons with mental illness through the coordination of appropriate services as well as the provision of constant and on-going support as needed by the individual, responsive to multiple and changing needs (Ministry of Health and Long-Term Care, 2005). Assertive Community Treatment (ACT) is a type of ICM that is designed as a one-stop shop for services, while ICM teams provide services and support to aid people living with mental illness in realizing personal recovery goals, stabilizing his/her life, and improving his/her quality of life through individual case managers, who carry a caseload of between 10 and 20 clients, who then link clients with other community services (Ministry of Health and Long-Term Care, 2005; Burns et al., 2007). Integral components of the ICM process include direct involvement of the individual and the development of a caring, supportive relationship with the case manager (Ministry of Health and Long-Term Care, 2005). The specific functions of ICM include: (1) outreach and consumer identification; (2) assessment and planning; (3) direct service provision/intervention; (4) monitoring, evaluation, and follow-up; (5) information, liaison, advocacy, consultation, and collaboration (Ministry of Health and Long-Term Care, 1999).

ICM has been widely adopted throughout the United States, Canada, Australia, and Europe (Burns et al., 2007). However, international research over the past 35 years has found inconsistent effects of ICM on hospital care (Burns et al., 2007). Researchers have found that ICM may help to decrease reliance on institutional care and hospitalization, improve quality of life, increase housing stability, and be more cost-effective than the standard of care (Ministry of Health and Long-Term Care, 2004; Nelson, Aubry & Lafrance, 2007; Dieterich, Irving, Park & Marshall, 2010; Kuno, Rothbard, & Sands, 1999; Birnie, 2010). Although ICM has been shown to reduce homelessness, it has also been shown to be most effective for those who were high users of hospital care already (Marshall, 2008), and superior results have been found for ACT, housing plus supports or supported housing versus case management alone (Nelson et al., 2007; Rosenheck, Kasprow, Frisman & Lio-Mares, 2003).

The inconsistent findings in the literature have been hypothesized to be due, in part, to the contexts within which the trials were conducted as well as potential variations in models practiced (Burns et al., 2007). Burns et al. (2007) found that the inconsistency in findings were due mainly to the fact that ICM is most effective in contexts where hospital use is high and is less successful where hospital use is already low, which is supported by other research (Marshall, 2008). However, research has also found that ICM may be a less clearly articulated model overall as compared with ACT, with a study from the U.S. in 2000 finding that there is no standard conceptualization of ICM and only moderate consensus of the operationalization of ICM (Schaedle, McGrew, Bond, & Epstein, 2002; Schaedle & Epstein, 2000). However, in 2005, the Ontario Ministry of Health and Long-Term Care (MoHLTC) released standards for ICM. Given these inconsistencies in the research and contexts, it is important to examine the ICM model specifically within a Canadian context.

ICM services had been provided across the province of Ontario for over twenty years prior to 2005, with programs often developing in response to local needs (Ministry of Health and Long-Term Care, 2005). Within a larger policy context of healthcare reform moving towards an individual-oriented and community-based healthcare system and more mental health service system responsibility, accountability, and accessibility, the MoHLTC released standards for ICM in 2005. In part, these standards allow for the development of performance measures for evaluation, a priority of the mental health reform, and subsequent accountability and improvement of services (Ministry of Health and Long-Term Care, 2005). Furthermore, national healthcare initiatives have committed, in recent years, to providing improved community-based mental health services, including ICM (Ministry of Health and Long-Term Care, 2005).

In Ontario, it has been found that ICM and ACT serve somewhat different populations, and that both ICM and ACT should be maintained (Ministry of Health and Long-Term Care, 2004), though ICM teams have been found to be most effective when their organization reflects that of the ACT model, with less evidence of benefits from increasing staffing levels (Burns et al., 2007). In Ontario, ICM has been criticized for a need to provide a better balance between medical-therapeutic and rehabilitative-recovery services (Ministry of Health and Long-Term Care, 2004). Furthermore, a recent study by Stergiopoulos, Dewa, Durbin, Chau, and Svoboda (2010) found that there are a wide range of unmet specialized mental health needs, and that this would indicate a possible need for varying interventions of different structure and service intensity for the mentally ill homeless.

PEER SUPPORT AND ICM TEAM SERVICES

Interest in peer involvement in the delivery of mental health services has grown over the last decade, and may help to meet the challenge of social isolation and loneliness for people living with mental illness (Rivera, Sullivan, & Valenti, 2007). Benefits of peer involvement have been found to include reduced hospitalization, greater client satisfaction, a trend toward better social functioning, improved quality of life, and perceived physical and emotional well-being (Rivera et al., 2007; Klein, Cnaan, & Whitecraft, 1998). In Canada, it is of particular note that the MoHLTC implementation standards mandate a minimum of 0.5 FTE peer support workers positions within ACT teams, and that peer case managers have been found to have more face-to-face interactions and more emphasis on “being there” with the client versus being more task accomplishment-oriented (Rivera et al., 2007). Integrating peer support into case management may improve quality of life and social functioning, help to reduce stigma, build hope, and offer unique opportunities (Rivera et al., 2007). A study by Felton et al. (1995) found that integration of peer specialists into ICM programs leads to both enhanced quality of life for clients as well as more effective case management. However, a study by Rivera et al. (2007) did not find evidence for enhancement of case management with peer involvement, though it was noted that further research and evaluation perspectives are needed, such as benefits for the peer-providers and systems-change perspectives (Rivera et al., 2007).

CLIENT PERCEPTIONS OF ICM TEAM SERVICES

In general, researchers’ evaluation of case management needs to move towards a more recovery-oriented approach with greater peer involvement in even the development of evaluations of case management (Marshall, Crowe, Oades, Deane, & Kavanagh, 2007). Furthermore, the use of general measures of satisfaction has been found to potentially result in overly positive or “whitewashed” results. The use of domain-specific measures is much more favourable, particularly in light of achieving greater accountability to clients (Gerber & Prince, 1999; Marshall et al., 2007). A study in the U.K. examining the perceptions of clients with severe psychotic illnesses of ICM versus standard case management (CM), utilizing domain-specific measures rather than general measures of satisfaction, found that general perceptions were more favourable towards ICM than CM, though no difference was found between ICM and CM regarding perceptions of quality of care (Samele et al., 2002). In a study assessing client satisfaction, utilizing domain-specific measures, of ACT models specifically, worker-client connection (e.g. therapeutic alliance, rapport) was found to be as important as in other models (e.g. casework models or crisis interventions; Gerber & Prince, 1999).

In the U.S., role-conflict from bureaucratic disjunction was found to create frustration, resentment, and burnout within an agency providing ICM services to homeless persons suffering from mental disorders and substance abuse (Francis, 2000). Furthermore, a study of case managers in the U.S. in an intensive case management program also found that there was a need for early support and preventive intervention for job difficulties relating to changes in attitudes towards clients over time and increased job-related stress and emotional exhaustion over time (Kirk, Koeske, & Koeske, 1993). These findings could have important implications for clinicians in Canada and would seem to warrant further research in the Canadian context.

In summary, the ICM model is one of the most developed and extensively researched models of service delivery for people with mental health issues in Canada. While research is somewhat mixed as to the extent of the effectiveness of ICM, ICM has been found to be effective in reducing hospitalizations, homelessness, and to be cost-effective, particularly in contexts where hospital use is high. It has also been noted that ICM models need to achieve a greater balance with rehabilitative-recovery oriented services and medical-therapeutic services. Further research is needed regarding the effects of peers on service delivery, quality of life, and social functioning (Rivera et al., 2007). Furthermore, there is a growing recognition that further research is needed into the practices of staff teams, rather than simply looking at their labels (Burns et al., 2007). Given the movement towards greater system accountability and the development of standards for ICM, and subsequent evaluation, further research is needed into the ICM model and its effectiveness and operationalization in various contexts.

ASSERTIVE COMMUNITY TREATMENT (ACT) WITHIN THE CANADIAN CONTEXT

Assertive Community Treatment (ACT) proposes to provide individuals with mental illness with coping skills that allow them to maintain independent lives in their communities, and offers the potential to decrease inpatient stays and increase community tenure. Theoretically, ACT teams should provide services and support that include a range of medical and psychosocial services and supports. These can be grouped into five broad categories: (1) vocational and work-related skills; (2) activities of daily living; (3) social and recreational activities; (4) family support; (5) medications, psychotherapy, and nursing care (Dewa, Horgan, McIntyre, Robinson, Krupa, & Easabrook, 2003).

An extensive body of research has shown that ACT may decrease hospitalization rates, increase housing stability, and improve quality of life (Bond, Drake, Mueser, & Latimer, 2001). However, other studies have revealed alternative results, wherein ACT did not significantly reduce the use and cost of psychiatric services (McCrone et al., 2009). Overall, results on effectiveness of ACT vary from international perspectives. Thus, it is important to acknowledge the specificities of the ACT model within a Canadian context.

In Canada, ACT has been most extensively developed in Ontario. Since 1998, the Ontario Ministry of Health and Long-Term Care (MoHLTC) has funded the dissemination of ACT through the Province of Ontario. The Canadian Senate identified ACT as a key community treatment in a recent national report on mental illness in Canada (George, Durbin, & Koegl, 2008). In 1998, the MoHLTC developed the first set of provincial ACT team standards, as an adaptation from American standards, which have been endorsed by the National Alliance for the Mentally Ill, the Health Care Financing Administration, and the surgeon general in a report on mental illness (George et al., 2008). This provincial set of standards formed part of the Memorandum of Agreement between the Ministry and each ACT sponsoring agency (George, Durbin, & Koegl, 2008). Further, due to concerns and challenges ACT teams face when working with clients, including but not limited to team under-capacity and lack of funding, revised ACT standards were developed by the MoHLTC through a Technical Advisory Panel (TAP) and adopted provincially in late 2004 (George et al., 2008).

The MoHLTC TAP report showed that Ontario ACT teams achieve significant reduction in hospital days for clients and improvement in housing (Lurie, Kirsh, & Hodge, 2007). Lafave, Souza, and Gerber (1996) conducted an experimental study in which clients were randomly assigned to either an ACT or hospital based rehabilitation

program. The study found that clients in the ACT treatment group had used only 16% of the amount of hospital days used by clients in the hospital-based comparison program. Clients in the ACT treatment model also had better living situations, and more control over their symptoms.

Despite studies showing the effectiveness of ACT in Ontario in regards to decreasing rehospitalizations rates and increasing quality of life, a fundamental question remains to be examined. Specifically, studies have yet to delineate which element(s) of the ACT model is/are most effective and for which population is the model most effective. The majority of current research on the effectiveness of ACT within a Canadian context focuses on exploring different components of the model and ways to improve model delivery (Dewa et al., 2003; Drake, O'Neil, & Wallach, 2008; Lurie et al., 2007). For example, when examining ACT teams within Ontario, Dewa and colleagues (2003) found that the current ACT model focuses more on medication management, rather then psychosocial elements. Thus, it was suggested that more emphasis on psychosocial characteristics, such as employment, housing, and social networking, might promote client rehabilitation more effectively, compared to the current biomedical approach.

The implementation of ACT into routine-care settings has also seen many challenges. Critics have pointed to the fact that ACT's unique elements also make it a potential resource intensive program (Dewa et al., 2003). The authors also suggest that three main dimensions of ACT, namely staffing, organization, and service, are crucial elements when assessing effectiveness. To illustrate this, the authors compared four ACT teams located in a semi-urban centre in Ontario, Canada. Results revealed that on average, 37% of time, ACT focuses on medication management and medication related symptoms (Dewa et al., 2003). Moreover, for every two hours a case worker spent directly with the client, at least one hour was devoted to supporting this contact (e.g., documentation, traveling, treatment plan).

These findings are also in line with a needs assessment conducted in British Columbia by Hanson, Houde, McDowell, and Dixon (2007), where the researchers evaluated clients' needs and determined gaps in service delivery provision by mental health agencies. The authors stated the results suggest an imbalance between needs and services provided. In particular, service needs, such as vocational services, housing support, peer support, and group therapy were under met by the majority of ACT teams. On the other hand, estimated needs for other services, such as medication management, nutrition, and activities of daily living, were much lower than what was used (Hanson et al., 2007). Furthermore, these findings also correspond with a systematic review of psychosocial research and interventions for people with mental health issues and substance use disorders, wherein researchers noted mixed results on the effectiveness of ACT when applying the model to this particular population (Drake et al., 2008).

Canadian research on ACT has paid particular attention to the inclusion of peer support workers within the ACT team. Several studies examined the roles and effectiveness of peer support workers within ACT teams (Dewa et al., 2003; White et al., 2003). The peer involvement in mental health services delivery is not new to the field. However, the unique experience in Canada is that the MoHLTC implementation standards mandate a minimum of 0.5 FTE peer support worker positions within the ACT team. Still, 22% of the respondents reported that they are not planning to implement such a position (White et al., 2003). The common concerns are different tasks assigned to peer and non-peer staff, and staff attitude towards peer team members. The authors also found that peer case managers tend to be more engaged in street outreach, and less likely to be reached for emergencies and have contacts with other mental health professionals. The results on attitude towards peer staff members are mixed. On one hand, there is a tendency to perceive peer providers as less competent or less accountable due to their mental illnesses. However, on the other hand, research also illustrates that peer case management teams follow an empowerment model and peer support workers consider their positions as valuable, with a high level of satisfaction. Thus, it is suggested that broader incorporation of peer support workers in ACT teams might benefit both clients and non-peer staff members (White et al., 2003).

CLIENT PERCEPTIONS OF ACT TEAM SERVICES

Given that the ACT model increasingly represents a set standard for treating persons with serious mental illnesses, soliciting clients' opinions about the services they receive from this model is crucial. As such, Gerber and Prince (1999) conducted a study which examined client satisfaction with ACT services. The majority of client satisfaction surveys either used the Client Satisfaction Questionnaire, which is based on general measures, or ad hoc questionnaires as part of larger studies. Gerber and Prince (1999) pointed out that the worker-client connection (e.g. therapeutic alliance, rapport) contains the same importance in ACT as in other models, such as casework model or crisis interventions. Thus, despite the primarily focus on medication management and meeting basic needs, clients also value interpersonal factors. Therefore, elements such as spending more time with the client, counselling, housing support, and helping with employment might be more beneficial for clients and should be incorporated into routine ACT treatment more broadly.

In summary, the ACT model is the most developed and extensively researched model of service delivery for people with mental health issues in Canada. It is one of three treatments selected for implementation in the Implementing Evidence-based Practices for Severe Mental Illness Project (George et al., 2008). While studies acknowledge the proven effectiveness of ACT, the majority of Canadian research focuses on which element(s) of the model is/are the most effective and for which population. Thus, while not questioning the effectiveness of ACT model, research suggests that broader aspects, such as therapeutic alliance, housing support, and employment support should be emphasized rather than medication management.

To date, research findings propose that ACT teams place a greater emphasis on delivering medically oriented activities as opposed to psychosocial ones, in part due to a lack of research into the effectiveness of psychosocial services from ACT teams (Drake, O'Neil, & Wallach, 2008). Therefore, it is strongly urged that more emphasis is placed on examining activities, such as the impact of family intervention, supported employment, and social intervention, on ACT service delivery.

CRISIS RESPONSE SERVICES (CRS)

A crisis response service (CRS) can be conceptualized as a range of functions to provide appropriate, timely, and well-coordinated responses for persons in crisis situations. In general, crisis response services are seen as a key part of the continuum of mental health services and supports for people with serious mental health issues. Crisis response services offer treatment and support to individuals experiencing a crisis by providing immediate relief from symptoms, preventing worsening symptoms, and resolving crisis as soon as possible. Because mental health crises differ in their origins and symptoms, crisis response services must be able to respond to individual needs by providing a range of appropriate services in a variety of settings.

DESCRIPTION OF CRISIS SERVICES

According to the literature, crisis services are divided into several categories. The most often cited services are: crisis telephone hotlines, drop-ins (short-term involvement), mobile crisis teams (also short-term, but might also include referral and follow-up), and residential short-term or safe beds (longer involvement, usually 30 days). All services have the main aim of decreasing immediate danger and addressing the crisis first, in an effort to avoid hospitalization (e.g., for mobile crisis teams and safe beds), or prevent suicide (e.g., hotlines and drop-ins). However, these services differ significantly in service delivery, method of evaluation, and structure. Moreover, most of the published literature on emergency services has been descriptive in nature.

Telephone Crisis Hotlines

In the literature, three main types of telephone crisis services are described. Type I is a basic referral system and an extension of a community agency. Type II is a hotline that is a component of a larger multi-service organization,

such as a walk-in crisis centre. The main purpose of the hotline is to act as a switchboard and help inform the community of the services provided by the associated centre. Type III hotlines are not connected to any particular agency and do not provide face-to-face services (Slem & Cotler, 1973). They are primarily run by volunteers, who are trained in risk assessment and suicide prevention. However, there is no consistency in legislation and requirements, and they differ across provinces.

Walk-In Crisis Centres (Drop-Ins)

Next, walk-in crisis services can operate as a stand-alone drop-in center in the community or they can be associated with a hospital. There are two main services that walk-in crisis centers provide: (1) screening and assessment, and (2) crisis intervention and stabilization (Stroul, 1993). However, walk-in centers range in the degree of services provided. Some walk-in centers solely provide a non-judgmental place to talk, while some can provide initial treatment, medication, short-term crisis counselling, and referral to community resources (Stroul, 1993).

There is no consensus among researchers on the effectiveness of telephone and walk-in crisis services because the evaluation of effectiveness has many hurdles. First, most hotlines and walk-in centres are anonymous or operate on a first-name basis, which means that data collection after the person has hung-up or left the centre is near impossible (Rosenbaum & Calhoun, 1977). Second, most hotlines operate as a referral source and don't provide treatment so the eventual outcome is determined by the referral agency (Rosenbaum & Calhoun, 1977). Third, sometimes problems are solved spontaneously and since randomized studies are not usually conducted for ethical and methodological reasons, it is hard to determine whether it was the hotline or life events themselves that solved the issue (Rosenbaum & Calhoun, 1977). For this reason there is a limited amount of research on the clinical effectiveness of telephone hotlines and walk-in crisis services.

Mobile Crisis Teams

Mobile crisis services were developed out of a need to reach persons in mental health crises at home and to help persons with mental illnesses that have come in contact with police and other emergency services. The three main goals of mobile crisis services are to: "provide crisis services in natural environments, provide services to difficult to reach persons, and to reduce hospitalization by mobilizing treatment resources and environmental support systems" (Stroul, 1993). Mobile crisis services are, in some areas, connected with the local police service. Mobile crisis teams help to deescalate a mental health crisis by: building trust and confidence, achieving a therapeutic alliance, gaining acceptance and compliance, and reaching resolution (Gillig, 1995). Many studies, except one (Fischer, Geller, & Wirth-Cauchon, 1990) have found positive outcomes in terms of hospitalization rates (Hugo, Smout, & Bannister, 2002; Buhrich & Teeson, 1996; Guo, Biegel, Johnsen, & Dyches, 2001; Geller, Firsher, & McDermeit, 1995). One key characteristic of mobile crisis service identified in the literature is the presence of a psychiatrist on the mobile crisis team. By having a psychiatrist on the team, the team can act like an emergency department on wheels because they are able to prescribe and dispense medication (Benglesdorf & Alden, 1987). Many aspects of mobile crisis teams, such as preventing re-hospitalization, frequent visits, referring services, and crisis interaction are similar to ACT teams. Thus, it is yet to be examined whether one service provision could be substituted for another with the same effectiveness, as there is a possible overlap in services.

Residential Short-Term Safe Beds Crisis Services

Words synonymous with residential crisis services include: crisis beds, safe beds, and respite beds. The function of residential crisis services is to "provide crisis intervention in residential non-hospital settings to persons experiencing psychiatric crises to help them re-establish community functioning" (Stroul, 1988). They are characterized by providing short-term housing, acute treatment, and support services to individuals or a small group of people with mental health issues who are experiencing a mental health crisis. The main purpose is to prevent hospitalization (Stroul, 1988).

A vast majority of research indicates that residential crisis services are just as effective as inpatient treatment (e.g., Sledge, Tebes, Rakfeldt, Davidson, Lyons, & Druss, 1996; Fenton, Mosher, Herrell, & Blyer, 1998) if not greater

(e.g., Braun et al., 1984; Kiesler, 1982). Experimentally randomized studies that compare residential crisis services to conventional inpatient hospitalization found a slimmer decline in psychiatric symptoms (Sledge et al., 1996; Fenton et al., 1998). A non-randomized study also found that residential crisis services are effective at decreasing psychiatric symptoms (Goodwin & Lyons, 2001). Additionally, two published literature reviews found that alternatives to hospital admission led to similar psychiatric outcomes as inpatient treatment (Braun et al., 1984; Kiesler, 1982). Moreover, one review reported that there was a lack of research showing that outcomes after inpatient treatment were more positive than residential crisis services (Kiesler, 1982).

CRISIS SERVICES WITHIN THE CANADIAN CONTEXT

Mobile crisis teams and safe beds are among the most researched crisis services in Canada. Crisis response services are regulated in British Columbia, Nova Scotia, and recently in Ontario; however, service guidelines and regulations vary from province to province. For example, British Columbia has fully articulated its standards and defined five key crisis services: crisis lines, mobile crisis outreach teams, walk-in crisis stabilization services, community crisis stabilization services, and hospital-based services (Government of British Columbia, Ministry of Health, 2003). Nova Scotia has developed crisis response standards to address accessibility, appropriateness, competence, safety, acceptability, and continuity, in addition to using a typology of evidence to evaluate the standards based on available evidence supporting best practices (Government of Nova Scotia, Department of Health, 2003).

In Ontario, crisis programs were developed in response to local needs, and service components were not consistent across the province. As a part of mental health reform, the Crisis Service Standards for Ontario were developed (Government of Ontario, 2005).

While British Columbia has specific standards for all of its community crisis stabilization services (including crisis housing; Ministry of Health Services, n.d.), both Ontario (Ministry of Health and Long-Term Care, 2005) and Nova Scotia (Nova Scotia, 2004) have only general standards with respect to crisis responses. British Columbia standards outline eight core functions of community crisis stabilization services: (1) screening and referrals; (2) support and stabilization; (3) crisis intervention; (4) safety of clients and staff; (5) alternative to hospitalization; (6) discharge planning; (7) teaching coping skills; and (8) care planning. British Columbia standards, with respect to providing an alterative to hospitalization, include 24-hour staff coverage and short turnover of clients. As well, referral agents are aware of the criteria for appropriate referrals.

The 24-hour staff coverage is echoed in standards for crisis response services in Nova Scotia; however, the standard in Ontario only states that, “all CRS will have access to other services 24 hours a day, seven days a week” (Government of Ontario, 2005). Staff competency is emphasized in B.C.’s standards such that staff are trained in assessment of risk, presence of mental disorders, stressors and the need for medical evaluation, and in evidence-based group and individual interventions. Nova Scotia standards require staff to be trained in risk assessment only. Ontario requires that staff have training in a variety of areas, to the best extent possible, and that the crisis worker is knowledgeable about services that the individual needs and has the necessary information to do their job. Overall, there is a need for more mental health service standards to be developed in each province and territory as well as more specific standards with respect to residential crisis services.

SUMMARY

Literature on the effectiveness of different models of crisis response services is scarce due to the nature of service delivery (e.g., anonymity of hotlines and walk-ins, confidentiality, etc.). It is evident from our literature search that few evaluations of crisis services have been conducted and the reported outcomes of these studies must be treated with caution due to generally weak research designs. There is almost no evidence supporting the efficacy of different crisis interventions (Goering et al., 1997). Compared to service areas such as case management, vocational supports, and treatment services, components of a crisis intervention system have been poorly studied either as individual programs or as necessary parts of the system.

CONSIDERING THE NEEDS OF PEOPLE LIVING IN RURAL AND REMOTE AREAS

Keyword Searches
rural, remote, urban, regional, homeless*, housing, models, programs, mental health, health, mental* ill,* mental,* ill*

Databases
PsycINFO, Illustrata: Natural Sciences, Illustrata: Technology, ProQuest, E-Journals @ Scholars Portal, Social Work Abstracts, Sociological Abstracts, Urban Studies Abstracts, Social Sciences Abstracts @ Scholars Portal, Web of Science, Social Sciences Citation Index ® (1956 to present), FRANCIS, ASSIA: Applied Social Sciences Index and Abstracts, Google, Google Scholar, professional networks

RURAL/REMOTE AND URBAN/ACCESSIBLE DEFINITIONS

Though there is no universally accepted definition of 'rural' in research literature, it is commonly described in relation to population density or location in terms of distance from service availability. The Organisation for Economic Cooperation and Development (OECD) defines a rural community as one with fewer than 150 persons per square kilometres, while Statistics Canada defines a region as 'predominantly rural' if more than 50% of the population lives in rural communities, 'intermediate' for a population density of 15 – 50% and 'predominantly urban' if below 15% (Pong et al., 2002). The National Rural Health Association (NRHA; 1996) defines an urban (metropolitan) area as a district of 50,000 population or more, and a rural (non-metropolitan) area with less than 50,000 inhabitants (Post, 2002).

The Accessibility/Remoteness Index of Australia (ARIA) categorizes a community's level of remoteness based on road distance to service centres ranging from highly accessible to very remote (Commonwealth Department of Health and Ageing, 1999; Rajkumar & Hoolahan, 2004). Rural also includes the mostly "sparsely populated" and "very isolated" northern Canadian communities and remotely located cities due to "geographical isolation, economic and labour force characteristics, and access to services and amenities" (Pong, 2000).

RURAL/REMOTE VERSUS URBAN ISSUES

Rural communities worldwide share common issues with poor health status and access to health care, with rurality internationally recognized as a risk in relation to health outcomes (Ryan-Nicholls, 2004). Studies in Canada reveal significant disparities in health outcomes between inhabitants of Northern versus Southern areas, Atlantic Canada versus the rest of the country (Ryan-Nicholls, 2004), and poorer health status in rural versus urban areas; furthermore, the most rural areas tend to report the worst health status (Pong, DesMeules, & Lagace, 2009).

Research on Canadian rural mental health issues, though limited and "piecemeal" (Ryan-Nicholls, 2004), consistently identify themes around increasing need, difficulty recruiting/retraining professional staff and restricted/limited resources which strain existing services and limit access (Rajkumar & Hoolahan, 2004; Sawyer, Gale, & Lambert, 2006). Unique rural geographical and cultural challenges further impact current service delivery models (Sawyer et al., 2006).

There is a clear need for increased rural mental health research (Philo, Parr, & Burns, 2003), specifically tailored policies and programs, as well as the development of evidence-based models of care that may be replicated across a range of rural communities (Sawyer et al., 2006).

URBAN ASSUMPTIONS

The Substance Abuse and Mental Health Services Administration (2009) found that rural issues are "often misunderstood, minimized, and not considered in forming national mental health policy." As well, urban policies and practices are often assumed to apply to rural areas (Sawyer et al., 2006) despite research that supports its uniqueness (Ryan-Nicholls, 2004). According to Romanow (2002), this reliance on urban models will "create barriers for rural communities in their efforts to achieve equal status with their urban counterparts" (Ryan-Nicholls, 2004) and as well inhibit the efforts of providers in rural/remote areas (Sawyer et al., 2006). There is a need to develop models and practices specifically for rural/remote communities that address their unique context and challenges.

PREVALENCE OF MENTAL ILLNESS IN RURAL/REMOTE AREAS

There is a dearth of research on the prevalence of serious mental illness (SMI) in rural and northern communities in Canada (Montgomery et al., 2008) as well as the mental health needs of rural communities (Philo et al., 2003). Drawing on rural data from the United States, the incidence of serious mental and behavioural health problems is equal to or greater than urban areas (Sawyer et al., 2006).

Incidence and Prevalence of Rural Homelessness

There is little research regarding the prevalence of homelessness among the mentally ill in rural/remote areas (Grigg, Judd, Ryan, & Komiti, 2005); however, the incidence of homelessness in rural communities has been found to be similar to or greater than that in major metropolitan areas, particularly those experiencing economic distress (Post, 2002).

Prevalence of Mental Illness among Rural Homeless

Homelessness is more prevalent among individuals with SMI than the Canadian population at large (Montgomery et al., 2008). The prevalence of SMI is reported in similar proportions among the rural and urban homeless (Burt, 1999; Post, 2002); however, greater stigmatization of mental illness in rural areas suggests underreporting (Wagner et al., 1995; Post, 2002) and is supported by the nearly 80% higher suicide rates for rural males over age 14 (Post, 2002).

HOUSING, SUPPORTS, AND SERVICES

Availability of Mental Health Services and Related Supports

There is a lack of appropriate and accessible mental health treatment and community support services in rural and northern communities in Canada (Montgomery et al., 2008; Rajkumar & Hoolahan, 2004; Turpin, Bartlett, Kavanagh, & Gallois, 2007). These gaps include dual-diagnosis treatment, telehealth services, peer support and peer led groups, treatment and support for homeless people with substance abuse problems, and a sufficient number of high quality health care facilities.

Due to the lack of specialists in rural/remote areas, primary care workers are often a key resource for mental health care (Rajkumar & Hoolahan, 2004). Despite the challenges of access and limited resources, some rural areas show greater inter-agency collaboration and integration with a stronger preventive and psychosocial focus where various disciplines, peer support groups, teachers, and clergy play a role in mental health care delivery (Rajkumar & Hoolahan, 2004).

Availability of Housing and Related Supports

Rural areas typically face inadequate housing and lack of continuum of housing services (Montgomery et al., 2008). People with a mental illness in rural areas report housing issues associated with access, affordability, uncertain

tenure, and risk of violence (Grigg et al., 2005), which are further exacerbated by inadequate attention to policy development in smaller communities (Montgomery et al., 2008).

The geography of rural and remote areas increases the sense of isolation of its Canadian inhabitants, as well as the divide between the rich and the poor and a corresponding decline in social programming, quality food, and affordable housing (Ryan-Nicholls, 2004). Lack of mental health services, "aging" demographics, rural poverty, and changes in economic and labour forces further impact the implementation of supportive housing in these areas (Montgomery et al., 2008).

CHALLENGES TO SERVICE PLANNING AND DELIVERY

Recruitment/Retention of Professional Staff

In addition to the challenge of recruiting and retaining professional staff (Housing Assistance Council, 2001; Rajkumar & Hoolahan, 2004; Sawyer et al., 2006; Turpin et al., 2007), rural, northern, and remote regions in Canada often face 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).

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 scholarships and grants for training (Housing Assistance Council, 2001; Sawyer et al., 2006).

Stigmatization and Cultural Issues

Rural areas report higher rates of stigmatization of mental illness and substance abuse (Wagner et al., 1995; Post, 2002). In addition, mistrust of health professionals and inadequate early intervention and prevention pose barriers to accessing mental health services in rural America. This may be further exacerbated by the culture of self-reliance in some rural areas (Housing Assistance Council, 2001; Philo et al., 2003; Turpin et al., 2007) as well as lack of cultural competence in health care providers (Sawyer et al., 2006).

Transportation and Geographic Barrier Access Issues

The large distance between rural areas and available services pose barriers to access. These include transportation, associated travel costs, and the negative impact of leaving one's social support network and community (Housing Assistance Council, 2001; Ryan-Nicholls, 2004), as well as poor roads, inclement weather (Pong & Russell, 2003), and/or inadequate public transportation (Sawyer et al., 2006). The implementation of Telehealth in response to these challenges is an innovative initiative, however, rural health in Canada remains less than optimal (Ryan-Nicholls, 2004).

Funding

The capacity for care and access to services in rural areas is hindered by lack of financial resources and emphasis on the "need to make better use of limited resources in rural communities" (Sawyer et al., 2006). Innovative programs are often lost on grant expiration or terminated reimbursement streams (Sawyer et al., 2006). Inappropriate, limited, and insecure funding models for service providers in some areas, particularly non-governmental organizations, negatively impact service delivery, thus outlining the need for a 'funding mix' to meet the needs of different areas (Turpin et al., 2007).

Lack of Relevant Research

Research on supported housing has typically focused on urban settings, so that the needs and outcomes for rural populations remain largely unknown (Montgomery et al., 2008). This is indicative of the need for more research and evaluation of models of care in rural/remote areas to assess their efficacy, aid in planning (Rajkumar & Hoolahan, 2004), overcome unique challenges in rural and northern communities, and deliver tailored strategies for these areas.

RECOMMENDATIONS

Rural health and sustainability enhancement requires innovative strategies "that employ both capacity building partnerships with rural people that are supported overall, by adequate funding allocation" (Ryan-Nicholls, 2004). Furthermore, the "fundamental causes of the 'rural health deficit' must be addressed" (Romanow, 2002; Ryan-Nicholls, 2004) rather than focusing solely on the "symptoms of rural health and sustainability problems" (Ryan-Nicholls, 2004).

Strode and Roll (2007) outlined several specific recommendations in a report on disparities in mental health services between rural and urban communities in Washington State, which included supporting housing and employment programs for people with mentally illness in rural areas and providing transportation subsidies to rural service providers to reach isolated individuals. Sawyer et al. (2006) highlighted the need for outreach, such as with para-professionals who are trusted, native individuals to the community, financing and system reform, and innovative community based programs. Post (2002) echoed the need to use community networks and indigenous workers to facilitate mobile outreach to homeless people in remote areas, as well as advocate for affordable housing and adequate income in rural communities. A recurring recommendation (Strode et al., 2007; Sawyer et al., 2006, Post, 2002) was the need for interagency collaboration, service coordination, and the integration of mental health and primary care services wherever feasible.

Policy strategy recommendations by Sawyer at el. (2006) include financing and reimbursement changes, development of rural specific programs and services, and enhancing functioning of existing services in rural areas. The World Health Organization (2010) included a policy recommendation on the expanded use of telehealth services in rural areas to further support rural health workers and enhance retention.

Past literature identifies the need for further evaluation and documentation of the efficacy of rural/remote models of care to better inform policy makers in decision making (Rajkumar & Hoolahan, 2004). "A variety of approaches are needed to improve access to mental health care," as noted by Judd & Humphreys (2001; Rajkumar & Hoolahan, 2004).

PEER SUPPORT AND HOUSING

Keyword Searches
peer support, peer-run housing, consumer-run housing, consumer-run services, peer specialist, self-help groups, mutual help groups, consumer-operated services, congregate housing

Databases
PsycINFO, Medline (Pubmed), Medline (Ovid), Sociological Abstracts, Social Services Abstracts, CBCA Complete, Social Work Abstracts, ERIC, PAIS, Web of Science, Applied Social Sciences Index and Abstracts, JSTOR, PsycARTICLES, Canadian Periodical Index, The REHABDATA Database, Scopus, Google and Google Scholar, professional networks

Based on 32 articles, from a total of 81 articles found

RELATIONSHIP OF PEER SUPPORT AND HOUSING

Why is a discussion of peer support relevant for housing policy? Peer support has increasingly become acknowledged as a key element in the process of recovery for people with experiences of mental illness. A review of the Canadian, American, and international academic and grey literatures shows that, while there is limited research on the specific role of peer support within housing or peer-run housing models, there is a wealth of

material on the role peer support plays in building social connections and networks, as well as enhancing choice and empowerment. As a result of these positive outcomes, there is research demonstrating the role in which these processes lead to reductions in hospital use and stronger connections to the community.

OVERVIEW OF PEER SUPPORT

Peer support has a wide variety of meanings. Within the mental health, academic and grey literature, peer support has been defined as a "self help movement […] incorporating peer lay individuals with experiential knowledge who extend natural (embedded) social networks and complement professional health services" (Dennis, 2003). A psychologist and psychiatric survivor advocate in the United States, Pat Deegan, defines it as "a natural human response to the alienation and adversity associated with being given a psychiatric diagnosis" (2006).

Coatsworth-Puspoky, Forchuk, and Ward-Griffin used the definition of mutual support, proposed by Davidson et al., as a "naturally occurring […] process of people coming together voluntarily and sharing problems and understanding to solve problems" (2006). A transitional discharge program involving peer supporters helping peers leave the hospital and re-enter the community was developed on this "friendship model" of peer support (Forchuk, Martin, Chan, & Jensen, 2005).

Peer support in mental health and health literature is often located along a continuum of social relationships (Davidson, Chinman, Sells, & Rowe, 2006; Dennis, 2003). This continuum ranges from "lay" or "natural" relationships (e.g., family, friends) to the professional support provided by formal health care services. Other authors propose 'matrix' models, where the type of peer relationship (informal self help, formal peer support provider), the type of support provided (self-help, service), and the location (consumer-run, located within mainstream service) determine the specific type of 'peer support' (Deegan, 2006; Mowbray & Moxley, cited in Dixon, Hackman, & Lehman, 1997).

Thus, peer support takes a wide variety of forms; from people living in the same housing setting spending time together socially, to attending self-help groups, to working as a peer support worker in a mainstream or peer-run agency and providing traditional and alternative forms of support (Davidson et al., 2006; O'Hagan, McKee, & Priest, 2009).

These different types and approaches towards peer support are relevant in relation to housing. While our scan of the literature did not discover any research that specifically addressed the impact of formal models of peer support or peer-run services on housing outcomes, more generally, there are studies on the relationship between social support and housing (Goering, Durbin, Foster, Boyles, Babiak, & Lancee, 1992), the impact of peer support on decreased hospitalization (Forchuk et al., 2005), and descriptive reports on peer workers within supportive housing, consumer-run residential programs, and other housing options (Center for Psychiatric Rehabilitation, 2009; Hamilton Addiction and Mental Health Network, 2006). From these different sources, some of the impact on housing from peer support, both informal and more formal models, can be better understood.

While research has demonstrated the positive impact of housing on reduced homelessness, housing instability, and some improvements in quality of life and decreased psychiatric and other symptoms, the process by which these positive outcomes are achieved remain a topic of interest (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Nelson, Sylvestre, Aubry, George, & Trainor, 2005).

Writing about the *Housing First* model, the innovative approach that offers access to housing units for people coming directly out of homelessness regardless of their addiction or psychiatric status, researchers have made an argument for the importance of individual choice. They propose that programs that enhance a person's choice increase sense of mastery, which in turn decreases psychiatric symptoms (Greenwood et al., 2005).

By identifying the mechanism of change as increased 'choice,' this research has implications broader than the specific housing model including the role of peer support. While the research on *Housing First* does not refer directly to peer support, the researchers note in passing that a significant number of the program staff are people with lived experience of mental illness, addictions, and homelessness. They also acknowledge the survivor movements' role in advocating for increased choice and control over mental health treatment which helped lead to the development of approaches like *Housing First* (Greenwood et al., 2005).

Increased sense of choice, empowerment, and control are some of the key positive outcomes of engagement with peer supports (Chinman, Weingarten, Stayner, & Davidson, 2001; Corrigan, 2006; Resnick & Rosenheck, 2008). A wide range of other positive outcomes have been demonstrated for both informal self-help and more formalized models of peer support and consumer-run services including higher levels of confidence (Chinman et al., 2001; Resnick & Rosenheck, 2008; Salyers, Hicks, McGuire, Baumgarnder, Ring, & Kim, 2009), self-esteem (Wong, Nath, & Solomon, 2007), and community integration and increased social networks (Castelein, Bruggeman, van Busschbach, van der Gaag, Stant, et al., 2008; Chinman et al., 2001; Coatsworth-Puspoky et al., 2006; Forchuk et al., 2001; Goering, Durbin, Foster, Boyles, Babiak, & Lancee, 1992).

Depending on the criteria of the review and research, peer support and peer-run services have been shown to produce equally positive outcomes for people with mental illness in comparison to traditional mental health services (Campbell, 2009; Center for Psychiatric Rehabilitation, 2009; Doughty & Tse, 2011; Pistrang, Barker, & Humphreys, 2008). The research currently available thus shows the benefits of peer support in a general sense upon the lives of people with mental illness, as well as some of the indirect ways that peer support can enhance positive outcomes that affect the ability to achieve and maintain housing.

PEER-RUN HOUSING AND FORMAL PEER SUPPORT WITHIN HOUSING

There are few examples of peer-run housing, peer support workers in supported/supportive housing programs, or formal peer supports provided by housing services (e.g., self-help groups facilitated by a housing provider onsite, referral agreements between housing and peer-run programs).

There are a few examples of peer-run housing options in Canada, none of which have been studied. Willow-Creek House in London, Ontario provides an eight-bed residence and is operated by a peer-run organization "following a peer support model of management" (Consumers Survivor Community Support Services, 2010). A needs analysis conducted in Hamilton, Ontario "found tremendous support and excitement about the idea of a consumer-driven housing co-operative among consumer/survivors, family members, community mental health workers and non-profit housing professionals" with over 40% of respondents, who lived with mental illness, indicating they would be interesting in living in such a setting (Hamilton Addiction and Mental Health Network, 2006).

A dedicated mental health supportive housing program in Toronto, Ontario partnered with the Toronto Community Housing Corporation (TCHC), the largest social housing provider in Canada, on a pilot project to support the development of a mental health framework for over 160,000 low and middle income tenants (Toronto Community Housing Corporation & Houselink, 2008). Building upon the mental health program's expertise and "extensive peer support program" (Toronto Community Housing Corporation & Houselink, 2008), the project recommended that TCHC "investigate possibilities for tenants to be trained and hired as peer supports to help new tenants transition from homelessness to tenancy; recovery educators or coaches; and as drop-in co-coordinators or staff" (Toronto Community Housing Corporation & Houselink, 2008).

International examples exist, although defining a housing program from a residential treatment facility, as well as confirming the degree of peer control versus involvement or input can be challenging due to the quality of the research and reporting. For example, in their systematic review of peer delivered services, the Centre for Psychiatric Rehabilitation found two studies on "residential options," only one of which had been published in peer reviewed literature (2009). A peer-run hostel inpatient program demonstrated comparable outcomes on a

number of variables to standard inpatient treatment, save for a significantly higher level of satisfaction among the people in the peer-run service (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008; Centre for Psychiatric Rehabilitation, 2009). The unpublished study (Dumont & Jones, 2002) also showed positive outcomes in empowerment and satisfaction, as well as reduced hospital costs.

The Fair-weather lodge model is an approach that has been in place since the 1960s, starting in the United States representing a "cooperative, communal, and collectivist [model] of housing for people with serious mental illness" (Sylvestre, Nelson, Selloff, & Peddle, 2007). Although it is not exclusively run by people living with mental illness, their involvement is key; "persons in the program lived together, worked together, and learned skills necessary to function in a peer supported environment empowering them to function and make decisions relatively autonomous from staff" (Haertl, 2007).

PEER SUPPORT ROLE IN REDUCING HOSPITALIZATIONS

Hospitalizations are noted as a major cause for people with mental illness losing their housing (Forchuk et al., 2006). A multitude of studies have shown the positive effects of peer support on reducing the length of stays in a hospital, as well as the frequency of hospitalizations (Campbell, 2003; Chinman et al., 2001; Dixon et al., 1997; Forchuk et al., 2005; Forchuk et al., 2006; Goering et al., 1992; Haertl, 2007; Lawn et al., 2008; Mead, Hilton, & Curtis, 2001; Onaga et al., 2000; Solomon, 2004).

An Australian study showed that the phenomenon of cyclic hospital re-admissions was more significantly linked to a lack of community supports than to actual psychiatric symptoms (Lawn et al., 2008). Through the implementation of hospital avoidance and early discharge support through connecting individuals leaving the hospital with a dedicated peer support worker, the program saved 300 bed days within the first three months – representing a substantial cost savings (Lawn et al., 2008).

Another study of a transitional discharge model showed similar positive findings. The model consisted of peer support for one year, and ongoing support from the hospital until relationships were developed within the community (Forchuk et al., 2005). The results found improved rates of finance management, safety, and satisfaction with living situation, leading to significantly reduced lengths of hospitalizations, averaging a discharge of 116 days earlier than a control group (Forchuk et al., 2005). The "Welcome Basket" program "developed, staffed, and managed entirely by mental health consumers" helped people make the transition out of hospital and demonstrated positive effects on the prevention of re-hospitalization (Chinman et al., 2001).

Finally, a study on the Fairweather model supported this argument as well, showing a 90% reduction in hospitalization rates in comparison to pre-admission to the program (Haertl, 2007). These findings not only contribute towards the case for peer support in assisting with housing stability, it also presents a cost-benefit case for the implementation of peer support programs within mental health service settings.

SOCIAL SUPPORT AND SOCIAL NETWORKS

Social support, a natural effect from the provision of peer support, was found to have a positive effect on contributing towards stable housing (Calsyn & Winter, 2002). Social support/peer support groups were noted as one of four essential categories for community sustainability by Forchuk, Ward-Griffin, Csiernik, & Turner (2006).

Feeling like a worthy and contributing member of society is a key component to mental health recovery (Jacobson & Greenley, 2001). Yet people living with mental illness face stigma from the broader community, reduced social networks, and barriers to information and services, directly contributing to a sense of being outsiders to society (Hardiman, 2004).

One proven effect of peer support is expansion of individuals' social networks, connections, and the prevention of social isolation (Castelein et al., 2008; Chinman et al., 2001; Coatsworth-Putspoky et al., 2006). Jacobson & Greenley (2001) referred to this as "rejoining the social world," noting it has a significant impact on individual recovery.

As mentioned in the previous section on hospitalizations, it has been shown that the phenomenon of cyclic hospital re-admissions is linked to a lack of community supports more often than actual psychiatric symptoms (Lawn et al., 2008). These issues are interrelated, as a lack of community integration causes an inability to thrive in a public setting, leading to crisis, and eventually without sufficient supports, hospital re-admission. Supportive housing models were naturally seen as a contributing factor to improve social support networks due to their congregate living nature (Goering et al., 1992). The risk in this scenario is that social networks become more homogenous, as in the example of the Regeneration House study, a supportive housing program in Toronto, Ontario, where other residents and staff members accounted for an average of 42% of the social supports an individual had (Goering et al., 1992).

Some existing housing models have attempted to incorporate the concept of peer support and community integration directly into their program structure. Study findings on the Fairweather model have shown significant improvement for residents in their overall functioning, community adaption, and even income, allowing individuals to maintain and thrive in their living environment (Haertl, 2007).

In the recent study done through a collaborative effort by the Toronto Community Housing Corporation and Houselink, preferences of people living with mental illness referenced the expansion of social networks and social supports as instrumental to the maintenance of desirable housing, and requested services that emphasized the development of peer and social networks within the housing corporation (2008).

CONCLUSION

Multiple studies conducted in Canada and internationally have shown the positive effects of peer support in reducing the length and number of hospitalizations, and on expanding and strengthening social networks, which contribute to successful maintenance of housing. While research on peer-run models of housing is lacking, the indirect effects of peer support on recovery provides support for an argument that enhancing and supporting the growth within housing programs could be a promising approach.

ONSITE SUPPORTS IN HOUSING

ONSITE SUPPORTS IN THE DEDICATED MENTAL HEALTH HOUSING SECTOR

There is a consensus in the research literature that 'supports' of some nature are a key component of people with significant mental health problems keeping their housing for a length of time (Nelson, Aubry, & Lafrance, 2007; Rog, 2004). However, the types of supports, how they are provided and by whom, that are most effective of achieving housing stability and individual recovery are not known (Roman, McBride, & Osborne, 2006). One of the key challenges in understanding the nature of beneficial supports is the lack of clear definitions, or even descriptions at all, of the type of housing and related supports (Leff, Chow, Pepin, Conley, Allen, & Seaman, 2009; O'Brien, Inglis, Herbert, & Reynolds, 2002; Roman et al., 2006; Tabol, Drebing, & Rosenheck, 2010).

While some researchers have suggested that the lack of clarity in housing models and the resulting ambiguity in the research evidence have contributed to supported housing being a model whose "potential has not being fully realized" (Tabol et al., 2010), other researchers are confident that there is at least sufficient evidence to "guide mental health providers in how best to meet the housing needs of their clients" (Rog, 2004).

Based on the literature to date, the dominant model or approach to providing supports in relation to housing is commonly known as "supported housing," that is "consumers living in regular housing (i.e., available to the general population) and in which any support is delinked or provided separately from the housing" (Nelson, Sylvestre, Aubry, George, & Trainor, 2007). This type of housing is preferred by people with mental illness (Nelson, Hall, & Forchuk, 2003; Tanzman, 1993) and has demonstrated success in reducing hospitalization and improving peoples' quality of life (Greenwood, Schaefer-McDonald, Winkel, & Tsemberis, 2005). Partly as a result of the research demonstrating its effectiveness, supported housing is advocated by the Substance Abuse and Mental Health Administration (SAMHSA) of the United States, who have produced a fidelity scale to encourage self-evaluation and best practices (although the linguistic confusion in this area is demonstrated by the fact that SAMHSA uses the term 'supportive' housing for the model and scale; Substance Abuse and Mental Health Administration, 2010).

Despite successful outcomes for the supported housing approach, "there are many different ways in which coordination between housing and support services can occur" (Reynolds, Inglis, & O'Brien, 2002) and so-called 'supportive housing' remains a common alternative model, being popular with family members, service providers, and some people living with mental illness in terms of being able to provide onsite, often more structured, services (Goering, Sylph, Foster, Boyles, & Babiak, 1992; Piat, Ricard, & Lesage, 2006; Piat, Lesage, Boyer, Dorvil, Couture, et al., 2008; Rog, 2004; Roman et al., 2006; Sylvestre, Ollenberg, & Trainor, 2007).

Another challenge noted is that, "support is difficult to define, as it varies depending on the individual, the nature of mental illness, and many other contextual factors. Moreover, the level of support will not be constant for a particular individual over time" (Patterson, Somers, McIntosh, Schiell, & Frankish, 2008).

Onsite supports are often defined in the academic and grey literature as the mental health and housing-related services provided in residential treatment facilities, group living sites, or congregate housing (supportive housing, for the purposes of this review). As a practical measure, onsite support will be provided in settings where groups of clients live. These housing configurations include:

- dedicated buildings (all tenants are part of the agency)
- clustered programs (small unit buildings with all units held by clients/residents)
- mixed-use buildings (large unit buildings with 20–25% dedicated to clients/residents; or, mixed in terms of the composition of tenants who are all clients of an agency, e.g., formerly homeless people, both singles and families; Patterson, Somers, McIntosh, Schiell, & Frankish, 2008)

Specific examples of 'onsite support' range from clinical treatment services (e.g., medication management, psychotherapy) to generic support, such as socialization, linkage to external mental health and other services, managing tenant/resident associated issues, group discussions on mental health and housing issues, and activities of daily living (e.g., cleaning, shopping, taking transportation, 'personal care'; Kirsh, Gewurtz, Bakewell, Singer, Badsha, & Giles, n.d.; Patterson et al., 2008).

Broadly defined examples of 'support' may be found in descriptions of different programs. A review of "permanent housing programs" in British Columbia described different types of onsite supports and appears to make some distinctions between 'treatment,' 'rehabilitation,' and 'recovery-oriented' services (Patterson et al., 2008). For example, 'licensed residential care facilities' in B.C. are defined under provincial legislation as able to provide "intensive treatment (e.g., medication management, psychotherapy)" as well as other services (Patterson et al., 2008). This on-site support is 24-hours a day care, which includes nursing staff from 8 to 12 hours a day.

However, another type of residential programs called 'family care homes' are run by 'a family or individual' who, in addition to room and board also provide social supports including 'medication administration' (Patterson et al., 2008). Thus, 'medication management/administration,' while a treatment-related service (although not necessarily a controlled act requiring the role of a registered health professional), can be a type of onsite support that may be provided by clinical providers as well as non- or para-professionals.

Examples of discrepancy between the level of support and the skill level, or formal qualifications of the staff providers are available on both sides of the globe. On-site support models of housing available to people in Victoria, Australia include "supported residential services" which are private sector housing for low income people with complex needs, including many with mental illnesses, who "have fallen through the gaps of the government subsidized housing and support service system" (Reynolds et al., 2002). In Ontario, in 1999, the almost $24 million dollars that was made available by the provincial government to provide housing to people with serious mental illness and who were homeless or at risk of homelessness was invested into a full range of housing models, from structured congregate settings to independent units. Regardless of model, all were funded to provide "a common staff/peer support ratio of 10:1," a level of service equivalent to Assertive Community Treatment (ACT) teams and up to double that available through case management services in Ontario.

The challenge in conceptual definitions is that, to some degree, the availability of support onsite becomes conflated with supportive housing, which also includes many of the following elements: "group living options (e.g., congregate settings, supervised apartments) […] professional support, in whole or in part, [which] is linked to residency in the dwelling and focuses on rehabilitation" (Sylvestre et al., 2007).

While onsite support may be found in permanent housing models, other models, including the 'housing ready' approach, are transitional, designed in principle to move residents along a range from higher level of support to more independent living (Roman et al., 2006). At the higher levels of support, services are provided onsite, as the dwelling is considered to be 'residential treatment.'

Further defining the nature of the housing and supports, services may be viewed as a range from 'high demand' to 'low demand.' Onsite supports are often described as part of the 'high demand' service approach in terms of the requirement for participating in services, often compulsory while living in the dwelling. High demand services are usually designed "to target special needs populations and provide services matched to particular needs" (Roman et al., 2006).

Although there is great diversity in the services described in the literature, high demand can include staff supervision of residents including their use of substances, medication compliance, attendance at services, and restrictions on resident mobility through curfews (Barrow & Zimmer, 1999; Roman, 2006). The goal of many high intensity approaches is the development of independent living skills in residents, although it is also provided in permanent housing options.

Leff et al. (2009) propose a four-group scheme consisting of three housing model types and a fourth 'uncategorizable' group of unique approaches. They describe the housing models as having evolved over time, beginning with the "residential care and treatment" approach, which resembled institution life in that "services, typically support services but occasionally treatment, were routinely provided on site by 'housing staff,' who sometimes lived in the program's housing."

A key element of the evolution of the models was the location of services and the staff who provided them. In the Leff et al. (2009) scheme, the 'residential continuum' model emerged and was characterized by the absence of services and staff in the housing dwelling in order to promote a 'normalizing' environment.

Leff et al. (2009) appear to distinguish between "supports" and "treatment" in residential care and treatment models where staff provide the services onsite. Separation of housing and support services is considered one of the key elements of supported housing (Nelson et al., 2007; Substance Abuse and Mental Health Administration, 2010). The *Housing First* model, which began in New York City, defines itself as a consumer-preference model, in part because it does not require participation in substance abuse or psychiatric treatment to be a condition of residency in scattered site settings, nor are services provided within the housing setting or staff present (Greenwood et al., 2005).

However, the *Housing First* model exemplifies the conceptual ambiguities that underlie housing research. *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, histories of homelessness, and involvement with the criminal justice system). This approach has demonstrated successful outcomes in housing stability, reduced homelessness, psychiatric symptoms, and improved quality of life (Greenwood et al., 2005; Pearson et al., 2007; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003).

The New York City Pathways to Housing program declares that "housing is a basic right for all people" and thus "housing is not connected to compliance or treatment; however, every individual in the program receives support services or treatment from Pathways' Assertive Community Treatment (ACT) teams" which are consistent with the ACT fidelity criteria (Tsemberis & Asmussen, 1999). There are only two requirements for tenancy; guaranteeing rent payment, mostly through participation in money management program, and agreeing to let a staff person, who is a staff member of the ACT team, visit them twice a month in their apartment for the first year of tenancy (Greenwood et al., 2005; Tsemberis & Asmussen, 1999). Thus, although "treatment" and "support" are theoretically separated, becoming a client of an ACT team (although not necessarily agreeing to medication or other physical, psychosocial treatment, or rehabilitation) is a requirement of this approach, thus further confounding conceptual rigor, and reducing the ability the draw conclusions of what constitutes 'onsite' and delinked support.

Several overarching frameworks to set and promote good practices and quality in housing with supports include the role of services, but do not distinguish between onsite supports and those made available in the community (Center for Supportive Housing, 2009; Sylvestre et al., 2007). For example, the American Center for Supportive Housing includes "supportive services design and delivery" as one of the seven dimensions of quality (2009). While this framework distinguishes between different types of housing (including 'tenant-based,' 'scattered site,' and 'master-leased'), it is proposed that most of the quality dimensions "should be applicable" to the different models.

In a Canadian example, a group of housing providers in Toronto, Ontario developed 40 service benchmarks for supportive (including supported) housing services in four domains, of which one was 'support.' This was defined as housing support "provided to individuals and to groups oriented toward promoting healthy living environments" (Sylvestre et al., 2007).

Within the 'support' domain, five areas and eleven benchmarks were created. These included: providing information, supporting open communication (among housing staff, other support providers and tenants/residents), providing housing support, providing individualized support, and providing crisis support (Sylvestre et al., 2007). Housing support was further defined as "tenants/residents are supported in a way that promotes comfort, safety, and positive living experiences; tenants/residents have access to housing supports and services to live successfully in their housing" (Sylvestre et al., 2007).

The benchmarks that arose from this process were designed to be applicable to a range of services and thus, intended to be achieved differently by different providers (i.e., those providing off and/or on-site services). Performance indicators were not established, again reflecting the desire for flexibility in implementation.

In conclusion, while the research evidence clearly shows that support of some nature and degree is a foundation for successful housing outcomes, the evidence is not available to demonstrate what aspects of support and services are best offered 'on-site' versus in other locations. Nor is there evidence suggesting what, if any, differences might be in a service being offered in different locations. Any conclusions that might be inferred from the literature could be achieved by situating the research question among the broader approaches to housing, of which the location of services is but one characteristic among others.

HOUSING AND SUPPORT PREFERENCES FOR PEOPLE LIVING WITH MENTAL ILLNESS

OVERVIEW

Choice or preference about housing is considered to be an essential feature of the supported housing model (Carling & Tanzman, 2006; Nelson, Sylvestre, Aubry, George, & Trainor, 2007; Srebnik, Livingston, Gordon, & King, 1995). Supported housing developed in part as a response to research on the housing preferences of people living with mental illness demonstrating support for independent housing with off-site support and the lack of choice in other approaches to mental health-dedicated housing (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Tanzman, 1993).

When asked about their choices, research has consistently found that people with mental illness share the same preferences for the place they call home as people without mental illness. That is, people with mental illness want to live independent lives, on their own or with people who they choose (e.g., partners, other family, friends, chosen roommates), in affordable, regular homes in livable neighbourhoods with 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).

There are a number of paradoxes in the research and practice of housing for people with mental illness. Concerns exist about the quality of the research produced to date (O'Brien, Inglis, Herbert, & Reynolds, 2002) including from a recent comprehensive review of the peer-reviewed literature, "we encountered a number of limitations in the literature, including conflicting use of program labels, inconsistent definitions of supported housing and its elements, and use of inadequate measurement indices in assessing adherence to program elements" (Tabol, Drebin, & Rosenheck, 2010).

There is a strong move towards greater standardization within mental health services in Canada and internationally which may address these issues in the future (The Substance Abuse and Mental Health Services Administration, 2010; Tabol et al., 2010), including development of tools to evaluate 'choice' and the nature of the concept. A counter-argument by other researchers has been made that this emphasis on evidence-based practice confirmed by rigorous research has "tended to minimize the role of other stakeholders in discussions of effective practice" (Sylvestre, Ollenberg, & Trainor, 2007) and threatens to exclude the expertise of service providers and clients.

However, although there are challenges with research designs for evaluating complex social systems, like community-based housing, there have also been advances in understanding the importance of 'choice' in contributing to recovery through increases in housing stability, happiness, overall life satisfaction, increased mastery and decreased psychiatric symptoms (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Srebnik et al., 1995).

Another paradox is that although research has led to understanding of the importance of choice, the choices people make, and the positive impacts of chosen housing, choice in housing "is honoured more often in theory than in practice" (Minsky, Reisser, & Duffy, 1995; Schutt & Goldfinger, 2000). Lack of affordable housing, discrimination, poverty, and inflexible service systems all lead to people with mental illness not only not having real choices but being forced to 'choose not to choose when they have no choices' (Tsai, Bond, Salyers, Godfrey, & Davis, 2010). Homelessness and instable housing remain significant challenges for people with significant mental health challenges in achieving recovery and community inclusion. Research into the importance of choice and ways to achieve it remain pressing concerns.

STUDIES INCLUDED IN THIS REVIEW

This scan of the literature on the housing preferences of people living with mental illness primarily consists of peer reviewed, academic literature from the early 1990s through to 2010. Articles are from Canadian, American, and Australian sources. A review of social science databases produced 46 results using the search terms of 'housing or supportive housing,' 'mental illness or disorders,' and 'preference, satisfaction or choice'. Of those, less than half were eliminated (includes studies on people with development/intellectual disabilities, clinical case studies, those with a broader focus on 'quality of life' and clinical outcome studies, of which preference was just one variable).

The remaining 26 were reviewed for inclusion. Reference lists were scanned for additional articles. Selected grey literature sources were also included, including those from government funded policy agencies (e.g., Canadian Mortgage and Housing Corporation).

WHAT IS 'CHOICE' AND WHY IS IT IMPORTANT FOR HOUSING?

Choice and preferences are defined in the reviewed literature in a variety of ways, including as an element or behaviour that is closely tied to concepts of independence, control, empowerment, self-efficacy, satisfaction, and community integration (Gulcur, Tsemberis, Stefancic, & Greenwood, 2007; Srebnick et al., 1995; Tabol et al., 2010).

While choice for people living with mental illness is a stated goal of many services, the concept remains challenging to define and evaluate, "if empowerment and increased choice were truly goals in community mental health, research needs to further explore choice conceptualization and definition as well as the relationship of choice to outcomes" (Srebnick et al., 1995).

As the foundational program for the *Housing First* model of supported housing that has emerged to challenge the hegemony of the "linear continuum model of residential services" (Tabol et al., 2010), Pathways to Housing in New York City, United States describes itself as a "consumer preference" housing model (Tsemberis & Asmussen, 1999). Interestingly, in their article outlining the logic model and basis of the approach they do not explicitly define 'choice;' instead offering a description of the "flexibility" in staff, program structure, services, and funding that is "an essential ingredient to operate a program truly based on clients' preferences" (Tsemberis & Asmussen, 1999).

One of the first instruments developed to measure choice was developed by the Center for Community Change in the United States building upon the work of the Independent Living Movement for people with developmental disabilities and applying it to those with psychiatric conditions (Carling & Tanzman, 2006). The instrument includes questions about "current housing, preferred housing, preferred living companions, and supports needed" (Nelson, Hall, & Forchuk, 2003). Tanzman used the scale to conduct one of the first studies reviewing the housing preferences of people living with mental illness (1993).

Srebnick, Livingston, Gordon, & King developed a 'housing choice' instrument in 1995 that has since been used by several studies to define and evaluate the existence and level of choice that people have in regards to different housing situations. The instrument was developed based on factors "discussed in the literature as relating to the perception of choice" (Srebnick et al, 1995). Tabol et al. (2010) critique the original scale in that they claim "no desirable threshold score was identified" and revised versions used by other authors did not include information on psychometrics of their versions.

Despite these limitations, it remains a popular instrument and has been used in a variety of studies in modified formats (Gulcur et al., 2007; Nelson et al., 2007). The 'housing choice' instrument includes questions on the number of options people were provided in their housing, how many of these they considered to be "attractive,"

the amount of influence exerted by others in their decision (higher levels of independence are ranked as more positive), if they received information about their options, and how much importance they attached to their decision (Srebnick et al., 1995).

Most recently, the "ability to choose services and rights of tenancy" as well as choice in housing, has been identified as a key component of the 'fidelity scale' developed by the United States Substance Abuse and Mental Health Services Administration for supportive housing (2010). Elements of 'choice' evaluated in this tool include choice in the type of housing, "real choice" of specific housing unit, people able to wait without losing "their place in line" [on a waiting list], and having control over who they live with (Substance Abuse and Mental Health Services Administration, 2010).

While there is a long tradition of research in housing choice, one criticism that has not received sufficient attention is the degree to which the diversity of the experiences of people living with mental illness has been explored, for example, "the specific experiences and needs of racialised and ethnic minority tenants in such housing first schemes" (Warner et al., 2008).

WHAT ARE PEOPLES' PREFERRED HOUSING CHOICES?

Despite methodological differences in the types of instruments used, the specific groups of people with mental illness, and geographic locations and housing models, consistency in some key characteristics of housing have emerged. An Australian review of important housing characteristics, built upon an early American review (Massey & Wu, 1993), developed six main themes that can also be found in more recent research, including Canadian sources (O'Brien, Inglis, Herbert, & Reynolds, 2002). These six are listed below, and described in more detail in the following paragraphs.

Important Housing Characteristics for People Living with Mental Illness	
Independence and Choice	▪ In own home and alone ▪ Autonomous ▪ Sense of freedom ▪ Independent
Convenient Location	▪ Located close to community services, transport, vocational and rehabilitation services ▪ Located close to social networks ▪ Located close to the person's preferred location
Safety and Comfort	▪ Safe ▪ Secure tenure ▪ Comfortable
Affordable	▪ Leaves enough money for other things
Privacy	▪ Private – have own space
Social Opportunity	▪ Compatible social milieu, i.e., like neighbours ▪ Physical and social supports available which reduce stress

	▪ Place to entertain visitors ▪ Recreational facilities nearby

Independence and Choice

One of the most consistent themes in the literature on housing is the importance of choice, autonomy, and control **(**Carling & Tanzman, 2006; Tanzman, 1993); consistent with the reality that "choice, self-determination, and empowerment are foundational values for people with disabilities, including people with psychiatric disabilities" (Deegan & Drake, 2006). Based on interviews with consumers in Toronto, Ontario, one of the most culturally diverse cities in Canada, this finding was also stressed:

> "The importance of such fruits of empowerment for people who have been historically oppressed and who have had their voices minimized and silenced – both as people with mental health and/or addictions issues, and as members of non-dominant socio-cultural groups – is that much greater."
>
> - Warner, Zahraei, Farah, Nandlal, Jaskulka, et al. (2008)

People with mental illness want to live in independent housing (Nelson, Hall, & Forchuk, 2003; Parkinson & Nelson, 2003; Piat, Lesage, Boyer, Dorvil, Couture, et al., 2008; Tanzman, 1993). Independence may mean living alone but it primarily reflects the desire to choose one's own living companions, which for most people with mental illness, as for non-mentally ill persons, means their family or friends (Rogers, Danley, Anthony, Martin, & Walsh, 1994). Conversely, people do not want to live with other mentally ill people, although the literature is not clear on the specifics of why this or whether this is more accurately defined as not being forced to live in congregate housing with people whose only connection is the shared experience of being labeled as ill (Rogers et al., 1994; Warren & Bell, 2000).

Equally, people prefer accessing their mental health and other support services in a location separate from where they live (Browne & Courtney, 2005; Nelson et al., 2003; Rogers et al., 1994; Tsai et al., 2010). Beyond the physical location of the support is the importance of having control over the support they receive and having it serve their individual needs, or as one person described it, "I'm not told what to do and how to do it, this is what you thinks always. I'm writing the play" (Parkinson & Nelson, 2003).

Access to support and housing must be separated, including strong peer opposition to requirements that people must receive certain treatment services in order to be eligible for housing (Carling & Tanzman, 2006; Tanzman, 1993). Having the choice whether or not to access services, as well as having choice and flexibility in the types of services provided is considered one of the key elements of the successful outcomes of the *Housing First* approach (Greenwood et al., 2005; Tsemberis & Asmussen, 1999).

Having the choice of independence in their housing impacts upon peoples' sense of self-efficacy, and not simply their satisfaction with housing, which in turn has positive benefits for overall quality of life and health (Seilheimer & Doyal, 1996). The 'sense of home' emerges from independent living has impact on housing stability, and hence reduced homelessness and use of inpatient hospital services (Parkinson & Nelson, 2003).

Overall, people with mental illness desire the same need for autonomy as anyone else, or what one qualitative study of peoples' experiences elegantly summed up as "a normal life" (Warren & Bell, 2000).

Despite the clear preference for independence and choice identified by people with mental illness, the process of recovery is complex. The reality of lack of choice in quality, affordable housing means that people often end up living in undesirable situations including group/congregate settings with on-site staffing. In a qualitative study of people with mental health and addiction histories who lived in such housing at one point, findings showed that

while it was not their preference at the time, some agreed, in retrospect, that it was supportive of their goals for recovery and helped them move at some point towards the desired state of independence (Tsai et al., 2010).

In evaluating their 'housing choice' instrument with people living with mental illness, Srebnick and associates noted an apparent paradox that they described as "apparent satisfaction with little choice" (1995). While people did not have many housing options, they were heavily influenced by service providers to make specific choices yet valued having the opportunity to make their own decisions, they nevertheless reported satisfaction with the results and felt they had adequate information.

The authors of this study propose that this may be a result of "learned helplessness" or simply valuing living in the community (as opposed to being hospitalized) and that any setting was appreciated, but they also encouraged more research on this apparent discrepancy (Srebnick et al., 1995). Greenwood and associates, in their study of the *Housing First* model, noted that the subjective perception of choice appeared to be more important in leading to positive outcomes in peoples' sense of mastery and reductions in psychiatric symptoms, as much as actual levels of choice (2005).

Independence could also mean loneliness and isolation, a common criticism of independent living models (Parkinson & Nelson, 2003). Another complexity in the appreciating the importance of choice and independence for people with mental illness in regards to their housing (often as a foundation for all the other aspects of their life) is that this preference has often stood in direct contrast to the importance placed upon supervised, often group living by family members and mental health service providers (Piat et al., 2008; Rogers, Danley, Anthony, Martin, & Walsh, 1994).

Convenient Location

As will be seen, many of the themes identified in the literature are interrelated. Neighbourhoods with amenities are also often the ones that can command higher rents and mortgages, thus "low-income housing is not centrally located, and shops and services are inaccessible" (Carling & Tanzman, 2006; Forchuk, Nelson, & Hall, 2006; Forchuk, Ward-Griffin, Csiernik, & Turner, 2006; Tanzman, 1993; Warren & Bell, 2000).

Safety and Comfort

Living in fear—afraid of being physically hurt or sexually assaulted, losing their lives or their possessions while living in shelters, or shared living arrangements with strangers, in sex/gender-mixed fellow residents, with others who were also struggling with mental health and/or addiction issues—was a dominant theme in many accounts of psychiatric survivors' experiences (Browne & Courtney, 2005; Carling & Tanzman, 2006; Forchuk, Nelson,& Hall, 2006; Parkinson & Nelson, 2003; Tanzman, 1993; Warren & Bell, 2000).

As Ontarian survivors described it in a qualitative study, they were afraid of loosing control of basic human rights due to their lack of quality housing (Forchuk, Ward-Griffin, Csiernik, & Turner, 2006). This fear can take different forms. For example, an Australian in-depth qualitative study of ten people with mental illness living in the community found that four of the group "did not have either a lease or a contract, and expressed feelings of powerlessness and fear of eviction" (Warren & Bell, 2000).

Affordability

Based on an extensive body of research, academics and policy makers have concluded that not having a large enough income acts as a major barrier to acquiring safe and comfortable housing for all disability groups, including people with mental illness**.** Indeed, one study found this to be true for every housing market in the United States (Srebnik et al., 1995).

People living with mental illness emphasize the importance of financial support in successful community living (Carling & Tanzman, 2006; Forchuk, Nelson, & Hall, 2006; Tanzman, 1993). One study found that the people with mental illness were spending 50-80% of their income on rent, and thus concluded that poverty, as much as

anything else, was the major issue for people with mental illness (Carling, 1993; Lambert, Ricci, Harris, & Deane, 1999).

In regards to cost of housing, one participant in a study by Browne & Courtney (2005) on housing and support for people with schizophrenia said, "I can't even begin to think how much it affects my feelings and that it's extremely stressful to pay that sort of rent." The other participant said, "I wouldn't mind a flat, but I know I can't afford a flat for myself." According to the study by Rogers et al. (1994), both people living with mental illness and their families saw help with the rent deposit as one of the most important needs.

Adequate income to pay for suitable housing is one of the four categories of resources identified in a Canadian study as being necessary to promote housing stability (the others being safeguarding human rights; access to service resources and personal support services; and social resources such as community and family support; Forchuk, Ward-Griffin, Sciernik, & Turner, 2006). As disability income programs across Canada and internationally provide incomes that are below the poverty line and fail to keep with the costs of living, few people with significant mental health challenges can access affordable housing (Forchuk et al., 2006).

Affordability was linked to more than the material comforts or quality of housing, it also was essential to achieving independence. In one study, participants who lived on their own and paid high rents were afraid to lose their independence which would mean they would be forced to move into congregate housing (Warren & Bell, 2000).

Privacy

The importance of privacy is related to the emphasis placed on independent living; freedom from supervision by staff; and having access to private bedrooms, washrooms, and other living space (Warren & Bell, 2000).

Social Opportunity

While preferring to live independently, people with mental illness want to have services that emphasize social interaction and development of social networks, such as: peer support, family, friends, and drop-in centres. However, they expressed a need with help in developing friendships and getting along with others (Carling & Tanzman, 2006; Tanzman, 1993) and dealing with loneliness and isolation (Forchuk, Nelson, & Hall, 2006).

A study by Parkinson & Nelson (2003) on the effects of a supported housing program found that this living setting helped people to establish new friendships; improve family relationships; and integrate in the community through volunteer work, employment, educational, and recreational initiatives; "in comparison to the isolation experienced beforehand, these individuals feel more involved and active."

Not simply the quantity, but also the quality of personal relationships have been shown to bloom in a quality living environment, with people finding "friendships were more plentiful, healthy, trusting, reciprocal, and of their choice; and were recognized as long-term and dependable support. Isolation was reduced for all" (Parkinson & Nelson, 2003).

The challenging balance in housing is between the potential source of social support, especially peer support, that can develop in group or congregate living situations, that is "coming home to someone," with the need for privacy and independence (Browne & Courtney, 2005). Being able to talk with others in one's own home was described by some individuals as an important way to "stop the mental illness from 'taking over'" (Browne & Courtney, 2005).

Related to this importance of connection was the need to feel accepted and understood in the broader community. Discrimination and stigma are identified by people with mental illness as being one of the main barriers to their integration into the community, as well as in a psychological sense of "belonging in the community" (Gulcur et al., 2007).

As described by people with mental illness in an Australian qualitative study receiving acceptance and understanding from the broader community were "high priorities" with people placing "a high value on others

having a positive attitude towards mental illness" (Browne & Courtney, 2005). In a different Australian study, it was precisely the concern that neighbours could identify them as being mentally ill because they lived in a congregate setting; that served as one of the key reasons people rejected this living situation, even though there were potential benefits of social support inside the house (Warren & Bell, 2000).

IMPLICATIONS FOR HOUSING POLICY AND PROGRAMMING

While research is clear and consistent with the values that are held by many in society, it remains that "a major challenge to mental health service programs is to move from a poster of rhetoric about choice and empowerment, to actually expanding the extent to which choices are available, including lessening outside constraints on choice by professionals" (Srebnik et al., 1995).

Suggested ways that individual case workers can act to promote choice include presenting their clients with the full range of options that exist (which may be limited); fostering decision making in the people they work with; and recognizing, valuing, and trusting the decisions that people make (Srebnik et al., 1995).

In advocating for the importance of choice, the architects of the *Housing First* approach noted that "models that make housing contingent on relinquishment of control over daily living practices and preferences actually erode an important tool for coping with the very circumstances they are intended to redress" (Greenwood et al., 2005). Increasingly, the importance of choice that has been demonstrated in housing research is becoming recognized in the whole of mental health services, not simply as a way to achieve positive clinical and social outcomes, but as an "ethical imperative" (Drake & Deegan, 2009).

While choice may be the 'right' thing to do, as well as the 'healthy choice,' more investments are required into the development of supportive, affordable housing options as "the concept of consumer choice can only be put into practice if there is a range of housing options available to cater for varying individual needs" (O'Brien et al., 2002).

APPENDIX FIVE: BROADER CONSIDERATION IN HOUSING – SOCIAL HOUSING, THE BROADER DETERMINANTS OF HEALTH, AND HUMAN RIGHTS

CONTEXT

In addition to considering models of housing and support that are dedicated to people living with mental illness and/or mental health problems[21], it is important to consider the broader array of affordable housing programs across Canada to truly understand how we can move forward as a country to devise a real strategy for housing and mental health. While there is no doubt that the continuum of housing and supports includes these dedicated models, the reality is that people with mental illness live in many different types of housing arrangements, as does any person in Canada. These include:

- Owning a home.
- Living with parents or friends.
- Renting an apartment in the private market.
- Living in social housing (including public, non-profits and co-operatives, and other affordable housing initiatives).
- Living in dedicated housing[22] (including 'scattered site' housing, where a rent supplement enables rental in the private rental market; dedicated buildings with self-contained apartments; dedicated homes with private or shared bedrooms) with a variety of housing and/or clinical supports ranging from low to high in intensity.

The reality, too, is that there are also people who, due to lack of appropriate housing and support options, are living in hospitals, shelters, or inadequate and unsafe housing situations, and that this is having a devastating impact on their ability to move towards recovery. **While Canada has a long history of affordable housing, significant changes beginning in the mid-1980s have had a major impact on the availability of safe and appropriate housing in communities across the nation. This has greatly limited the capacity of the housing system to meet the needs of all Canadians and, in particular, of vulnerable groups, including people living with mental illness.** This section of the report has been developed to:

- Explain the history and current status of social housing in Canada,
- Describe housing's role in health and the "fit" within the social policy context,
- Discuss housing as a basic human right and the implications this has for government,
- Review how other countries have addressed affordable housing needs,
- Provide information on the economic, social and personal costs that are incurred when the range of affordable housing is inadequate to meet communities' needs, and

[21] 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).

[22] 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.

- Summarize some considerations for policy and long-term strategies for affordable housing.

The goal of this section is to provide relevant background information to root any future national strategy in good practices with respect to determinants of health, human rights, and relevant policy directions.

METHODS

Multiple activities have been undertaken to develop this section, including:

- Interviews with key contacts and government sources with a focus on mapping existing housing and mental health supports, together with existing policy frameworks relating to housing, mental health, poverty reduction, and prosperity promotion,
- A review of existing provincial/territorial, national, and international reports that discuss issues that impact affordable housing, policy directions that support affordable housing for people with special needs, and effective planning for affordable housing and people experiencing core housing need,
- A review of provincial, territorial and government websites on existing policies and practices related to affordable housing,
- A review of research related to better practices in fostering the creation of affordable housing, with a particular emphasis on social housing and people with special needs, and
- A review of publications issued by key organizations in Canada, including the Canada Mortgage and Housing Corporation, Statistics Canada, the Canadian Policy Research Networks, the Canada Housing and Renewal Association, the Wellesley Institute, the Caledon Institute of Social Policy, the National Council on Welfare, the Canadian Centre for Policy Alternatives, the National Housing Research Committee (CMHC), and the National Aboriginal Housing Organization, together with past work from the project lead organizations (the Canadian Council on Social Development and the Centre for Addiction and Mental Health).

Key words used in searches included: affordable housing, social housing, public housing, mental health, mental illness, policy, social policy, core housing need, better practice, inclusionary housing, housing benefit, housing supplement, zoning, supportive housing, supported housing, green housing, determinants of health, income, human rights, health, and homeless.

DEFINITIONS AND TERMINOLOGY

Policy[23] is about decisions that impact other decisions. Each level of policy impacts what is done at the level below it.

Affordable housing refers to housing that is provided at a price or rent substantially "below-market" through a subsidy or other intervention, and subject to enduring controls on affordability and occupancy. It encompasses social housing typically provided through government assistance, and also affordable rental and ownership housing that might be provided by regulatory concessions or incentives.

Social housing refers to all forms of publicly-assisted housing, including public housing, non-profit and co-operative housing, supportive housing, and more recent "affordable housing" initiatives. It should be noted that there are variations in the degree of targeting and tenant income levels across different social housing programs.

Canada Mortgage and Housing Corporation (CMHC) is Canada's national housing agency. Established as a government-owned corporation in 1946 to address Canada's post-war housing shortage, the agency has grown

[23] da Silva et al., 2008

into a major national institution. CMHC provides mortgage loan insurance, mortgage-backed securities, housing policy and programs, and housing research.

Core housing need (Canada Mortgage and Housing Corporation, n.d.): The CMHC has been analyzing incomes and housing costs for many years to determine the level of "core need". The definition of "core need" is complex and involves three standards: acceptability, suitability, and affordability. There are two steps considered to determine core housing need – the first focuses on whether a dwelling meets the three standards:

- Adequate dwellings: This is a measure of housing condition to determine if 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 if households have a sufficient number of bedrooms based on family composition (effectively a crowding measure).
- Affordable dwellings: This standard is based on a ratio of housing expenditures to total household income; a household paying more than 30% of its before-tax income for housing is considered in need.

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

Housing Income Limits (HILs): are determined for each province by CMHC in consultation with the respective province, based on market surveys and the application of the National Occupancy Standards. HILs also vary by geographic location within a province.

Inclusionary housing[24] refers to a broad range of practices and policies directed at securing affordable housing in mixed-income projects through the development regulations and approval process.

Supportive housing: supportive housing, in the broadest sense, is housing provided in conjunction with the support services necessary to live independently in the community. The level of support may vary, and supports may be provided on-site or off-site. Examples of services include housekeeping, life-skills counselling, substance abuse counselling, and mental health counselling. For the purposes of this project, we have also used the term "housing with supports."

HISTORY OF SOCIAL HOUSING

The following is a summary of policy changes as outlined by the Atlantic Seniors Health Promotion Network (2004), with additional references as noted:

- **Before 1935**: There was very limited government intervention in housing in the first part of the century, with the exception of some housing for veterans of World War I, 334 public housing units built in Toronto in the late 1920's, and assistance to residents following the Halifax explosion in 1917.

The National Housing Act is the federal government's principal legislative instrument for implementation of housing policies.

- **1935**: The *National Housing Act* (NHA) stated that developing/implementing a policy of adequate housing should be seen as a social responsibility – but the focus was on promoting housing development via the private sector, not though the public domain. A driving force for the development of the NHA was the downturn of the economy in the 1930s. Government involvement was seen as temporary rather than permanent.

The dominant theme from 1945 until 1964 was home ownership for every Canadian.

[24] http://www.inclusionaryhousing.ca/glossary-of-terms/

- **1940**: The first crown corporation for housing, Wartime Housing Limited, was created to provide needed housing in urban centers. Government became involved in the control of prices, wages, and rents in 1941 because of the extent to which prices (and rentals) had been increasing.

The 1964 National Housing Act affirmed the provincial role in public housing for the first time.

- **1944**: The second NHA Act was passed, identifying a role for the federal government in stimulating home ownership (seen as an economic stimulus).
- **1949**: CMHC was created and administered via the NHA. At the same time, legislation was passed that affirmed the provincial role in housing through a federal-provincial partnership.
- **1960s**: Increasingly, there was a social movement developing around the housing needs of people living on lower incomes. The NHA, as revised and passed in 1964, reflected this movement, simplifying the process by which provinces could secure funding for public housing (with the federal government assuming 75% of costs, and provinces and municipalities 25%) and firmly placing the responsibility for affordable, appropriate housing for people living with lower incomes or particular needs (such as seniors) within the purview of provincial governments.
- **1973**: In response to a national task force on housing, an assessment of national housing policy or lack thereof (Dennis & Fish, 1972), and pressure from the NDP on the minority Liberal government for a social housing policy, amendments were made to the National Housing Act that introduced programs supporting home ownership and incentives for non-profit housing. After 1973, the federal government directly funded new social housing projects through non-profit societies and housing corporations established by municipalities

"First and foremost, federal housing activity must shift from financing or insuring to meet a specified number of unit starts to planning for housing need, housing quality, the preservation of the existing stock, and the social implications of governmental housing efforts."
(Dennis & Fish, 1972).

- **1979**: Federal/provincial cost-sharing was replaced by an 'interest differential scheme' at least in part due to rising interest rates, together with rising construction and land costs which had a profound impact on construction of public and private non-profit housing. CMHC provided subsidies (equal to the difference between actual interest costs and a 2% interest cost) to municipal, provincial or private corporations or co-ops which were intended to stimulate private sector development of social housing.
- From the **mid-1980s** on, almost $2 billion was cut from federal housing programs.
- **1993**: **All federal funding for new social housing was ended**. Concurrently, provincial and territorial spending on housing begins to decline – in 1993/94 provincial-territorial housing spending stood at just under $2.1 billion annually – within six years, this figure stood at just over $1.5 billion (Falvo, 2003).
- **1996**: Paul Martin, Federal Finance Minister, announced in his budget the transfer of existing federal social housing programs to the provinces., excluding federally funded co-ops, but including all other social housing – **almost half a billion dollars was cut from federal, provincial and territorial housing budgets in the 1990s**.
- **1998**: The mayors of Canada's largest cities declare homelessness a national disaster (Canadian Mental Health Association, 2004).

In 1990, the Liberal Task Force on Housing (co-led by Paul Martin and Joe Fontana, Opposition MPs) released *Finding Room: Solutions for the Future* stating that "there is currently a vacuum in federal policy and direction… Only the national government has the financial resources to address the full dimensions of the needs in this country. Only the national government can put in place the framework for a Canadian housing policy."

- By **2000**, Canada spent less on social housing compared to most western nations, excepting the United States.
- **From 1995–2010**: about 96% of homes built have been on the ownership side, compared to 4% on the rental side – in the previous 20 years (1975-1995), 75% were ownership and 25% rental (Cooper, 2009).

Various governmental decisions limiting involvement over the last 25 years have culminated in a crisis in affordable housing across Canada (Falvo, 2003; Hulchanski 2003; Wellesley Institute, 2008; Sylvestre et al., 2008; daSilva et al., 2008; Mikkonen & Raphael, 2010) – the depth of which is having a profound impact on the range of housing options available to people living with mental illness and/or mental health problems:

- One in 5 renter households pay over 50% of their income for rent – a measure of "serious affordability" issues that is used as a criterion for being at risk of homelessness (Cooper, 2009).
- Over the past 20 years, rents have risen well above the cost of living (Mikkonen & Raphael, 2010).
- Social housing waiting lists continue to grow.
- Vacancy rates continue to decrease.
- Existing social housing is aging, and much of it requires major capital investment. A series of studies have found that the capital reserves of these building are seriously under-funded (Cooper, 2009).

AFFORDABLE HOUSING TODAY

Existing affordable housing is facilitated primarily through some level of government funding. There are a number of ways in which government is involved in affordable housing (Cooper, 2009):

- Government-provided financial assistance to make housing development affordable, including capital grants, mortgage subsidies, tax incentives/write-offs, or other financing mechanisms.
- Rent supplements for some of the units. Rent supplements address the gap between the private market rental rate and what a person can afford. There is great variation in the ways in which rent supplements are calculated (i.e., what is an appropriate level of funding to reflect the actual private market rental rate, required maintenance and operating costs).
- Funding for long-term capital replacement reserve contribution.

While the types of housing programs available to renters or owners vary by province and territory, there are typically the following categories of programs:

- Social housing, which provides a variety of rent geared to income options:
    1. Public housing – this may be focused broadly on people living on lower incomes, but the housing may also be designated for specific populations within this group, such as seniors or families.
    2. Non-profit housing – where the public housing is delivered via not-for-profit agencies.
    3. Co-operative housing – housing that is member-owned and directed, and in which rent is geared to income for 25-75% of tenants.
- Rent supplement programs that subsidize a person's rent to private market levels.
- Programs that promote/facilitate home ownership.
- Programs that promote/facilitate renovation of existing dwellings.

Adequate social housing stock is central to ensuring that there is 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 ways that governments provide housing options for people living with mental illness, with supports provided via regional health authorities or non-profit organizations.

FEDERAL PROGRAMS AND INITIATIVES

The following provides a brief overview of different types of affordable housing programs and initiatives at a federal level:

Program Area	Policy Issue
Affordable Housing Agreement Programs	Affordable Housing
Residential Rehabilitation Programs	Sustainable, safe and secure housing Universal/accessible/flexible design
Energy Efficiency Programs	Sustainable housing
Social/Public Housing Programs	Affordable, safe and secure housing, community supports Universal/accessible/flexible design/aging in place features
Supportive Housing Programs	In-home and community Universal/ accessible/ flexible design

Source: modified from daSilva et al. (2008).

Social/Public Housing Programs

Following 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[25]. Annual federal subsidies are paid to the province or territory, and the agreements identify that these subsidies will extend into the 2030s; however, they are frozen at 1995/1996 levels. Coupled with the declining values of the subsidies, the existing stock is aging, which means that the costs of ongoing maintenance are increasing every year.

Affordable Housing Agreement Programs

In 2001, the federal government and the provinces and territories signed an Affordable Housing Framework. The federal government committed to increasing the supply of housing and preserving existing affordable housing, and each province designed its own programs to deliver the funding. There is a 50-50 matching agreement, whereby the province and its partners must match the funds contributed by the federal government. Federal funding is for capital only – there are no ongoing housing subsidies (including rent supplements) available.

Federal Homelessness Partnering Strategy

The first iteration of the Homelessness Partnering Strategy (HPS) was created in 1999 as the Supportive Community Partnership Initiative (SCPI), part of 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.

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

- Encourage community partnerships to bring together provincial/territorial social services to help homeless individuals attain self-sufficiency.
- Increase the knowledge base about homelessness.

Federal funding has been extended for each of the Affordable Housing, Residential Rehabilitation Assistance, and Homelessness Partnering Strategy Programs until March 31, 2011.

The HPS provides capital grants to community-based organizations, and is overseen by the federal department of Human Resources and Skills Development Canada (HRSDC). Organizations may be in the private or not- for-profit sectors, and provide a range of services and programs that are 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. As noted, the HPS provides grants, not ongoing, permanent funding. Organizations receiving funding through the HPS, or previously, through SCPI, have generally received funding on a one- to three-year basis, with renewals possible shortly before the end date of each granting period. At the current time, funding has been extended until March 2011. HPS is divided into four components[26]:

- Designated Communities: Communities identified as having a significant homelessness problem are able to access funding, which must be matched by other sources (similar to the previous SCPI model).
- Outreach Communities: Smaller cities, rural and outlying areas, including areas in the North, can access funding for specific projects that address homelessness.
- Aboriginal Communities: Partnerships achieved under this component work to address specific issues relevant to the Aboriginal community.
- Federal Horizontal Pilot Projects: This component pulls together the various federal departments, such as Health Canada, the Department of Justice, Citizenship and Immigration, and Indian and Northern Affairs to address a variety of issues that may lead to homelessness.

In addition, there are knowledge exchange and information system initiatives in place to support the HPS.

Residential Rehabilitation Assistance Programs

In the Atlantic provinces, a low of 7.9% of the population in Newfoundland to a high of 9.7% of the population in New Brunswick lived in housing in need of major repairs, according to Statistics Canada 2006 Census data.

These programs, administered by the Canada Mortgage and Housing Corporation, focus on preserving existing housing occupied by low-income households and modifying 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. Again, provinces and territories enter into a cost-sharing agreement with the federal government. Generally speaking, provinces and territories deliver the programs, although there are exceptions, such as PEI, where the CMHC delivers the federal RRAP programs. The RRAPs have been in existence in some form since 1973. At this point in time, funding is available for only two components (Homeowner RRAP and Disabilities RRAP)[27].

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

Energy Efficiency Programs

Statistics Canada, in its Survey of Household Spending, reports that median household spending on water, fuel, and electricity grew by 55% from 1997 to 2006 – much faster than the increase in accommodation costs for

[26] http://www.onpha.on.ca/AM/Template.cfm?Section=Specific_Funding_Options#hpi
[27] http://www.onpha.on.ca/AM/Template.cfm?Section=Specific_Funding_Options#hpi

owners or renters, and more than double the rate of inflation. The Low Income Energy Network reports that the high cost of energy is the second leading cause of evictions among renters in Ontario (Wellesley Institute, 2008).

These provincial programs are focused on making homes more energy-efficient and encouraging energy conservation, thereby helping households to reduce energy costs and save money. In addition, CMHC offers a 10% refund on its mortgage loan insurance premium when a borrower buys or builds an energy-efficient home. To qualify for this refund, the home's energy efficiency must either be rated using the EnerGuide rating system, or be R-2000 certified and meet certain minimum requirements.

Supportive Living Programs

These programs facilitate the provision of what is commonly termed "supportive housing" in the social housing sector - housing that incorporates support services that promote independence and life skills.

- Services can be provided through a combination of on-site and off-site arrangements.
- Programs can be developed by the for-profit, the not for-profit, or the public sector, or by collaborative efforts among these sectors.
- Types of housing may be rental, leasehold, condominium, and life lease.
- Different programs focus on different populations – for example, seniors, people living with mental illness, or people who are homeless.

In the mental health realm, we sometimes differentiate between "supported" (where supports offered are not tied to a specific dwelling, but to an individual who has mental illness) versus "supportive" housing (where supports are linked to a specific dwelling and these dwellings are made available specifically to people with mental illness).

THE RANGE OF AFFORDABLE HOUSING STRATEGIES

The overarching goal of social housing policy is to help low- and moderate-income households to obtain acceptable housing at a price they can afford (Pomeroy, 2001; Policy Research Initiative, 2005). Pomeroy discusses different approaches to this goal:

Supply measures: reducing or subsidizing the construction cost of housing so that it is more affordable. Usually involves measures related to increasing production of housing. Strategies include:

- Direct support for public/non-profit production.
- Incentives for private rental unit development.
- Creating a level playing field for rental development.
- Reducing development costs.
- Encouraging lower cost forms of development – single-room occupancy, secondary suites.
- Shifting patterns of ownership (facilitating non-profit ownership).

> "While supply approaches can play an important role in moderating the market pressures that exacerbate affordability problems, supply initiatives cannot be implemented on a sufficient scale to tackle the large backlog of these problems. Some form of rental assistance is necessary to address the affordability gap."
> Pomeroy (2001)

Demand-side measures: increasing a household's ability to pay by increasing/ supplementing income. Strategies include:

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

As evidenced in Appendix 7 (Provincial and Territorial Maps of Housing and Supports), these two approaches are not mutually exclusive.

Pomeroy also describes a third approach, involving influencing the price of existing rental housing through rent controls, diverting demand from the rental sector (i.e., through facilitating home ownership options) and securing private, for-profit stock and transferring ownership to not-for-profit owners. Table 1 provides a summary of the types of strategies Canada has used, together with the advantages and disadvantages of various approaches.

Table 1. *Comparison of Supply and Demand-Side Measures in Affordable Housing Strategies*

Strategy Description	Advantages	Disadvantages
Supply Measures		
Public/non-profit production ▪ Predominant program response in Canada through postwar period. ▪ Public or not-for-profit owner/operator with a specific mandate to operate housing for low-income households – can be "fully targeted" (100% low-income households) or "mixed income" (some units are rented at market rates, others are subsidized). ▪ Mixed income generally preferable – avoids concentration of very poor households and contributed to stereotyping. ▪ Some form of subsidy, either as a capital, grant, favourable mortgage rate, or ongoing subsidy, so that the rents charged to tenants are affordable – the operating agreement between the provider and the government is signed. ▪ Tenants are charged "Rent Geared to Income" (RGI) – generally 30% of income. ▪ Any ongoing subsidy usually matches the amortization period of the mortgage – assumes rents will cover operating costs after subsidy ceases. **Variations on a theme to lower program cost** ▪ Non-profit organization develops housing at market level than receives rent supplement assistance – demand side measure – to address affordability. ▪ Assist non-profit organization to buy existing private rental housing – doesn't create new supply, but does address affordability issues.	▪ Creates a permanent stock of units specifically to serve lower income households – some assurance that rents will be affordable over the long-term. ▪ Long-term investment in a permanent asset. ▪ Addresses supply issues and affordability within one program – may be why costs are high. ▪ Responds directly to low levels of production – can moderate the inflated rents when supply is low. ▪ Units can be designed to meet particular needs (i.e., physically accessible). ▪ New supply funding can be geographically targeted to markets with acute supply problems.	▪ New construction costs and the associated subsidy costs tend to be quite high on a per unit basis. ▪ Generally involve long-term (35-year) subsidy commitments - with new commitments come 'exponential' increases in subsidy cost. ▪ Revenues are low at rent-geared-to-income rents – income mixing improves viability and lowers the capital grant requirement. ▪ At their peak, non-profit programs produced 25,000 – 30,000 units annually –incremental new supply programs don't have the capacity to address the need (e.g., 590,000 households who spend 50% of income ore more on housing).
Incentives for private rental development ▪ Have been used in the past, including providing grant or interest-free loan to a developer in return for modestly designed units (assuming they will rent for less money) as well as temporary tax measures. ▪ Intention is for these programs to replace some portion of the owner's own equity with government funds without impacting rental revenue – makes development more attractive. ▪ Given the lower rate of return expected for modest rental housing, significant	▪ Provides new rental stock supply – has a trickle down effect for lower-income households. ▪ Depending on the development economics in a particular city, stimulus measures leverage private investment and will cost less than assisting non-profit development (because	▪ Stimulus measures have been controversial – may disrupt market equilibrium. ▪ Does not create permanent affordable housing. ▪ Permanent – once operating agreements around conditions and

Strategy Description	Advantages	Disadvantages
capital grant or interest-free deferred loan would be needed to make this option appealing (estimated in excess of $15,000 to $20,000 per unit in 2001).	they generally have little to no equity to invest).	targeting expire, units are no longer affordable housing. ▪ No long term public asset created through government investment.
Creating a level playing field for rental development rate of return on rental investment is impacted by tax treatment. For example: rent not charged on GST but still must be paid for supplies and services (cannot claim input tax credits against GST paid) – there is a partial rebate for new rental construction and substantial rental renovations; small rental investors are not considered small businesses so are not eligible for the lower tax rate on first portion of income; 'pooling' provisions eliminated 'Pooling' provisions – tax reform in 1972 terminated the practice of pooling rental properties to defer recapture of depreciation (difference between sale price and the depreciated value of the building) upon the sale of a property. It used to be that investors could 'pool' recaptured depreciation with the undepreciated value of other buildings, effectively deferring paying income taxes. Importantly, the loss of 'pooling' provisions may actually contribute to building demolition (i.e., it is sometimes more beneficial from a tax perspective to demolish the building to avoid the recapture of depreciation).	▪ Could correct inefficiencies in tax treatment. ▪ May improve after-tax feasibility for new production and stimulate new construction. ▪ Most tax measures would apply only to private developers. However, any reduction in GST also would benefit non-profit providers.	▪ Resistance from federal finance officials to implement tax changes. ▪ These measures have a direct impact upon the production of affordable housing but may stimulate market rent development at higher rent ranges.
Reducing development costs ▪ Land costs, labour and material costs all contribute to the relatively high cost of producing new housing in Canada – Total development costs are also increasing due to taxes and fees on development. ▪ At the time of the review (2001), new rental housing in an urban centre cost $65,000 to $105,000 for one-bedroom apartments and $90,000 to $160,000 for three-bedroom family units – costs in today's economy are likely substantively more ▪ Land costs equate to 15-30% of costs – condominium markets have driven up land costs. Land is zoned based on use (e.g., residential) and density (units per hectare or as a ratio of the total site area) – legislation from provinces could empower municipalities to bonus densities for rental development (i.e., allow for higher density for rental development compared to condo development). ▪ The significant growth of the construction industry during strong economic times has driven up costs of labour and materials: affordable housing	▪ Lowering land costs and development charges have major impact in reducing costs and encourage private development and new supply. ▪ Waiving development fees for certain types of housing encourages residential development in the core and helps to narrow the cost gap for non-profit organizations.	▪ Cost-reducing approaches on their own still won't create housing at affordable rents without some level of subsidy. ▪ Requiring municipalities to lower or remove development costs eliminates municipal revenue while the province and federal government gain income tax revenues from the construction labour and ongoing operations (if for-profit).

Strategy Description	Advantages	Disadvantages
strategies can incorporate assistance to reflect the market. ▪ GST, as well as harmonized sales taxes where they exist, have also contributed to increasing costs.		
Encouraging lower cost forms of development Options include secondary suites in single detached homes (often done without approval or conformance with existing building regulations) and small unit or 'single room occupancy' accommodation. Secondary suites: often created in basements, subdividing upper floors, or conversion of garage; home is usually owner occupied – main concern from municipalities is health and safety ▪ Some municipalities have legalized secondary suites, and there are some examples of provincial or territorial programs which provide some financial support to create the suites SRO approach: development of very small bed-sitting rooms (often 150-300 square feet compared to 350-400 square feet in a typical bachelor) ▪ When well-designed, they can provide cost-effective options for urban singles ▪ Development and construction costs may be as much as 40-50% less than construction of one-bedroom units	▪ Significant cost advantages. ▪ Effectively augment more traditional building forms. ▪ Stretch subsidies further (i.e., per unit costs are lower.	▪ Regulatory barriers and neighbourhood resistance may limit opportunities. ▪ SROs that currently exist are usually older hotels that have transitioned into a form of affordable housing – they are often in ill-repair, and people do not have access to the supports they need. British Columbia provides an interesting example in terms of how existing SRO hotels have been purchased by the province and renovated. Ensuring health and safety of the units, together with making appropriate supports available, is crucial.
Shifting patterns of ownership and facilitating not-for-profit ownership ▪ Non-profit housing sector tends to focus on new building where costs are high to create stock, consequently creating the need for higher levels of subsidies ▪ Acquisition of existing rental stock is not often used as a strategy because: buildings often in serious disrepair with costs to renovate sometimes outpacing what it would cost to build; social housing funding programs required all tenants to be in core housing need, with incomes below specified thresholds (i.e., problematic to acquire buildings that already were occupied with some tenants not in core need, as this would require evictions). ▪ Far more multiple unit rental properties are sold each year than the number of non-profit units that were constructed by the programs of the early 1990s: while not all rental properties will be appropriate, some may be – income and	▪ Relative cost-effectiveness compared to new construction. ▪ Decreases likelihood of NIMBY (not in my backyard) because properties already exist. ▪ Purchase by non-profit organizations can preserve and potentially expand the remaining stock of housing that is relatively affordable to lower income households. ▪ Access to lower-income households would be improved as they no longer would be competing against 'better' higher-income tenants.	▪ Reluctance of non-profit sector. ▪ Acquisition option is limited by the availability and quality of properties on the market – requires careful selection and assessment. ▪ Well suited for market downturns but the strong economy, low vacancy rates and high rents have driven up prices.

Strategy Description	Advantages	Disadvantages
capital tax incentives can also be provided to private landlords where they sell to non-profit providers. ▪ Currently, private landlords tend to sell to private landlords – these landlords upgrade the buildings with the intention of increasing rental cash flow, further increasing rents and decreasing affordability in the private market. ▪ Subsidy would be required - ideally a capital grant to facilitate down payment – total cost per units is still 40-50% less than building new so the same total grant can secure more units than building new. ▪ Can incorporate opportunities for lower-income households gradually to become homeowners – requires counselling and ongoing mentorship, and assistance with down payment.	▪ Acquisition with existing tenants remaining can effectively facilitate a mixing of income without added cost (since market rents cover breakeven rent). ▪ Homeownership and scattered rental portfolios offer options to access existing rehabilitation programs to upgrade dwellings.	
Demand Side Measures		
Rent Supplement ▪ Agreement between public funding agency and landlord where landlord provides rental units for low-income tenants on specified terms ▪ Tenant's out-of-pocket rent based on rent-geared-to-income basis (generally 30% or less of income). ▪ Agreement makes up the difference between the tenant's "RGI" rent and actual market rent – often includes an inflationary index to allow market rent to increase annually (but leaving the tenant's RGI portion stable; i.e., drives up the cost of the subsidy). ▪ Requires interest of private landlords – often a poor history of success. ▪ Initial terms for agreements in the 1970s were for 15 years – more generally now on a 3-5 year term. ▪ Rent supplement programs can also be used in non-profit projects – older projects weren't necessarily RGI based but included units with rents slightly below market levels (facilitated by capital grants or good mortgage rates) – allocating rent supplements to these units can then facilitate RGI rents for very low income households. ▪ Combining rent market supplements with acquisition of property is another strategy.	▪ Addresses affordability issues. ▪ Agreement is specific to contracted units so condition/quality can be monitored. ▪ More cost-effective to stack rent supplements on non-profit housing.	▪ Does not address lack of supply. ▪ Depends on willing landlords and available units. ▪ When vacancy levels are low, private landlords can fill apartments with private market tenants. ▪ Administrative requirements can be seen as deterrents by private landlords. ▪ If private landlords choose not to renew agreements, can create issues for existing tenants.
Shelter Allowance ▪ Direct payments to tenants so that they can secure housing in the private market. ▪ Assistance is formula-based – takes into account both income and market rent for the unit.	▪ Directly addresses affordability issues. ▪ Can be broad-based or rationed. ▪ Funding formula can allow for targeting and varying levels of assistance to reflect different target groups and markets.	▪ Potential higher number of applicants and higher levels of total expenditure ▪ Does not address low levels of supply

Strategy Description	Advantages	Disadvantages
▪ Setting maximum levels of assistance (maximum rent level) can limit overconsumption and manage overall budget. ▪ Costs can be reduced by restricting potential client groups, phasing in benefits, or using lower levels of benefit.	▪ In contrast to rent supplements and all supply measures, all tenants who are in need and eligible for assistance potentially can receive it – there are no waiting lists. ▪ Used in combination with non-profit supply, stacked shelter allowance reduces cost challenges in generating non-profit supply.	▪ Subsidy costs are impacted by inflated rents ▪ Does not create a long-term asset
Reform of welfare shelter benefits – A transitional shelter allowance ▪ Roughly half of core need households and households with severe affordability issues are social assistance recipients. ▪ Benefits generally include a shelter component that is not related to actual rental costs or indexed to the cost of living – issue has been exacerbated by increasing rental costs. ▪ Most provinces and territories have educational and employment initiatives for people on social assistance, but haven't recognized the importance of stable and affordable housing in people making gains in employment and education. ▪ Most social assistance programs discourage work because people lose their shelter benefit when they leave welfare. ▪ Transitional shelter allowances delink shelter from ongoing benefits. Transitional shelter allowances act as an ongoing support for people who leave welfare for work, but require a modest allowance to maintain affordable housing.	▪ People are less at risk of losing their housing when moving off welfare into work. ▪ The costs of this transitional initiative would be significantly lower than ongoing full welfare benefits. ▪ The shelter allowance formula is based on actual rent and earned income and benefits educe as income increases.	▪ Over time, more households may remain on assistance and costs could expand – unlike welfare, which tends to be more intermittent and transitional. ▪ Implementing this approach requires significant commitment to welfare reform.

CURRENT TRENDS AND ISSUES IN AFFORDABLE HOUSING

GROWING AFFORDABILITY GAP

Across Canada, the number of households spending **more than 30% of their income on shelter** grew by 17% from 1991 to 2001 to include almost 1.5 million households. Of these 1.5 million households, 590,100 were paying 50% or more of their income for shelter. Average shelter cost-to-income ratios for these households were 67% (Canadian Mortgage and Housing Corporation, 2004). Ontario posted the biggest growth in core housing need among the provinces and territories, with a 47% increase from 1991 to 2001, for a total of almost 600,000 households in 2001 (Wellesley Institute, 2008). Similar trends were observed in homeowners' rates of shelter spending (Ontario Non-Profit Housing Association & Co-operative Housing Federation of Canada Ontario Region, 2009).

Renters have, on average, household incomes that are half those of owners. Between 1997 and 2005, housing spending by the average tenant household grew by 21%, while the average tenant household income grew by only about half of that (12%; Wellesley Institute, 2008). For example:

- Prince Edward Island: Housing spending up 25%; incomes up 6%.
- Ontario: Housing costs up 17%; income up 4%.
- Saskatchewan: Housing spending up 24%, income up 3%.
- Alberta renters saw the single biggest increase in spending on rental housing for the median household, at 32%, while the median renter in Ontario faced the largest annual housing bill, at $8,395.

While there have been significant increases in shelter-to-income ratios, the proportion of Canadian households in **core housing need** declined from 15.6% to 12.7% between 1996 and 2006 (Canadian Mortgage and Housing Corporation, 2009). A subset of households in core housing need are those that spend more than 50% of their household income on shelter – 5.3% of all households (573,000) were deemed to have these **serious affordability problems** in 2001. While this was less than in 1996, it was still an increase from the 1991 rate of 4.7%. These households are considered to be at higher risk for homelessness and d, on average, close to $4,800 in before-tax income remaining after paying shelter costs in 2001, compared to the $9,700 averaged by households in core housing need and the $52,000 averaged by the typical Canadian household[28].

Highest Housing Costs

Ontario has the highest housing costs of any province (median household shelter costs of $10,878, according to Statistics Canada). One in every three Toronto households spends 30% or more of their income on housing – the worst record among metropolitan areas across Canada. (Michael Shapcott, 2009). In Toronto, more than 66,000 people are waiting up to 12 years for rent geared to income accommodation (Housing Opportunities Toronto, 2009).

Not surprisingly, core housing need is highest among low-income households. About two-thirds of low-income households (earning less than $20,000 a year) make up a disproportionate share of those who pay a high proportion of their incomes on housing (TD Bank Financial Group, 2003). Human Resources and Skills Development Canada identified that in 2006, half of households with incomes less than $27,607 per year were in core housing need. Young adults, elderly women, female-headed lone parent families (28.6% in 2006), single persons (18.9% aged 18-64 and 25.6% aged 65+ in 2006) and Aboriginal households (20.4% in 2006) disproportionately experience core housing need (Canadian Mental Health Association, 2004; Human Resources and Skills Development Canada, 2009). **Although there have been slight decreases in core housing need for both renters and homeowners since 1996, renters**

[28] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing Need http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

were still four times more likely than homeowners to be in core housing need in 2006. Immigrant tenant households tend to experience high core housing need levels, with the highest levels experienced by those who have recently immigrated (35.4% in 2006), and levels declining over time (Ontario Non-Profit Housing Association & Co-operative Housing Federation of Canada Ontario Region, 2008).

There are variations in core housing need across the country. In 2006 (Canadian Mortgage and Housing Corporation, 2009):

- Higher than average need was identified in British Columbia (14.6%), Ontario (14.5%), Newfoundland and Labrador (14.2%), the Yukon (16.3%), and the Northwest Territories (17.5%) – and the proportion of households in core housing need in Nunavut (37.3%) was almost three times the national average.
- Lower than average need was identified in Alberta (10.1%), New Brunswick (10.3%), and Québec (10.6%).

Additionally, **there are significant differences in comparing core housing need in Canada's 33 largest urban areas** (averaging 13.6% in 2006) with need **outside of large urban areas** (which averaged 9.3%)– urban areas with highest need in 2006 included Toronto (19%) and Vancouver (17%).

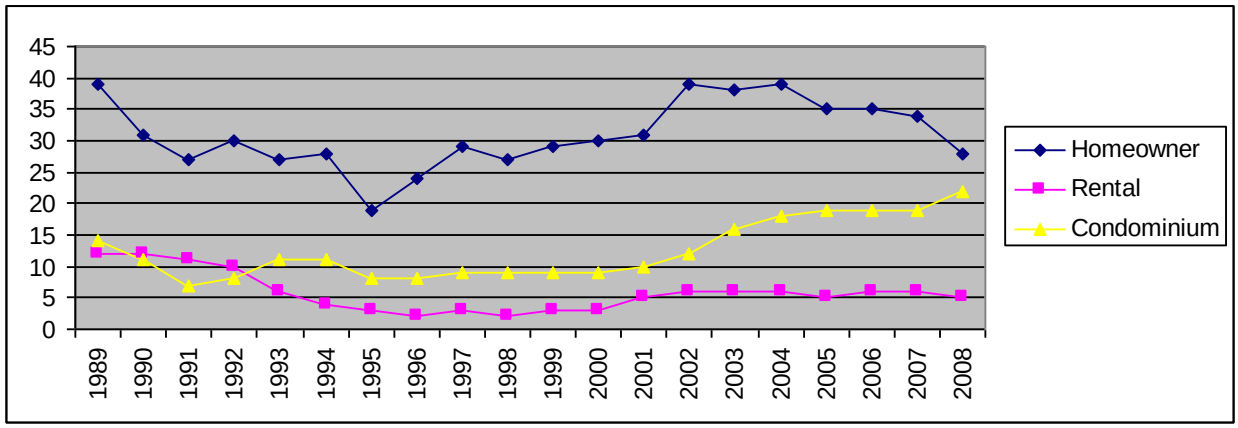
But housing affordability is affecting all Canadians. The ratio of average residential prices to median family income measures the home ownership affordability gap. This ratio rose from 3.23 in 2000 to 4.11 in 2005, meaning that in 2000, the cost of the average Canadian house was 3.23 times the amount of a Canadian family's annual pre-tax income, while in 2005, the house cost more than 4 times the family's income. In practical terms, this means that the 45% increase in house prices far outpaced the 19% increase in income. Vancouver, Victoria and Toronto have seen the largest disparities between housing cost and income (Community Foundations of Canada, 2008). There have been some improvements to housing affordability during the economic downturn, with markets in Alberta and British Columbia showing the most significant improvements (Royal Bank of Canada, 2009).

Most low-income Canadians are among the one-third of Canadians who are renters, and rents are increasing faster than renter household incomes. Canada's social housing sector remains stagnant at about 5% of the overall housing stock, and little new non-profit or co-operative housing has been created since the national program to fund new affordable homes was cancelled in the 1990s (Mikkonen & Raphael, 2010).

STAGNANT DEVELOPMENT IN THE PRIVATE RENTAL AND AFFORDABLE HOUSING MARKETS

Although there have been a significant number of new homes developed over the last decade, there is very little affordable rental housing and almost no new social housing. According to the Wellesley Institute's 2008 National Report Card, in 2005, 184,411 new homes were completed across Canada – but fewer than 10% were in the rental market. In contrast, in 1982, about 1 in every 6 new homes was in the non-profit or co-op housing communities alone (not even including the overarching rental market) and was funded by the federal government. In 1995, when the federal government moved out of social housing, the number of new non-profit or co-op housing units hit a low of 1,000 units for all of Canada. Between 1980 and 2000, the number of affordable housing units created by the federal government dropped from 24,000 to 940 annually (Canadian Mental Health Association, 2004).

Figure 1. *Housing starts, by intended market, communities of 10,000 or more, 1989-2008.*



Sources: reproduced from Human Resources and Skills Development Canada (Canadian Mortgage and Housing Corporation, 2008; Statistics Canada, 2009).

Rental investment has been discouraged by changes to the federal tax treatment of rental housing over the past 30 years – for example, prior to the federal tax reforms in 1972, rental investors could use Capital Cost Allowance deductions in excess of rental property income against income from other sources. Tax reform restricted the use of excessive CCA deductions to principal business corporations. Currently, when real estate investors sell a property, they must pay tax on the amount that the sale price exceeds the depreciated value (the 'recaptured depreciation' up to the original value of the property). Before 1972, rental investors could 'pool' recaptured amount with undepreciated capital on other buildings, effectively deferring the income taxes on the building sold. After 1972, taxes had to be paid on recaptured depreciation upon the sale of any rental property valued at $50,000 or more. Capital gains tax was also introduced as part of 1972 tax reform. Previously, the sale of a rental building (or any other capital property) was not subject to capital gains tax.[29]

Policies at other levels of government, as well as the overall economic picture, also affect the attractiveness of the private rental market for investors. The tax treatment of rental housing, the accessibility of competitive mortgage insurance, complex and changing regulatory requirements, and local development charges and fees are all controlled by one level of government or another. Removing such barriers would result in significant new private rental investment. The bulk of the new investment would be at market rents less than those commonly charged in new rental projects today, which tend to be targeted to the high end of the market (where the demand for housing is relatively small).

The net effect of the changing environment has been a greater interest and focus on condominium and new home development by builders, and a diminishing level of development of private rental market housing. As the availability of private rental market housing has decreased, rental costs have increased, effectively 'shutting out' people living on income assistance programs (National Council on Welfare, 2008) due to both affordability issues and the fact that landlords are less willing to rent to people with mental health issues. People living on low incomes or income assistance are left with no option but social housing, which also has seen dramatic declines in development over the last twenty years.

[29] Ministry of Municipal Affairs and Housing, Ontario Rental Market Dynamics http://www.mah.gov.on.ca/Page1280.aspx

FUNDING AND INVESTMENT IN AFFORDABLE HOUSING

The Wellesley Institute's 2008 National Report Card noted the following with respect to progress made since the signing of the **Federal/Provincial/Territorial Affordable Housing Agreement** in 2001[30]. Since this time, the federal government has committed an additional $2 billion in funding for social housing development or renovation as part of the 2009 Economic Stimulus package, generally requiring matching funds from provinces/territories and their partners.

Provincial Investment in Affordable Housing

Ontario has made the fewest investments in affordable housing – in the fiscal year ending March 31, 2009, Ontario spent $64 per capita on affordable housing, about half the provincial average of $115 per person (source: Wellesley Institute calculation based on Statistics Canada Government Revenue and Expenditures database). At the head of the provincial pack are Saskatchewan ($214 per capita – almost three and one-half times greater than Ontario), Nova Scotia ($175) and Alberta ($154). On March 12, 2009, the Alberta government announced a $3.2 billion, 10-year housing plan.

- The provincial and territorial governments were supposed to provide annual audited financial statements and detailed performance reports, but these have not been released publicly.
- Federal housing spending, as of 2007, was $1.7 billion higher than in 2001 due to a one-time payment of $1.4 billion authorized by Bill C-48 in 2005[31]. There is no provision for matching funds from provinces and territories for C-48 funding, nor are there directions that it be used for social housing. This funding was supposed to be in addition to the $1 billion previously promised through the Affordable Housing Agreement.
- Every province and territory except Ontario has made at least modest gains in raising housing funding since 2001, but those gains have been largely offset by housing cuts in Ontario as it downloaded housing to municipalities – Ontario cut provincial spending by $732 million from 2001 to 2007. When combined with the $358 million the Ontario government was to have invested as part of the AFH Agreement, there was an overall deficit of $1 billion in comparing its commitments to housing versus actual expenditures between 2001 and the issuing of the 2008 National Report Card.
- **As of 2008, only Prince Edward Island, Nova Scotia, Saskatchewan, the Northwest Territories and Nunavut have met or exceeded their original 2001 commitments**.
- **Nunavut has the best spending record**, increasing funding by 713% from the $7.5 million promised in 2001 to an additional $61 million in housing funding actually delivered between 2001 and 2007.
- When looking at per capita housing spending, **spending ranges from a low of $41 in British Columbia to a provincial high of $256 in Saskatchewan**. The three Northern territories have the highest per capita spending, with Nunavut recording $4,853.

Current federal initiatives are typically time-limited with small amounts of funding. Coupled with this is a **lack of overall strategy and policy direction at the national level**. A number of provinces and territories, including Ontario, do not have a housing strategy. Additionally, Ontario has downloaded the cost of affordable housing to municipal governments to a greater extent than any other province. According to Statistics Canada, in fiscal year

[30] Michael Shapcott, pp.2-4

[31] Bill C-48 authorized $4.5 billion on various policy areas including post-secondary education, housing, the environment, public transit and foreign aid. It was the result of an agreement between the minority Liberal Government and the New Democratic Party (Proceedings of the Standing Senate Committee on National Finance Issue 27 - Sixteenth Report of the Committee, July 18, 2005).

2008-2009, the Ontario provincial government invested $829 million in affordable housing, compared to $1.3 billion invested by municipal governments (despite the limited revenue sources they are able to access)[32].

VACANCY AND AVAILABILITY RATES IN THE PRIVATE RENTAL MARKET

According to Human Resources and Skills Development Canada[33], the national rental vacancy rate in 2009 was 3.1% - lower than it was in 1995 at 4.5%, but a great improvement over the 2001 low of 1.7%.

Vacancy rates for two-bedroom apartments ranged from 7.1% in Fredericton to less than 0.5% in Sudbury and Victoria in 2007. The national average was 2.6% (Community Foundations of Canada, 2008).

- Provinces with vacancy rates higher than the national average: Alberta (5.5%), New Brunswick (3.8%) and Ontario (3.6%).
- Provinces with vacancy rates below the national average: British Columbia (3.0%), Prince Edward Island (2.8%), Québec (2.4%), Saskatchewan (1.5%), Manitoba (1.0%) and Newfoundland and Labrador (1.0%).
- Nova Scotia was on a par with the national average (3.1%).

In 2009, among Canada's 15 largest urban areas, Calgary had the highest vacancy rate (5.3%), and vacancy rates were lowest in Québec (0.6%). Rates tended to be higher in large urban areas in Ontario and Alberta, but were below the national average in Montréal (2.5%) and Halifax (2.9%). Rates were very low in Québec City (0.6%), Winnipeg (1.1%), Victoria (1.4%), and in Ottawa/Gatineau on the Ontario side (1.7%).

Availability rates include vacant units, but also units that are occupied but available – in 2005, the Canada Mortgage and Housing Corporation availability rate survey identified that 4.1% of all apartment and row house units in Canada were available for rent – 2.8% were vacant and 1.3% were occupied but available. In 2009, the availability rate across Canada had increased to 4.3% (3.1% vacant and 1.2% occupied but available).

AGING HOUSING STOCK

Private and social housing rental stock is aging – by 2020, some 60% of rental apartments in Toronto will be at least 50 years old (Housing Opportunities Toronto, 2009). As housing ages, the need for costly repairs for basic components (roofs, plumbing, electrical) also increases. Additionally, living in aging buildings creates an “energy burden” on low-income households, who pay increasing utility and heating costs due to living in dwellings that are not energy efficient.

CHALLENGES IN PROVISION OF ONGOING SUPPORTS

The increasingly limited resources available to social housing agencies to maintain their aging housing, pay their staff appropriately, and invest in their organizations (Hulchanski, 2002) have left few, if any, additional resources that could be used to provide housing support for tenants. Alongside this challenge are an increasingly pressured mental health service system and a lack of consistency in who plays what roles in the provision of housing and related supports to people with mental health issues.

[32] Shapcott, M., July 21, 2009
[33] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing Need http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

CHANGING DEMOGRAPHICS AND VULNERABLE GROUPS

Aging Population

By 2036, 25% of the Canadian population, and 30% of the Atlantic Canadian population, will be over 65 (Lilley, 1999). The Atlantic Seniors Health Promotion Network outlined, as part of a broader 2004 review, the significant physical, social, and financial impact of housing on seniors' lives:

- Physically: Seniors experience increasingly lower levels of mental and physical ability, and therefore, the social and physical characteristics of the housing context may have a more significant impact on their well-being and life satisfaction than they would have on a younger population.
- Socially: Research identifies housing as a key determinant of the quality and quantity of social contact and social support in the lives of the elderly. It can determine levels of social interaction, and, therefore, have a positive or negative effect on a person's feeling of loneliness.
- Financially: Housing can consume up to 50% of an older person's income, and older women who live alone are more likely to have financial problems related to their housing.

We need to give serious consideration to how the changing needs of our aging population are going to be met by housing and support models and future policy frameworks. **People living with mental illness are already a marginalized population in the housing market, and there will be a compounding effect due to aging** (Beer & Faulkner, 2009).

Youth and Young Adults

Youth under 24 years of age are said to be the fastest growing segment of the homeless population in Canada (Koeller, 2006). The lifestyle of homeless youth places their health at risk, and the longer a person is homeless, the worse his or her health becomes. Health problems can be worsened by cold, hunger, poor housing, poor diets and high-risk behaviours – in local studies in Halifax, many homeless youth reported depression, anxiety, post-traumatic stress, and suicidal tendencies, as well as substance use issues (Koeller, 2006).

People with Mental Illness

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

- As many as 30% of people without housing live with a mental illness.
- 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 supports.

First Nations, Métis, and Inuit Peoples

The Winnipeg Right to Housing Alliance notes that Aboriginal housing agencies have waiting lists including thousands of families and individuals on and off reserve – an issue seen consistently across the country. Housing issues facing people who are First Nations, Métis or Inuit are more fully discussed in Appendix Six, and also in the context of Canada's treaty obligations to house Aboriginal peoples.

THE BROADER SOCIAL POLICY CONTEXT OF AFFORDABLE HOUSING

Statistics Canada estimated that the cost of bringing all poor people out of poverty in 1996 would have been $17.8 billion (National Welfare Council as cited in Rupert Coalition, 1998).

HOUSING AS A SOCIAL DETERMINANT OF HEALTH

The greatest influences on our health status are not addressed through our traditional health care system. Traditional health care is only one of 12 key determinants of health identified by Health Canada[34]. 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). **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 there has been increased income inequality since at least the mid-1980s in most, if not all, of the countries. **Canada was identified as one of a small group of countries that have had significant increases in income inequality since the mid-1990s** (Organisation for Economic Cooperation and Development, 2008). The analysis further shows that the differences across countries are, at least in part, **due to different government policies, either through more effective redistribution, or better investment in the capabilities of the population to support themselves**.

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. While the median family income in Canada was $60,600 in 2005, an increase of 19.3% over 2000 (or a 6.4% increase in real income when adjusted for inflation), 20.6% of Canada's families lived in poverty. Between 1980 and 2005, the poverty rate as measured by the Low Income Cut-Off has dipped below 20% only once, in 1989 (Community Foundations of Canada, 2008).

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

- **There is a strong relationship between housing quality and health: the better the dwelling, the better the health status**. (World Health Organization, 2007). **Poor treatment retention and mortality are associated with substandard housing**.

Substandard housing conditions and substance use were associated with treatment abandonment among 10% of patients (n = 671) receiving treatment for multidrug-resistant tuberculosis. Among the default group, a sub-sample were traced (n = 47), and 53% of these died within one year of the default time. High levels of psychiatric diagnoses and low levels of education were found among the group of patients that died (Franke et al., 2008).

- **Stable housing is associated with reduced use of expensive hospital health care services (Culhane & Metraux, 2002)**.

Use of hospital emergency services and hospital admissions among a study group (n = 75) of women living with HIV was found to be *associated with concurrent mental illness and substance abuse*. This strength of the association was **impacted by the women's access to stable housing** (Andersen et al., 2005).

- **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**.

Street involved, homeless and substance abusing individuals are at *risk of morbidity and mortality*. Pauly (2008) found that harm reduction approaches in acute care settings improve access to health care among street involved persons but do not impact housing status. While this study did not look specifically at the variable of mental health, from the body of data about the prevalence of concurrent disorders, one may assume a high prevalence of mental health problems among this study population.

[34] Health Canada (http://www.hc-sc.gc.ca/hppb/phdd/does/common/appendix_c.htm).

- **The neighborhood level of social disorganization or organization is an important determinant of mental health** (Braubach, 2007).

The risk of substance related mental disorders increases with neighborhood deprivation and neighborhood disorganization (Chaix et al., 2006).

- Recovery is associated with social role satisfaction and a positive sense of community.

An adult age group of women (n = 80) recovering from child sexual abuse participated in a longitudinal study across seven years. The study found that **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).

In poor districts, many factors make healthy lifestyles more difficult (World Health Organization, 1999):

  - There are fewer recreation areas;
  - A heightened sense of crime inhibits people from going outdoors, socializing, and engaging in a physical activity;
  - Access to public transport is poor;
  - The types of food recommended in health-promoting strategies are not available or affordable; and
  - Primary health care services are less available than in more advantaged areas.

- Among the elderly (65 to 85 years), low educational attainment is associated with the risk of poor health (n = 9225). **Poor mental health was associated with type of 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.**

Recent housing statistics indicate that a growing number of older persons, mostly women, live alone. In 2003, 35% of women aged 65-74 lived alone. The proportion jumps to 42.8% for those 75-84, and among the very old (those over 85), 38.5% live alone. In 1971, 39% of widowed persons lived alone and by 2001, this percentage had risen to 72% (Atlantic Seniors Health Promotion Network, 2004).

"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).

SOCIAL POLICY DISCOURSE IN CANADA

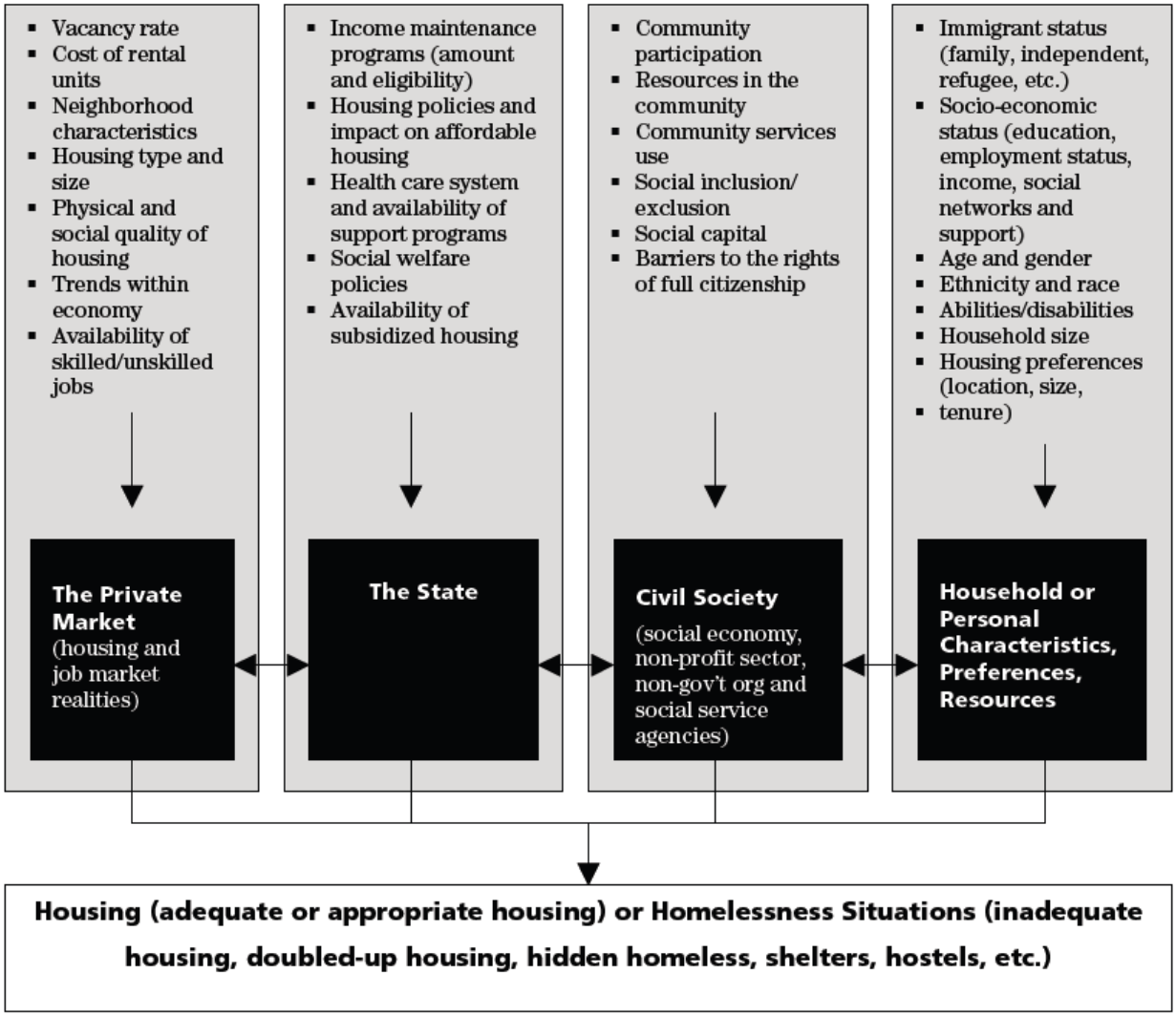
The **Policy Research Initiative (PRI)** of the Government of Canada has existed in one form or another since 1996 and is tasked with:

- Providing leadership in carrying out research projects that cross-cut various departmental mandates.
- Supporting the research needs of the federal public service.

- Providing support to the Deputy Ministers' Policy Committees on the medium and longer-term aspects of their policy agendas.

PRI activities are overseen by a Steering Committee of Deputy Ministers, chaired by the Deputy Minister of Human Resources and Skills Development. **In a 2005 analysis of housing, poverty, and social exclusion, the PRI noted the policy disconnect between housing and broader social policy development** that "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" (Policy Research Initiative, 2005). Historically, the CMHC and the National Secretariat on Homelessness have collaborated on policy activities, but generally operated their programs separately. Although housing issues and homelessness are now consolidated under one ministry (Human Resources and Skills Development Canada), the PRI notes that "an administrative divide remains". From a poverty and exclusion perspective, homelessness and/or inadequate housing is a form of exclusion - a product of persistent poverty that "accentuates the negative effects of that socio-economic situation" (Policy Research Initiative, 2005). Figure 1 provides a framework that identifies factors, and their interactions, that are associated with housing stress.

Figure 2. *Factors that impact housing.*



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

Using this model, we can see how social and economic forces can disproportionally affect certain groups who can often face other social and economic integration challenges – to be fully effective, housing policy cannot be isolated from other social and economic policies targeting long-term poverty: "the self-reinforcing nature of these connections also suggests that housing policy can be made more effective if social supports are incorporated into housing policy (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: households that must spend a disproportionate amount of income on rent often "face food insecurity, possible, and are unable to participate in healthy community activities such as active recreation and children's social programs" (Bryant et al., 2002).

The Province of Quebec 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 et al., 2009).

The province of Quebec provides some insight as to the impact of social policy – the social environment – on health inequities. A recent study 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, Quebec's low-income residents were at the least risk for major chronic diseases – this is despite the better behavioural risk factor profiles and higher level of education among B.C.'s low-income population as compared to Quebec. Until recently, the province of Quebec was the only province in Canada to have a comprehensive poverty reduction strategy in place (formalized as law in 2002) and the study concludes 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).

"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).

A true "social policy" approach to housing policy then, means moving beyond social housing, or housing dedicated specifically to people with serious mental illness - it is an integral component of a social policy designed to secure the well-being of the population as a whole (Hay, 2005).

IMPLICATIONS OF A SOCIAL POLICY APPROACH TO HOUSING AND SUPPORTS FOR PEOPLE WITH MENTAL ILLNESS

Because of the complex interactions across the social determinants of health, and because housing intersects with so many areas of social and economic policy, 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** (housing, income, health services, etc.) **together with multiple sectors** (departments within government, multiple levels of government, community members, the private market, and so forth).
- Effective social policy also reflects a **place-based understanding** – this means that local community knowledge and capacity is harnessed in the implementation of local programs, rather than hampered by a one-size-fits-all approach to housing for people with mental illness (Hay, 2005). The Homelessness Partnering Strategy

(formerly the National Homelessness Initiative's Supporting Community Partnerships Initiative) is one example where there was strong community engagement in translating social policy 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, businesses, and the public through to the most senior levels of government ensures there is the **right balance between local solutions (place-based approach) and national goals**, and also facilitates sharing of resources and 'lessons learned.'
- 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.

The National Council on Welfare (2007) described a social policy approach to eradicating poverty in Canada that integrates the elements outlined by Hay: the need for an overarching vision and plan of action, accountability and leadership for implementation of the strategy, targeted investments, and outcomes to measure the progress of the strategy. The "four cornerstones," which we can learn from in considering the development of a national housing strategy for persons with mental health issues, are:

1. A national strategy with a long-term vision and measurable targets and timelines.
    a. Comparative target or aim (i.e., relative to other countries) or a specific target (i.e., to reduce poverty by a certain proportion)
    b. Progressive short, medium and long-term targets
    c. Targets for segments of the population that are most at risk
2. A plan of action and budget that coordinates initiatives within and across governments and other partners.
    a. Includes federal, provincial/territorial, municipal and Aboriginal governments, as well as agencies outside of government
    b. Common objectives together with resources required for implementation (financial and human)
    c. Government mechanisms to ensure coordination and cooperation among departments and ministries
    d. Specific focus may be needed on factors that put some Canadians at greater risk than others
3. A government accountability structure for ensuring results and for consulting Canadians in the design, implementation and evaluation of the actions that will affect them.
    a. Achieved through legislation, ministerial responsibility for the strategy, public progress reports
4. A set of agreed-upon indicators to plan, monitor change and assess progress.
    a. Core set of indicators, informed by Canadians, tied to the targets and priorities of the national strategy
    b. Multiple measures track different dimensions of poverty, i.e. deprivation, social exclusion, and inequality

Housing policy, then, is only one part of a broader social policy approach, and this has been evidenced in more recent national work, in particular, the report on poverty, housing and homelessness by the Senate Standing Committee (Eggleton & Segal, 2009). Indeed, this project's policy mapping process has shown an increasing trend by provinces and territories to develop social inclusion, poverty reduction, and/or prosperity promoting strategies, in which housing is one of the main thrusts. In their work for the Ontario Non-Profit Housing Association, Pomeroy and Evans (2008) explore how housing acts as a mechanism in poverty reduction strategies internationally. In their analysis, they identify three ways that housing can contribute to poverty reduction:

1. **Reducing net housing cost**/increasing after-shelter disposable income (through **rental assistance funding** that can be used in private rental market housing or through social housing units where rent is geared to income).

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 – something that rental subsidies on their own will not achieve.

Rental assistance can be "person-based" (tied to the individual or family) or "dwelling-based" (tied to the actual housing unit in a community).

"Aspatial" subsidies focus on relieving high shelter cost and are "person-based" – they can be used in any geographic location or for any type of housing. Aspatial subsidies address affordability through the provision of the rental subsidy. They can include:

- Portable shelter allowances that address the gap between actual housing cost and a specified percentage of income (up to a maximum), and
- Set shelter allowances that are integrated as part of the social assistance or income assistance programs in a province or territory.

Pomeroy and Evans (2008) summarize the impacts of aspatial subsidies for individuals and households:

- Individuals can afford to secure and keep housing.
- Households are more stable financially. More income is available to both pay the rent and secure other necessities of life.
- Household members are not as vulnerable, even if they have unstable employment situations.
- Increased residential stability helps to build social support networks that facilitate identifying and pursuing employment opportunities.
- Increased residential stability benefits young families by decreasing the disruption to children's school environments caused by frequent moving.

Poorly designed social housing programs can exacerbate poverty and its attendant social repercussions (Pomeroy & Evans, 2008).

These positive impacts are augmented when rental assistance is provided in the environment of social housing:

- Social housing landlords tend to be more collaborative in working with tenants who are in arrears.
- Housing often includes on-site or community-based links to support people with particular needs, including people with long-term disabilities and/or mental health issues, the formerly homeless, or the frail elderly.
- When social housing is designed as a mixed-income community and located outside of a high-poverty area, social networks may be expanded, which can increase access to employment and educational opportunities.

"Place-based" subsidies have direct links to a place of residence and involve building or buying housing that is fixed in location.

While Pomeroy and Evans note that facilitating asset building through ownership can be counter-productive for very low-income households, but that for some low-moderate income households it can be a very effective strategy in asset building/poverty reduction, provided there is strong mentoring and ongoing support.

On the other hand, poorly designed social housing and poverty reduction programs and policies can have unintended consequences:

- Work disincentives are created when person-based housing assistance has high levels of "claw-back" rates if some level of employment is achieved.
- Low benefit levels of person-based housing assistance may actually encourage families and individuals to seek low-cost and inadequate housing, thus contributing to a concentration of poverty in particular neighbourhoods. The benefits of increased housing affordability are counteracted by the negative neighbourhood issues.

To develop effective housing policy – including housing policy for people living with mental illness – that does not have unintended consequences of "concentrating" poverty in particular neighbourhoods, a variety of approaches need to be considered:

- **Rehabilitation programs** to improve physical 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 that neglect the 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 U.S. – the so called Moving to Opportunities program).
- **Emergency programs** to provide housing for the street homeless, abused women and other priority households.
- **Tax-based incentives** to encourage private sector construction or rehabilitation of rental housing.

HOUSING AND CITIZENSHIP

This holistic understanding of the social determinants of health – and the social policy environment - is inextricable tied with the principle of housing as a basic human right of all citizens. "Housing" as a human right is explicitly stated in the United Nations Universal Declaration on Human Rights (UDHR; 1948):

> *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 UDHR (United Nations, 1948)[1]

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 and medical care and social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age. Article 7 guarantees equality before the law and equal protection by the law for all people, including against discrimination.

Likewise the United Nations Declaration of Indigenous Peoples which was recently passed by the United Nations Human Rights Council also identifies housing in its rights declaration:

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).

"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."[1]

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 on the national territory.

The United Nations has identified these immediate steps that a country is obligated to take in meeting 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.

"Human rights, without social and economic rights, have little meaning for most people." – John Humphrey (Humphrey, 1984). Humphrey was a Canadian law professor, and wrote the first draft of the United Nations Declaration of Human Rights.

Many nations have embedded the concept of health, housing and human rights within their policy and legislative frameworks. The European Union has identified that "health security" includes "the basic human right of every individual to a good standard of physical and mental health, including the right to sufficient, healthy food, the right to decent housing, the right to live and work in safe environments, and the right of access to education and information on health" (World Health Organization European Region, 1999).

Our own Canadian Charter of Rights and Freedom (1982) was built upon a set of principles with an optic to unify Canadian society under a set of common legal rights framework. These legal rights, however, do not specify access to specific provisions such as housing. Some attempts have been made to read into the Charter "economic rights" from subsections 7 and 15 ("security of the person" and "equality rights") but this has been a subject of controversy.

Two approaches therefore may be considered in the creation of a larger policy framework to address the housing needs of persons with mental health problems: a *human rights approach* and/or a *social determinants of health approach*. Both of these approaches are not necessarily exclusive of each other.

The World Health Organization (WHO) Medium Strategic Plan for 2008-2013 integrates these two perspectives (social determinants of health approach together with rights-based considerations) through the following strategic objective: "to address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights based Approaches."[35]

The *Health for All* Policy Framework issued by the WHO (1999) further identifies three main approaches in focusing on specific health inequities where there are significant differences between socioeconomic groups:

- Focus on **specific health problems** where significant differences between socioeconomic groups have been observed – easily understood by the public, government officials and health service providers.

[35] Ibid p.194

- Focus on the **risk factors and underlying causes of inequities** in health – this is identified as **being more appropriate when wide income differences** are apparent, or when there are pockets of severe unemployment or poor **housing**, particularly at the local level.
- Focus on **groups at particular risk** - in **overall health** policies, differential targets may be set for these groups.[36]

The United Nations makes the following observations with respect to people who are homeless[37] or people with disabilities, in the context of the right to adequate housing:

- The most common definitions of homelessness recognize that social exclusion as part of the person's experience - "homelessness implies belonging nowhere rather than simply having nowhere to sleep" (United Nations, 2009).
- Poverty is the common denominator for people who are homeless – other factors that increase people's risk of homelessness: 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.
- "The "deinstitutionalization" of mental health care, which first started in many countries during the 1960s and 1970s, led to persons with disabilities swelling the ranks of the homeless unless it was accompanied by a parallel growth in community or other support.

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 not only that housing should be physically and economically accessible to persons with disabilities, but that they should be able to effectively participate in the life of the community where they live.

What does the right to adequate housing mean?

The following summarizes the clarifications of the right to adequate housing by the United Nations Committee on Economic, Social and Cultural Rights[38] - we have included those elements that are of particular relevance in thinking about current issues and trends in social housing:

1. The right to adequate housing **contains freedoms** including protection against forced evictions, freedom from arbitrary interference with one's home, and choice in determining residence,
2. The right to adequate housing **contains entitlements** including security of tenure, equal and non-discriminatory access to adequate housing, and participation in housing-related decision-making at the national and community levels.
3. **Adequate housing must provide more than four walls and a roof**: Housing must meet minimum criteria – of particular note:
    - *Affordability*: housing is not adequate if its cost threatens or compromises the occupants' enjoyment of other human rights.
    - A*ccessibility*: housing is not adequate if the specific needs of disadvantaged and marginalized groups are not taken into account.

[36] Health 21: The Health for All Policy Framework for the WHO European Region (1999), European Health for All Series ; No. 6, ISBN 92 890 1349 4, p.17.
[37] For statistical purposes, the United Nations has defined homeless households as households without a shelter that would fall within the scope of living quarters. They carry their few possessions with them, sleeping in the streets, in doorways or on piers, or in any other space, on a more or less random basis
[38] Office of the United Nations High Commissioner for Human Rights. The Right to Adequate Housing, Fact Sheet No. 21/Rev.1, excerpted from pp. 4-10.

- *Location:* housing is not adequate if it is cut off from employment opportunities, health-care services, schools, childcare centres and other social facilities, or if located in polluted or dangerous areas.

- *Cultural adequacy*: housing is not adequate if it does not respect and take into account the expression of cultural identity.

4. **Protection against forced evictions – forced** evictions are defined as the "permanent or temporary removal against their will of individuals, families and/or communities from the homes and/or land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection." These evictions can be carried out for a variety of reasons including making space for development or infrastructure projects, urban redevelopment or city beautification, or prestigious international events, or societal patterns of discrimination.

The right to adequate housing:

5. **Does not require the State to build housing for the entire population** – instead it includes strategies that are needed to prevent homelessness, prohibit forced evictions, address discrimination, focus on the most vulnerable and marginalized groups, ensure security of tenure to all, and guarantee that everyone's housing is adequate. Measures can require intervention from the Government at various levels: legislative, administrative, policy or spending priorities.

6. **Is not only a programmatic goal to be attained in the long term. Governments are obligated to make every possible effort**, within their available resources, to realize the right to adequate housing and to take steps in that direction without delay. Some obligations are immediate including guaranteeing the right to adequate housing in an equal and non-discriminatory manner, to develop specific legislation and plans of action, to prevent forced evictions or to guarantee a certain degree of security of tenure to all.

7. **Does not prohibit development projects which could displace people** but imposes conditions and procedural limits on redevelopment - it is the way in which such projects are conceived, developed and implemented that is important.

8. **Is not the same as the right to property** – it is intended, instead, intended to ensure that *everyone* has a safe and secure place to live in peace and dignity, including non-owners of property. Security of tenure, the cornerstone of the right to adequate housing, can take a variety of forms, including rental accommodation, cooperative housing, lease, owner-occupation, emergency housing or informal settlements.

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 (United Nations Right to Adequate Housing, Fact Sheet 21, 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" (May 1993). The Committee also expressed concern about "the persistence of poverty in Canada."

In 1998, the United Nations Committee on Economic, Social and Cultural Rights maintained that Canada's failure to implement poverty reduction policies between 1993 and 1998 had further exacerbated homelessness among vulnerable groups in the population.

By 2006, most of the 1993 and 1998 recommendations by the CESCR had not been implemented (Kothari, 2009).

> Homelessness is 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, Kothari "confirm[ed] the **deep and devastating impact of this national crisis** on the lives of women, youth, children and men, including a large number of deaths. The Special Rapporteur also noted as a cause of this national crisis the lack of a properly funded national poverty reduction strategy" (Kothari, 2007).

In his 2009 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, he made these recommendations with respect to housing (p. 2):

> "The Special Rapporteur confirms the deep and devastating impact of this national crisis on the lives of women, youth, children and men, including a large number of deaths[2]. The Special Rapporteur also noted as a cause of this national crisis the lack of a properly funded national poverty reduction strategy" (Kothari, 2007).

1. **Recognize the right to adequate housing by all levels of Government 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 (p. 10).
   - It appears that no action has been taken in response to the repeated recommendations of the CESCR to include economic, social and cultural rights in the Canadian Human Rights Act and in provincial/territorial human rights legislation (p. 11).
   - 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 (p. 13).
   - Many landlords operating in the private market continue to engage in discriminatory practices such as: screening-out tenants based on their **social condition, source of income or because they receive social assistance**; refusing to rent to single mothers, families with children; precluding young people and new immigrants from accessing accommodation because of their inability to provide landlord references, credit history, and substantial work history; refusing to accommodate persons with disabilities; and denying accommodation to 16 and 17 year olds living independently of parents (p. 15).
2. **Commit to a comprehensive national housing strategy with stable and long-term funding**
   - Municipal authorities are often on the forefront of requests related to adequate housing and have to deal with concrete situations. In his discussions with many of these authorities, the Special Rapporteur noted a perception that higher authorities have discharged their share of responsibility for providing adequate housing for the population to them, yet without providing them with adequate resources (p. 7).

- 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 that have been described by housing experts in Canada as a "fraying patchwork" (p. 8).

- 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.

3. **Adopt a comprehensive and coordinated national strategy for the reduction of homelessness and poverty**

- As early as 1999, the Human Rights Committee expressed concern that homelessness had led to serious health problems and even to death in Canada. It recommended 'that the State party take positive measures required by article 6 to address this serious problem.' The federal government has committed a one-time-only allocation of $22 million per year for five years for a pilot project [Mental Health Commission of Canada's Homelessness Demonstration Project] that will address mental health and homelessness (pp. 16-17).

- It is hoped that all human rights bodies in Canada will devote increasing attention to the crisis of homelessness and inadequate housing and seek effective remedies (p. 11).

- The Special Rapporteur remains concerned about the significant number of homeless 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 (p. 16).

4. **Address the situation of Aboriginals in and off reserves through a comprehensive and coordinated housing strategy**

- The federal government has accepted responsibility under the Indian Act and other legislation and programs for Aboriginal people living on federal recognized reserves, including housing programs. The 2009 federal budget contains a one-time-only allocation of $400 for on-reserve Aboriginal housing. The federal government provides an annual subsidy of $272 million for on-reserve Aboriginal housing. However, the Special Rapporteur was informed about the significant on-reserve housing problems in every part of the country. In addition, with a majority of Aboriginal people living in urban areas or in areas where their claim to land is not yet recognized, neither the federal government, nor the provinces or territories, accepts responsibility for funding Aboriginal housing initiatives. Aboriginal people are told that they have to compete with non-Aboriginal groups for any available housing or other funding (p. 20).

> "Throughout his mission, the Special Rapporteur was disturbed to see the devastating impact of the paternalism that marks federal and provincial government, legislations, policies and budgetary allocation for Aboriginal people on and off reserve. These policies have seriously compromised the right to self determination that Aboriginal people enjoy under the original treaties and the International human rights instruments and deeply affected their housing and living conditions" (Kothari, 2007).

- Overcrowded and inadequate housing conditions, as well as difficulties accessing basic services, including water and sanitation, are major problems for Aboriginal peoples. These challenges have been identified for many years but progress has been very slow leaving entire communities in poor living conditions for decades (p. 21).

Finally, the March 2009 Universal Periodic Review of Canada, again reinforced the importance of the rights to adequate housing, and subsequent strategies and investments needed.

The ways in which Canada is in violation of its obligations in making progress on the right to adequate housing were first summarized by the Rupert Rooming House Coalition in its submission to the United Nations Committee on Economic, Social and Cultural Rights (1998)[39]:

- Acts of racial or other forms of discrimination in the housing sphere;
- Adoption of legislation or policies clearly inconsistent with housing rights obligations, particularly when these result in homelessness, greater levels of inadequate housing, the inability of persons to pay for housing and so forth;
- Repealing legislation consistent with, and in support of, housing rights;
- Unreasonable reductions in public expenditures on housing and other related areas, in the absence of adequate compensatory measures; and
- Overtly prioritizing the housing interests of high-income groups when significant portions of society live without their housing rights having been achieved.

While there has been some progress made through provincial and territorial policy and legislative initiatives, as well as some limited federal initiatives, successive reports and recommendations through the UN Human Rights Council identify ongoing, serious concerns in Canada's progress since 1998.

BILL C-304: CREATING A NATIONAL HOUSING PLAN

Most recently, 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 Canadian Mortgage and Housing Corporation (CMHC), which falls under the federal Human Resources and Skills Development, 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) from Senators Eggleton & Segal (2009), 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** – for example, 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. Housing plays a central role in national poverty reduction strategies in France, Ireland and Sweden. Housing is integrated in related initiatives to broader social strategies in the Netherlands and the United Kingdom. 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 in 2007, is summarized in Table 1. In Canada, we have a number of examples of such strategies at a provincial level, discussed in Appendix 3, which are also referred to as "**prosperity promoting**" or "**social inclusion**" strategies.

[39] Excerpted from Rupert Rooming House Coalition (1998). The Human Right to Adequate Housing in Canada: A Comment on Canada's Compliance with the International Covenant on Economic, Social and Cultural Rights, with a Focus on Homelessness. Submission to the United Nations Committee of Economic, Social and Cultural Rights. Written by J. David Hulchanski (http://www.web.net/rupert/un.htm).

Ultimately, Canada stands virtually alone among G8 countries, indeed among most developed countries, in lacking a national framework to address affordable housing.

For purposes of comparison in Table 2, 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). Total owner households in Canada stood at about 68% of total households according to the Statistics Canada 2006 census. Table 3 summarizes specific housing policies and the social housing landscape among **G8 countries** (excepting Japan).

Table 2. *Interplay of housing and poverty reduction strategies in a section of developed countries.*

Country	Description of Housing and/or Poverty Reduction Strategy
European Union	▪ Common framework guides member countries 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 a. EU Countries develop plans to further these objectives and report progress publicly on the EU website
France	▪ The third priority of their 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 ▪ Utilize a broad number of measures to assess progress 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 within their 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 within 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 – this is substantively more than in Canada
Netherlands	▪ Affordable housing programs are primarily funded by 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 subsidized the purchase and development of social housing stock as their primary housing strategy ▪ In 1991, the national government stopped subsidizing low-income housing providers, replacing them with housing allowance (calculated using a rent-geared-to-income model). About 30% of renter households receive the national rent allowance (universal program;

	given out on the basis of income to rent ratio) ▪ Found that 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 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 on social well-being in New Zealand 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 long-term vision: for the period 2006-2008, included job creation, reduction of ill-health at work, improvement of 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 reduced from 27% in 1997 to 22% in 2004. A million pensioners and 800,000 children moved out of relative poverty since 1999 (National Council on Welfare, 2007)

Table 3. *Housing Policies in G8 Countries.*

Country	Policy Initiative	Features
United States	Housing Choice Voucher Program[40] Recently released Open Doors: Federal Strategic Plan to Prevent and End Chronic Homelessness	**Overview** **Federal Strategic Plan to Prevent and End Chronic Homelessness** (2010): targets ending chronic homelessness in five years, preventing/ending homelessness among Veterans in five years; preventing/ending homelessness for families, youth and children in ten years; and setting a path to end all types of homelessness. Action themes: 1. Increase leadership, collaboration and civic engagement (across all levels of government, community members, and public and private organizations) 2. Increase access to stable and affordable housing (providing affordable housing and supportive housing) 3. Increase economic security (increase employment opportunities and access to programs and services that reduce people's vulnerability) 4. Improve health and stability (integration of primary and behavioural health services with homeless assistance programs and housing; increase health/housing stability for youth aging out of the 'system' i.e. foster care, juvenile system; increase health/housing stability for people who have frequent contacts with the hospital and justice systems) 5. Retool the homeless crisis response system (transform homeless services to crisis response systems that focus on housing loss prevention and rapid rehousing) Note that the vision was prepared by the **United States Interagency Council on Homelessness**, with membership including Secretaries for 13 Departments among others. **Policies providing subsidies to the housing consumer** are made by the federal government. These policies are implemented by the Internal Revenue Service (IRS) and the Department of Housing and Urban Development (HUD) Housing subsidies through the federal tax code (IRS-originated in 1915) Deemed as the most generous in the developed countries and most expensive housing policy for the U.S. is the **treatment of owner-occupied housing for tax purposes**. (Most developed countries have similar policies with Canada being an exception). **Low Income Housing Tax Credit Program (IRS- originated in 1986)** Tax credit incentives provided to builders of rental housing stock.

[40] Quigley, J. (May 2008). *Housing Policy in the United States* http://www.escholarship.org/uc/item/89p9r7w9 Prepared for the Institute of Business and Economic Research and the Fisher Center for Real Estate and Urban Economics.

Country	Policy Initiative	Features
		Rental subsidies The HUD administers policies that provide subsidies to **approximately one third of all low income households.** These include subsidies through rental supplements and the support of public housing. **Housing Choice Voucher Program** – this policy instrument is a radical policy shift from subsidizing builders and developers to providing subsidies directly in the hands of low-income households. Under this program, low-income households are eligible to receive the difference between the cost of 'fair market rent' and 30 % of their household income. This voucher system is completely portable and is administered by Local Housing Authorities. This approach has proved to be less costly per household than the policy instrument of subsidizing the creation of the supply side. The advantage of this approach is that it removes the politicizing in regards to the 'location' of social housing; it de-stigmatizes the client, and reduces the ghettoizing of low income neighborhood patches. This voucher program is acknowledged as having a positive impact for people living with mental illness.
United Kingdom	Planning Policy Statement 3 – Housing (2006)[41] Delivering Affordable Housing[42]	**Overview: Policy response to the recommendations set forth in the Baker Review of Housing Supply (2004)**. Policy objectives: ▪ To achieve a wide choice of high quality homes, both **affordable and market housing**, to address the requirements of the community. ▪ To widen opportunities for **home ownership** and ensure high quality housing for those who cannot afford market housing, in particular those who are vulnerable or in need. ▪ To improve affordability across the housing market, including by increasing the **supply of housing**. ▪ To create sustainable, inclusive, mixed communities in all areas, both urban and rural. The national policy is implemented at a regional and local level. Key principles: sustainable development, visionary & strategic, market responsiveness, collaboration, evidenced-based policy approach and, outcome and delivery focus. Affordable Housing Policy Statement (includes social, rented and intermediate housing). Directs Local Planning Authorities to define **overall affordable housing targets** to address both current and future needs, set separate targets for social-rented and intermediate affordable housing. Specify size and type of affordable housing and seeks

[41] Government of the United Kingdom. *Planning Policy Statement 3 – Housing (2006).* www.eukn.org/binaries/greatbritain/bulk/policy/2007/planning-policy-statement-3-housing.pdf

[42] Government of the United Kingdom. *Delivering Affordable Housing* www.communities.gov.uk/documents/housing/pdf/152897.pdf

Country	Policy Initiative	Features
		developer contributions in the creation of mixed communities.
Russia	Law on Privatization of Housing National Housing Project "Affordable and Comfortable Housing for Russian Citizens".[43,44]	**Overview** Major shift from a "paternalistic" housing policy framework towards a **market driven policy framework**. Implications of this change is one of devolution of responsibilities from the state to the individual., the privatization of the housing stock and the creation of a housing market, and state support targeted solely for "vulnerable population" groups. This last policy objective is accompanied with reforms to the social allowance program. Description: The main thrust of Russia's national housing policy reforms is (1) the creation of a housing market economy supported by government financed mortgage market and, (2) addressing the loss of housing stock (150,000 flats per year) due to deterioration. Wait-time for access to state housing is expected to drop from 20 years to an 8 year waiting period. Through its policy of "**cost-free privatization**" the ownership of rental housing stock was transferred from state to the tenant .As a result, tenant-ownership of rental stock has increased to 75 % in 2006 compared to 33% in 1990 when it was introduced. It should be noted that the concept of "home ownership" was a new word and a key challenge was conveying associated responsibilities. **Social housing**: This reform brought with it the introduction of "social housing" to the concept of "social tenant." Social housing is allocated on the basis of income and targets "low-income families." Housing is provided for a 5 year term (to be reviewed at the end of the term). The "social tenant" does not have the right to the "privatization of the flat" as do non-social tenants. (Note – at the time the thresholds for 'low-income' had not been yet identified. One of the consequences of these reforms has been the appearance for the first time of "homelessness" in Russia and the politicizing of 'housing' as a key issue of public controversy and protest. Subsequently, in 2005 legislative reforms brought in a new housing policy focused on increasing affordable housing stock for the middle-class and to provide social housing for the poor. The definition of the low-income thresholds is left up to local a municipality which has resulted in varying eligibility standards between regions for access to social housing.
Germany	Housing Subsidy Act[45]	**Overview** **Legal framework** with emphasis on regulatory and economic levers to influence the housing market through the use of fiscal and funding mechanisms (such as loans and grants to developers and municipal housing companies). The

[43] Vihavainen, R. (2005) *Housing in Russia: Policies and Practices*. University of Helsinki, Department of Sociology. http://blogit.helsinki.fi/respublica/RP05_Interim_Housing.pdf

[44] Shomina, Y. (2007)*Housing policy and housing reforms in Russia,* State University-Higher School of Economics Housing in Russia. http://www.iut.nu/Congress/Congress2007/PresentationsNational/Shomina_Russia.ppt

[45] www.eukn.org/binaries/germany/bulk/text/houisng-policy_engl070801.pdf

Country	Policy Initiative	Features
		housing needs of disadvantaged populations groups are addressed by the welfare state through tax and subsidy policy measures. In 2007 responsibility for social housing was transferred from the federal government to the level of the states. **Description** ▪ Rental allowance: A '**housing benefit**' paid out as a rent allowance is a benefit geared to income provided to lower income families. ▪ Social housing- Little housing stock is provided by the public sector in any direct measure, rather majority **of social housing stock comes from the public subsidization of private landlords**. These types of housing policy however has generated social housing stock that tends to be **more affected by market rental pressures**. As a result, people with less income, larger families or the disabled have difficulty finding suitable housing. Their support falls onto the responsibility of the welfare state through the provision of the housing benefit. The housing stock for this most disadvantaged population is provided by private sector developers and municipal housing companies. Owner-occupancy housing is also supported.
France	Politique de la Ville[46]	**Overview** Cross-ministerial and multi-sectoral holistic policy framework that addresses housing needs (and related social, economic and health needs) in targeted and deprived neighborhoods. The national body contracts with local cities to implement the priorities in targeted and deprived areas. Description: Policy history dates back to 1977 with development of a social housing policy framework. In 1988 , the "Interministerial Delegation for Urban and Social Development" under the Ministry of Urban Development and is chaired by the Prime Minister with mission: " To give disadvantaged neighbourhoods and their inhabitants the help they need, no one public or para-public organization will be completely effective on its own." The key functions undertaken by the Interministerial delegation include: designing, organizing, coordinating, experimenting, and assessing. (The latter function is evaluated with the following key indicators – employment, economic development, education, access to health care and safety). The interministeral committee and its policy framework provide leadership and the coordination for multiple actors across national and local levels. Partners include actors from the social, cultural, employment, urban development, citizenship, crime prevention and health sectors. There are five priorities in the 'Politique de la Ville' include: ▪ Housing and standard of living ▪ Employment and economic development ▪ Education

[46] www.eukn.org/binaries/eukn/text/plaquettediv_gb_2409.pdf

Country	Policy Initiative	Features
		▪ Citizenship and crime prevention ▪ Health
Italy	Edilizia sovvenzionata (Public Housing) Edilizia agevolata (Subsidy Provision)[47]	**Overview** Italy' s housing policy has been characterized by a trend in the last 50 years **from centralized national policy stance towards** the present day devolved model with a diffused policy regime, whereby **regional authorities** develop policies and adminster housing programs under the guise of limited national policy framework. The other trend has been one of **diminishing public investment** in housing. Housing policies have been relatively weak from a welfare viewpoint. On the one hand, the supply of social housing has been scarce and, on the other hand, social housing policies have not been sufficiently targeted to the needs of marginalized groups and groups in extreme poverty as well as being **poorly integrated** with general social welfare programs. Two principal policies have shaped the direction for social housing in Italy: ▪ Edilizia sovvenzionata: this program develops public housing financed entirely and owned by the state. ▪ Edilizia agevolata: This program provides subsidies to cover cost of interest on loans for the construction of rental or owner-occupied housing. In the context of other European countries, in 2004 Italy **ranked at the bottom in terms of public housing stock**. "All this means (a) that the social housing sector has not been able to play the same welfare role in Italy as it has in other European countries; and (b) that given the demand their is a large social tutelage deficit (considering that such protection is in any case not provided in the private sector). It has been estimated that genuine social protection is provided for only the tiniest proportion of the population, between 15-30 per cent of that provided in most European countries."[48] Responsibility for public housing is now transferred over to the Regions who play a planning function, while local authorities have the responsibilities to allocate the social housing according to regionally defined criteria. The role of the central government is to define general principals and set high level social housing objectives within the context of its social welfare policy agenda. Other trends: re-definition of 'social housing' in terms of criteria for effectiveness; privatization of social housing (public-private partnerships) institutions, allocation of rent supplements. No dedicated national programs exist for the "homeless".

[47] Tosi, A., Cremaschi, M. (1999) *Housing policies in Italy. Università di Roma* http://www.iut.nu/members/Europe/West/Italy_Housing%20policies.doc
[48] Ibid.

ECONOMIC, PERSONAL, AND SOCIAL IMPLICATIONS OF HOUSING, INADEQUATE HOUSING, AND HOMELESSNESS

The following information is intended to be complementary to the more detailed cost-benefit discussion on housing and supports in the final report.

ESTIMATING HOMELESSNESS AND INADEQUATE HOUSING

While the intention of our work is to focus broadly on people living with mental health problems and the variety of housing situations they live in, the reality is that many people who are homeless are experiencing significant mental health issues – this is the most basic reality of our findings and countless national and international reports: **people living with mental health problems are at greater risk of becoming homeless through the complex interactions of the social determinants of health, including income, and homelessness is the most visible evidence of inadequate housing and supports' systems. Moreover, residing in inadequate housing is a risk factor for homelessness - most of the people who become homeless started off being inadequately housed**[49].

In some ways, it is easier to capture the extent of inadequate housing compared to capturing the extent of homelessness because of the existing definition of core housing need by CMHC, together with the broader measure of affordability of spending 30% or less of gross income on shelter. What is **more complicated is measuring the costs of inadequate housing**.

INADEQUATE HOUSING

Further discussion follows on the various definitions relating to homelessness – of which the Kirby report estimates that 30-40% of people have serious mental health issues. Here, we briefly discuss individuals at risk of homelessness (sometimes referred to as inadequately housed) which refers to families and individuals with formal shelter but in precarious circumstances (Pomeroy, 2001; Policy Research Initative, 2005). Risk factors relate to the trajectory of homelessness which is complex and usually the result of a variety of factors (i.e., personal levels of human and social capital, mental health, macro-economic trends, the accessibility of community-level supports, and government policies).

Individuals at risk of homelessness (sometimes referred to as inadequately housed) refers to families and individuals with formal shelter but in precarious circumstances (Pomeroy, 2001; Policy Research Imitative, 2005). Risk factors relate to the trajectory of homelessness which is complex and usually the result of a variety of factors (i.e., personal levels of human and social capital, mental health, macro-economic trends, the accessibility of community-level supports, and government policies).

"Without a physical place to call 'home' in the social, psychological and emotional sense, the hour-to-hour struggle for physical survival **replaces all other possible activities**. This social exclusion also increasingly means physical exclusion from many locations and neighbourhoods by municipal ordinances and police harassment" (Hulchanski, 2002).

The affordability of housing is of fundamental importance to the 'trajectory' of being inadequately housed or homeless. In 2001, 590,100 households were paying 50% or more of their income on shelter – average shelter cost to income ratios was 67% (Policy Research Imitative, 2005). Practically speaking, the stress of this level of household expenditures may create a vulnerability for people to develop mental health issues, or exacerbate existing mental health issues.

The City of Calgary, through its review of the literature in developing its 10-year plan, identifies a range **of "root causes" that contribute to homelessness and marginalization** (2007, pp. 29-30):

[49] J. David Hulchanski, Question and Answer, Homelessness in Canada: www.raisingtheroof.org/Irn-home-QandA-index.cfm - Note that definitions are consistent with those of the federal government's 2004 National Homelessness Initiative.

- Poverty;
- Mental illness, addictions, and concurrent disorders (mental illness and addiction);
- People fleeing violence;
- Relocating to find employment;
- Population group (visible minorities tend to be under-represented among the absolutely homeless, whereas Aboriginal persons are generally overrepresented);
- Federal and provincial withdrawal from non-market (social or subsidized) housing initiatives starting in the mid-1980s;
- Provincial deinstitutionalization of psychiatric patients who were housed in specialized facilities up until the early 1990s, without the transfer of comparable funding levels to community-based mental health service providers;
- Low-income due to: low earned income (minimum wage versus living wage); scaled-back and clawed-back federal and provincial social support benefits; or lack of income for those leaving the foster care or child welfare systems and those exiting prison; and
- The high cost of housing (owned and rented) compounded by low vacancy rates.

Municipalities often use "homeless counts" ("point in time" snapshots) to try to determine the number of people who are absolutely homeless – the 2008 Saskatchewan Housing Forum summarized issues relating to these counts including:

- Homeless counts traditionally underestimate the numbers due to an inability to reach this entire target group;
- Results are a snap shot in time only, and do not capture cyclical/long-term data;
- These counts do not include people at-risk of being homeless, categorized as individuals or families currently living in inadequate, overpriced, unsafe, and/or overcrowded housing; and
- These counts do not include people who are considered part of the concealed homeless.

Similarly, the United Way of Calgary and Area, provides a thoughtful analysis of homeless counts and learning from U.S. cities (2007) that was reported in the City of Calgary's Background Research for the 10-year Plan to End Homelessness in Calgary (p.44): for example, despite some data that suggests that homelessness in New York is on the decrease, homelessness actually remains at record highs – there are increases in family homelessness and general shelter use despite the appearance of reduction in usage. The report also discusses the widely circulated cost-savings argument that the chronically homeless make up 10% of the homeless but are using 90% of services:

> "This statistic is based on a 1997 study that only included data for *single adults who used publicly funded shelters in two major metropolitan areas*. It did not examine resource use by families with children, unaccompanied youth, or rural or suburban homeless populations. Moreover, the study did not measure the use of any "service" other than publicly-funded, centrally-administered emergency shelter days. Based on this very limited study, which cannot be generalized to the entire homeless population, many cities are making significant planning decisions for their 10-year plans. One consequence of the diversion of resources to the single male population is an upsurge in the number of homeless families and children in the United States."

Most recently, the Health and Housing in Transition (HHiT) study by the Research Alliance for Canadian Homelessness (REACH) has produced some 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" had their own place, but at some point in 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. There are an estimated 400,000 people who are vulnerably housed – using the definition provided by Hwang et al. – note that the Wellesley Institute identifies a range of 450,000 – 900,000 for people who are precariously housed and part of the "hidden homeless". Findings to date of the study group that relate **both** to people who are homeless or vulnerably housed:

- More than half (52%) 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.
- 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 2 in 5 (38%) do.
- About 1 in 5 (23%) reported having had unmet mental health care needs, - a similar proportion (19%) reported that they didn't know where to go to get the mental health care they needed.
- Two in 5 unmet health care needs in the past year.
- 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 identified having mobility issues.

The Centre for Applied Research in Mental Health and Addictions at Simon Fraser University estimates that roughly 20% to 40% of people with serious addictions and/or mental illness are inadequately housed. Of this group, they further estimate that 70% of individuals are also inadequately supported.

WAITING LISTS

While there isn't a standardized process for measuring waiting lists for affordable housing in Canada, there is a central waiting list process for most types of affordable housing in Ontario. The Ontario Non-Profit Housing Association (ONPHA) 2011 Annual Wait List Report identified that 152,077 households were on the municipal waiting lists. The number of households looking for housing across Ontario grew by 10,442 over the previous year (7.4% increase) and by 22,824 since 2009 (17.7% increase). The Wellesley Institute's (2010) Precarious Housing report suggest extrapolating this to a national level as a crude measure of need, equating to roughly 3.4 million households.

ESTIMATING HOMELESSNESS

The Mental Health Commission estimates that 30-40% of people who are homeless experience serious mental health issues.
One of the problems in capturing the costs of homelessness is the challenges in trying to capture the extent of homelessness and, thus, the strategies needed to **address homelessness**. In the 2007 mission to Canada by the UN

Special Rapporteur on the right to adequate housing, Kothari notes that Canada has yet to come to national consensus on the **definition of homelessness**. Consistent with past UN reviews, it was recommended that this warranted **immediate attention**: without appropriate definitions of homelessness, and the factors that put people at risk of homelessness, official national data can grossly underestimate the level of need (Kothari, 2009).

The types of homelessness (or "houselessness") experienced by people can be "absolute" or "concealed"[50]:

- **Absolute homelessness**: Houseless persons are defined as people "sleeping rough" or using public or private shelters. People sleeping rough, which means in the street, in public places or in any other place not meant for human habitation are those forming the core population of the "homeless". This approach is consistent with the United Nations' definition for absolute homelessness - meaning people who are living in the street with no physical shelter of their own, including those who spend their nights in shelters.
- **Concealed (also referred to as relative or hidden) homelessness**: Under this category fall all people living with family members or friends because they cannot afford any shelter for themselves. Without this privately offered housing opportunity, they would be living in the street or be sheltered by an institution of the welfare system. This phenomenon is extremely difficult to enumerate.

The nature of homelessness can be chronic, cyclical or temporary in nature (Policy Research Initiative, 2005 pp. 4-5):

- **Chronic homelessness**: faced by people who live on the periphery of society, often with problems of drug or alcohol abuse, or mental illness. Many different definitions have been used to try and capture "chronicity" of homelessness. For the purposes of this report, and consistent with the federal government's National Homelessness Initiative's 2004 definitions, a person or family is considered chronically homeless if they have either been continuously homeless for six months or more, or have had a least two episodes of homelessness in the last two years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter. **It is estimated that roughly 20-30% of the homeless population is chronically homeless**.
- **Cyclical homelessness**: affects those who have lost their dwelling as a result of some change in their situation, such as loss of a job, a move, a prison term or hospital stay.
- **Temporary homelessness**: captures those who are homeless as a result of a disaster or significant change of personal situation, such as a separation.

Municipalities often use "homeless counts" ("point in time" snapshots) to try to determine the number of people who are absolutely homeless – the 2008 Saskatchewan Housing Forum summarized issues relating to these counts including:

- Homeless counts traditionally underestimate the numbers due to an inability to reach this entire target group;
- Results are a snap shot in time only, and do not capture cyclical/long-term data;
- These counts do not include people at-risk of being homeless, categorized as individuals or families currently living in inadequate, overpriced, unsafe, and/or overcrowded housing; and
- These counts do not include people who are considered part of the concealed homeles

[50] Ibid.

Table 4. **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

ECONOMIC BENEFITS OF HOUSING

Housing is a major productive factor in the Canadian economy, generating community investment and economic development, jobs and consumer spending. Residential housing spending contributed over $70 billion to the Canadian economy in 2002 (Canada Mortgage and Housing Corporation, 2004). Building one new home creates nearly three jobs per year, while sales of existing housing account for over $7 billion in consumer spending and contributes to the creation of around 100,000 jobs annually (Hay, 2005).

Toronto City Council, in its Affordable Housing Action Plan identified that affordable housing is an **engine for prosperity** (Housing Opportunities Toronto, 2009):

- Attracts immigrants, key workers and a skilled labour force.
- Encourages businesses to locate and expand locally.
- Every 1,000 units of affordable housing built creates between 2,000 and 2,500 person years of employment.
- Costs less on average ($23 per day) than use of emergency shelters ($69), jails ($142) and hospitals ($665) when people are homeless.

In 2003, Don Drummond, Senior Vice President and Chief Economist at the TD Bank Financial Group, recognized the pivotal role of housing when he proposed that "an inadequate housing supply can be a roadblock to business investment and growth, and influences a potential immigrant's decision on whether or not to locate in Canada" (TD Bank Financial Group, 2003). TD Economics estimates that every dollar invested in housing creates two dollars in additional economic activity, and indirectly induces as much as seven additional dollars in economic activity (2003). This is consistent with a backgrounder on public housing investments produced by Michael Shapcott of the Wellesley Institute (2008), identifying that:

- A 2007 study of nine U.S. cities found **that every dollar invested in affordable housing had a multiplier effect of 1.93**.
- A detailed study of three housing projects in Oregon **put the multiplier at 2.1**, and noted that the housing also **leveraged as much as seven additional dollars for every dollar invested**.
- An Ontario study in the early 1990s found that **every 1,000 new co-op homes generated 2,210 person-years of employment**.

An evaluation of "Streets to Homes" – a *Housing First* model in Toronto – found the following demonstrated results (Raine & Marcellin, 2009)**:**

- Improved overall health and improved mental health,
- Decreased levels of stress,
- Decreased use of alcohol and drugs,
- Decreased panhandling, and
- Decreased use in emergency services.

DIRECT AND INDIRECT ECONOMIC COSTS

In the Province of Alberta's Plan for Alberta, Ending Homelessness in Ten Years, they identified that costs for continuing to manage homelessness would equate to roughly $6.65 billion over 10 years for 11,000 people (Alberta Secretariat for Action on Homelessness, 2008). Their costing analysis revealed direct costs (including emergency shelter use, services for people who are homeless and programming for agencies) and indirect costs (including government systems such as health, corrections and justice systems). These costs and savings were generated through a "Homeless Management Model" developed by Dynawise in 2008 for the Secretariat. The model estimates that homelessness will continue to grow

by 7% annually, meaning by 2019, there will be over 22,000 people who are homeless, requiring an investment of $13.6 billion in direct and indirect costs – thus, implementation of the plan (including targeted prevention approaches) will ultimately save up to $7.1 billion (p. 9).

The cost gradient is highest for institutional uses, moderately high for emergency services, and lowest for supportive and permanent housing – even when support costs are factored in (Pomeroy, 2005).

Quantifying the indirect and direct costs can be challenging – ultimately, there is strong evidence to support much higher level of costs associated with inadequate housing and supports than housing and support models. In looking at cities from across Canada (Toronto, Vancouver, Montreal, and Halifax), Pomeroy found a difference in annual costs of different housing, institutional and emergency responses:

- $66,000 to $120,000 for institutional responses (prison, detention, and psychiatric hospitals),
- $13,000 to $42,000 for emergency shelters (cross section of youth, men's facilities, women's facilities, family facilities, and shelters for victims of violence),
- $13,000 to $18,000 for supportive and transitional housing, and
- $5,000 to $8,000 for affordable housing without supports (singles and family).

While there are significant ranges in costs, at least in part attributable to different service delivery models and support levels, Pomeroy notes that the objective of the analysis is "to illustrate the order of magnitude of costs across the continuum of responses" (p. 19) .

As part of its background work in creating its 10-year plan to end homelessness, the City of Calgary undertook a review that produced a wealth of information that supports this "order of magnitude" including:

- The City of Denver which estimates that approximately $40,000 per year is needed to serve a person who is chronically homeless – this average cost decreases to $17,000 once the person is housed.
- The City of San Francisco where an analysis of system expenditures showed that the city spends $61,000 per year for emergency room services and incarceration for each chronically homeless person.

They also highlight the City of Chicago's ten-year plan to end homelessness (2003) – one of the first North American cities to undertake such an initiative. By 2005, the City was able to phase out over 1,900 emergency and transitional shelter beds. The City's 2007 update was able to provide an evaluation of people who had received *Housing First* intervention: 28% had increased their income, emergency rooms had decreased by 54%, inpatient hospitalizations by 52%, arrests decreased by 78%, and days spent incarcerated by 93% (City of Chicago, 2007). Similarly, Calgary's Pathways to Housing (incorporating health, social and housing supports for people who have been chronically homeless) demonstrated a 44% reduction in EMS responses, 63% reduction in emergency room visits and 69% reduction in psychiatric hospitalizations in one year of participation for 79 participants – the savings in reduced hospitalizations alone amounted to over $440,000 (Calgary Homeless Foundation, 2010).

MORBIDITY AND MORTALITY

In a review of the homelessness crisis in Canada, Falvo notes 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" (2003) and highlighted findings from recent studies of homeless populations:

- A four-year study of 9,000 homeless people in Toronto demonstrated that the mean age of death was 46 years. The mortality rate for 18-24 year old homeless men was more than eight times than that in the housed population.
- Mortality rates for homeless youth in Montreal are nine times greater for males and thirty-one times greater for females, compared with non-homeless youth in Quebec.

- Increased rates of chronic disease including arthritis/rheumatism, emphysema/chronic bronchitis, epilepsy and asthma.
- Increased prevalence of active tuberculosis (ten times the rate in Toronto's homeless population compared to Ontario).

FAMILIES AND CHILDREN

A 1998 Toronto study found that "over half of all female street youth become pregnant, with the average onset of first pregnancy being just over 16 years. All told, an estimated 300 babies are born to homeless women each year in Toronto" (Falvo, 2003). There are broader social costs to homelessness and inadequate housing (Falvo, 2003):

- Family's housing situation is a frequent factor in children being taken into care. "The average cost of placing a child into the temporary care of the Children's Aid Society of Toronto (CAST) is $40,761. With roughly 450 CAST cases where housing was a factor in 2000, CAST estimates the cost for those admissions at $18 million annually." (Falvo, 2003).
- Children in inadequate housing have substantially worse rates of problems in their overall health, asthma, motor skills and social development, language skills, emotional health and levels of anxiety; and levels of aggression.
- A New Zealand longitudinal study found that adults at age 32 who were exposed to poor socioeconomic conditions during childhood (n = 1,037) ranging from birth to age 15, had a strong association with increased risk of substance dependence and poor physical health (Melchior, Moffitt, Milne, Poulton, & Caspi, 2007).
- Poor children are almost twice as as likely as non-poor children to die in childhood, more likely to have physical and mental health problems, perform poorly or drop out of school, and engage in dangerous behaviours in their teens (City of Calgary, 2007).

SOCIOECONOMIC STATUS

Lower socioeconomic status associated with premature self-discharge from hospitals
Among a large sample of cirrhotic patients (n = 581,380) admitted to hospitals 1 in 36 self-discharged against medical advice. Self-discharge was associated among persons with: alcohol cirrhosis, lower socioeconomic status, HIV, psychiatric disorders, and substance abuse (Myers, Shaheen, Hubbard, & Kaplan, 2009).

Lower socioeconomic status among recent onset schizophrenia patients
Concurrent schizophrenia and substance abuse (high prevalence of cannabis use) associated with younger age, male gender, and lower socioeconomic status (Wobrock, Sittinger, Behrendt, D'Amelio, Falkai, & Caspar, 2007).

Organizing services to make client selection criteria based on low-income (Social Determinants of Health) works
Data from the national Women's Employment Study (WES) in the United States. Women on low-income and with both addictions and mental health disorders were found to have high association with receiving treatment. Providing affirmative access to disadvantaged women (in WES) was associated with participation in appropriate services (Rosen, Tolman, & Warner, 2004).

EMPLOYMENT AND EDUCATION

Range of treatment - primary medical care needs and treatment for both mental health and substance abuse required among opiate users in methadone programs
SDH (age, employment status), chronic medical condition, hospitalization, emotional abuse, sexual abuse, age at first injection) associated with physical health scores. Mental health problems, sexual abuse, physical abuse, use of sedatives, use of cocaine, number of days of cocaine use, polydrug use in past month associated with mental composite scores (Milson, Challacombe, Villeneuve, Paul, Strike, Fisher, Shore, & Hopkins, 2006).

Level of educational attainment

Among the elderly (65-85 years) low educational attainment is associated with risk of poor health (n = 9,225). Poor mental health was associated with type of living arrangement. (Rueda et al., 2008).

BUILDING ON PAST EXERCISES: KEY POLICY DIRECTIONS

The need to define a strategy for improving the availability of and access to appropriate, adequate housing, and related supports was the foundation for this research project. This section focuses on what we can learn from the pan-Canadian movement for a broader National Housing Strategy in informing such a strategy that focuses on the needs of people with mental health issues. **The Senate Committee on Mental Health, in "Out of the Shadows at Last," identified the need for major investment in housing including increased financial assistance for the construction of new units and rent subsidies**.

This section has been structured to summarize the findings of numerous national, provincial, and municipal reports with respect to specific strategies that impact the quality and supply of affordable housing for all Canadians.

Key goals of an effective national strategy would include (Wellesley Institute, 2010; Mikkonen & Raphael, 2010; Housing Network of Ontario, 2009; Tota, 2005; Hulchanski, 2002):

- **Ensure affordability**: All Canadians should have homes that cost no more than 30% of their pre-tax income and which leaves them with sufficient income for the other necessities of life.
- **Ensure stable, adequate supply of housing**: All Canadians should have homes that are in a good state of repair, safe, and up to property standards, without overcrowding.
- **Provide housing supports, programs and protections**: All Canadians need to have supports and programs to ensure that they can equitably access and maintain their homes.
- **Measure progress**.

WHAT LEADERSHIP AND COLLABORATION IS NEEDED?

Many national think tanks and past policy papers have made reference to the need for a "joined-up" housing agenda. Significant funding cuts and downloading of social housing at the federal and provincial levels over the last 25 years has created a "patchwork" of funding and programs that is complex to navigate as policy makers, funders, service providers, and tenants. Funding proposals' approval processes are often lengthy, complex, and costly.

"Housing and homelessness policy, in order to be effective and efficient, needs to be 'joined-up' across levels of government; among government departments and ministries; linked to municipalities, non-profit and private interests; respectful of the cultural and historic relationships of Aboriginal people; relevant to the needs of racialized communities; responsive to the special physical and mental health needs of a variety of people; cost-effective and administratively efficient for project sponsors and government administrators; and – most importantly – properly and fully funded" (Wellesley Institute, 2008). Shapcott provides a number of examples of where lack of coordination would impact desired results of funding initiatives:

- Providing a housing benefit for people renting in the private sector, without concurrently ensuring effective rent regulation;
- New supply initiatives could fail to produce a net increase in new housing without controls on the demolition and conversion of existing housing; and,
- Increased funding for new support services may not be taken up if this is not tied to new supply and affordability programs (or the supportive housing may simply displace other affordable housing.

The leadership that can be provided through a national affordable housing strategy can also support (Tota, 2005):

- Expansion of products available to households below the 20th income percentile that can be provided via the Canada Mortgage and Housing Corporation.
- Ongoing investment in appropriate operating funding (for both building maintenance and ongoing support needs) tied to capital initiatives.
- Strong partnerships amongst all levels of government, providers and community members including formation of a store-front consortium of services and programs that provide integrated support for affordable housing project development and fast-track proposals.

Leadership is also needed at all levels to promote collaboration across health, housing, social services, finance and urban development (Bryant et al., 2002). This collaboration would include mechanisms to:

- Promote a comprehensive continuum of affordable housing and supports.
- Prevent people from becoming homeless.
- Support people when they are homeless.
- Helps homeless people obtain appropriate housing.

WHAT IS THE LEVEL OF FUNDING NEEDED TO INCREASE AFFORDABLE HOUSING?

There is broad support amongst housing and mental health providers for the "1% Solution", which identifies that governments need to increase their spending on housing by one per cent of overall spending and adopt a national housing strategy that recognizes that housing affects the population's health and other social determinants of health (Mikkonen & Raphael, 2010; Bryant, 2003; Canadian Mental Health Association, 2004; National Housing and Homelessness Network, 2002).

The 1% Solution Campaign was launched by the Toronto Disaster Relief Committee (TDRC) in 1998, and is grounded in an analysis by Hulchanski which demonstrated that in the mid-1990s (prior to the most profound cuts to social housing initiatives), various levels of government were spending about 1% of their budgets on housing. In 1998, this was equivalent to an additional $2 billion annual investment by the federal government, and $2 billion combined annual investment from provincial and territorial governments.

This level of investment would likely create roughly 20,000 units annually, generating up to 80,000 jobs in the construction industry (Falvo, 2003).

HOW CAN WE ENSURE HOUSING IS AFFORDABLE?

Targeted, precise actions to address affordability needs

> The crucial and ultimate test of the effectiveness of housing policy is the condition of the worst housed families in our communities (Carver, 1948).

The Affordable Housing Framework uses a definition of affordability based on average market rents, rather than working with the CMHC definition that housing should not exceed 30% of pre-tax income. In a detailed national analysis, the Conference Board of Canada noted that this definition will mean that some of the AHI projects "will produce rental stock for essentially upwardly mobile young households earning over $40,000 a year" (Conference Board of Canada, 2010). Thus, funding is being invested, in part, in a way that will not address Canadians who are in dire need of housing. Housing affordability is an issue that should be considered for all Canadians, but governments need to determine which funding decisions will have the greatest impact on Canadians in dire need of housing, particularly in times of fiscal constraint. In a recent work on the social determinants of health in Canada, Mikkonen and Raphael (2010) recommend that housing policy needs to be more explicitly linked to comprehensive income (including a jobs strategy), public health, and health services policy. **Housing policy, in the context of broader social policy, should reflect a levels of need approach, identifying how best to target the highest needs of the population, with a longer-term view to addressing broader housing affordability issues**.

Universal Housing Benefits: Rent supplements or Shelter Allowances

Housing benefits are generally provided to assist individuals/households living on lower incomes to access private rental market housing. Different forms of housing benefits have been part of past and current governments' initiatives – these include rent supplements and shelter allowances. Housing benefits facilitate rapid access to stable, affordable housing because households can immediately access existing housing through the private market. There can be, however, significant challenges inherent in the delivery of these benefits which can be mitigated if the following elements of a successful housing benefit include (Wellesley Institute, 2008; Pomeroy & Evans, 2008; Housing Network of Ontario, 2010):

- **Eligibility that is flexible rather than restrictive**: households living on low income and in core housing need as defined by CMHC (spending 30% or more of their income on housing) – as the number and complexity of criteria attached to eligibility increases, the risk increases that fewer people in core need will be able to access the assistance they need;
- **No arbitrary time limit** on the length of time that a household can access the benefit – use of the benefit should be based on the household's core housing need;
- The benefit should reflect the **actual gap between affordable and market rents** in specific towns, cities, regions etc – if the benefit amount does not, combined with household income, enable the household to secure affordable housing, the level of benefit needs to be reassessed; and
- **Realistic cost increases** have to be built into housing benefits reflecting the increases in rent that people will need to pay in their private market housing – from a value-for-money perspective, housing benefit programs are **best integrated as part of a longer-term housing strategy** to increase housing supply.

As discussed in the international comparison section, the United States uses a housing voucher system as part of their housing strategy – research has shown that these housing benefits have **an inflationary impact on the overall rental markets**[51]. Pomeroy and Evans, in a review of international poverty reduction strategies (2008), noted that "heavy reliance on portable housing allowance programs that encourage people to seek out the cheapest rental housing can, over time, concentrate poverty and its consequences in specific neighbourhoods". Thus, a strong system of **rent regulation and tenant protection** is important to ensure that housing benefits do not inadvertently raise the overall cost of housing. Additionally, having the benefit paid directly to the tenant counteracts the private market's tendency to increase rental rates[52].

A Housing Benefit can be an important tool during economic downturns:

- Improves housing affordability for many households at a time when people are losing jobs, being moved to part time, or are retraining
- May prevent some people from having to spend assets to qualify for welfare
- Extends assistance to the working poor
- Puts money in the pockets of people on social assistance, which is spent in the local economy

Rent Regulation

In general, rent regulation legislation protects tenants who are living in a rental unit, but there is limited to no regulation of rental rates for vacant properties and new properties. Of particular concern is that this allows rapid increases to rents on vacant rental units (Wellesley Institute, 2008).

Income Support Programs

Ensure flexibility in income support programs to enable people to adjust their living situation appropriately as their income improves (Housing Network of Ontario, 2009).

Shelter allowance components of income supports programs should reflect housing cost variations in communities

[51] Scott Susin, *Rent Vouchers and the Private of Low-Income Housing*, Berkeley Program on Housing and Urban Policy, Working Paper Series No. 1005, 2006. as cited in Wellesley Institue (July 2008) *Housing, homelessness and Ontario's Poverty Reduction Strategy.*

[52] Housing Network of Ontario (2010). Accessible at http://www.stableandaffordable.com/sites/default/files/HousingBenefitHNO.pdf

Costs of Energy and Utilities
Most provinces and territories have some form of assistance available to low-income households to address the rising cost of energy and utilities. The Ontario Low Income Energy Network has proposed a comprehensive low-income energy assistance program and a low-income energy conservation initiative (Wellesley Institute, 2008).

HOW DO WE ENSURE THERE IS A SUFFICIENT SUPPLY OF ACCEPTABLE HOUSING?

As buildings age, the natural wear and tear plus other factors require increasing investments to ensure the housing remains habitable. Wealthier homeowners are able to make the capital repairs, but lower-income owners and renters don't have the financial resources – and, in the case of tenants, they usually don't have the legal authority to make repairs.

Aging social housing stock is a significant concern. For example, According to Statistics Canada's 2006 Census, more than two-thirds of Ontario's homes (or a total of 3.1 million dwellings) are more than 20 years old.

All housing in Canada is aging – upgrading buildings can mean that these costs are passed along from landlord to tenants. Financial incentives provided to private market landlords can help in balancing the need to maintain, upgrade and repair housing, against maintaining affordability of units (Housing Opportunities Toronto, 2009). Mayor's Tower Renewal, a long-term initiative of the City of Toronto, will provide upgrades, community investment, and 'greening for public and private high-rise towers. It's estimated that hundreds of buildings may be participating in the program by 2020.

Strategies and policy directions to support appropriate maintenance of existing housing supply (Housing Opportunities Toronto, 2009; Housing Network of Ontario 2009, 2010; Mikkonen & Raphael, 2010):

- Investments in regular repair and ongoing maintenance of existing and new affordable housing.
    - Federal, provincial and territorial governments provide ongoing and sustainable funding to ensure the social housing stock achieves and maintains a state of good repair.
    - The federal and provincial governments expand flexibility in redevelopment and refinancing regulations for social housing, so that these assets can be used for building repairs, expansions and energy retrofits.
    - The federal and provincial governments increase funding for private-sector rental repair and energy retrofit programs while ensuring rents remain affordable through rent control legislation and financial incentives.
- Ensure strong building standards and enforcement.
- Create an annualized fund to repair & maintain existing and new affordable housing units.

Protecting Stock
Municipalities can set policies to limit conversion or demolition of rental housing that reduces the choices available to lower income residents – an issue that is compounded when there is a lack of new supply in affordable housing. For example, the City of Toronto adopted an enhanced bylaw preventing the demolition or conversion of residences with six or more units, unless replacements are provided in the case of demolition. Between 2002 and 2008, a much lower number of rental homes were lost in Toronto (600 homes) compared to other large Ontario cities (Toronto City Council, 2009).

New Stock
The Federation of Canadian Municipalities has developed a framework for a National Affordable Housing Strategy to promote affordable, new and existing housing. Four programs are included within the framework:

- A flexible capital grant program: a locally designed and administered program of housing initiatives financed by federal or joint federal/provincial/ territorial capital fund.
- A private rental program to stimulate private rental production.
- Investment pools of money to create affordable housing by attracting new funding for the development, acquisition or rehabilitation of affordable housing.
- Provincially administered income supplement programs to assist tenants who cannot afford private market rents.

Changes in programs and complicated funding formulas have reduced the amount of rent-geared-to-income subsidies available to many social housing providers, which means that they are able to provide homes for fewer low-income households. Increasing rent supplements to social housing providers is a quick and efficient way to increase housing affordability (Wellesley Institute, 2008).

Mikkonen and Raphael (2010) recommend that the federal government increase funding for social housing programs targeted for low-income Canadians with housing policies supporting mixed housing approaches.

HOW CAN WE MAXIMIZE THE ROLE OF THE PRIVATE MARKET IN INCREASING THE SUPPLY OF HOUSING?

The private sector alone will not be able to meet the housing needs of all Canadians – even if incentives are provided. Establishing the right balance between private and public sector collaboration in affordable housing is a necessary pre-requisite to any successful strategy. Key ways to improve affordability and supply in the private markets is through direct grants, tax spending and/or other benefits, plus effective regulation and legislation (Wellesley Institute, 2008). There are three main tools that can be used to bridge the affordability gap between what private rental and private home ownership costs, versus what low and moderate-income households can afford to pay:

- Universal housing benefit for low-moderate-middle income earners
- Effective rent regulation and tenant protection laws to protect tenants from predatory practices and to shield against the inflationary impact of housing benefits; and
- Rent-geared-to-income subsidies for households living in non-market housing.
- Increase the supply of co-operative, non-profit, supportive and other non-market housing with direct grants, tax spending and/or other benefits.

From a broader perspective, the Saskatchewan Housing Forum, which engaged leaders from the private, housing, and government sectors, identified a number of strategies to increase private sector engagement, including:

- The importance of establishing a provincial Affordable Housing Growth Fund, with tax incentives to encourage housing development.
- The need for the provincial Housing Corporation to act as a 'one-stop shop' for builders, developers and the general public.
- Development of strategies to address the skilled labour requirements.
- Development of mechanisms to link various stakeholders within the housing sector including builders, people needing housing, community developers, investors and government.

Inclusionary Housing Practices

While there are many iterations of these policies, in essence, they require all new housing developments to include housing opportunities for people with a range of incomes. The municipality offsets this cost to the developer by allowing extra density in that particular development. Numerous provincial and national – level synthesis reports recommend that provinces and territories must provide municipalities with the authority incorporate inclusionary zoning practices.

Notes on inclusionary zoning:

- Used in hundreds of American cities – if municipalities across Ontario (for example) had used a similar inclusionary housing policy to that used in Montgomery County, Maryland, this would have created 12,500 new affordable homes across the province from 2007 new housing starts (Wellesley Institute, 2008).
- Spin-off benefits of inclusionary zoning include mitigation of urban sprawl (because of higher density) as well as environmental and land use advantages.

CHANGING THE PARADIGM

While Appendix Four provides more information on the *Housing First* model, it is worthy to note the strong movement towards realignment of public funding to sustainable solutions to homelessness. Some examples follow.

The Province of Alberta's ten-year plan shifts investment from management of homelessness to ending homelessness. Investments now focus on moving people off streets and out of shelters, and into permanent housing with supports. This fundamental change in funding services is premised on the belief that providing people with appropriate housing and support options not only is the right thing to do, but it is the fiscally responsible thing to do, resulting in savings of $3.3 billion over the course of the ten year plan.

The City of Chicago was one of the first North American cities to implement a 10-year plan to end homelessness – their plan, too, centres on this shift from funding emergency services to providing permanent housing using a *Housing First* model.

WHAT IS THE ROLE OF SOCIAL HOUSING PROVIDERS IN SUPPORTING PEOPLE WITH MENTAL ILLNESS?

In the often-cited "Best Practices in Mental Health Reform" (Public Health Agency of Canada, 1997), a housing checklist is presented. It includes the requirement that a range of different housing alternatives is provided but there is a shift of resources and emphasis on supported housing.

The Public Health Agency of Canada (PHAC) report further adds to the supported housing concept and indicates that it incorporates the following critical elements:

- use of generic housing dispersed widely in the community;
- provision of flexible individualized supports which vary in intensity;
- consumer choice;
- assistance in locating and maintaining housing;
- no restrictions on length of time client can remain in the residence;
- case management services are not tied to particular residential settings but are available to the client regardless of whether the client moves or is hospitalized;
- community residential housing is provided as a substitute for long-term inpatient care; and
- housing needs of the homeless mentally ill include an assertive outreach component.

Research further identifies sex differences and gender influences in mental health/illness and highlights the need to incorporate these factors in the development of policies and programs (Salmon et al., 2006).

Lastly, but not of less importance, any housing approach for individuals with mental illness needs to adequately address substance use. It is acknowledged that individuals with mental illness will also often be struggling with substance abuse. Therefore, there needs to be a welcoming environment, a tolerance of relapse for these individuals and treatment capacity from a harm reduction perspective with wet, dry and damp housing options.

Many people with mental health problems and/or mental illness live in non-dedicated social housing options – consequently, social housing providers have evolved different models of support to help people in maintaining their housing tenure and improving their quality of life. The learnings from these models often have equal applicability to all housing providers – whether they provide dedicated mental health housing, or non-dedicated housing.

Toronto Community Housing Corporation is one of the largest social housing providers in North America, has undertaken a number of initiatives specific to identifying how best to support the needs of people with mental illness. Findings from a pilot project involving tenants and staff (Houselink, 2008) ultimately informed development of TCHC's mental health framework.

> "Social isolation is the enemy of recovery."
> (Houselink, 2008)

Create an environment that supports recovery: this means creating an environment that facilitates hope (believing recovery is possible), healing (reclaiming sense of self and control through self-care), empowerment (self-determination, courage and autonomy), and connection (rejoining the social world). **From the social housing provider's perspective, staff foster recovery** by operating from a human rights' philosophy (sharing power and responsibility), creating a positive culture of healing where staff believe they can make a difference in tenants' lives and are collaborators with tenants, and provide recovery-oriented services where the common denominator is a collaboration of services provided by professional services (case management, medication and therapy), consumer-run services (such as advocacy and peer support) and the broader community services.

Strengthen the community in each building: social housing providers can facilitate connections among tenants – these are tenant-led activities for all tenants. This can include opening up meeting rooms (which are usually locked most of the time), organize a tenant-led social recreation program, partner with local agencies or groups to provide programs, and integrating partners into the life of the building.

Create many opportunities for tenant participation: this can include tenant representation at board levels, smaller focus groups to seek input, conduct regular evaluations that engage tenants in the research. On a larger scale, tenants can elect representatives to speak on tenants' behalf in various forums. The key is to create a variety of different opportunities that capitalize on tenants' experience and input, but recognizes that different people are comfortable in different settings (i.e., not everyone is comfortable speaking in large meetings).

Train peer support workers: "[tenants] are the resources that are available, literally, in house. And they have the knowledge, experience and the credibility to offer support to their neighbours" (Houselink, 2008). Particularly given ongoing resource constraints that social housing providers face across the country, this is a source of evidence-based support that should be mined to the benefit of all tenants. A more formal system of peer support can be created where tenants are trained, accredited, paid and supervised to provide specific supports to other tenants – there is a significant body of research to support this approach in multiple settings (mental health, HIV/AIDS, developmental services, community development). Types of roles could include Peer Bridgers (supporting new tenants), Recovery Educators or Coaches (facilitating Wellness Recovery Action groups or acting as a supplement to case management), drop-in coordinators or staff to provide informal supports to participants (Houselink, 2008).

Organize joint staff-tenant training opportunities: opportunities for social housing staff and tenants to learn together about such topics as the principles of recovery or crisis intervention. The way in which these opportunities are developed is also important – for example, both tenants and staff should be involved in planning and/or delivering the training.

Seek out new partners to provide support services: some tenants access community supports that are crucial in maintaining their housing tenure. The reality is, however, that tenants can sometimes withdraw from these services, or it may be that services are not meeting the support needs of the tenants' for a variety of reasons. Strategies for social housing providers can include:

- Developing straightforward partnership agreements with community agencies including mental health and addictions' services: agreements address issues such as values, roles and responsibilities, relevant consent for information sharing, response timeframe, communication protocols, and evaluation.
- Identifying a lead staff who coordinates and maximizes partnerships: for example, facilitating new partnerships, ensuring existing partnerships are working effectively, identifying service or system gaps and potential solutions.
- Establishing supportive housing partnerships for specific buildings: in buildings where there is a high number of people living with mental illness (the TCHC/Houselink pilot project identifies where there are 30 or more people), the social housing provider may want to consider partnering with a supportive housing provider. The supportive housing provider can be provided space in the building to provide individual and community development supports.
- Coordinating a local agency network.
- Building good relationships with City services – including police and health services.

Review corporate policies and practices: Policies and practices can include:

- Tenant, unit selection and move-in process.
- Eviction prevention protocol for behaviour-related issues.
- Crisis intervention protocol.
- Community standards that set out norms and boundaries, and foster community culture (developed working with tenants).
- Hiring practices that recognize that a diverse workplace includes people with mental illness.
- Application of privacy legislation (e.g., when can information be asked for/shared with family, friends, neighbours, support organizations).

Additional enablers of the above strategies include:

- Identify designated staff experts to work specifically with mental health and addictions issues.
- Resource strategy: social housing providers.

HOW DO WE MEASURE OUR PROGRESS IN AN AFFORDABLE HOUSING STRATEGY?

The Housing Network of Ontario (2010) outlined a number of indicators that should be tracked in measuring progress on affordable housing strategies:

- Reduction in number of households on affordable housing wait lists.
- Equity in reduction of number of households on affordable housing wait lists across communities.
- Consistent annual reductions in the percentage of tenants spending 30% or more of income on housing.
- Improved access to housing for members of marginalized groups, including Aboriginal People, communities of colour, people with disabilities, and mental health issues, lone mothers and people living in rural and northern communities.
- Consistent reductions in the number of households in core housing need, the number of households facing eviction due to high rent costs, and the number of people using homeless shelters.

The Calgary Homeless Foundation, in its Submission on the Alberta Health Act in June 2010, identified some key elements to the Department of Health and Wellness, for integration into the Health Act:

- There should be policies in place to ensure a zero discharge into homelessness from a health facility.
- Fund multidisciplinary teams of health providers, income support workers, and housing locators.

- Develop consistent risk assessment and triage processes for people who are homeless or at risk of homelessness to help them gain immediate access to housing and supports.
- Create a streamlined point of entry 4. Create a streamlined point of entry to housing, mental health and addiction programs.
- Create and maintain a range of supported housing options – including detoxification, mental health, addictions treatment and recovery and long-term nursing care for people with complex needs.
- Prioritize the importance of collaboration in achieving health and housing outcomes across departments and ministries. This would include formal administrative and strategic partnerships amongst health care facilities, addictions services and community based housing and service providers.

Engagement of people with lived experience of mental health problems and housing issues is central to any strategy.

WHAT ARE THE DIFFERENCES BETWEEN RURAL AND URBAN NEED?

In looking more closely at the reasons why Canadians are identified as being in core housing need (Policy Research Initiative, 2005):

- At the national level, three in four households (75.3 percent) in core housing need are in this state solely for reasons of affordability. Shortfalls in the suitability and adequacy measures accounted for 2.5 and 6.3 percent of all households in core housing need respectively.
- Both affordability and suitability figure prominently in predominately urban areas.
- In areas typically adjacent to urban areas (intermediate and rural metro-adjacent regions), however, affordability is the main concern.
- Northern rural areas, in contrast, experience suitability challenges far more frequently than issues of affordability.

APPENDIX SIX: HIGHLIGHTING HOUSING NEED AMONG CANADA'S ABORIGINAL POPULATION

> "Aboriginal people make up a small proportion of the overall population, but they experience a significant housing burden."
>
> Wellesley Institute, 2008

An examination of the key issues related to Aboriginal housing need in Canada was done by the National Aboriginal Housing Association (NAHA; 2009) with their proposed action plan called, A Time for Action: A National Plan to Address Aboriginal Housing.

ABORIGINAL POPULATION RELOCATING TO MUNICIPAL URBAN CENTRES

Aboriginal people comprise **3.8% of Canada's population**, according to the 2006 Canadian Census. In Canada, the majority of Aboriginal persons live off the reserve. In 2006, 73.4% of the Aboriginal population in Canada lived in non-reserve communities (National Aboriginal Housing Association, 2009). In order to best understand the issues and challenges related to accessing safe, secure and affordable housing by Aboriginal populations in Canada, it is important to make the distinction between Aboriginal populations living off-reserve (non-reserve Aboriginal population) and the housing issues and challenges faced by Aboriginal people living on-reserve (on-reserve Aboriginal population).

The trend of Aboriginal persons relocating to live in urban centres parallels the relocation observed in Canada's rural populations who are also migrating towards urban centres. While the reasons for this relocation may be largely socio-economic, the Aboriginal population living on-reserve experience significantly higher rates of poverty, limited economic opportunities and poorer health than other Canadians.

> "[Aboriginal persons] seek to improve their capacity to earn a living and to improve the opportunities for their children. In most cases they are pushed from the reserves by lack of opportunity…At the same time, as citizens of urban communities Aboriginal persons access and enjoy a range of services and have needs that impose costs on provincial and municipal governments. So as Aboriginal people increasingly migrate off reserve (and existing non reserve families have children) funding for services they consume is increasingly paid by provincial and local government, with reduced federal support"
>
> National Aboriginal Housing Association, 2009

The relocation of Aboriginal people in Canada suggests a critical need to develop policy and mechanisms in collaboration with Aboriginal people in order to best respond to the housing needs of the non-reserve Aboriginal population across Canada.

There have been some efforts to address this challenge by governments. To this end, coordinated and cross-jurisdictional discussions by federal, provincial and territorial governments to address housing needs among Aboriginal populations have taken place. In these discussions key principles were affirmed at the White Point, Nova Scotia meeting in 2005 of the Provincial-Territorial Meeting of Ministers for Housing:

> "Aboriginal peoples should not forego the special relationship that historic rights have conveyed upon Aboriginal peoples and associated funding obligations of the federal government."

- The provinces and territories respect the special relationship and fiduciary responsibility that Canada has with First nations, Métis, and Inuit people.
- Federal, provincial, and territorial governments recognize that one of the highest areas of need and challenge is in providing adequate housing for Aboriginal people. It is through collaboration among governments and Aboriginal people that housing improvements for Aboriginal people living off-reserve are possible.

Clearly given that the majority of Aboriginal citizens now live in municipalities across Canada, similar cross-jurisdictional and coordination efforts in collaboration with Aboriginal people needs to extend into provincial and municipal discussions. NAHA highlights the need to, "…develop a comprehensive and purposeful strategy that establishes an explicit funding stream for non-reserve Aboriginal people linked directly to core objectives and measurable outcomes" (National Aboriginal Housing Association, 2009).

Aboriginal Canadians experience a disproportionate burden of housing need in Canada compared to the non-aboriginal population.

The housing need of the Aboriginal population (who live off-reserve) is estimated to be **more than 20%** of this population. This far exceeds the prevalence of housing need observed in the non-Aboriginal population, which is estimated to be at 12.4%. NAHA's Action Plan proposes specific targeted actions that will reduce the level of housing need among the Aboriginal population to the same level of Canada's non-Aboriginal population.

Aboriginal citizens living in municipalities across Canada are disproportionately burdened with homelessness and associated mental health, addiction, and concurrent disorders.

The urgency to respond to housing needs of Aboriginal persons who also experience addiction and or mental health problems is most evident when we examine the rates of homelessness in Canada. While the rates of homelessness across Canada vary from municipality to municipality, Aboriginal populations are consistently observed to be over-represented in studies examining these rates.

A 2006 study in Toronto, Ontario found that 26% of the homeless population were Aboriginal persons. Similarly, a 2007 study found Aboriginal persons made up 25% of the homelessness population in Victoria, British Columbia. In Vancouver (2008), Aboriginal persons made up 32% of the homelessness' population. In smaller urban centres homelessness rates among Aboriginal citizens have been observed to be even much higher such as in Lethbridge (2007) and Edmonton (2008) with the prevalence of Aboriginal homelessness to be as high as 45% and 38% respectively (National Aboriginal Housing Association, 2009).

ASSOCIATED MENTAL HEALTH AND ADDICTION PROBLEMS IN THE HOMELESS ABORIGINAL POPULATION

Research has consistently reported a high prevalence of mental health, addiction and concurrent disorders problems among the homeless population in both Canada and in the United States. The association between homelessness and co-morbid mental health, addiction and other health problems is clearly evident in research.

Studies among the homeless populations in Canada (and in the U.S.) report very high incidences of addiction, mental health, or concurrent addiction and mental health problems. In one study in Canada, 25–33% of the homeless population were observed to have mental health problems with 60–70% of this group also having concurrent addictions problems.[53]

In an Ottawa study, a prevalence of 67% of concurrent addiction and mental health problems was reported in a randomized sample of homeless men (Farrell, Aubry, Klodawsky, & Pettey, 2000).

[53] BC Partners for Mental Health and Addictions Information, www.heretohelp.bc.ca

Given that Aboriginal persons are disproportionately over represented in municipal homeless populations across Canada, they also share a disproportionate burden of associated health problems in regards to mental health, addiction, and concurrent disorders as well as other associated primary care health needs.

ADDRESSING THE HOUSING NEED AMONG THE ABORIGINAL PERSONS WHO ARE HOMELESS

This high prevalence of Aboriginal homelessness and its associated mental health and addiction problems across Canadian municipalities is a challenge that requires important attention. Are current provincial-municipal funding mechanisms adequate to address the housing need among the Aboriginal homelessness population? The high prevalence of mental health, addiction, and /or concurrent disorders suggest the need to develop targeted intervention models that enable Aboriginal citizens to access housing and culturally appropriate housing supports. These are important challenges that federal, territorial, provincial, and municipal bodies need to undertake in collaboration with Aboriginal people.

The NAHA points out that provincial Homelessness Funding Initiatives have "…lacked a coherent strategy with explicit outcomes." NAHA advocates for, "…a comprehensive and purposeful strategy that establishes an explicit funding stream for non-reserve Aboriginal people linked directly to core objectives and measurable outcomes" (National Aboriginal Housing Association, 2009).

KEY ISSUES REGARDING HOUSING NEEDS AMONG THE NON-RESERVE ABORIGINAL POPULATION

The National Aboriginal Housing Association's action plan highlights some of the key challenges related to housing need among the non-reserve Aboriginal population.

- Implications for provincial to municipal funding mechanisms as a result of majority of Aboriginal population living off-reserve.
- The housing need among Aboriginal non-reserve population is disproportionately high compared to the housing need among non-Aboriginal population.
- High rates of homelessness not only in large but also in smaller 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 Aboriginal housing need.
- Access to dedicated funding to address homelessness has been burdened with too much process.

In response to these housing challenges faced by non-reserve Aboriginal population, NAHA advocates and defends the principle of Aboriginal control over Aboriginal housing and "…calls on the federal government to extend and make permanent the off-reserve Aboriginal Housing Trust" (National Aboriginal Housing Association, 2009). NAHA has defined specific funding targets aimed at reducing Aboriginal housing needs at a level at par with the housing need in the general non-Aboriginal population.

HOUSING CHALLENGES FACED BY ABORIGINAL POPULATION LIVING ON-RESERVE

The rates of housing need among Aboriginal persons living on reserve are twice that of the non-Aboriginal population in Canada (Hay, 2005). Some of the challenges related to housing for Aboriginal populations living on-reserve are highlighted in Housing, Horizontality and Social Policy (Hay, 2005). The key challenges faced by Aboriginal populations living on reserve with respect to housing include some serious infrastructure problems such as inadequate water and sewage systems. Another critical challenge is overcrowding. On-reserve housing is burdened with problems of overcrowding which is associated with significant health problems such as high rates of infectious diseases and tuberculosis. These are of critical and imminent concern.

The report recommends policy direction in support of Aboriginal-controlled housing management structures in order to best address these challenges. “Aboriginal housing under Aboriginal control is not only an important value, but it is the most effective way to ensure Aboriginal people have the homes that they require” (Wellesley Institute, 2008).

RESPONDING TO HOUSING NEED AMONG ABORIGINAL PEOPLE LIVING WITH MENTAL HEALTH AND/OR ADDICTION PROBLEMS

Action to address housing need among Aboriginal populations living both on and off-reserve is urgently needed. The way forward to address any of these challenges all require commitment, participation, and cooperation from different levels of government (federal, provincial, territorial, and municipal) in collaboration with Aboriginal people. Identifying solutions to address the housing need and support needs among Aboriginal people living mental health and/or addiction problems will require the engagement of provincial and municipal governments in collaboration with Aboriginal people.

One area of urgent need is among the Aboriginal populations across municipalities in Canada who share a disproportionate burden of homelessness and its associated mental health, addiction and other health problems. The NAHA action plan highlights, “Aboriginal individuals account for a very significant proportion of homelessness…and require culturally sensitive appropriate interventions – housing first and supports to address addictions, mental health and where possible labour market reintegration. A target of creating 1,000 new transitional and supportive spaces over the next decade is established” (National Aboriginal Housing Association, 2009).

APPENDIX SEVEN: MAPPING HOUSING AND SUPPORTS BY PROVINCE AND TERRITORY

PARAMETERS

The intention of the mapping exercise was not to gather and collate existing information about how housing and related supports are structured, funded and operate on the ground. These provincial and territorial "pictures" include the **range of existing housing and mental health service options, together with approximate figures on current capacity as well as information on current policy initiatives, and challenges being faced on the ground**. The maps were generated using interviews from key informants, generally working in the housing and mental health sectors, as recommended by reference group members. Government websites, annual reports, and existing planning reports were also used in generating the maps. The maps were further refined by broad feedback from members of the Provincial and Territorial Reference Groups as well as representatives from provincial and territorial governments. Appendix Seven includes all individual maps. This section also integrates information from Appendix Five (Broader Considerations in Housing).

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 inherent 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, there are some social housing initiatives that are recognized as serving people living with mental illness but are not funded to do so,
- Adequately capturing housing provided by non-profit organizations – this information was not always readily available and/or there are instances of organizations providing housing to this population but are not necessarily receiving government or targeted funding to do so, and
- While the maps cover a range of housing options, there are some options 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. Halfway homes or other justice/corrections related transitional housing were generally not captured within the data.

Additionally, housing on Aboriginal[54] reserves has not been captured through this exercise: Appendix Six discusses themes on housing and supports for First Nations, Métis and Inuit peoples. For these reasons, housing stock figures, and particularly housing stock figures for dedicated housing, are likely underestimates of actual capacity. Nevertheless, this exercise represents **the first time that such a national picture of housing for people living with mental health problems and/or mental illness has been created and represents a reasonable approximation of government-funded housing capacity across the country**.

TERMINOLOGY: BREAKING DOWN BARRIERS TO COLLABORATION

What follows is a summary of the type of housing and supports captured through the mapping exercise, as well as the terminology used.

[54] 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 does sometimes refer to "Aboriginal" peoples rather than always First Nations, Metis and Inuit peoples.

Dedicated housing: Housing that is funded specifically for people living with mental illness or a concurrent disorder[55] (co-occurring mental health issues and problematic substance use). In general, the funding sources originate from municipal, provincial and/or federal governments, although there are some instances where 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 – this 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 targeting specific groups, et cetera. 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 the maps could have been limited to Dedicated Housing options alone, the reality is that many people living with mental illness or mental health problems live in a variety of non-dedicated, government-funded housing options, particularly when income levels are lower.

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 housing options for people living with intellectual disabilities[56]. While we acknowledge that these options may not be permanent, or may not be appropriate, for people with mental health issues, we have included these recognizing that people can and do access these facilities or options.

In the context of dedicated mental health housing, **different definitions are used across the country when it comes to housing and support options** – this is a concern that was expressed consistently by reference groups. Terminology can vary nationally, within provinces and territories, and even within regions. Different understandings of what is meant by supportive housing, by supported housing, by residential care options, and so forth all contribute to perceived difficulties in having a dialogue on housing needs of Canadians living with mental illness. Nowhere is this challenge more prevalent than in the discussion surrounding "supported" versus "supportive" housing. In general terms, we can summarize the following elements of supported and supportive housing options:

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

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

Supportive housing – at least 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 – this could include 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 where there are private bedrooms and baths, but shared common spaces.

[55] 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.

[56] 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.

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

- Consider, for example, the cross-over in functions between mental health clinical services and housing support services that 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 to them, but also incorporates a variety of activities that are more closely tied to housing support services such as learning household skills like meal preparation, grocery shopping, or budgeting). Conversely, a key component of a housing support worker includes linking people to services in the community to help to address issues (such as substance use, mental health issues, physical health issues) that could impact housing stability, which is similar to functions also provided by a case manager.
- While there may be "linked" housing support functions to a particular housing option, the mental health services may be "delinked" and so will follow tenants if they move to a new apartment – is this supportive or supported in nature?
- There are many examples of housing where each person has their 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.

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 strategy for housing, a shared understanding of terminology and definitions is crucial – the strategy adopted by the research team was to use 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 common attributes of both supported and supportive housing:

- Low-cost housing combined with some type of support.
- Consistent population: both models are funded to serve people living with mental illness and/or mental health problems
- A Common philosophy: Providers of both of these options tend to focus on the importance of empowerment, independence and recovery in how they provide housing and supports.
- Tenancy: People living in either supported or supportive housing are tenants, and sign leases with private landlords or mental health or social housing providers – depending on how that particular housing is managed and organized.
- 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 can include:
  - 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

A dedicated mental health supportive housing program in Toronto, Ontario partnered with the Toronto Community Housing corporation, the largest social housing provider in Canada, on a pilot project to support the development of a mental health framework for over 160,000 low and middle income tenants (TCH & Houselink, 2008). Building upon the mental health program's expertise and "extensive peer support program" (ibid., p.8) the project recommended that Toronto Community Housing "investigate possibilities for tenants to be trained and hired as peer supports to help new tenants transition from homelessness to tenancy; recovery educators or coaches; and as drop-in co-ordinators or staff" (ibid., p.4).

By identifying the mechanism of change as increased 'choice', this research has implications broader than the specific housing model including the role of peer support. While the research on Housing First does not refer directly to peer support, the researchers note in passing that a significant number of the program staff are people with lived experience of mental illness, addictions and homelessness. They also acknowledge the consumer movements' role in advocating for increased choice and control over mental health treatment which helped lead to the development of approaches like Housing First (Greenwood et al., 2005).

Authorities or through contracts with community-based mental health organizations, and/or

- Housing support services which focus on skill-building and empowerment to help maintain housing stability and tenure (for example, finances and budgeting, setting life goals, addressing issues which are impacting housing stability, helping people to connect to natural supports and activities in their communities). These services may be funded via provincial or territorial governments' housing or health departments and delivered by regional health authorities or community-based mental health or housing organizations, but they may also be funded via municipal or federal initiatives, or other ministries provincially and delivered by, for example, social housing providers or other support service providers (including providers who serve people living with mental illness, perhaps as part of a broader population but are not 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.
- Creative approaches and partnerships between housing and mental health organizations may exist in the provision of tenant support.

Appendix Four provides a full description of the *Housing First* approach: begun in New York City, ***Housing First*, at its most basic level, provides low-cost housing but does not require participation in substance abuse or psychiatric treatment to be a condition of residency**. Additional 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 minimal 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, involvement with the criminal justice system). This approach has demonstrated successful outcomes in housing stability, reduced homelessness, psychiatric symptoms, and improved quality of life (Greenwood et al., 2005; Pearson et al., 2007; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003).

Residential care options typically have 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. The fixed basket of services can seriously limit individualized recovery strategies, for example a client doing his or her own cooking. Most residential care 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. It would be unfair and untrue to suggest, however, that there haven't been some changes in residential care approaches and that serious attempts are being made, sometimes on a pilot basis, and sometimes on a broader provincial basis, to identify ways in which residential care options can evolve to reflect more recovery-oriented approaches. Sections 8 and 9 further discuss this evolution.

Affordable housing refers to housing that is provided at a price or rent substantially "below-market" through a subsidy or other intervention, and subject to enduring controls on affordability and occupancy. It encompasses social housing typically provided through government assistance, and also affordable rental and ownership housing that might be provided by regulatory concessions or incentives. **Social housing** refers to all forms of publicly assisted housing, including public housing, non-profit and co-operatives, supportive housing and more recent "affordable housing" initiatives. It should be noted that there are subtle variations in the degree of targeting and tenant income levels across different social housing programs. **Housing co-operatives** are member-owned and controlled organizations. The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. Between 1973 and 1991, the Canada Mortgage and Housing Corporation participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme, however, is that all of these co-operatives provide some type of financial support. The federal government ceased funding new development at the end of 1991, but continues to honour its operating agreements with existing co-operatives, which house over 92,000 members across Canada under these legacy programs.

Core housing need (Canada Mortgage and Housing Corporation, 2001) – The Canada Mortgage and Housing Corporation (CMHC) has been analyzing incomes and housing costs for many years to determine the level of "core need". The definition of "core need" is complex and involves three standards: acceptability, suitability, and affordability. There are two steps considered to determine core housing need – the first focuses on whether a dwelling meets the three standards:

- Adequate dwellings: This is a measure of housing condition to determine if 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 if households have a sufficient number of bedrooms based on family composition (effectively a crowding measure).
- Affordable dwellings: This standard is based on a ratio of housing expenditures to total household income; a household paying more than 30 percent of its before-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 alternatives in the same community. If not, they are considered to be in core housing need.

Table 1. ***Range of housing and support models by province and territory*.**

	Dedicated Mental Health	Non-Dedicated Affordable Housing	Additional Facilities or Housing
Alberta	Supported Housing Options Regional Mental Health Housing Approved Home Program Mental Health Support Homes	Community Housing Program Seniors' Self-contained Housing Program Special Needs Program Homelessness Strategy Housing Lodge Accommodation Rent Support Programs Rural and Native Housing Program (Rental)	Emergency and transitional shelters Personal Care Homes Supportive Living Long-Term Care Facilities Designated Assisted Living Program (in Retirement Residences)
British Columbia	Mental Health and Addictions Supported Housing – Includes supported apartments, Group homes, Supported hotels, Rental subsidies BC Housing Health Low barrier housing (low and high level support) Community Residential Care Family Care Homes	Public housing Non-profit and co-operative housing Rent assistance for seniors Rent assistance for families Aboriginal housing Transition House Services Seniors' Supportive Housing	BC Housing Emergency Shelter Program Home Care and Community Services (assisted living, supportive housing, community care facilities) Residential Options for People with Developmental Disabilities (Supports to Home Living, Home Sharing, Staffed Residential Living, Semi-independent Living Support, Supported Apartments, Cluster Living)
Manitoba	Supported Housing Supportive Housing Portable Housing Benefit (Supported Housing) Residential care facilities	Social/public housing program Not-for-profit sector housing Rural and Native housing program Co-operative housing Single room occupancy hotels and rooming houses (privately operated) Manitoba Shelter Benefit Rent Supplement Program	Emergency and transitional shelters Personal Care Homes Supported Living Program

New Brunswick	Some dedicated options as part of the non-profit housing program	Non-profit housing Public Housing Rent Supplement Rural/Native and Basic Shelter Program Affordable Rental Housing Program Housing Cooperatives	Emergency Shelters for the homeless and Transitional Housing for youth Special Care Homes Community Residences Nursing Homes Transition Housing and Second-stage housing for women leaving relationship violence
Newfoundland and Labrador	Boarding homes Supportive Housing	Rental Housing Program Rent Supplement Program Housing Cooperatives Lower End market Units Rent Geared to Income Program	Emergency/Transitional Shelters Nursing Homes Personal Care Homes Residential Options for People with Intellectual Disabilities (Cooperative Apartments, Alternative Family Care Homes, Board and Lodging Supplement, Individualized or shared living arrangements)
Northwest Territories	n/a	Social Housing Programs Rent Supplement Program Co-operative ILM Housing Program Rural and Native Rental Housing	Supported Living Transitional Housing Emergency Shelter In the NWT Supported Living refers to longer term 24/7 support to people with disabilities Transitional Housing refers to housing that is shorter term and provides life skills support
Nova Scotia	Supported Housing Supportive Housing Homes for Special Care	Public Housing for Families Public Housing for Seniors Housing Co-operatives Rent Supplements	Emergency Shelters and Transitional Housing Residential Care Facilities Long-Term Care Homes Licensed Group Homes
Nunavut	Transitional housing	Public Housing (includes rent supplements) Staff Housing (includes rent supplements)	Emergency Shelters Residential Facilities Medical Boarding Homes (located outside Nunavut)
Ontario	Supported housing Supportive housing Homes for Special Care Habitat Services Mental Health Supportive Housing Rent Supplements	Social Housing Rental & Supportive Housing Housing Allowance/Rent Supplement Program Strong Communities Rent Supplement Program Rental Opportunity for Ontario Families (ROOF) Housing Co-operatives Domiciliary Hostels Rural and Native Rental Housing	Emergency Shelters and Transitional Housing Ontario Works - Hostels to Homes Pilot (H2H) Consolidated Homelessness Prevention Program Provincial Rent Bank Emergency Energy Fund Long-Term Care Facilities Residential Options for people living with intellectual disabilities
Prince Edward Island	Supported Housing Supportive Housing	Public Housing for Seniors Public Housing for Families Rent Supplements Housing Co-operatives	Emergency Shelters and Transitional Housing Long-Term Care Homes Community Care Facilities Residential options for people with developmental disabilities: group homes, associate families, shared care, supported apartment, supervised room and board
Québec	structured community-based residential housing	Municipal Housing Programs	

Saskatchewan	Community-based residential accommodation Mental Health Approved Private Service Homes	Co-operative and other-nonprofit housing corporations Aboriginal off-reserve units Inuit units Rent Supplement program Social Housing Rental program Special purpose units Family Housing Supplement Disability Rental Housing Supplement Co-operative housing Rent Supplement Program	Personal Care Homes Special Care Homes (Nursing Homes) Residential options for people with intellectual disabilities: group homes, group living homes, supported independent living programs, supported apartment living programs, specialized homes, Approved Private Service Homes
Yukon	n/a	Social housing Housing co-operatives (total of two for the Territory) Rent supplement program	Home Care and Community Services: small number of models premised on assisted living and community care Residential Options for People with Developmental Disabilities (Supports to Home Living, Home Sharing, Staffed Residential Living, Semi-independent Living Support, Supported Apartments, Cluster Living)

ALBERTA

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of Alberta is approximately 3,290,350 (Statistics Canada, 2009) with an unemployment rate of 6.5% compared to a rate of 8.1% across Canada (Statistics Canada, 2010). Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of 10.6%** since 2001, significantly higher than the national average of 5.4%. Alberta had the highest growth rate, with Nunavut close behind at 10.2% - the next highest growth rate was Ontario at 6.6% - and this is due predominantly to a strong net inflow of migrants from other provinces.
- While the population is aging, consistent with all other regions across Canada, the proportion of **the population aged 65 and over is the lowest amongst all the provinces** at 10.7% (compared to 13.6% nationally) – only the territories have lower proportions.
- The census enumerated **188,365 people reporting Aboriginal identity** in Alberta in 2006, representing 16% of the national total.
- The Aboriginal population is becoming increasingly urban. In 2006, 54% lived in an urban centre, an increase from 50% in 1996. Urban areas include large cities, or census metropolitan areas, and smaller urban centres. In comparison, 81% of non-Aboriginal people were urban dwellers in 2006. The difference between the two proportions is due mainly to the large share of First Nations people who live on reserves.
- About 9.3%, or 103,700, of the **1.1 million new immigrants** who came to Canada between 2001 and 2006 settled in Alberta (5.2% of all newcomers settled in Calgary). This was an increase from the last census in 2001, when 6.9% of newcomers settled there.

    - An estimated 57,900 recent immigrants settled in Calgary. These newcomers made up 5.4% of the city's total population in 2006. The working-aged population (25 to 54 years old) increased 10.9% between 2001 and 2006 and recent immigrants in this age group accounted for nearly two-thirds of that growth.
    - Calgary was the census metropolitan area with the fourth-largest share of newcomers, after Toronto, Montréal and Vancouver.
    - Recent immigrants living in Calgary came from all around the world, but the People's Republic of China, India and the Philippines were the top three source countries of recent immigrants.

- In Alberta, the census enumerated a total of **527,000 foreign-born individuals**, who represented 16.2% of its population. This proportion was the third-highest in Canada, after Ontario and British Columbia.

    - Calgary’s census metropolitan area's (CMA) foreign-born population increased by 28% between 2001 and 2006 (one of the fastest rates in the country), compared with 9.1% for its Canadian-born population. Growth in Calgary's foreign-born population was one of the fastest in the country.
    - The foreign-born population made up almost one-quarter (23.6%) of Calgary's population in 2006, up from 20.9% in 2001 – the fifth highest in Canada.

- Of the 1,256,195 households in 2006, **73.1% owned the dwelling** they lived in (consistent with the national average) and had the third fastest proportional increases among the provinces in rates of home ownership since 2001. Of owner households, 62.1% held a mortgage compared to the national average of 57.9%. This is the **highest rate among all the provinces**, and is exceeded only by the Northwest Territories and Nunavut.
- The **median price** Alberta homeowners expected to receive from selling their home rose from $145,115 in 2001 to $250,473 in 2006. This was well **above the national median** of $200,474.

- After Ontario, Alberta had the **second highest median shelter costs** among the provinces in 2006. For owners, it was $12,190 annually, up 23.1%, and for renters, it was $9,033, a 17.5% increase
- The proportion of households **spending 30% or more of their income on shelter** was below the national average of 24.9% at 22.2% (up from 21.6% five years earlier)
    - Of owner households, 16.6% spent 30% or more of their income on shelter (up from 15.5% in 2001), 37.2% of renter households spent 30% or more (up from 36%)

According to the Canadian Council on Social Development's 2009 Social Development Series:

- The rate of poverty in Alberta has continued to decline for most household types, reflecting the sustained economic growth over the last decade.
- The percentage of poor among all economic families in Alberta is 8.7%, down from 10.4% in 2001 and 14.9% in 1996: among lone-parent families with children under age 18, the percentage of poor dropped from 39.1% in 2001 to 24.7% by 2006. For couples with children under age 18, however, the poverty rate rose by 3.2% to 12% in 2006: this increase is largely due to higher costs for school fees and housing, particularly rents.
- As homelessness and poverty in urban areas has become more visible, public concerns have grown. In January 2007, leaders from business, the non-profit sector, the faith community, and the three levels of government came together to form the Calgary Committee to End Homelessness, and a year later, released a plan to reach its goal in 10 years' time. Estimating the cost of homelessness in Calgary at $322 million per year, the group predicts that unless action is taken, there could be as many as 15,000 homeless people in the city by 2018. In February 2008, the Mayor of Edmonton struck a committee to end homelessness, and similar initiatives have been introduced in other municipalities.
- The province's annual inflation rate rose from 2.1% in 2004 to 5.0% in 2007. In a survey conducted in April-May 2008, the Edmonton Social Planning Council found that rents had increased for 80% of renters, with an average increase of $195 per month. Where rents were less than $500 a month, the average increase over the last year was 61%; renters paying $1,000 or more faced an average increase of 18%.

The Alberta Secretariat on Homelessness noted that there were an **estimated 8,400 people who were homeless** in 2006 and that this is a diverse population (Alberta Secretariat on Homelessness, 2008, p.6):

- 14% of homeless are living on the street;
- 40% have some form of mental health problem;
- 50% have some history of substance abuse;
- 25% are employed;
- 10% are young adults;
- 11% are families with school age children;

The Secretariat further discusses the large population of "hidden" homeless made up largely of women, youth and families, as well as the people who are at risk of becoming homeless in that they spend more than 30% of their income on housing. In January of 2010, the YWCA of Calgary released a research and position paper, Women and Homelessness in Calgary, and identified that women's homelessness is especially hidden – with women using every strategy at their disposal to avoid street homelessness given concerns around safety as well as fear that social services will apprehend their children. The report cites figures from the Calgary Committee to End Homelessness (2008) that an estimated 58,000 households in Calgary were living **one paycheque away from homelessness** (cited in YWCA Calgary, 2010, p.5)

This is set against the backdrop of the province's strong and consistent economic growth – in 2006, almost one quarter of all new jobs created in Canada were located in Alberta. While the growing demand for energy and higher prices led to tremendous growth in the oil and gas sector in Alberta, lower-income Albertans have struggled as the costs of living far

exceed welfare and other benefit rates, and often wage earnings (Parkland Institute, 2007; Edmonton Social Planning Council, 2007). For example,

- The monthly Assured Income for the Severely Handicapped (AISH) payment increased from $810 to $850 from 1993 and 1999 (Faid, 2009, p.10) – the current rate is $1,188.
- While the GDP in Calgary's economic region increased by 76% between 1994 and 2006, the homeless population increased by 645% during the same period (City of Calgary, 2007, p.9).
- The City of Edmonton's Community Plan on Homelessness identifies a critical affordable housing shortage, requiring approximately 20,000 emergency, transitional, and long-term housing units in Edmonton and another 20,000 affordable housing units needed in Edmonton. The number of homeless persons in Edmonton tripled from 1999 to 2006 (836 people in 1999 to 2,618 people in 2006).
- Over 14% of employed individuals in Calgary earn their living in the retail and wholesale trade sector – their real average earnings dropped by 7.4% between 1998 and 2005 (from $31,000 to $28,700). (City of Calgary, 2007, p.11)
- In 2007 (at the height of the economic boom), over one in 12 children in Alberta lived in poverty – one in two children in poverty live in a household where one or more adults works full-time for the full year (Edmonton Social Planning Council and Public Interest Canada, 2009, p.8)
- Over one in four Albertans works for low wages – and low wage workers are more likely to lose their jobs during this economic downturn: from October 2008 to October 2009, there were net job losses of 31.2% for workers earning less than $10 an hour (the minimum wage in Alberta is currently $8.80/hour) and 9.6% for workers making $10 to $19.99. This compares to job gains of 13.9% for those making $40 or more per hour (Edmonton Social Planning Council and Public Interest Canada, 2009, p.10)

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

- The **Department of Health and Wellness** implements and ensures compliance with policy. **Alberta Health Services** (AHS) is responsible for delivering health services and reports directly to the Minister of Health and Wellness. Announced in 2008, AHS represents the integration of the previous nine regional health authorities, the Alberta Alcohol and Drug Abuse Commission, the Alberta Mental Health Board and the Alberta Cancer Board.
- The **Department of Housing and Urban Affairs** develops strategic directions and supports development/delivery of affordable housing. There are three main divisions[57]:
  - **Housing Development and Operations Division:** works with over 400 community based organizations, including municipalities, housing providers, private non-profit and private for profit organizations to ensure provision of affordable housing through grant programs to increase supply; ensuring provincially owned or supported housing is well managed; overseeing program and grant initiatives through the **Alberta Social Housing Corporation**; and administers rent supplement programs.
  - **Homeless Support and Land Development**: helps ensure homeless Albertans have access to emergency shelter and supports needed to transition into permanent housing and toward self-sufficiency; provides support to the **Alberta Secretariat for Action on Homelessness** in implementing Alberta's 10-year plan to address homelessness; and facilitates access to/release of suitable land for affordable housing development in high-growth communities
  - **Policy and Urban Affairs**: responsible for strategic policy development, statistical analysis and the dissemination of strategic information.
- The **Alberta Social Housing Corporation** operates under the authority of the Alberta Housing Act. The ASHC's main purpose is to facilitate the provision of affordable housing through community-based **Housing Management Bodies** (HMBs) and to administer the seniors' self-contained housing program. The Corporation owns and administers the

[57] See Ministry of Housing and Urban Affairs website http://www.housing.alberta.ca/

Crown's portfolio of housing assets and manages provincial debts and agreements associated with those assets. Most provincially-owned housing is operated and maintained by HMBs, which also operate under the authority of the Housing Act. The Corporation directly operates units not administered by HMBs, including administering the sale of provincially-owned properties that are no longer efficient or effective for social housing programs.

- The **Alberta Secretariat for Action on Homelessness** is mandated to develop and lead a ten-year provincial strategic plan to end homelessness, report to the public on progress, and provide advice on strategic directions and potential revisions to the plan as needed. The Secretariat is a public agency of the Government of Alberta and is accountable to the **Minister of Housing and Urban Affairs**.

PROGRESS TO DATE: KEY INITIATIVES

The **Alberta Secretariat for Action on Homelessness** was established in 2008 and was mandated to develop and lead a ten-year provincial strategic plan to end homelessness, in collaboration with municipalities and communities. The plan was released in March, 2009 and sets out an aggressive strategy to end homelessness by 2019, using a *Housing First* approach. The emphasis is on community-led action with the role of the province as a facilitator. Investments are focused on three key areas:

- Rapid re-housing of people who are homeless (moving people from streets and shelters into permanent housing)
- Providing client-centered supports to people to assist them in maintaining their housing
- Preventing homelessness through emergency assistance and by providing adequate and accessible government programs and services

Over the course of ten years, the government plans to build 8,000 new units which will rehouse an estimated 11,000 people who are homeless, requiring a total investment of $3.316 billion (includes $1.258 billion in capital and $2.058 billion in costs to provide the support program). Compared to the estimated costs of continuing to 'manage' homelessness through status quo approaches ($6.65 billion), the government is projecting cost savings in the amount of $3.334 billion (Alberta Secretariat on Homelessness, 2008, p.11).

The Secretariat is directly responsible for the creation of the Alberta Homelessness Research Consortium, initiated in 2010, charged with coordinating and conducting research to support the objective of ending homelessness.

The **Provincial Mental Health Plan** was released in April 2004. The plan outlines a vision for mental health, roles and responsibilities in the provision of services, priority areas for service expansion, funding guidelines, a human resource strategy, research agenda, and accountability and system performance strategies. Core principles include clients and families coming first, accessibility, balance between treatment and mental health promotion, integration and coordination, innovation, accountability, appropriate funding and investment, adequate human resources, effective partnerships, strong commitment to research, and emphasis on the importance of positive mental health.

The **Health Promotion, Disease and Injury Prevention Action Plan: 2010-2012** and beyond was developed by Alberta Health and Wellness to enhance the health of the population and support Albertans to increase control over their health. It also provides direction for investment in health promotion and disease prevention. Five priority areas of action for HPDIP include: Social and Physical Environments, Healthy Development, Cancer and Chronic Disease Prevention, Injury Prevention, and Addiction and Mental Health. Key performance areas for addictions and mental health are: resiliency, stigma and discrimination, and alcohol consumption.

RANGE OF HOUSING ACCOMODATIONS

Table 1: *Overall range of housing and support options in Alberta.*

Dedicated Mental Health Housing	Supported Housing Options Regional Mental Health Housing Approved Home Program Mental Health Support Homes
Non-Dedicated Affordable Housing	Community Housing Program Seniors' Self-contained Housing Program Special Needs Program Homelessness Strategy Housing Lodge Accommodation Rent Support Programs Rural and Native Housing Program (Rental)
Additional Facilities or Housing Options	Emergency and Transitional Shelters Personal Care Homes Designated Assisted Living Program in Private Retirement Residences Supportive Living Long-Term Care Facilities

DEDICATED MENTAL HEALTH HOUSING

Table 2 provides a summary of housing which is dedicated solely for people living with mental health issues: the following sections outline housing options that are often used by people living with mental health issues but are dedicated specifically to this population. Information is based on MHCC Reference Group meetings, interviews with key government contacts, and websites of community agencies and government departments. In addition, the May 2007 Mental Health Sector Housing Services Inventory informed the range of options available in the Calgary Region. Table 2 should be viewed as an underestimate at this time – because of significant investments through the provincial plan to end homelessness within ten years, together with initiatives ongoing as part of the Calgary Region's plan to end homelessness by 2018, there are major changes that are ongoing with respect to capacity.

In addition to residential care settings that are dedicated to people living with mental illness and/or mental health issues, there can be dedicated apartments or buildings where people are provided with supports. These mental health supports are provided via community-based organizations and Alberta Health Services to people living in affordable housing programs provided through the Ministry of Housing and Urban Affairs.

Supports are also provided to people living in their own homes, or in 'non-dedicated' settings but these are not captured as part of the dedicated housing stock.

Regional Mental Health Housing: Regional mental health homes are designated for people with severe or persistent mental health problems. Residents are provided with services such as medication supervision, life skills, diet and nutrition, professional community follow-up workers who work with home operators, leisure recreational groups, and community support workers who help people maintain their housing[58].

Approved Home Program: Health authorities contract with and monitor family homes to provide room, board, assistance and support in a family atmosphere to adults 18 and over with severe and persistent mental health problems. Supports include medication supervision, diet, and life skills. Clients have assigned community follow-up workers who work with the Approved Home Operator and client. Independent living support services are also provided. Clients must be referred

[58] Alberta Health Services, http://www.albertahealthservices.ca/services.asp?pid=service&rid=425

by community follow up workers or discharge workers from inpatient programs. People with a recent history of alcohol or drug abuse, aggressive behaviour or active forensic history are not eligible for this program.

Mental Health Support Homes: Mental Health Support Homes are operated by host families that provide assistance with personal care, home making, meal preparation, medication assistance, health monitoring and liaison, and assistance to access recreational activities. Homes generally serve one to four residents with severe and persistent mental illness. People generally have lighter care needs, who need on-site availability of host families, but who don't require continuous access to nursing services. Room and board fees are approximately $600 per month, and residents are responsible for their personal expenses.

Table 2. *Dedicated Housing Options in Alberta.*

Program	Description	Capacity
Self-contained apartments or suites		
CMHA Alberta Northwest Region: Affordable and Transitional Housing	Provided through 58 units at Willow Place and 2 community housing locations (including 4-bed Fraser House). Support is based on a wrap-around approach promoting individual and community mental health. Willow Place Tenant Support Workers work with other CMHA staff to provide life skills coaching, health and recovery support, and links to other agencies and resources. Primary focus of support is on addressing issues which can impact housing tenure.	58 units, 2 community house locations
CMHA Calgary Region: Apartments	Seven buildings (three of which have mixed tenant populations) provide affordable housing units together with limited on-site services (people also access other CMHA services such as case management). There are a total of 372 apartments across the buildings (all of which share Horizon Housing as a landlord, except for two buildings where the landlord is Potential Place Society).	178 apartments
Community LAMDA Association: Apartments	Two buildings providing 32 2-bedroom suites and 30 1-bedroom apartments. Provide accommodation and limited on-site supports for people with mental illness (specific diagnoses identified). Subsidized by Calgary Housing Company (landlord). Tenants must be accessing the disability income supports, have and keep a case manager.	62 units
Pathways to Housing: Calgary	Pathways to Housing – provided by the Alex Community Health Centre: provides housing to people who are chronically homeless and have been diagnosed with mental illness – the support is based on a *Housing First* model (i.e., housing is a basic right and is the first priority in addressing the needs of people who are homeless). Once housed, people's choice is paramount in determining the type and level of support they receive. Pathways is part of Calgary 10-Year Plan to End Homelessness – the program began in October 2007 and targets housing 120 people.	120 units targeted
Pathways to Housing: Edmonton	Provided by the Boyle McCauley Health Centre: targets chronically homeless persons with serious mental illness and addiction, and often with complex health issues. Focus on *Housing First* approach using a scattered-site apartment model. Clients receive supportive treatment services provided by an Assertive Community Treatment Team, providing 24/7 coverage through on call availability.	Implementation in process
CMHA Central Region: The Buffalo	40 unit apartment building in downtown Red Deer provides housing and supports to people who have been homeless, have addictions and/or mental illness, and have had difficulty in maintaining housing. Operates on a *Housing First* model. Staff available to assist with day to day activities, engaging in meaningful activities, and connecting with health services.	40 units
CMHA Edmonton Region: Housing Program	Provides affordable housing units combined with support services for people with mental illness and/or low income. Housing Wood Manor (8 1-bedroom and 1 bachelor single occupancy suites), Citrus Court (27 1-bedroom single occupancy suites), Santa Rosa (38 1- and 2-bedroom suites), and Place 103 (30 1-bedroom suites). Rents are geared to income (30%).	104 units
CMHA Lethbridge Region: Permanent Housing	CMHA in partnership with the Lethbridge Housing Authority, provides six subsidized housing allocations for persons with mental illness. Lethbridge housing funds the individuals and CMHA provides the support needed for the individual to maintain their residence. **Scenic Drive Apartments**: A partnership between the Chinook Health Region, Lethbridge Housing authority and the CMHA, the project provides three community mental health crisis beds and supported.	6 units

Program	Description	Capacity
	apartment living.	
Shared Housing		
CMHA Calgary Region: Group Homes	Three homes provide varying degrees of on-site staff support (ranging from 24/7 to 35 hours per week) for people with severe and persistent mental illness. Housing is provided by Horizon Housing, and CMHA provides range of on-site supports that focus on achieving greater independence. Landlord is Horizon Housing.	24 spaces
CMHA Calgary Region: Shared Housing	Four duplexes/homes that provide housing and limited on-site housing support for people with severe and persistent mental illness (people also access CMHA services such as case management) who have fairly strong independent living skills and are willing to work on goals. Landlord is Horizon Housing.	27 spaces
CMHA East Central Region: Residential Program	This program is for individuals over the age of eighteen with a severe and persistent mental illness. Individuals must be willing to work in cooperation with an Independent Living Skills Worker. Individuals must want to live in a shared living arrangement and be able to get along with others.	
Transitional Housing		
CMHA Calgary Region/Corrections Canada: Roberts House	Halfway house with 24/7 supervision designated for people who are on parole and have a mental health diagnosis. Offered in conjunction with Corrections Service Canada (who makes the referrals to the program). Landlord is Horizon Housing.	10 residents (transitional)
CMHA Calgary Region: Stabilization and Transition to Community Options	Three buildings (one with over 100 units with 8 beds on-site) provide 3 2-bedroom stabilization suites (maximum six months) and 16 post-discharge beds for people with mental illness (24 hour staffing, maximum six months). Landlord is Horizon Housing. Individuals are not considered tenants but program participants	22 spaces
CMHA Lethbridge Region: Transitional Housing	Laura House Group Home provides a 6-bed transitional home (including respite) with support and life skill development to promote independent community living. Skill development includes symptom management, medication management, personal budgeting, personal presentation, community and health education	6 beds
Residential Care		
Community Mental Health Homes		450 beds[59]
Mental Health Support Homes	Operated by host families that provide assistance with personal care, home making, meal preparation, medication assistance, health monitoring and liaison, and assistance to access recreational activities. Homes generally serve one to four residents with severe and persistent mental illness, generally with lighter care needs who don't need continuous access to nursing services.	
Regional Mental Health Housing	Designated for people with severe or persistent mental health problems. Residents are provided with services such as medication supervision, life skills, diet and nutrition, professional community follow-up workers who work with home	

[59] Alberta Health Services, 2009/10 Annual Report, p.18

Program	Description	Capacity
	operators, leisure recreational groups, and community support workers who help people maintain their housing[60].	
Approved Homes Program: Calgary and Edmonton	Furnished room and board in a family home with supervision and support by the host family. People must have a diagnosis of severe and persistent mental illness, have and keep a case manager, be aged 18-64 years old and on the AISH program (disability supports). Other approved homes (not captured here) serve people with other needs such as developmental disabilities	112 spaces – Calgary 109 spaces - Edmonton
Personal Care Homes: Calgary	Support and care for people with mental illness and high needs requiring 24/7 care (Personal Care Homes are further discussed under "Additional Facilities" as they don't usually specify people with mental illness as the target population).	29 spaces - Calgary

[60]Alberta Health Services, http://www.albertahealthservices.ca/services.asp?pid=service&rid=425

NON-DEDICATED AFFORDABLE HOUSING OPTIONS IN ALBERTA

There are a total of about **26,000 provincially-owned or support housing units and 20,500 privately-owned rent supplement units** across Alberta: the Alberta Social Housing Corporation owns and administers the Crown's portfolio of housing assets and manages provincial debts and agreements associated with those assets. Total funding for 2009/10 to Housing Management Bodies was almost $140 million to support existing housing. Some of the dedicated housing stock makes use of some of the programs below, including rent supplements so overlap does exist across the two categories. As noted under the 'dedicated' housing section, this capacity should be considered a moving target as the provincial plan to end homelessness continues to implement its 10 year plan for **8,000 new units**. Most provincially-owned housing is operated and maintained by Housing Management Boards, which also operate under the authority of the Housing Act. Main programs include[61]:

THE COMMUNITY HOUSING PROGRAM

Provides subsidized rental housing (30% of household's adjusted income) to low-income families, senior citizens, and individuals with special needs who cannot afford private sector accommodation. Applicants whose income falls below local income limits (Core Need Income Threshold) can apply.

- Local housing operators are responsible for management and tenant selection.
- Applicants are given priority based on need, as determined by income, assets, and current housing condition.

SENIORS' SELF-CONTAINED HOUSING PROGRAM

Administered directly by the Alberta Social Housing Corporation. Apartment type accommodation to low and moderate-income seniors who are functionally independent with or without the assistance of existing community based services. Rent includes heat, water and sewer and based on 30 percent of a household's adjusted income.

- Province owns most apartments under this program
- Operating deficits are fully funded by the province through an annual budget review
- Management and tenant selection are delegated to the local housing operators.
- Applicants are prioritized on the basis of need

SPECIAL NEEDS PROGRAM

Delivered by municipalities, non-profit and community groups, these units provide a middle option for people with special needs who aren't able to live independently, but do not require residential care. Occupants to pay a reduced rent based on 30 per cent of their household income:

- Municipal Non-Profit: Province provides a subsidy based on the difference between the principal and interest payment on the mortgage at the lender's interest rate and that same mortgage amount at a two percent interest rate. Enables Calgary and Edmonton to provide affordable rental housing to a mixture of low, moderate, and mid-income tenants. The subsidy agreements are based over a 35-year loan period with the last agreement expiring in 2017.
- Private Non-Profit Special Purpose: Eligible non-profit organizations receive a monthly subsidy equal to the difference between the principal and interest payment on the mortgage at the lender's interest rate and that same mortgage amount at a two percent interest rate. Enables non-profits to develop and manage projects, with on-site care services and facilities to residents with common physical, social, and emotional conditions or disabilities. Cost shared with Canada Mortgage and Housing Corporation.

[61] Alberta Housing and Urban Affairs, http://www.housing.alberta.ca/ah_inde.g.cfm

- Public Non-Profit Special Needs: Provincially owned and provide modest and affordable rental accommodations appropriate to the needs of low and moderate-income households, senior citizens, and physically handicapped or any other group having special housing needs. Operating deficits and amortization costs are cost-shared with Canada Mortgage and Housing Corporation.
- Public Non-Profit Municipally Owned: This program provides monthly subsidies to municipalities to cover operating deficits, including the mortgage principal and interest payment based on eligible capital costs. Individuals who currently occupy a crowded or inadequate dwelling would be eligible for housing in these municipally owned units. The operating deficits are cost-shared with Canada Mortgage and Housing Corporation.
- Private Non-Profit: This program provides monthly subsidies to non-profit organizations to cover operating deficits, including a reserve allocation and the mortgage principal and interest payment based on eligible capital costs. Individuals who currently occupy a crowded or inadequate dwelling would be eligible for housing in these units owned by private non-profit groups. The operating deficits are cost-shared with Canada Mortgage and Housing Corporation. The non-profit organization establishes the monthly changes on these units.

HOMELESSNESS STRATEGY

Of **the 8,000 new units** identified in the Ending Homelessness in 10 Years plan, it's estimated that a significant proportion will be for people who require supports to maintain their housing tenure. This could include provision of supports for people with mental health issues, substance use issues or health needs. The type of supports focuses more on housing supports rather than clinical supports per se. The Alberta Secretariat on Action to End Homelessness estimates that **roughly 40% of people who are homeless experience significant mental health issues**. Although the units created are captured under this non-dedicated section as the population targeted are people who are homeless, it's well understood that a substantive number of people will have mental health issues or mental illness. Most of the units created to date are run by non-profit organizations.

Units created under the strategy utilize a ***Housing First*** **model**:

- Are used for rapid re-housing of people who are homeless
- Permanent housing is provided along with needed support services that help re-housed individuals to get the help they need to maintain their housing
- Support services may include intensive medical, psychiatric and case management services including life skills training, landlord liaison assistance and addictions counselling.

Addressing these needs through support services helps people maintain their housing over the long term. Community-based organizations assist people in securing housing and ensuring they have the supports they require and desire. The goal is that at least some proportion of people who access these units (about 15%) would eventually move on to other successful housing placements by securing employment. Ultimately, people should be supported in achieving as high a level of **self-sufficiency** as possible.

Although the economy has been in a downturn, the government still committed approximately $132 million in the **initiative's first year** ($100 million for capital funding and $32 million for outreach and support services) and **the target of housing 1,000 people with supports has been achieved and surpassed**. According to its 2010 progress report, community-led *Housing First* programs have **moved 1,779 people** who were homeless into permanent housing with supports. The progress report also notes the importance of focusing efforts on prevention of homelessness, youth homelessness, and cross-departmental and cross-sectoral collaboration. There was a particular focus in housing people who have had chronic homelessness issues. Strengthening connections between mental health and addictions services has been sometimes challenging but of particular importance.

In 2010/11, the Ministry of Housing and Urban Affairs has committed an additional **$100 million** under a Request for Proposals to develop housing for the homeless. Grant funding for housing for the homeless is 70 per cent of the total

capital costs to a maximum of $150,000 per unit (total funding from all provincial government sources or government-funded agencies cannot exceed 70 per cent). An additional **$42 million** in funding is being provided to community-based organizations in the seven municipalities targeted under the plan, who will work with community partners to deliver outreach support services for the homeless.

Calgary Homeless Foundation	$19.14 million
City of Red Deer	$1.76 million
Lethbridge Social Housing in Action	$1.36 million
Medicine Hat Community Housing Agency	$1.32 million
Edmonton Homeward Trust	$13.5 million
Regional Municipality of Wood Buffalo	$1.56 million
City of Grande Prairie	$1.36 million

The remaining $2 million will be retained by Housing and Urban Affairs to help meet emergent needs in the province.

The Ministry has noted some better practices as part of the RFP:

- Priority is given to projects incorporating **self-contained units** for individuals (including bachelors and studio suites),
- **Sliding scale for mixed housing**: proposals of 20 units or less may contain all housing for the homeless units, 20-50 units can contain no more than 30% of units as housing for the homeless, 51+units no more than 20 per cent of the units as housing for the homeless, to a maximum of 40 units.
- In situations where projects that are greater than 20 units are targeted exclusively to the homeless, proposals need to provide the rationale for how this facilitates economy of scale in the provision of **specialized support services**, fits with the overall municipal plan to end homelessness, and has support from community stakeholders.

In 2009-10, the **Ministry of Housing and Urban Affairs** committed to develop 2,899 affordable housing units. Through partnerships with municipalities, non-profit, and private sector organizations, the Ministry provided funding for the following capital funding initiatives[62]:

- The Affordable Housing Municipal Block Funding Program – 891 units
- The Affordable Housing Program Request for Proposals – 1,075 units
- The Housing for the Homeless Request for Proposals – 933 units

The total amount of funding available under the 2010/11 RFP to increase accessibility to affordable housing options for low- to moderate-income families, individuals, seniors who are functionally independent, persons with special needs, and homeless people in need of housing is $188.31 million, $38 million of which is federal funding. Applicants can include municipalities, not-for-profit organizations, Housing Management Bodies and private sector organizations or developers.

- Any duly incorporated not-for-profit organization registered under the Alberta Societies Act or any corporation established under the Business Corporations Act (Part 9)
- Management bodies established under the Alberta Housing Act
- Private sector organizations, developers, or contractors

The Ministry notes that preference is given to proposals that focus on **mixed use**, and don't contribute to the overconcentration of publicly funded or supported housing in any one neighbourhood.

[62] Ministry of Housing and Urban Affairs 2009/10 Annual Report

RENT SUPPORT PROGRAMS

Rent Support Programs provide assistance to households in need to obtain and maintain affordable and suitable rental accommodation by subsidizing the gap between actual rent and 30% of the household's adjusted income. The programs provide rent subsidies in eligible rental projects. Management and tenant selection is the responsibility of local housing management bodies applicants are prioritized on the basis of need, as determined by income, assets and current housing conditions.

- Regular Rent Supplement: Local housing management bodies pay private landlords a rent supplement
- Direct to Tenant Supplement: A subsidy is paid directly to an eligible tenant to assist with rental costs, and is delivered by local housing management bodies.

RURAL AND NATIVE HOUSING PROGRAM (RENTAL)

Provides modest rental accommodation to low-income families in small rural communities – there is no new capital funding available to increase the current portfolio. Coordinated through the Ministry of Seniors and Community Supports.

Table 3: Non-Dedicated Affordable Housing Options in Alberta

Program	Description	Capacity
Community Housing Program	Provides subsidized rental housing to individuals and those with special needs who cannot afford private sector accommodation. Includes low-income families, senior citizens, and individuals with special needs Rent is 30% of household adjusted income.	10,421 units[63]
Special Needs Program—Non-Profit	Delivered by municipalities, non-profit and community groups, these units provide a middle option for people with special needs who aren't able to live independently, but do not require residential care. Occupants to pay a reduced rent based on 30 per cent of their household income	1,634 units and $5.8 million
Seniors' Self-Contained Housing Program	Provides affordable rental apartments (owned by the province) for low- and moderate-income seniors to enable them to live independently. Rent is 30% of household adjusted income. Cottage units were the predecessors of this program – they are usually small, self-contained units built prior to 1969 and are located on the same site as a lodge. Food and housekeeping services are not supplied to cottage units; however, they may be available for an additional cost. Cottage units receive a Lodge Assistance Program grant of $1.20 per day for each low- and moderate-income resident. Cottage unit residents are not covered by the Residential Tenancies Act.	14,253 units
Unique Homes Program	Provide seniors supportive housing in lodge-type accommodations. Unique Homes are owned and or managed by non-profit organizations and do not qualify for assistance under the Nursing Home Act or the Alberta Housing Act. The province provides financial assistance to eligible private senior citizen homes to assist with their operating deficits. Funding is provided through a grant of $6.45 per unit per day. No new funding is available for this program.	8 homes across the province
Ending Homelessness Strategy	Operates on a *Housing First* model: rapid rehousing with provision of needed support services to rehoused individuals. This could include provision of supports for people with mental health issues, substance use issues or health needs. The Alberta Secretariat on Action to End Homelessness estimates that **roughly 40% of people who are homeless experience significant mental health issues**. Although the units created are captured under this non-dedicated section as the population targeted are people who are homeless, it's well understood that a substantive number of people will have mental health issues or mental illness.	1,779 people in 2009/2010
Regular/Direct-to-Tenant Rent Supplements	Rent supplements are provided to low income households to subsidize the gap between 30% of a household's income and market rent. Local housing groups either provide rent supplements to landlords or directly to tenants.	Direct to Tenant: 15,500 households at $44.4 million Private Landlord: 4,700 households at $30.8 million
Housing Co-operatives	Between 1973 and 1991, CMHC participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme, however, is that all of these co-operatives provide some type of financial support. Housing co-ops are member-owned and controlled organizations. The monthly	3,050 units across 63 co-ops (16 in Calgary, 34 in Edmonton, 6 in

[63] Unless otherwise noted # of units and funding levels drawn from Conference Board of Canada (March 2010). Building from the Ground Up, p.81-82.

Program	Description	Capacity
	housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. The federal government ceased funding new development at the end of 1991, but continues to honour its operating agreements with existing co-operatives, which **house over 92,000 members across Canada** under these legacy programs. The Agency for Cooperative Housing is the not-for-profit administrator of federal co-operative housing programs in PEI, Ontario, Alberta and B.C., under a contract with CMHC.[64]	Northern Alberta and 7 in Southern Alberta
Off-Reserve Aboriginal Housing	Organizations involved with Aboriginal households living off-reserve can apply for funding through Request for Proposal processes to increase accessibility to new housing units, housing repairs, homeownership assistance, and affordable housing options for low-income Aboriginal households.	264 units
Rural and Native Housing Program	Provides modest rental accommodation to low-income families in small rural communities – there is no new capital funding available to increase the current portfolio. Coordinated through the Ministry of Seniors and Community Supports	

[64] Co-operative Housing Federation of Canada.

ADDITIONAL INITIATIVES AND INFORMATION

Affordable Housing Initiative/Canada-Alberta Affordable Housing Program Agreement: based on the housing framework agreed to in **November 2001** by federal, provincial/territorial housing ministers. 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 a grant, a stream of ongoing subsidies or the value of in-kind contributions (e.g. land). Within these terms and 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. The Program was intended to create affordable housing for households on social housing lists, or those eligible to be on such lists. As of June 30, 2010, $110.6 million of the federal allocation of $122.58 million had been committed and/or announced for a total of 4,093 units[65].

National Homelessness Partnering Strategy: launched on April 1, 2007 by the federal government, building on the foundation of its predecessor program, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five year commitment. Of the sixty-one "Designated Communities" funding component under the strategy, Alberta has: Calgary, Edmonton, Grande Prairie, Lethbridge, Medicine Hat, Red Deer, and Wood Buffalo. A key focus of the HPS is a housing-first approach and focuses on transitional and supportive housing as important ways to move individuals out of homelessness.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, but aren't dedicated to serving this population. Within Alberta this includes: **shelters, transitional housing** not specifically targeted to people with mental illness, **Personal Care Homes, Supportive Living options, Long-Term Care Facilities, and Residential options for People with Developmental Delays**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity.

SHELTERS AND TRANSITIONAL HOUSING

The Ministry of Housing and Urban Affairs provides the following overview of shelters in Alberta:

- Emergency: overnight accommodation for people with no permanent address, available on a drop in basis.
- Temporary: short term accommodation for people or families designed to increase the stability and self-sufficiency needed for independent living, requires an application process to access.
- Long Term Serviced Accommodation: unlimited stay at a facility with support services requires an application process to access.
- In total, agencies providing shelter spaces will receive $40.5 million in 2010/11 (30 shelters providing 3,473 spaces across the province).

According to figures from HRSDC, there were **approximately 5,185 beds** in Alberta's emergency and transitional shelters in 2007[66], or 19.3% of known shelter beds across Canada. There were **153 shelter beds per 100,000** population, almost

[65] Canada Mortgage and Housing Corporation (June 30, 2010), National Afford Housing Initiative Funding Table. http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm

[66] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

double the 82 shelter beds/100,000 people national average. The **number of shelter beds is likely an underestimate** because:

- It is based on the number of known shelters – there may be additional shelters not captured in this data set.
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available.
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007.

Also according to HRSDC, of the known 1,020 shelters identified across Canada as of March 2007, 723 or **71% were emergency shelters**, providing temporary and short-term accommodation for homeless individuals and/or families. Such shelters typically also offer essential services such as food, clothing and counselling. **Transitional shelters** offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. Transitional shelters numbered 291 and represented a little more than 28% of the total. There were, in addition, 6 shelters providing both emergency and transitional services, representing less than 1% of the total.

While the discrepancy between the Ministry and HRSDC figures is, in part, due to a broader array of shelters being included within the HRSDC calculations (i.e., shelters not provincially funded), the Ministry of Housing and Urban Affairs does note reduced shelter usage in its 2009/10 annual report: shelter usage was reduced during 2009, and from July 2009 to March 2010 remained below 2008 levels. Alberta's 10-year plan to end homelessness was approved March 16, 2009. For example, in December 2008, 554 more shelter spaces were utilized than in December 2007 whereas in December 2009, 427 fewer shelter spaces were utilized than at the same time one year earlier (p.18).

PERSONAL CARE HOMES[67]

Provided through Alberta Health Services, these homes provide personal assistance, supportive services, lodging and meals to one or more adults aged 18 and up who are unrelated to the operator. In personal care homes the emphasis is on helping residents with daily activities, rather than treating them for medical conditions. People who need 24-hour support, but who want to live in a homelike atmosphere may choose to move into a personal care home. There are generally three to six people per home. Personal care homes that provide accommodation and services to four or more individuals are required to obtain a license under the provincial Social Care Facilities Act. Homes with fewer than four residents are not covered by this legislation and do not require a license. Supportive Living Community Care Coordinators monitor PCHs, and provide assessments for admission.

There are over 180 spaces in 47 homes throughout Calgary, and room and board fees are $850 per month with shared bathroom, $900 per month with private bathroom – the health authority pays operators directly.

CONTINUING CARE: SUPPORTIVE LIVING AND LONG-TERM CARE FACILITIES

The Supportive Living Framework (2007) distinguishes three streams within the continuing care stream:

Table 4. *Continuing Care Accommodations and Supports.*

[67] As described in http://www.calgaryhealthregion.ca/pch/inde.g.htm

Home Living Stream	Supportive Living Stream	Facility Living Stream
▪ **People live in their own homes**, including but not limited to single family dwellings, apartments, condominiums, and other seniors' independent living options. ▪ People are mainly responsible for, and capable of, arranging any care and assistance they may need. ▪ Can access publicly funded health services such as Home Care as needed.	▪ Combines accommodation or housing and hospitality services with other supports and care for **people with a wide range of needs** (but not highly complex and serious health needs, or unpredictable and high-risk behaviours) ▪ Supportive living operators are responsible for coordinating and arranging hospitality services and may coordinate or directly provide personal care and other support services ▪ Includes basic hospitality services such as meals (at least one main meal per day), housekeeping, laundry, and life-enrichment services on site; a common area for meals, social functions, etc.; a safe and accessible environment. ▪ 24-hour, 7 days a week, safety and security. ▪ Within supportive living, client needs are assessed along a continuum from Level 1 (lowest need) to Level 4 (highest need) ▪ There are four types of supportive living: residential living (1), lodge living (2), assisted living (3) and enhanced assisted living (4) corresponding to the levels of need	▪ Includes long-term care facilities (e.g., nursing homes and auxiliary hospitals) that provide care for individuals with the **highest and most complex needs** (unable to remain at home or in a supportive living option) ▪ Medical conditions may be serious, chronic and/or unpredictable and require access to 24/7 registered nursing services that can respond immediately ▪ Specialized physical design and infrastructure to address highly complex needs. ▪ Is governed by the Nursing Homes Act or the Hospitals Act.

Supportive living facilities[68] are not limited to serving only one level of resident – they operate on the concept of "unbundling" health and housing services in that services can often be modified or enhanced based on people's needs. People can generally access these facilities by directly applying to the housing operator for "designated"[69] spaces under a contract between Alberta Health Services and a housing operator), entry is based on an assessment and collaborative process between Alberta Health Services and the housing operator.

- Ideally, every suite in supportive living facilities is private, includes a lockable door, a bedroom, sitting area, bathroom and a kitchenette. Suites for residents with Residential Living - Level 1 needs may also include a full kitchen.
- Except for Residential Living - Level 1, that might only contain a common area for dining, all other levels of supportive living are expected to have common areas for dining and social/recreational activities.

Facilities must comply with the Supportive Living Accommodation Standards (building cleanliness and maintenance, safety and security, food preparation and laundry) monitored by the Department of Seniors and Community Supports.

Residential Living – Level 1
In general, people in residential living can arrange, manage and direct own care, are responsible for decisions about day-to-day activities and can manage most daily tasks independently. Some supports/services are required but all personal assistance can be scheduled. Housing is mainly needed for safety, security, and socialization. 24 hour security is provided. Assistance with accessing community services may be available.

[68] See Alberta Health Services http://www.albertahealthservices.ca/services.asp?pid=service&rid=7798Supportive Living for additional information

[69] The term designated can refer to spaces in a variety of supportive living facilities, thus terms such as "designated Assisted Living", "designated Supportive Living" as well as "designated Supportive Housing" are often referred to within services

Lodge Living – Level 2
Also referred to as Seniors lodges and Enhanced lodges. In general, people in lodge living can arrange, manage and direct own care, are responsible for decisions about day-to-day activities and can manage some daily tasks independently. A basic set of supports/services is required and all or most personal assistance can be scheduled. Some supports/services are required. 24-hour staff are on site and assistance with accessing community services is available.

Additional elements include:

- Management of lodges and resident selection is the responsibility of local management bodies, of which municipalities are members. Local management bodies, as per the Alberta Housing Act, are responsible for day-to-day operation of seniors' housing programs in their areas.
- Municipalities support the lodges by paying facilities' operating deficits
- The provincial lodge assistance program provides funding assistance to the management bodies
- Resident fees are set by the local management bodies
- Although residents are not covered by the Residential Tenancies Act, low-income seniors are protected by the Alberta Housing Act, which ensures that every senior resident is left with at least $265 a month in disposable (after tax) income to spend on personal needs after paying their monthly basic lodge rate.
- Lodges do not unusually have health professionals on staff and are not trained to serve people with health or complex personal care needs
- Health services can be received via Alberta Health Services' Home Care Program
- Some management bodies have made formal arrangements with Alberta Health Services to coordinate or provide health and personal care services to their lodge residents.

Assisted Living – Level 3
In general, people in assisted living may need assistance in making some decisions about day-to-day activities and requires assistance with many daily tasks. Most personal assistance can be scheduled. People may require assistance to participate in social, recreational and rehabilitation programs. 24 hour staff are on site and routine checking of residents as required. Assistance with accessing community services is available.

Clients receive case management services through the health authority's Home Care Program, and on-site personal care support including 24/7 access to a Licensed Practical Nurse. There are designated assisted living suites that are located within privately owned and operated Retirement Residences. Suites are either shared privates (shared washrooms and living spaces) and/or studios (own living space and washroom). For example, there are currently thirteen sites with Designated Assisted Living in Calgary with a total of 464 beds[70].

Enhanced Assisted Living – Level 4
In general, people in enhanced assisted living need assistance in making decisions about day-to-day activities and requires assistance with most/all daily tasks. The need for unscheduled personal assistance is infrequent. People require assistance to participate in social, recreational and rehabilitation programs. 24 hour staff are on site and routine checking of residents as required. Assistance with accessing community services is available.

Long-term care facilities are also known as nursing homes or auxiliary hospitals. Alberta Heath Services determines eligibility for placement. There were approximately 14,654 long-term care beds in 2008 – while the population aged 75 and over had increased by 27.7% between 2001 and 2008 (the highest rate in Canada), the number of beds increased by only 1.2% leading to an overall 20.8% decrease in beds per 1,000 population aged 75 and over (CUPE, 2009, p.8 citing Alberta Health and Wellness). Of the total beds, 70% were owned by non-profit entities, which compares to 65% of beds

[70] http://www.calgaryhealthregion.ca/dal/

nationally (CUPE, 2009, p.50 citing Alberta Health and Wellness). As of March 31, 2010, Alberta Health Services reported a slightly lower total of **14,391 beds** (2009/10 Annual Report, p.141).

Residents in long-term care facilities pay accommodation fees to cover the costs of accommodations and services such as meals, housekeeping and building maintenance. Health services in LTC are publicly funded and provide through Alberta Health Services. Fees for long-term care accommodation are the lowest of any province: as of February 1, 2011, rates will be as follows:

- Private room – $55.90 per day, from $54.25 (for an average monthly room rate of $1,700)
- Semi-Private room – $48.40 per day, from $47.00 (for an average monthly room rate of $1,472)
- Standard Room – $45.85 per day, from $44.50 (for an average monthly room rate of $1,395)[71]

Both accommodation and health services standards exist for clients receiving continuing care in Supported Living or Long-Term Care options. **Accommodation standards include building cleanliness and maintenance, safety and security, food preparation and laundry** (monitored by the Department of Seniors and Community Supports). Health service standards include assessed health and personal care services provided by nurses, therapists, health care aides and other health care professionals (monitored by the Department of Health and Wellness). According to Alberta Health Services' 2010/2011 Operating Budget and Business Plan, **up to 6,000 continuing care beds will be created over the next five years** (a 30% increase): at least 1100 and up to 1700 continuing care beds will be opened in this fiscal year, and over 4,000 in the subsequent four years (p.8).

Affordable Supportive Living Initiative and Capital Grants for Affordable Supportive Living Projects
In 2010-2011, the province is providing $105 million in funding from the Affordable Supportive Living Initiative ($50 million) and Alberta Capital Bonds to support the development and upgrading of more than 1,000 spaces of affordable seniors accommodations throughout Alberta.

The Affordable Supportive Living Initiative (ASLI) provided $50 million in capital grant funding in 2009/2010 to support the development and upgrading of affordable supportive living spaces and lodge units throughout Alberta. In 2009/2010, 17 projects in 10 communities received funding.

RESIDENTIAL OPTIONS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

The Persons with Developmental Disabilities (PDD) Program falls within the Department of Seniors and Community Supports. The program is administered at the local level by six community boards and focuses on four categories of service: community living supports, employment supports, community access supports and specialized community supports. In total, the program supports about 9,300 adults with developmental disabilities and has an annual budget of $597 million for 2010/11. Community boards with approximately 220 service provider agencies. A review of administration costs for the program is currently underway (roughly 20% of the total budget is spent on administration)[72]. Housing and supports can be provided to people living in their own home, in semi-independent living placements (usually in a host family setting), and in residential settings with paid staff (approved homes, group homes, etc).

[71] See Alberta Seniors and Community Supports http://www.seniors.alberta.ca/ContinuingCare/LTCare.asp
[72] Department of Seniors and Community Supports, 2009/10 Annual Report, 2010-13 Business Plan.

Table 5. *Additional Facilities or Housing Options in Alberta.*

Type	Program Description	Capacity
Emergency/ Transitional Shelters	Homeless individuals and/or families Emergency – approximately 70% of all shelters across Canada providing temporary and short-term accommodation for homeless individuals and/or families. Transitional shelters - offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities.	HRSDC estimates 5,185emergency/ transitional shelter spaces (likely an underestimate) Province funds 3,473 spaces
Personal Care Homes	Homes provide personal assistance, 24/7 supportive services, lodging and meals to one or more adults aged 18 and up who are unrelated to the private operator. In personal care homes the emphasis is on helping residents with daily activities, rather than treating them for medical conditions. Generally three to six people per home. Supportive Living Community Care Coordinators (Alberta Health Services) monitor PCHs, and provide assessments for admission.	180 spaces in 47 homes in Calgary $850 - $900 per month
Supportive Living Options[73] *	Residential Living (Level 1)	2,208 spaces
	Lodge Program – of the total spaces, 7,969 residents receive public funding from the Lodge Assistance Program	9.198 spaces
	Assisted Living and Designated Assisted Living (Levels 3 and 4)	9.042 spaces (Level 3) and 3,038 (Level 4)
Long Term Care	Provides continuing care to people requiring 24 hour nursing care and assistance for significant health needs. Residents in long-term care facilities pay accommodation fees to cover the costs of accommodations and services such as meals, housekeeping and building maintenance. Health services in LTC are publicly funded and provide through	14,654 beds in 173 facilities

*Note that an additional 890 supportive living spaces were created in 2008/09 and 500 new spaces are targeted for 2010/11[74]

[73] Supportive Living Options spaces from *Report of the Auditor General of Alberta*, April 2008, p.105 – based on 2007 data.

[74] Department of Seniors and Community Supports, Business Plan 2010-13, p.226

MENTAL HEALTH SUPPORTS

Table 6. *Range of Mental Health Supports in Alberta.*

Range of Mental Health Supports	
Community Connections	▪ Residential services ▪ Social/recreational ▪ Family education and support education ▪ Peer support ▪ Outreach services
Community Mental Health Services	▪ Intake/assessment/referral ▪ Crisis intervention (including mobile crisis response teams and crisis beds) ▪ Case management ▪ Assertive Community Treatment Teams ▪ Mental Health Clinics (intake and assessment, individual and group therapies) ▪ Outpatient services and clinics (including early intervention in psychosis and eating disorders) ▪ Family Violence Treatment Program ▪ Problem gambling support ▪ Street outreach for the homeless ▪ Specialized services (i.e., concurrent disorders, seniors, forensic) ▪ Addictions services (including counselling, detoxification services, residential treatment, Protection of Children Abusing Drugs Act safe houses)
Inpatient Services	▪ Acute and specialized ▪ Community transition beds (hospital to community transition)
Other	▪ Promotion/prevention/education ▪ Community Treatment Orders

FUNDING LEVELS

The Department of Health and Wellness estimates that 2010/11 total health funding will be $14.9 billion (including one-time funding of $0.527 million)[75]. Total Department Health and Wellness funding accounts for 38% of total government expenditure this fiscal year:

- Alberta Health Services receives $9 billion (61% of the budget).
- One-time funding of $527 million is to eliminate the 2009/2010 accumulated deficit.
- $3.3 billion has been allocated for physician compensation and development including funding for physician compensation, primary care networks, and physician office computerization.
- $930 million has been allocated for prescription drugs, ambulance services and other health benefits for Albertans. Included are cancer therapy drugs and specialized high cost drugs.
- $94 million has been allocated for service delivery enhancements and for additional post-secondary health workforce spaces.
- $25 million has been allocated for health services in correctional facilities.

According to a recent analysis by the Institute of Health Economics (Jacobs et al., 2010), the following were the total expenditures on mental health and addictions services[76] in Alberta for 2007/08:

[75] Department of Health and Wellness, http://www.health.alberta.ca/newsroom/funding-quick-facts.html, last updated August 25, 2010

[76] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.

- $339.3 million for inpatient care[77] ($199.1 million in general hospitals and $140.2 million in psychiatric hospitals).
- $134 million for physician services ($46.9 general practitioners – fee for service and $87.1 specialists – fee for service).
- $252.5 million for community and social services ($19.2 million for outpatient – emergency rooms, $103.8 million for community mental health, $102 million for addictions, and $27.5 million for First Nations mental health and addictions services).
- $68 million for non profit organizations excluding the provincial government and $118 million for educational mental health services.

These figures are consistent with the October 2008 report from the Auditor General of Alberta: at that time, mental health expenditures (not including physician services or addiction services) were estimated to be about $475 million – mental health as a proportion of total Regional health Authority budget ranged from 2.5% to 9.7% (p.159).

RANGE OF MENTAL HEALTH AND WELLNESS SERVICES

In 2003, the provincial government transferred most services delivered by the Alberta Mental Health Board to the regional health authorities. From then until its integration with Alberta Health Services (together with the regional health authorities), AMHB provided policy research and direction together with the administration of province-wide mental health programs. Under Alberta Health Services, there are five 'zones' – for each zone, there is a Director of Mental Health Services for acute care and community mental health services. Core functions of the current system include:

- Mobile crisis response teams
- Case management
- Assertive community treatment teams
- Outreach services, which are less intensive than ACT, assist the client with appointments, paperwork, and day-to-day chores such as shopping or home maintenance.
- Street outreach for the homeless
- Mental health clinics exist across the province – these clinics provide:
  - Intake, assessment and diagnosis
  - Individual therapies: brief, short-term and long-term
  - Group therapies and activities
- Both acute and specialized inpatient services
- Crisis beds house a client short-term (usually no more than five days) – provides 24 hour, seven days a week oversight.
- Transition beds serve clients who have stabilized in hospital but need temporary help before returning to independent living.
- Outpatient services (including group programs that can be specialized in nature such as early intervention in psychosis or eating disorders)
- Specialized services including for people with concurrent disorders, seniors, forensic programs

[77] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.

Mental health services can be delivered directly by Alberta Health Services, or through contracts with not-for-profit organizations. For housing in particular, AHS engages with not-for-profit organizations, municipalities, and for-profit owners to develop and maintain housing units - mental health services for residents of these housing units are usually provided by the AHS or not-for-profit organizations.

The Provincial Mental Health Plan (2004) organizes services and supports according to three themes: support and treatment, risk reduction and capacity-building. Table 6 provides an overview of the general and population-specific service priorities organized by theme, as outlined in the PMHP. Current initiatives, identified below, support implementation of the Addiction and Mental Health three-year strategic plan:

- Implementation of Community Treatment Orders (for people with serious and persistent mental disorders who pose significant risk to themselves or others and require intensive case management.
- Enhancement of services for people in provincial correctional and remand centres (through a $7.5 million grant from the Solicitor General/Safe Communities initiative)
- The Safe Communities Initiative also funded the opening of 40 addiction treatment beds for young adults (3 month residential treatment), opening of 25 beds at the Centennial Centre in Ponoka with services targeted to clients with Axis IV disorders (psychosocial and environmental factors affecting the person)
- Introduction of Community Health Addiction Counsellors are hospital based and support concurrent disorder programming, consultation and cross training opportunities
- School-based prevention counsellors located in five Alberta communities.
- Expansion of the addiction services and supports for the Provincial Family Violence Treatment Program
- Introduction of mobile/outreach services in Edmonton and Calgary to engage/stabilize people who are street-involved
- During 2009/10, 451 youth were admitted to Protection of Children Abusing Drugs Act safe houses
- Continued implementation of the Children's Mental Health Action Plan

In its April 2008 report, the Auditor General of Alberta recommended that future provincial mental health plans incorporate four criteria:

1. Responsibility for each priority should be clearly assigned
2. An implementation plan and/or process should be created for each priority
3. Progress should be monitored and periodically reported on
4. Action and progress on the priorities should continue to promote the policy direction, collaboration, and momentum generated by the Provincial Mental Health Plan.

In its 2009/2010 Annual Report, Alberta Health Services identified the following beds available within the mental health and addictions continuum as of March 31, 2010 (p.18):

- 862 beds in five psychiatric facilities and 625 acute care psychiatric beds
- 1,409 addiction treatment beds
- 450 beds in community mental health homes

AHS further reported 15,000 Mental Health Hospital Admissions (Average Stay of 20 Days), 493,000 Outpatient Community Mental Health Visits, and 2,400 Treated for Addiction Problems (Average Stay of 20 Days) in 2009/10.

General Priorities	Population-Specific Priorities
Support And Treatment – Providing assessment, treatment, rehabilitation and community support for individuals and families.	
▪ Crisis services ▪ Care/case coordination: Tailor services to meet the needs of individual clients and their families. ▪ Shared care: Position mental health services as an integral part of all primary health care reform initiatives. ▪ Planning and follow-up ▪ Concurrent diagnosis/co-morbidity: Increase the capacity to respond to the needs of clients with more complex mental health problems including concurrent diagnosis/co-morbidities. ▪ Substance abuse and addictions: Collaboratively develop a provincial strategy for increasing investment and addressing the needs of mentally ill clients with addiction and substance abuse problems. ▪ Forensic services ▪ Tele-mental health services: Expand the utilization of tele-mental health to support service delivery. ▪ Brain injury: Develop a province-wide strategy for brain injury services through a process that effectively engages regional health authorities, Alberta Community Development (Brain Injury Network), key service providers and consumers.	▪ Assessment and treatment services for children and youth ▪ Alberta Children and Youth Initiative (ACYI): Use the organizational framework and management infrastructure of the ACYI to advance initiatives that have implications for the children's and youth mental health services. ▪ Services for children in care: Ensure that the needs of children in care are proactively and collaboratively addressed by regional health authorities, relevant ministries and related authorities. ▪ Adult Early Onset Dementia ▪ Psycho-geriatric services: Increase investment in psycho-geriatric services to accommodate increasing demand as a result of demographic trends. ▪ Treatment and support for vulnerable populations ▪ Programs for homeless people: Provide access to on-site mental health programs and referral services for homeless people who access shelters or drop-in centers. ▪ Access to culturally sensitive Aboriginal mental health programming
Risk Reduction – Reducing the risk of mental illness and optimizing mental health by decreasing factors that negatively affect well-being including physical illness, poverty, abuse or chronic neglect, violence, addictions, trauma, or harsh social conditions.	
▪ Prevention, promotion and public awareness ▪ Suicide prevention: Develop and implement an effective suicide prevention strategy designed to substantially reduce rates of suicide and suicidal behaviour in the province. ▪ Affordable housing: Create incentives to encourage private, public and voluntary providers to expand the supply of affordable housing across the province	▪ Children and youth – early intervention, prevention and education ▪ Seniors' community wellness programs: ▪ Services for expectant women and new mothers: Work cooperatively with women's and children's health services in each region to ensure that prenatal education, screening and pre- and postnatal counselling are provided to all expectant mothers.
Capacity building – Identifying, maintaining and strengthening factors that promote mental health and wellbeing across government, in communities, and with individuals and their families	
▪ Safe and supportive housing: Improve access to an appropriate range of supportive housing/living options for clients with severe and persistent mental health problems. ▪ Funded homes: Ensure compliance with the provisions of the Protection of Persons In-Care Act. ▪ Community capacity building and inclusion ▪ Individual family and community supports: Increase the resources for individuals, families and community-based support programs designed to: address the socio-economic factors that influence mental health, increase the ability of clients to cope with mental health issues,	▪ Youth in transition: Build bridges and supports to assist youth with mental health problems to transition from adolescent to adult programs and services. ▪ Community supports for seniors ▪ Aboriginal community-based strategies: Use integrated community-based service delivery strategies to address the determinants of health and ensure that services are available and accessible in the communities where Aboriginal people reside.

General Priorities	Population-Specific Priorities
increase the capacity of families and communities to care for clients with mental illnesses, and increase the capacity of clients and families to participate in their communities. ▪ Income supports and supportive employment ▪ Consumer support groups: Provide greater support for consumer owned and led supports and services, including the expansion of support for self-help groups, club houses, etc. ▪ Ethnic groups: Develop community-based support systems and culturally sensitive programming to reach high risk members of immigrant and ethnic populations. ▪ Developmental disabilities: Improve the coordination and integration of services for people with developmental disabilities with mental health services provided by regional health authorities.	▪ Aboriginal mental health service providers: Ensure that service providers have the training required to increase their capacity to become culturally competent to serve Aboriginal people.

INCOME SUPPORTS

The provincial social assistance program in Alberta is named **'Alberta Works – Income Supports'**. Alberta Employment Immigration and Industry is responsible for the delivery of the program. Key legislation includes the Income and Employment Supports Act, and the Income Supports Health and Training Benefits Regulations guides the administration of the program. Benefits include a core essential benefit (e.g., cost of food, clothing, household and personal needs, telephone installation, and laundry and transportation) and a core shelter benefit (e.g., rent, mortgage, utilities, heating, fuel, municipal taxes, insurance, condominium fees, lot rental, homeowner's maintenance and damage deposit).

The provincial assistance program for adults with severe and permanent disability is known as **'Assured Income for the Severely Handicapped' (AISH)**. Alberta Seniors and Community Supports administers the program. This assistance program is governed by the Assured Income fore the Severely Handicapped Regulation, the Facilities, Institutions, Health Benefits Regulation and the Income and Employment Supports Act. The program provides monthly living allowance, health related assistance (e.g., prescription drugs, optical, dental and emergency ambulance available to recipient, partner and dependent children under 18 years), a child benefit, and personal benefit.

The level of benefits that a recipient receives from AISH depends on the type and amount of income of the recipient and his/her cohabiting partner. Under AISH, income is classified into four categories: fully exempt (e.g., income tax refunds, an education or training grant, a goods and service tax credit), partially exempt (e.g., Chapter 11 – Alberta – Assured Income for the Severely Handicapped interest/investment, rental income), non-exempt (e.g. Canada Pension Plan Disability Benefits, Employment Insurance) and employment income. Recipients who live in facilities designated by the Facilities, Institutions, Health Benefits Regulation receive Modified AISH benefits (includes the facility daily accommodation rate plus a personal allowance).

Rapid reinstatement of AISH benefits is also available for those eligible former AISH recipients who need to come back onto AISH within 2 years due to a reduction in their employment earnings.

Clients of the Alberta Works – Income Supports social assistance program are placed in one of three client groups:

1. 'Expected to Work'
    - Individuals and families within this category include: those that are working (full or part-time) whose income is less than the financial benefits provided under the social assistance program; are able to work but unable to find employment; or, those that are temporarily unavailable for work due to reasons such as short-term illness
2. 'Not Expected to Work'
    - Individuals and families within this category include: those who have a permanent disability (defined by the AISH program); or, have multiple barriers or suffer from a 'chronic medical condition that inhibits their ability to seek and accept employment'
3. 'Learners'
    - Individuals and families in this category include those that are participating in occupational training or attending classes or courses to improve their employability

According to the Social Assistance Statistical Report, 2007 (Federal-Provincial-Territorial Directors of Income Support, May 2010, pp. 92-98),

- There were a reported 48,100 recipients (25, 100 cases) of Alberta Works-Income Support
    - Approximately 17% of all cases (4,300 of 25,100 cases) were due to a short-term disability
    - Approximately 46% of all cases were due to long-term disability (may include AISH clients who have been transferred to the Alberta Works - Income Support program to access supplemental benefits which are not available through AISH)

- Approximately 57% of all disability-related cases had been receiving assistance for over one year
- Approximately 19% of all disability-related cases had been receiving assistance for over five years

- There were a reported 36,100 recipients of AISH
  - **Of all recipients receiving AISH, 32% were due to mental illness disorders**.
- Social assistance clients of the **Alberta Works** – Income Supports program are eligible for the following monthly **earnings exemptions:** singles may retain $115 per month plus 25% of additional earnings; single parent families may retain $230 per month plus 25% of additional earnings; couples (with or without children) may retain $115 per month plus 25% of additional earnings for each working adult
- Clients of the **AISH** are eligible for the following **earnings exemptions:** $400 of employment income plus 50% of net remainder (maximum of $1,000 per month) for singles/childless couple; $975 of employment income plus 50% of the net remainder (maximum of $2000 per month) for single parents, childless couple (one AISH), couple with children
- **Total income for a single person with a disability receiving Alberta Works** – Income Support is $8773 (includes basic social assistance, other provincial/territorial benefits and GST credit)[78]
- **Total income for a single person with a disability receiving AISH** is $14,256 as of April 1, 2009 (includes basis social assistance and GST credit)[79]

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

The ten-year **Plan to End Homelessness** represents the first time that any province or territory has committed to ending homelessness, within a specific time frame, and with specific funding investments attached. The Plan has surpassed its first year target (housing 1,779 individuals together with needed supports rather than 1,000). If the plan is carried out in its entirety, the province will have created 8,000 units, housing an estimated 11,000 people by 2019. The expectation is that the plan will pay for itself by about the midway point of the strategy in terms of reduced shelter, health and other costs that will be saved by providing adequate and appropriate housing and support systems. Enablers for success, from the perspective of people who have participated in the MHCC project, have included:

- The current Premier identified this as a priority within his election platform. There are also champions at the ministerial level. This level of leadership has been the main driver in achieving completion and implementation of the strategy.
- The Task Force that created the plan held significant consultation processes across the province to assist in the development of the strategy. This gave a real 'grass-roots' sense of the issues involved in addressing the needs of people who are homeless.
- The creation of the Alberta Secretariat is a meaningful way to monitor the implementation of the strategy, to identify where there are issues, and to facilitate making the plan a reality.
- All the 'players' – civil servants, politicians, service providers all need to stay committed to the fundamental change in thinking on homelessness – moving from management of issues to solutions.

The City of Calgary, as part of its' 10 Year Plan to End Homelessness, has identified a priority of developing a system-wide "**Homeless Management Information System**". The plan itself was developed through a multi-sectoral Calgary Committee to End Homelessness – this Committee chose the Calgary Homeless Foundation to implement the plan. Strategy 4 of the plan identified the need for a locally developed and administered system **to improve data and systems knowledge. The HMIS will allow the community to**[80]:

[78] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability*, Bulletin Number 2.

[79] Department of Seniors and Community Supports 2009/2010 Annual Report, p.17

[80] Information from the 2010/11 Calgary Homeless Foundation Business Plan.

- Collect standard data in 'real-time' that will provide the total number of homeless, length and causes of homelessness, and demographic characteristics and needs,
- Better understand people's experiences being homeless and the services they use,
- Facilitate improved service co-ordination, tracking client outcomes, providing more informed program referrals and reducing the administrative burden,
- Improve research for evidence based decision making,
- Help shorten the length of time people are homeless and direct them through the system of care more efficiently and with more understanding

Pathways to Housing: Both Calgary and more recently, Edmonton have implemented a "Pathways to Housing" model to serve people with chronic homelessness, together with serious mental illness and/or addictions. An evidence-based practice pioneered in New York by Sam Tsemberis, the focus is on rapid rehousing, combined with provision of supports (including assertive community treatment teams) that are based on the principle of client choice.

CHALLENGES IN HOUSING AND RELATED SUPPORTS

- Having sufficient **housing stock**, and true **housing affordability**, is one of the most significant barriers to the provision of housing and supports for people with mental illness
  - Housing stock is not keeping pace with demand – housing affordability and development of new housing (social housing, private rental market and private housing) is impacted by higher construction and land costs
  - Private developers can face significant challenges in developing affordable housing options
- While the homelessness strategy is experiencing early success, there is concern about **overall capacity for mental health and addictions services**; i.e., there needs to be capacity built across this system, particularly as the new housing units come on-stream, and there thousands of people who, potentially, may wish to access services once they're housed. Support dollars for outreach and support workers are from the Ministry of Housing and Urban Affairs
  - There are gaps in mental health services **capacity**, **consistency** in availability of services across health 'zones', and **coordination** with health services
- Not-for-profit agencies are struggling to meet the level of demand for services and housing – can create an environment where agencies are constantly **reacting to crises**
- The Auditor General, in his review of mental health services (2008), noted the need for **greater accountability** in implementation of mental health reform (i.e., tying strategies/priorities to 'leads', to funding investment and to monitoring specific outcomes)
- The Auditor General further recommended that Alberta Health Services encourage mental health housing development and provide supportive living programs – consistent with priorities from the Provincial Mental Health Plan. Most of the 'bricks-and-mortar' housing belongs to the Ministry of Housing and Urban Affairs. Observations included:
  - Most Regional Health Authorities (now integrated under AHS) provided limited support for mental health housing in their region
  - There was limited **supply and demand data** relating to mental health housing (i.e., calculating what proportion of RHA clients needed housing, what supply existed)
  - Limited systems to encourage the development of mental health housing through the RHAs – tended to be engagement in initiatives around low income and housing etc., not specific to mental health housing
  - Limited monitoring of **quality/adequacy of housing** by RHAs *as of the report, mental health managers estimated that at least 1,500 people with mental illnesses in Calgary needed housing

- **Timely discharge from hospital** is not being achieved due to availability of appropriate housing
- Shortfall in **outreach and assertive community treatment programs** impacting on RHA capacity to support mental health housing – developers and housing partners identified that they could provide units if supports were available
- Positive practice for RHAs that provide some level of support to CMHAs – can be built on

- Coordination across Ministries and agencies in addressing housing and support needs for people with mental health issues needs to continue to improve
- The Alberta Secretariat notes that people from specialized groups – such as those with mental illness, those with addictions, victims of violence, seniors, those with disabilities, and homeless youth – are dealing with particularly challenging issues, and require special support to help address their unique situations.
- For some workers in particular, **income** has not kept pace with the cost of living that has been further increased by the significant growth in Alberta's economy. In particular, people with lower hourly wages have been impacted – this creates issues from a shelter cost perspective, but also the barrier this can present when people are trying to save sufficient funds to secure housing (i.e., down payments, first/last month rent, damage deposits)
- Alberta has had **significant in-migration** over recent years, both from other parts of Canada, and from other countries. This contributes to higher demand for available rental housing, putting upward pressure on rents.
- There are **outreach planning committees** at the local level, working on building relationships among front-line staff – absolutely crucial to ensure people are served well, in a seamless way
- Housing and urban affairs is funding the outreach workers and support workers we're providing directly through the cities to the agencies
- **Administrative and reporting burdens** can be very high on non-profit organizations; for example, reporting on municipal, provincial and federal (such as the Homelessness Partnering Strategy through HRSDC) funds received. Levels of government need to consider in what ways information could be reported through one source
- We need to look **beyond traditional clinical services** – many people benefit from housing support, support that focuses on skills/needs related to maintaining housing tenure
- Housing needs to be considered in the broader context of **an anti-poverty strategy**

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

- There is a focus on, and buy-in to, the idea of moving from management of homelessness to solutions – part of this solution is identified as prevention and there are opportunities to see how prevention might align with mental health promotion and early intervention
- Province is in the early stages of *Housing First* and there has been very positive uptake – this is a departure from more custodial models
- This shift of *Housing First* includes the philosophy and practices of harm reduction
- There is an excellent level of community leadership, in addition to leadership at the government level
- There has also been a growing movement on integrating housing, and more specifically stable housing, within key principles of the Alberta Health Act.

BRITISH COLUMBIA

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of British Columbia is approximately 4,113,500 (Statistics Canada, 2009) with an unemployment rate of 7.3% compared to a rate of 8.1% across Canada (Statistics Canada, 2010). Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of 5.3%** since 2001 on par with the national average of 5.4%.
- An **aging population**, consistent with all other regions across Canada, where 14.6% of the population is aged 65 and over (compared to 13.6% nationally).
- The census enumerated 196,075 people reporting Aboriginal identity in British Columbia in 2006, representing 17% of the national total – this is second only to Ontario where 21% of the population reporting Aboriginal identity resides.
- The Aboriginal population is becoming increasingly urban. In 2006, 54% lived in an urban centre, an increase from 50% in 1996. Urban areas include large cities, or census metropolitan areas, and smaller urban centres. In comparison, 81% of non-Aboriginal people were urban dwellers in 2006. The difference between the two proportions is due mainly to the large share of First Nations people who live on reserves.
- Aboriginal people do not typically live in census metropolitan areas (large cities) in large proportions - Vancouver had the third highest number of Aboriginal people in census metropolitan areas across Canada at 40,310, representing 2% of the population. More often, there are higher proportions in smaller urban centres, for example, they accounted for 35% of the population in Prince Rupert, British Columbia.
- About 16%, or 177,800, of the **1.1 million newcomers to Canada** settled in British Columbia from 2001 to 2006. In total, the census enumerated 1,119,200 foreign-born individuals in British Columbia. They represented 27.5% of the province's population, a proportion that is second only to Ontario.
- The population of foreign-born people in the census metropolitan area (CMA) of Vancouver increased five times faster than its Canadian-born population between 2001 and 2006 – a 12.6% growth rate compared to a growth rate of 2.3% in the Canadian-born population. The census counted 831,300 foreign-born people in the Vancouver CMA (accounting for about 39.6% of the total population), up about 92,700 from 2001.
- Of the 1,643,150 households in 2006, **70% owned the dwelling** they lived in – this represents an increase of just over 12.5% since 2001. Of owner households, 57.6% held a mortgage, on par with the national average of 57.9%.
- The proportion of households **spending 30% or more of their income on shelter** was **well above the national average** of 24.9% at 29.1% (up from 28.6% five years earlier)

The Canadian Council on Social Development, in its social development series in 2009, noted that poverty has been a persistent problem in British Columbia for decades, in part because of the "resource-based economy with its boom/bust cycles…unlike other parts of the country, the economy in British Columbia experienced a fairly severe downturn in the early 2000s, linked to the Asian financial crisis and negative impacts of the softwood lumber dispute with the United States" (p.2). The combination of the economy, with government tax cuts and spending reductions, had a wide-ranging impact on poverty trends.

In Canada, the percentage of the population living in poverty was slightly lower in 2006 compared to 1980; since the mid-1990s, the national trend has been a decrease in poverty, decreasing from 15.7% in 1996 to 10.5% in 2006, while in British Columbia, the poverty rate was peaking at 16% in 2002, before beginning to decline. In addition, it used to be that poverty rates were lower in rural areas (and lower compared to national rates) and higher in urban areas – by 2000, the rural poverty rate in B.C. surpassed the Canadian average (p.3).

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

- The British Columbia Housing Management Commission (BC Housing) was created in 1967 through an Order-in-Council under the Housing Act to fulfill the government's commitment to the development, management and administration of subsidized housing.
- **BC Housing** is a provincial crown agency responsible for the delivery and administration of housing programs.
  - Assist people in greatest need of affordable/appropriate housing by providing options along the continuum (emergency shelter and housing for the homeless through to affordable rental housing and homeownership)
  - Through new responsibilities under the Homeowner Protection Act, BC Housing licenses residential builders, administers owner builder authorizations, oversees the third-party home warranty insurance system and carries out research and education to improve the quality of construction of new homes.
  - Reports through a Board of Commissioners to the **Minister of Housing and Social Development:** government's housing direction is set out in the Stakeholder's Letter of Expectations (roles and responsibilities, high-level performance expectations, public policy issues, strategic priorities) signed with BC Housing.
- BC Housing directly provides and manages housing stock, and also provides financial, **administrative and technical support to non-profit and co-op housing providers**, and oversight through long-term operating agreements, for third-party provision of housing. The current inventory of social housing is delivered through a number of different funding programs and service delivery models.
- The **BC Non-Profit Housing Association** provides leadership and support to members in creating and supporting a high standard of affordable housing throughout British Columbia – members are primarily **non-profit housing providers**
- The **Co-operative Housing Federation of BC** was formed in 1982 by members of BC housing co-ops who wanted to work together to expand co-op housing, promote better housing conditions, share skills and information within the sector, and represent co-op housing to the government and the public. The Federation is funded via annual membership dues by member housing co-ops, fees for services provided, revenue from the national Co-operative Housing Federation, and one-time funding for special projects.
- In June 2005, the provincial government formed the **Office of Housing and Construction Standards** to consolidate provincial government housing policy, programs and services in one ministry and address emerging housing needs. (In June 2008, the Office of Housing and Construction Standards was merged with the former income assistance ministry to become the new **Ministry of Housing and Social Development**).
- The **federal government also has a role with housing in BC** including federally administered co-ops and First Nations housing on-reserve.
- The **Ministry of Health Services has overall responsibility** for ensuring that quality, appropriate and timely health services are available to all British Columbians.
  - Provides leadership, direction and support to these service delivery partners and sets province-wide goals, standards and expectations for health service delivery by health authorities.
- **Six health authorities** are the organizations primarily responsible for health service delivery.
  - Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions.
  - The **Provincial Health Services Authority** is responsible for managing the quality, coordination and accessibility of selected province wide health programs and services. These include the specialized programs and services provided through the following agencies: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Women's Hospital and Health Centre, BC Provincial Renal Agency, BC Transplant Society, Cardiac Services BC, and **BC Mental Health and Addiction Services including Riverview Hospital and the Forensic Psychiatric Services Commission**.

PROGRESS TO DATE: KEY INITIATIVES

- As a result of the Premier's Task Force on Homelessness, Mental Illness and Addictions, and funding from the second phase of the federal Affordable Housing Initiative, the **Provincial Homelessness Initiative (PHI)** launched in 2004. PHI is working to provide more than 4,400 emergency shelter beds and housing units with support services for the high-needs group of homeless people who frequent shelters.
- In October 2006, the provincial government released "**Housing Matters BC", the provincial housing strategy**, to focus on providing supportive housing to vulnerable populations, a Rental Assistance Program for low-income working families, Homeless Outreach Teams to help people who were homeless address immediate physical and safety needs including housing
- In 2007, the BC Government announced its **Breaking the Cycle of Homelessness** initiative, built upon the previous two initiatives to include an annual commitment of $41 million to sustain emergency shelters, expand outreach to the homeless, with a special allocation for Aboriginal persons, rent supplements, and fast-track approvals of housing applications. One-time capital funding was also part of the announcement at the time.

BC Housing has identified a series of goals, objectives, and measures as part of its annual performance reporting, aligned with the provincial housing strategy (Housing Matters BC) which might serve as a guide for other provinces and territories[81].

Goals	Objectives	Measures
Respond to gaps in the housing continuum	Increasing housing options	▪ Number of new units/beds created in priority areas ▪ Number of new households assisted through rent assistance programs
	Adapt existing stock to target resources to vulnerable households	▪ Number of existing units adapted to higher priority needs
Protect and manage existing housing for the long term	Maintain the quality of existing assets	▪ Percentage of clients reporting satisfaction with the quality and safety of their housing ▪ Percentage of social housing providers meeting financial and operational standards
	Adequate provisions for future requirements	▪ Ratio of replacement reserve contributions to actual expenditures
Provide access to appropriate housing and services for vulnerable British Columbians	Ease of access to housing	▪ Percentage of new applicants reporting satisfaction with the process ▪ Percentage of nights where shelters are at full occupancy ▪ Percentage of homeless individuals accessing housing who remain housed six months after placement
	Available housing targeted to vulnerable residents	▪ Percentage of clients belonging to priority groups in subsidized housing
Organizational excellence	Financial and operating success	▪ Controllable administration costs as percentage of program delivery costs ▪ Per-square-foot construction costs within 2.72% of private sector benchmark
	Environmental Leadership in the Housing Sector	▪ Percentage reduction in Greenhouse Gas Emissions
	High level of employee engagement	▪ Employee engagement index

[81] BC Housing's Report on Performance (2008/09).

RANGE OF HOUSING ACCOMMODATIONS

Table 1. *Overall Range of Housing Options in British Columbia.*

Dedicated Mental Health Housing	▪ Mental Health and Addictions Supported Housing – Includes supported apartments (scattered site, block apartments, congregate housing), Group homes, Supported hotels, Rental subsidies ▪ BC Housing Health ▪ Low barrier housing (low and high level support) ▪ Community Residential Care ▪ Family Care Homes ▪ Note that various housing types can be provided by non-profit organizations
Non-Dedicated Affordable Housing	▪ Public housing ▪ Non-profit and co-operative housing ▪ Rent assistance for seniors ▪ Rent assistance for families ▪ Aboriginal housing ▪ Transition House Services ▪ Seniors' Supportive Housing
Additional Facilities or Housing Options	▪ BC Housing Emergency Shelter Program ▪ Home Care and Community Services (assisted living, supportive housing, community care facilities) ▪ Residential Options for People with Developmental Disabilities (Supports to Home Living, Home Sharing, Staffed Residential Living, Semi-independent Living Support, Supported Apartments, Cluster Living)

DEDICATED MENTAL HEALTH HOUSING

British Columbia has a well-developed range of dedicated housing options for people living with mental illness. The follow reflect key initiatives supported by the province through BC Housing, as well as some of the **Health Authorities and non-profit organizations** which provide housing programs, in partnership with BC Housing, or provide rent supplements independently of BC Housing.

- **Provincial Homelessness Initiative – Affordable Housing Initiative**: Emerged from the work of the Premier's Task Force on Homelessness, Mental Illness and Addictions. Under this program, 1,220 units of housing will be created for individuals who are homeless or are at risk of homelessness. Some capital funding was available via the Affordable Housing Framework Agreement (with the federal government)
- **Provincial Housing Program**: Helps fund the development of new non-profit and co-operative subsidized housing for frail seniors, people at risk of homelessness, **people with disabilities** and low-income families including women and their children fleeing abuse. Total of 3350 units
- **Low-barrier housing initiative**: As part of government's strategic direction, BC Housing has invested nearly $130 million to purchase 45 apartment buildings, townhouse buildings and single room occupancy hotels around the province, protecting and upgrading approximately 2,000 units of affordable housing for those who need it most.
    - Buildings have been purchased in Vancouver, New Westminster, Victoria, Kamloops, Burnaby, Surrey, Quesnel, Port Alberni, Prince George, Penticton, Williams Lake, Mission, Logan Lake, Nanaimo, Abbotsford and Osoyoos.
    - Most of these buildings faced conversion to more expensive forms of housing or other uses.
    - Newly purchased buildings are first renovated to bring them up to health and safety standards.
    - The Province owns the property while non-profit housing providers operate the buildings and providing a range of supports to residents including: health care, meals, counselling and other life skills assistance they may need.

Streetohome Foundation, Province of BC, and City of Vancouver partnership

- Most recently, the Province of British Columbia, City of Vancouver and the Streetohome Foundation announced that they were partnering to provide 1,006 new supportive housing units in Vancouver, targeting people who are homeless or at risk of homelessness. Province is contributing $205 million and the Streetohome Foundation $20 million (which will focus fundraising from the private sector) towards construction costs[82]
- City of Vancouver is providing eight sites valued at about $32 million
- These projects are in addition to six projects previously announced by the Province and the City that will see 569 new supportive housing apartments (based on a similar contribution model) – in total, the 14 sites will provide 1,575 new units, create more than 2,100 direct jobs and represent a capital investment of $333.4 million. The City has contributed 14 parcels of land valued at about $64 million to the overall project. Construction on the original six sites has already begun.
- Housing will be operated by (or is currently operating under) non-profit organizations.

DESCRIPTION OF RANGE OF AVAILABLE HOUSING[83]

The following models target people living with serious addictions and/or mental illness.

1. Mental Health and Addictions Supported Housing

Supported Housing includes a variety of health authority funded registered facilities under the CCALA, as well as facilities subjected to the Residential Tenancy Act and standards enforced by the regional health authority. Services include provision of safe, secure and affordable accommodation and support services, which vary in the level of intensity, such as case management, assistance with personal life skills and crisis management. Some Supported Housing services are designated for people with addictions issues only – the majority target people with addictions and/or mental illness. Supported Housing includes a variety of housing and support models which include:

- **Supported Apartments –** Tenants generally stay longer-term (two years and more):
  - **Supported apartments** (Self–contained subsidized private market apartments/mobile homes, usually one-bedroom units, governed by Residential Tenancy Act as well as Supported Independent Living (SIL) units)
    - Clients pay reduced rent based on income (max 35%)
    - Off-site home support and MHA services coordinated through a mental health case manager
  - **Block Apartments** (Self–contained subsidized one-bedroom apartments governed by Residential Tenancy Act in a building where all units are occupied by persons with mental disorders).
    - Clients pay reduced rent based on income (max 35%)
    - Off-site home support and MHA services coordinated through a mental health case manager
  - **Congregate Housing** (Bachelor suites governed by Residential Tenancy Act in a building where all units are occupied by persons with mental disorders; clients pay reduced rent).
    - Communal food services provided on site.
    - Clients pay reduced rent based on income (max 35%)

[82] Mapping Interviews and News Release from Province of BC, City of Vancouver and Streetohome Foundation (May 25, 2010). *$225M in housing investments to create 1,006 new homes.*

[83] Provided through Mapping Interviews, existing Ministry of Health and BC Housing documentation, and *Housing and Supports for Adults with Severe Addictions and/or Mental Illness in British Columbia* (2008), Center for Applied Research in Mental Health and Addictions, Simon Fraser University, Table 8, Mental Health and Addictions Community Beds by Health Authority, p.43.

- On-site home support services provided by non-profit agency.
- Home support and MHA services coordinated through MHA case-managers.
- Clients stay usually long term (over two years).

- **Group Homes** – Clients share a communal home and participate in shared living arrangements; clients stay usually short term – under 2 years. Not licensed under CCALA but must meet standards developed by the health authority
  - Off-site home support provided by non-profit agency.
  - In some cases, BC Housing administers capital funding/maintenance of the facility; in other cases, non-profit.
  - Agencies purchase the building and provide low market rents. Clients pay reduced rent based on income.
  - Home support and MHA services coordinated through MHA case-managers.
- **Supported Hotels** – Single room occupancy, leased or owned and managed by a non-profit agency; clients pay reduced rent based on income, receive on-site support and supervision. Clients usually stay long term – over two years.
  - BC Housing administers capital funding/maintenance of the facility; clients pay reduced rent based on income or non-profit society rents building.
  - On-site home support and supervision up to 24 hours per day by non-profit agency.
  - On-site home support and MHA services coordinated through MHA case managers.
- **Rental Subsidy** – Housing subsidies funded by health authorities serving clients with mental disorders who have graduated from mental health Supported Housing and continue to require a rent subsidy and case management services from the local community mental health centre to maintain their affordable housing.

2. BC Housing Health Services

A form of supported housing. This program is a partnership between BC Housing and health authorities to provide individuals with severe mental disorders increased access to BC Housing subsidized units directly managed through the housing portfolio of BC Housing. Health services coordinators, such as registered psychiatric nurses, co-located in regional BC Housing District Offices throughout BC, assist clients by providing direct access to subsidized housing, link tenants to community mental health and addictions treatment and support services, and facilitate education sessions for housing providers. Off-site home support and mental health and addictions services are coordinated through mental health case managers.

3. Low Barrier Housing

Low barrier housing is a form of supported housing funded by health authorities for individuals with substance use disorders including chronic alcoholism who are continually at risk of being homeless, or who are homeless as a result of their chronic alcoholism and require a safe place to live. Individuals are provided an opportunity to become connected with health, social and other community services. Uses a harm reduction approach. There is no requirement for the person to be involved in treatment to access this housing.

- Low-level support: Clients typically have active yet moderate addictions, untreated mental illness, and physical health issues related to homelessness and substance use
  - On-site support for daily living and employment skills as well as off-site professional case managers. Support sometimes provided via the housing provider, or through partnerships between housing and support providers.
  - Should be embedded in a continuum that allows priority access to “next step” housing
  - Minimum of one staff shift 7 days per week; overnight and/or additional staffing may be required if dealers, etc.
  - Disrupt the building community.

- Medications can be administered via an on-site program, external delivery, or nearby site.

- High-level support: Clients typically have complex health issues, active and severe addictions, untreated mental illness, and multiple physical health problems. Disruptive behaviours cause significant public disorder and challenges to housing providers
  - Require a specifically tailored access and referral process; outreach is necessary to engage clients and bring them into housing.
  - Support provider should also be the housing provider. Minimum two staff on duty 24/7
  - On-site medication management is recommended given clients' chaotic lifestyle and ambivalence about medication use; on-site needle exchange is also recommended.
  - Psychiatric, medical and case management services must be hard-targeted to the building via an assertive outreach model.

4. Community Residential Care

Services provided through community mental health residential care facilities that are licensed under the Community Care and Assisted Living Act (CCALA), and include various levels of supports for individuals unable to live independently. Facilities provide twenty-four hour on-site support for three or more residents (size is generally from 6-25 people), including accommodation, meals, personal life skills support, medication administration and bridging with external mental health, addictions and local community services. Nursing staff are generally available 8-12 hours/day. Services are coordinated through a health authority mental health case manager linked with a mental health centre. The target population is people with serious mental illness who are unable to live independently and/or who are in the process of acquiring the skills and confidence necessary for independent living. Some people may move to more independent options, others may stay for the longer-term.

5. Family Care Homes

Privately owned homes, operated by a family or an individual, and approved by the regional health authority according to regional standards enforced through contractual requirements. These homes accommodate a maximum of two individuals and provide 24-hour on-site care and support for persons unable to live independently and requiring support services within a family setting. Services include room and board, assistance with personal life skills and bridging with community mental health, addictions and local community services. Services are coordinated through a health authority mental health case manager linked with a mental health centre. Some people may move to more independent options, others may stay for the longer-term.

Table 2 summarizes how each of the different types of dedicated housing are funded, supported, owned and licensed.

Table 2. *Summary of BC Dedicated Mental Health Housing Funding, Supports, and Licensing.*

Description	Program funded by HA*, onsite mental health and addictions and staff	Rent Subsidized by BC Housing	Rent subsidized by Health Authority	Health authority determines access	Case Management Provided by Health Authority	Community Living Support (CLS) Services provided on/off site funded by HA*	Ownership of the Facility	Facility Licensed Registered
Community Residential Care	Yes	Client per diem funding $30.90	No	Yes	Yes	On-site CLS	BC Hsg/HA Private/Non Profit Org.	Licensed
Family Care Homes	Yes	Client per diem funding $30.90	No	Yes	Yes	On-Site CLS	Private	Not Licensed Max 2 residents
Supported Housing SILP	Yes	No	Yes	Yes	Yes	Yes-off site CLS	Private	Not Licensed
Supported (scattered) apartments	Yes	Yes	No	Yes	Yes	Yes-off site CLS	Private	N/A
Block Apartments	Yes	Yes	No	Yes	Yes	Yes- Onsite CLS	BC Hsg/HA Non Profit Org.	Registered with CCLAC
Congregate Housing	Yes	Yes	No	Yes	Yes	Yes Onsite CLS	BC Hsg/HA Non Profit Org.	Registered
Group Homes (no on-site staffing)	Yes	Yes	No	Yes	Yes	Yes Off site CLS	BC Hsg/HA Non Profit Org.	N/A
Supported Hotels	Yes	Yes	No	Yes	Yes	Yes Onsite CLS	BC Hsg/HA Non Profit Org.	Registered/ Licensed
Rental Subsidy	Yes	No	Yes	Yes	Yes	None	Private	Not Licensed/ Registered
BC Housing Health Services Program	Operational funding for staffing (PHSA)	Yes	No	BC Housing determines access in consultation with HA	Yes	Yes off site (staff funded by PHSA)	BC Housing	Not usually

* HA = Health Authority
Table provided by BC Housing and Ministry of Health

Table 3. *Summary of dedicated mental health housing options in British Columbia.*

Health Authority	Licensed Residential Care	Family Care Homes	Supported Housing	Low Barrier Housing (MH&A)	BC Housing Health Services	Total
Vancouver Coastal	456	23	1371 235A	776	405	**3266**
Vancouver Island	156 4 A(ddictions)	59 2 A	1052 6 A		166	**1445**
Fraser Health	650	13	903		322	**1888**
Interior	182	76	505		110	**873**
Northern	44	1	198		26	**269**
Total	**1492**	**174**	**4270**	**776**	**1029**	**7741**

Reproduced from Housing and Supports for Adults with Severe Addictions and/or Mental Illness in British Columbia (2008), Center for Applied Research in Mental Health and Addictions, Simon Fraser University, Table 8, Mental Health and Addictions Community Beds by Health Authority, p.43.

There are many other types of supported and non-supported units provided through various non-dedicated affordable housing options, but these have a broader focus on people living on low-income, including people with mental health issues, and so are not counted as part of the dedicated stock for people living with serious mental illness. The Ministry of Health targeted 7,916 people " with a mental disorder and/or substance addiction receiving housing with supports in 2008/09" and reported achieving this goal with an **actual figure of 8,189 people (as of July 2008)** in its annual report. This is consistent with a joint Ministry of Health/BC Housing target of 20 per cent increase in the availability of housing with supports by 2010/11.

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

Prior to 2001, BC Housing's focus was on developing and building social housing with most units targeted to families and low-income seniors – as of 2000/01, BC Housing had 50,098 social housing units, shelters and rental assistance units with an annual housing budget of $98.8 million. Since that time, BC Housing's mandate has significantly expanded and as of 2008/09, BC Housing's budget was $626.6 million (including $434.4 million of provincial funding) to fund or operate approximately 90,000 units. Government-assisted housing accounts for almost 6% of the province's total housing stock.

Typically, housing that is funded and/or directly managed by BC Housing is 'non-dedicated' to people living with mental illness, but there are targets for people with various needs, particularly within BC Housing's directly administered stock. While there is no data that directly tracks how many people with mental illness are living in BC Housing stock, BC Housing does place a priority on housing vulnerable clients within their directly managed units, and there are targets for housing people with mild, moderate and high needs. BC Housing works to ensure there is an appropriate mix of needs in their buildings, and that these needs align with what supports are available in the community and via the Health Authority. The current target for "priority clients" in directly managed housing is 82% - this would include people with mental health issues.

There has been a growing trend of people with mental illness being placed in seniors' public housing models – in some cases, particularly in smaller communities, partnerships exist with mental health staff to provide supports. Some seniors' non-profit housing operators have built up a significant expertise in working with people with co-occurring mental health issues, others to a lesser extent.

Application and eligibility for subsidized housing in BC takes several forms:

- **Public housing** is owned and managed by BC Housing. BC Housing is responsible for tenant selection and is the landlord. Priority is given to people with the greatest need including: women and children fleeing abuse; people who are homeless or who are at risk of homelessness; people with chronic health issues (**including people with mental illnesses**, physical disabilities or substance-misuse issues), frail seniors; families and youth.
- **Non-profit housing** is owned and managed by local non-profit housing societies. The ability of non-profit housing providers' to determine eligibility policies and select tenants is dependent on the nature of their operating agreement with BC Housing (roughly 80% of societies have active operating agreements with BC Housing). There are more than 50,000 units of long-term non-profit housing in BC – this does not include co-op housing temporary housing, emergency shelters or transition houses, rent supplements administered by non-profits and used on the private market, or housing stock directly managed by BC Housing. Some non-profits may dedicate these units to **people with mental health issues**, while others may serve this population but the units are not dedicated per se.
- **Housing co-operatives** are managed by the members who live there. Members are responsible for new member selection. Most housing co-ops in BC are federally funded (12,650 in BC) and are administered by CMHC (Canada Mortgage and Housing Corporation) not by BC Housing.

Many non profit housing providers and their subsidized housing developments are members of the BC Housing Registry which is managed by BC Housing. The Housing Registry allows prospective tenants to apply once and express interest in a variety of housing developments listed on the Registry. However, tenants must apply separately to each housing development not listed on the Housing Registry. In the Downtown Eastside in Vancouver, the Supportive Housing Registry (SHR) is operating now to suitably match applicants with appropriate housing and supports in the SROs, (single room occupancy buildings). Part of the application process for **SROs through the Supportive Housing Registry** includes more detailed information on health status. Where prospective tenants identify mental illness as part of this health assessment, it must be a "supported diagnosis" i.e. with a letter of confirmation from a mental health professional. Further information on SROs is contained in the dedicated housing section.

Key programs funded through Housing Matters BC are:

- **Rental Assistance Program** - The Rental Assistance Program provides eligible low-income working families with cash assistance to help with their monthly rent payments.
- **Homeless Outreach Program** - The Homeless Outreach Program connects homeless people to housing, income assistance, community-based, health and social services in 49 communities across the province. Further data captured under "Mental health-related housing supports" section
- **Provincial Homelessness Initiative (PHI)** - Launched as part of the Premier's Task Force on Homelessness, Mental Illness and Addictions, PHI provides support for non-profit housing developments that integrate subsidized housing with support services for individuals in the greatest need. Further data captured under "Dedicated Housing" section.
- **Aboriginal Housing Initiative (AHI) -** The Aboriginal Housing Initiative (AHI) provides funding to develop new, affordable housing for Aboriginal people living off-reserve. This initiative helps to ensure that Aboriginal housing needs are being addressed.
- **Aboriginal Homeless Outreach Program (AHOP)** - The Aboriginal Homeless Outreach Program (AHOP) directly engages homeless Aboriginal people living on the streets and provides access to housing, income assistance, and community-based support services to help break the cycle of homelessness. Further data captured under "Mental health-related housing supports" section
- **Emergency Shelter Program -** This program offers temporary shelter, food and other services to meet the basic nutritional and hygiene needs of people who are homeless as well as providing a gateway to support services that help individuals to re-stabilize their lives. There are over 60 homeless shelters and drop-in agencies funded by the government throughout British Columbia. Further data captured under "Additional Facilities" section
- **Seniors' Rental Housing initiative -** The initiative is to build up to 1,000 new housing units for seniors and people with disabilities, in most cases using modular, manufactured housing construction that promotes wood product use.
- **Independent Living BC (ILBC) -** This housing-for-health program serves seniors and people with disabilities who require some support, but do not need 24-hour institutional care. ILBC offers a middle option to bridge the gap between home care and residential care. Further data captured under "Additional Facilities and Models" section

As well some of the Health Authorities and non-profit organizations provide housing programs, some of which are in partnership with BC Housing, or provide rent supplements independently of BC Housing. Further details on the range and funding arrangement of these are provided under the Dedicated Housing section.

Table 4 provides an overview of non-dedicated housing in British Columbia, recognizing that some of the target populations with a certain type of housing may include people with disabilities.

Table 4. *Non-Dedicated Housing Options in British Columbia.*

Program	Description	Capacity
Public housing	Directly managed by BC Housing. Includes 7800 public housing units and 300+ group homes. Rent is based on 30% rent geared to income. Note that some units are provided with health and mental health supports via a partnership with health authorities (BC Housing Health partnership – discussed under dedicated housing section).	7,800 units 300+ group homes
Non-profit housing	Managed by more than 600 non-profit housing providers in BC that manage 1,500 buildings and more than 50,000 units. The majority of units are funded through operating agreements with BC Housing, but not all. Roughly 80% are funded (either in whole or in part) through operating agreements. The vast majority of these agreements will expire in the next 20 years, which has major implications for the sustainability of the sector and for affordable housing more broadly in the province. BC Housing provides financial, administrative and technical support to these groups as well as administering long-term operating agreements and managing the flow of subsidies.	57,000 units $319M or 63% of BC Housing Budget
Co-operative housing	There are roughly 14,575 co-operative housing units managed by more than 250 housing co-operatives across BC. non-profit societies and housing co-operatives in 200 communities with funding from BC Housing. BC Housing provides financial, administrative and technical support to these groups as well as administering long-term operating agreements and managing the flow of subsidies. Between 1973 and 1991, CMHC participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme, however, is that all of these co-operatives provide some type of financial support. Housing co-ops are member-owned and controlled organizations. The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. The federal government ceased funding new development at the end of 1991, but continues to honour its operating agreements with existing co-operatives, which house **over 92,000 members across Canada** under these legacy programs. The **Agency for Cooperative Housing** is the not-for-profit administrator of federal co-operative housing programs in PEI, Ontario, Alberta and B.C., under a contract with CMHC. By region: 1900 units – Burnaby, 1029 – Delta/Surrey, 685 – Fraser Valley, 450 – Interior, 417 – New Westminster, 563 – North Shore, 76 – Northern, 638 – Pitt Meadow/Maple Ridge, 1048 – Port Moodie/Coquitlam, 989 – Richmond, 3600 Vancouver Eastside, 2002 – Vancouver Westside, 1177 – Victoria and Vancouver Island [84]	14,575 units
Shelter Aid for Elderly Renters (SAFER)	Attached to the person - low-income senior citizens are provided rent assistance in the private market by BC Housing, typically scattered site apartments	15,960 seniors
Rental Assistance Program	Attached to the person - low-income working families are provided rent assistance in the private market by BC Housing, typically scattered site	10,330 families
Community Partnership	BC Housing partners with municipalities, non-profit organizations and other housing partners to implement innovative strategies and partnership initiatives to create additional housing units for vulnerable groups without the	1,334 units

[84] Co-operative Housing Federation of Canada. http://www.fhcc.coop/eng/pages2007/about_3.asp

Program	Description	Capacity
Initiatives – Affordable Housing Initiative	need for ongoing operating subsidies. Assistance can include one-time grants, access to consulting services, project development funding and construction and long-term financing.	
Aboriginal Housing Initiative	The federal government provided a $50.9 million grant for the Off-Reserve Aboriginal Housing Trust, which was transferred to the Province of B.C. This money helped to fund the Aboriginal Housing Initiative (AHI) which was launched in 2007 to develop over 200 units of off-reserve Aboriginal housing. This housing focuses on safe, secure and culturally-appropriate housing for youth, women, elders, and those who are struggling with addiction.	
Aboriginal Housing	BC Housing is supporting the eventual administrative transfer of 2,660 off-reserve units to the Aboriginal Housing Management Association (AHMA). The AHMA is the only Aboriginal social housing management agency in Canada formed in BC in mid-1990s and represents 12 Aboriginal housing associations across the province. In June 2006, the federal government signed the **Canada - BC Social Housing Agreement**, which included the transfer of the administration of approximately 2,660 off-reserve Aboriginal housing units. Currently, BC Housing, in co-operation with AHMA, is administering the off-reserve Aboriginal housing units until the process of transferring the files to AHMA is finalized.	2,660 units
Transition House Services	Provide programs and services for women and their children escaping violence and abuse. Part of the BC Housing portfolio	61 houses with 730 beds
Seniors' Supportive Housing Program	Provide specially modified rental apartments for low-income seniors to enable them to continue living in their home independently. Existing seniors' housing is converted/upgraded to improve accessibility and safety.	590 units

OTHER INITIATIVES[85]

Homelessness Partnership Strategy: launched on April 1, 2007 by the federal government, building on the foundation of its predecessor program, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five year commitment. Kelowna, Kamloops, Nanaimo, Nelson, Prince George, Vancouver and Victoria qualify under the "Designated Communities" funding component. A key focus of the HPS is a housing-first approach and focuses on transitional and supportive housing as important ways to move individuals out of homelessness.

Affordable Housing Initiative/Canada BC Affordable Housing Agreement: Based on the housing framework agreed to in **November 2001** by federal, provincial/territorial housing ministers. 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 a grant, a stream of ongoing subsidies or the value of in-kind contributions (e.g. land). Within these terms and 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. British Columbia has a commitment (through Phase I and II of funding) for a **total of $130.38M which has committed/announced for a total of 4.305 units**[86]. The federal government's Economic Action Plan builds on this existing commitment, extending the AHI to March 31, 2011 through a $1.9 billion investment over five years, and providing a further one-time investment of $1.525 billion in housing stimulus measures to build new and renovate existing social housing. This funding is being delivered through amendments to existing cost-sharing and delivery arrangements with provinces and territories through the AHI.

Property Tax Deferment: a provincial low interest loan program that assists qualified senior homeowners in paying annual property taxes. Approximately 11,000 households defer property taxes under the program.

Homeowner Grant Program: a provincial property tax assistance program that reduces the amount of property tax homeowners pay. Regular grant of $470 or additional grant of $745. Must meet one of qualifying criteria: aged 65 and over, veteran or spouse of veteran, person with disabilities receiving a disability allowance, or property owner with disabled spouse.

Homeowner's Reconstruction Loan Program: Administered by the Homeowner Protection Office. Provincial program provides no-interest loans to owners of condos, housing co-ops, or other homes who are not able to finance or pay for repairs related to premature building envelope failures (CMHC contribution ended in 2003).

Provincial Sales Tax Relief Grant Program: Administered by the Homeowner Protection Office. Grant is based on cost of PST paid on repairs by eligible recipients in coastal climactic zone.

First Time Home Buyers' Program: Provides exemption on property tax for first-time home buyers (maximum coverage depends on location).

RRAP Suite of Programs: This is a Federal/Provincial cost shared (75/25) program administered by CMHC Homeownership RRAP – provides assistance to low income homeowners to bring their property up to minimum health and safety standards.

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[85] Unless otherwise noted, funding levels and units identified for each type of initiative were obtained through: Conference Board of Canada. (March 2010). *Building from the ground up: enhancing affordable housing in Canada,* Appendix A, p.91-*93.*

[86] National AHI Funding Table, Canada Mortgage and Housing Corporation website. http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm

- RRAP for Disabled Persons – provides assistance to homeowners or landlords of apartments or rooming houses that need to make specific modifications to accommodate persons with disabilities. Maximum loan forgiveness: homeowner or rooming house - $16,000, Self-contained unit - $24,000.
- Homeowner RAP – provides assistance for mandatory repairs to meet basic requirements of health and safety. Maximum is $16,000.
- Rental RAP – provides assistance to landlords to make major repairs, or mandatory repairs to meet basic requirements for low-income units. Maximum per unit - $24,000.
- Rooming House RAP – provides assistance to landlords of rooming houses in urban or rural areas to make major repairs or address basic facilities' issues. Maximum per bed is $16,000.
- RRAP Conversion – provides assistance to convert existing commercial or buildings not used for housing, into new housing units for low-income tenants. Post RRAP rents must be equivalent to 60% of market rents in that area. Assistance is in the form of a fully forgivable loan. Maximum per unit converted is $24,000, per bed converted - $16,000.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, but aren't dedicated to serving this population, and/or may include settings that wouldn't be considered housing per se. Within British Columbia, this includes: **shelters, longer-term care (assisted living, supportive housing, and community care facilities), and Residential options for People with Developmental Delays**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity. We note where there is cross-over between models described and other sections of this report.

EMERGENCY SHELTERS

According to figures from HRSDC, there were **approximately 3,120 beds** in British Columbia's emergency and transitional shelters in 2007[87], or 11.6% of known shelter beds across Canada. This is consistent with British Columbia being home to approximately 13% of the nation's population (some provinces and territories have a larger discrepancy between these figures). There are **72 shelter beds per 100,000** population, slightly under the 82 shelter beds/100,000 people national average. **This is likely an underestimate** because:

- It is based on the number of known shelters – there may be additional shelters not captured in this data set,
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available,
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007.

1. BC Housing Emergency Shelter Program

- Provides 2610 year round or cold wet weather beds for individuals who are homeless and who are in need of immediate assistance. Shelters provide the basics of shelter, food and hygiene and also offer a gateway to more permanent housing and support services, helping individuals re-stabilize their lives.
- Almost 90% of shelters are now open 24-hours a day, seven days a week and provide meals.
- Daytime services provide opportunities for clients to connect to services, including employment and life skills programs, counselling, addictions treatment and mental health services.
- As some homeless people may not be using shelters, BC Housing also funds eight drop-in centres that provide a variety of support services and funds outreach teams

[87] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

2. **Emergency Shelters** – funded fully or partially by health authorities

- Providing temporary accommodation and meals for people with mental disorders who are homeless.
- Services include access to off-site mental health and addictions community services, support to obtain long term housing and referrals to appropriate community services.

HOME CARE AND COMMUNITY SERVICES[88]

The following supported living options primarily serve the seniors' population (approximately 70%) but also people living with disabilities, which includes people with mental illness.

1. **Assisted Living**

- Semi-independent form of housing that is regulated by the Assisted Living Registrar under the **Community Care and Assisted Living Act**. The Act defines an assisted living residence as: a premises or part of a premises in which housing, hospitality services, and at least one but not more than two prescribed services are provided by or through the operator to three or more adults who are not related by blood or marriage to the operator.
- British Columbia is the first province in Canada to regulate assisted living residences. An **Assisted Living Registrar** protects the health and safety of seniors and people with disabilities who live in publicly subsidized and private-pay assisted living residences.
- Considered a middle option between home support and care in an institution (e.g., a community care facility, also known as residential care or complex care).
- Facilities that provide high levels of care must be licensed under the Act, while residences that provide assisted living services must be registered.
- Assisted living residences offer three key components to adults who require regular help with daily activities: housing, hospitality services and personal assistance services.
- Provides housing and supports for **frail seniors and people with disabilities** who require some care, but who do not need 24-hour facility care.
- Are available both through publicly subsidized and private pay operators.
    - Residents must pay all costs in private-pay residences (may be a fixed rate for a package of services, fee-for-service, or a combination)
    - **Independent Living BC (ILBC)** is the province-wide program, through BC Housing, for the development of publicly subsidized assisted living units. Under the program, each regional health authority has received funding for units. In some cases, health authorities also directly subsidize units in addition to those that ILBC funds. A health authority case manager determines eligibility for publicly subsidized assisted living. Eligible residents pay a monthly fee of 70% of their after-tax income for rent, hospitality services and personal assistance services. Some operators may charge additional fees for some hospitality services *see also Non-Dedicated Housing section
    - Includes new housing construction, conversion of existing housing, and 1,000 rent supplement units for households in the private market. **Total of 1,010 rent supplements (over $1M in funding) and 5,530 people housed**
- This program is delivered in partnership with local health authorities.
- The housing and services may be adapted to meet the needs of seniors, adults with mental disorders and/or substance use disorders, and adults with physical disabilities or acquired brain injuries.

[88] http://www.hls.gov.bc.ca/assisted/about/who_for.html

- Operate under tenancy agreements
- Operators must respect residents' privacy and personal decisions, and accommodate residents' right to take risks — provided that those risks do not place other residents or staff in jeopardy.
- According to the BC Auditor General, approximately **2,100 people were served in Assisted Living in 2005/06**[89]

2. Supportive Housing

- Supportive housing and assisted living residences are similar in that they both offer housing and hospitality services but supportive housing operators can offer personal assistance only at the support level
- Residents can purchase personal assistance at the prescribed level from someone other than the operator or qualify to receive equivalent home support from their regional health authority
- Not regulated by the Assisted Living Registrar.
- If a significant number of supportive housing residents qualify for publicly subsidized home support services, a health authority may decide to assign a staff person to be on-site each day to provide scheduled home support services to that group of residents

3. Community Care Facilities

- Community care facilities provide care to vulnerable, dependent people in adult residential, group home, drug and alcohol treatment, child day care and child/youth residential settings.
- Licensed under the Community Care and Assisted Living Act: licensing programs are administered by the medical health officers and licensing officers in the regional health authorities administer the licensing programs (includes monitoring and inspection, investigating complaints)
- People in care might have moderate to severe dementia or developmental disabilities, or mental or substance abuse disorders (i.e., they might not be able to make decisions on their own behalf).
- Clients in care may wander.
- Operators provide 24-hour supervision to people in care.
- Professional (e.g., nursing) care can be routinely provided.
- Often monitor exit from the facility and/or have key-padded security systems because residents may be confused or wander.
- Publicly funded residential care facilities typically provide 24/7 professional care and supervision, in a protective, supportive environment, for people with complex care needs who are not able to live independently. In these facilities, the costs of care and accommodation are subsidized. Per diem rates range from $29.40 to $74.30[90], based on income.
- Assessment for admission to public funded facilities, and subsidized spaces in privately funded facilities, is managed via the regional health authorities.
- Privately funded licensed community care facilities do not receive funding from a health authority or other agency. Persons who live in these facilities are responsible to pay the full costs of their care and accommodation.
- According to the BC Auditor General, approximately **33,500 people were served in these facilities** in 2005/06[91]

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[89] Auditor General of British Columbia. Home and Community Care Services: *Meeting Needs and Preparing for the Future.* (October 2008). Data from 2006/07 excluded the Interior Health Authority and so has not been included here.
[90] Long Term Care in British Columbia (October 2009). Taking Care Inc.
[91] Auditor General of British Columbia. Home and Community Care Services: *Meeting Needs and Preparing for the Future.* (October 2008). Data from 2006/07 excluded the Interior Health Authority and so has not been included here.

- In addition, there are specialized facilities that exist for people with very complex, multiple needs

RESIDENTIAL OPTIONS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

- Community Living British Columbia (CLBC) was created as an independent authority in 2005 by the Minister of Children and Family Development
  - Vested with responsibility for delivery of community living services, and for fulfilling the transformation mandate
- There are a range of residential options available for people with developmental disabilities (these are in addition to a variety of home care support options to support people staying in their own homes)[92]:
  - Supports to Home Living or Live-In Support: Residential care for adults with developmental disabilities who require enhanced supports in a primary caregiver's home. The enhanced support or services are provided by staff hired either directly by the caregiver or through a private or non-profit agency. Funding for this support is determined by the individual's needs.
  - Home Sharing/Intentional Communities: A residential service for adults where an agency owns the home, but the support arrangements are based on the principle of sharing lives. People with disabilities, and those who assist them, live together and are equally responsible for their home and community. Such intentional communities are often created around a common belief system or faith.
  - Staffed Residential Living: Contracted residential services that support individuals within a staffed environment. Provided support includes: self-care, relationship-building skills, life-skills training, meal preparation, personal care and access to community resources, activities and generic services. This service is delivered by both private and non-profit agencies.
  - Semi-Independent Living Support: Semi-independent residential services provided to individuals who require targeted supports emphasizing increased independence and relationship building skills. The residence is provided by or subsidized by the service provider, which can be either a private or non-profit agency.
  - Supported Apartment Living: Individuals who have mastered basic life skills and require only minimal support living on their own within the community. Individuals own or rent their own residence. Support to individuals may include: assistance to effectively manage their homes, health, social relationships and working lives. This service is delivered by both private providers and non-profit agencies.
  - Cluster Living: Several individuals living in their own apartments, or apartments owned or leased by a service provider, where support is focused on life skills, home management, community involvement and relationship building. These programs may have an onsite support staff member that lives separately. This can be delivered by either private or non-profit agencies.
- From a capacity perspective, as of March 2008, CLBC provided:
  - Group and home sharing arrangements, as well as semi-independent living options for **5,167 people**[93]. At the time of the transfer to CLBC, approximately 57% of people were living in group care options, 36% in family model homes, and 7% in semi-independent living[94].
- The **Provincial Assessment Centre** is a designated 12 bed Mental Health Facility providing multi-disciplinary assessments, medication review and recommendations for **Dually Diagnosed Individuals 14 years and up** with a developmental disability and a concurrent mental illness, or behaviour issue.
  - Designated as a tertiary care mental health service under the Mental Health Act, PAC is a part of the Crown agency, Community Living British Columbia.

[92] As described by Community Living BC http://www.communitylivingbc.ca/what_we_do/support_for_adults.htm
[93] http://www.communitylivingbc.ca/what_we_do/support_for_adults.htm
[94] Community Living British Columbia (2005). Business Plan.

Table 5: Additional Facilities in British Columbia

Program	Description	Capacity
Emergency Shelters: BC Housing Emergency Shelter Program	Individuals who are homeless and who are in need of immediate assistance.	2,610 beds – BC Housing 3,120 provincial total – HRSDC (likely an underestimate)
Emergency Shelters: fully or partially funded by regional health authorities	Temporary accommodations and meals for people with mental illness who are homeless	
Home Care and Community Services: Assisted Living	Frail seniors (70%) and people with disabilities requiring some care, but not 24-hour	Through ILBC program: 1,010 Rent Supplements 5,530 people housed
Home Care and Community Services: Supportive Housing	Frail seniors (70%) and people with disabilities requiring basic personal support only	
Home Care and Community Services: Community Care Facilities	Frail seniors and people with disabilities requiring 24/7 care with access to nursing care on a routine basis	33,500 people in 2005/06
Community Living BC: Group and home sharing arrangements, as well as semi-independent living options	People with developmental disabilities	5,167 people (2008)
Community Living BC: Provincial Assessment Centre	People aged 14 and over with a developmental disability and a concurrent mental illness, or behaviour issue	12 beds

MENTAL HEALTH SUPPORTS

Range of Mental Health Supports	
Community Connections	▪ Peer support ▪ Employment support ▪ Social/recreational ▪ Clubhouse models ▪ Education
Community Mental Health Services (includes addictions' services)	▪ Harm reduction services ▪ Outreach and early intervention service ▪ Crisis response and stabilization services (including crisis/warm line, mobile response, walk-in crisis, crisis beds) ▪ Treatment and self-management ▪ Primary care services, shared care services ▪ Withdrawal Management Services ▪ Case Management ▪ Assertive community treatment teams ▪ Range of specialized services including perinatal mental health, psychogeriatric, dual diagnosis, forensic, youth forensic ▪ Methadone maintenance treatment program ▪ Aboriginal services ▪ Court diversion services ▪ Outpatient services (e.g., day programs/intensive day treatment services)
Inpatient Services	▪ Acute and specialized beds ▪ Burnaby Centre for Mental Health and Addictions ▪ Acute mental health community residential treatment services (licensed facilities under the Community Care and Assisted Living Act) ▪ Addictions residential treatment programs
Other	▪ Health promotion, prevention services

The **Ministry of Health** identifies the following as key service targets for the next three years[95]:

- Improving access to family physicians and mental health and addictions support teams for individuals with mental illness and/or addictions through intensive case management and assertive outreach services.
- Continuing to work with other ministries, BC Housing, health authorities and other partners on the Homelessness Integration Project to better address the housing and service needs of people with mental illness and addictions

FUNDING LEVELS

In 2009-10, the Province expects to spend almost **$1.26 billion on mental health and addictions** – an increase of 48 per cent since 2001.

According to a recent analysis by the Institute of Health Economics (Jacobs et al., 2010), the following were the total expenditures on mental health and addictions services[96] in British Columbia for 2007/08:

[95] Ministry of Health (March 2010). *2010/11 – 2012/13 Service Plan.*

- $303.0 million for inpatient care[97] ($249.4 million in general hospitals and $53.6 million in psychiatric hospitals)
- $124.8 million for physician services ($29.0 general practitioners – fee for service and $95.8 specialists – fee for service)
- $264.5 million for community and social services ($156.9 million for supportive housing, $6.2 million for employment support, $80 million for other community and social support and $21.4 million for First Nations mental health and addictions)
- $13.4 million for non-profit organizations (excluding the provincial government), $50.6 million to other housing types (including shelters, temporary housing)

SERVICE OVERVIEW

The Ministry of Health[98] has identified the following continuum of Mental Health and Addictions Services – for our purposes, we have presented the functions in brief.

- Health Promotion: Initiatives that support individuals to engage in safer and healthier lifestyles, and which create supportive environments, strengthen community action, and develop personal health and coping skills. These initiatives create conditions that make the healthy choice the easy choice. Includes Mental Health Promotion initiatives for individuals and families
- Prevention Services: primary prevention (information and education through universal and selective population strategies), secondary prevention (focused on early detection and treatment), and tertiary Prevention (targeted to alleviate or limit disability resulting from illness, reduction of co-morbidity and rehabilitation/restoration of effective function.)
- Harm Reduction Services: a form of secondary and tertiary prevention that seeks to lessen the harms associated with high-risk behaviours, impulse control, and substance use (without requiring abstinence).
- Outreach and Early Intervention Services: Outreach Services designed to contact, engage and link children, youth and adults who are at risk of developing mental disorders, or known to have or be at risk of having substance use problems, to treatment and support systems; early intervention/rapid response; and Early Psychosis Intervention (EPI) Programs serve young people with early psychosis, usually between the ages of 13 and 35 years, and their families.
- Crisis Response and Stabilization Services: available 24/7. Includes crisis/warm line, mobile response, walk-in crisis, emergency shelter, crisis beds
- Treatment and Self-Management:
  - Inpatient Treatment Services
    - Specific inpatient services available through the Riverview redevelopment are listed following this section
  - Primary Care Services: primary care settings are the milieu for treatment of mental health problems and problematic substance use
  - Shared Care Services: Services include mental health and addictions service providers and primary care providers sharing responsibility for mental health and addictions care of individuals and families. Variety of mechanisms used (e.g., direct consultation, joint rounds, educational programs)
  - Tele-Mental Health and Addictions Services: use of video conferencing for diagnosis and treatment

[96] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.
[97] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.
[98] Mental Health and Addictions Branch, Performance Management and Improvement Division, March 2007

- Withdrawal Management Services: Withdrawal management services support individuals through acute stages of withdrawal from alcohol or other drugs. These services may be inpatient/residential detox services or outpatient services such as daytox or home detox with professional supports.
- Case Management Services: Mental health and addictions case management services include a wide variety of functions, including client finding, screening, assessment, treatment, psycho-social education, referral services, coordination of client's care, self management support, relapse prevention, crisis management, and ongoing support.
    - There is a very specific **intensive case management** approach being used for the Vancouver MHCC study There are also ICM outreach services available throughout the province, but they are structured very differently depending on the community needs.
- Assertive Community Treatment (ACT): A service delivery model that provides flexible, comprehensive services to individuals with mental illness and/or addiction and who have multiple complex needs. Low client-to-staff ratio, operating after hours and weekends, multidisciplinary team approach, client-directed delivery of care, assertive outreach and continuous services.
    - There **are three active ACTT** (assertive community treatment teams) in Victoria, **two in development** (one of which is through the MHCC Demonstration Project site in Vancouver with Rain City, the other is attached to Burnaby) who are now taking clients; and **three ACTT that are approved** (Nanaimo, Prince George, Kelowna)

- Acute Mental Health Home Community Treatment Services: Services that are alternative to acute care hospitalization for acute psychiatric illness and include the following services in "Home" and community residential settings. Includes home treatment services (crisis intervention and short-term follow-up) and Acute Mental Health Community Residential Treatment Services (Licensed facilities under the Community Care and Assisted Living Act, designated to provide short-term assessment, treatment and intervention services and access to follow-up services)

Also detailed as part of the service continuum are: eating disorder programs, Perinatal Mental Health Services, Specialized Psycho-Geriatric Assessment and Treatment Services, Specialized Mental Health and Addictions Services for People with Developmental Disabilities, Outpatient services, Day Programs/Intensive Day treatment services, Gender-specific Mental Health and Addictions Services, Lesbian, Gay, Bisexual and Transgender Services, Multi-Cultural Services, Aboriginal Services, Methadone-Maintenance Treatment Program, Neuropsychiatry Services, Family Support, Residential Historical Abuse Program (RHAP) for adult survivors of sexual abuse, and a wide variety of Psychosocial Rehabilitation Services (personal life skills, employment support, volunteer services, peer support, social/recreational, clubhouse models, education, and advocacy), Adult Forensic Psychiatric Services, Youth Forensic and Justice Programs, and Criminal Justice Diversion Services.

Riverview Hospital is a former provincial psychiatric hospital which has been in the process of closure with redevelopment of specialized beds across the province. Provided target dates are met, it is anticipated that all patient care and non patient care services will be transferred or discontinued effective July 1, 2012. As part of the redevelopment process, the Ministry of Health is providing $138 million in capital funding to construct new facilities or renovate existing facilities within various health authorities' regions – as of January 2010; there were a total of **441 Riverview replacement beds providing specialized inpatient options** available across the province[99]:

- Vancouver Coastal Health Authority: 9 beds available – confirming remaining locations for Riverview replacement beds.
- Fraser Health Authority: 160 beds located in the communities of Delta, Coquitlam and Langley.
  Vancouver Island Health Authority: 68 beds available - 24 beds at the Seven Oaks Tertiary Mental Health Facility near Victoria, BC. 40 psycho-geriatric care at the Sandringham Care Centre, 10 minutes from Victoria, 4 beds in Comox.

[99] BC Mental Health and Addictions Services. Provincial Health Services Authority. http://www.bcmhas.ca/AboutUs/News/Riverview_Redevelopment/default.htm

- Northern Health Authority: 65 beds available – 20 at Iris House in Prince George, 14 at Bulkley Valley Lodge in Smithers, 8 at the North Peace Care Centre in Fort St. John, and 20 at Seven Sisters in Terrace. Three tertiary acute beds for residents of northern communities are located in Kamloops, co-managed with Interior Health as part of a larger acute care facility.
- Interior Health Authority: 139 beds - 40 beds at South Hills Psychiatric Rehabilitation Centre, 13 at Hilltop House, and 44 at the new Hillside Centre adjacent to Royal Inland Hospital (this facility houses a 25-bed component of the BC Neuropsychiatry Program, in addition to adult tertiary and geriatric psychiatric patients). A further 42 beds have been transferred to existing facilities in Cranbrook, Vernon, Osoyoos, Penticton and Trail.

Plans are being finalized to develop the remaining 402 beds of the Riverview Redevelopment project within regional facilities, including the projects going to RFP.

The province also opened in 2008 the **Burnaby Centre for Mental Health and Addiction** a 100-bed centre providing treatment to adults who are medically stable with a range of mental health and addiction issues. An additional 44 beds for adults are in the process of opening on the Riverview grounds to provide transitional, supportive housing for clients coming out of the Burnaby Centre. There is a significant waiting list for Burnaby of approximately one year. An additional, 20-bed program for Aboriginal women is being opened on the Riverview site.

As part of the Provincial Homelessness Initiative, provision of non-clinical supports in housing settings was realigned from health authorities' purview to that of BC Housing. This includes tenant support workers, life skills, supportive counselling, medication reminders, and goal-setting. These supports are provided by BC Housing in their directly managed units, and are provided through contracts with non-profit organizations in other settings. Two key initiatives of BC Housing and partners are outlined below:

- **Homeless Outreach Teams**: Homeless Outreach workers seek out people who are homeless and connect them with housing, income assistance, health and addictions services and other supports to help them regain their independence. There are teams working in 49 communities across the province, and Aboriginal HOTs in nine communities. To date more than 7,000 people facing homelessness have been provided with stable housing. An estimated 80 per cent of them remain housed.
- **The Homeless Intervention Project**: In March 2009, the Ministry of Housing and Social Development launched the Homeless Intervention Program (HIP). HIP established integrated and coordinated outreach teams in five pilot communities: Vancouver, Victoria, Surrey, Prince George and Kelowna. The community teams have members from all key ministries and agencies, including BC Housing, the Ministry of Health and the Health Authorities, with the immediate goal of reducing chronic homelessness.

RESIDENTIAL ADDICTIONS SERVICES (TREATMENT)

1. **Addictions Residential Treatment**

- Addictions treatment in a licensed facility under the Community Care and Assisted Living Act (CCALA) which provides a safe, structured, and substance-free living environment. Treatment includes assessment, education, structured individual, group and family counselling/therapy. Programs generally range from 30-90 days.
- Short-term options: Addictions treatment provided in a safe, structured, and substance-free living environment for individuals up to 30 days.
- Long-term options: Residential treatment provided for 30-90 days
- Concurrent Disorder Addictions Residential Treatment: Treatment for individuals with concurrent mental and substance use disorders for up to six months

2. **Support Recovery Homes**

- A temporary residential setting providing safe housing and a basic level of support appropriate for longer-term recovery from addiction. Individuals access outpatient and other community treatment services and supports. Programs generally range from 30-90 days

3. Adult and Youth Detox Beds

- Withdrawal management services to provide support through acute stages of withdrawal from alcohol or other drugs in a residential setting. Some services are provided in facilities required to be licensed under the Community Care and Assisted Living Act (CCALA), while others, for example youth detox, take place in a family care setting.

4. Sobering and Assessment Beds

- Beds/mats funded by the health authorities to provide a short-term (less than 24-hours) safe place for people under the influence of substances to have shelter, access to washrooms, and a snack.
- The objective is to provide short-term respite, and not necessarily facilitate a referral to other addictions or mental health services, although that may be a secondary outcome of the service.

INCOME SUPPORT PROGRAMS

In British Columbia, the provincial social assistance program is known as Employment and Assistance (BCEA) and is governed by the following legislation and regulations: British Columbia Employment and Assistance Act, the British Columbia Employment and Assistance for Persons with Disabilities Act, the British Columbia Employment and Assistance Regulations, and the British Columbia Employment and Assistance for Persons with Disabilities Regulations. The Ministry of Housing and Social Development is responsible for delivery of this assistance program. Basic support and shelter benefits are provided to family units – additionally, the BC Family Bonus provides a separate children's basic support benefit.

- Basic assistance consists of a support allowance and a shelter allowance. The shelter allowances pays actual shelter costs to a maximum amount (based on the number of persons in the family unit)
- There are three rate schedules: Income Assistance, Disability Assistance, and Hardship Assistance
- Income Assistance rates include two separate groups – one is classed as employable and receives a rate that reflects a temporary need, the second group is classed as people with persistent multiple barriers to employment and have a higher rate,
- **Disability Assistance** rates apply to all households that include at least one person aged 18 years or older who has a severe and confirmed mental or physical impairment that restricts their ability to perform daily living activities and that is expected to continue for at least two years
- Hardship Assistance rates apply to those persons requiring temporary financial assistance on a month-to-month basis who are not eligible for income or disability assistance for a number of specific reasons, but present circumstances of undue hardship if no assistance is provided.
- At the time of application for Employment and Assistance, applicants' with disabilities' liquid assets may not exceed $3,000 for an individual, or $5,000 for couples or families
- Once on employment assistance, disabled individuals may retain up to $500 in earned income on a monthly basis, couples up to $750
- **Total income for a single individual with a disability was estimated at $10,877** in 2008 (includes basic social assistance, GST credit, and limited provincial benefits and tax credits)[100]. This represents 62% of the income required to meet the Low-Income Cut-off

According to the Social Assistance Statistical Report, 2007 (Federal-Provincial-Territorial Directors of Income Support, May 2010, pp.108-111), an estimated

[100] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability*, Bulletin Number 2.

- 104,300 cases (approximately 138,700 people) were receiving Employment Assistance in March 2007 – excludes people who were transient
- 59% of cases' reason for assistance was due to persons with disabilities (physical or mental), 7% of cases were because of multiple persistent barriers (a medical condition must have existed for at least one year and be expected to continue for at least two more years), and 12% of cases were temporarily excused from working which includes (among other groups) people participating in drug or alcohol treatment and people living in a special care facility or hospital
- Of cases where the reason for assistance was disability, 12% had been on disability assistance for one year or less, 28% for more than one year but less than five years, and 55% for more than five years.

PROMISING PRACTICES IN HOUSING & RELATED SUPPORTS

- Portland Hotel Society: created in 1993 to advocate, develop and implement creative options for people living with mental health issues and/or substance use issues. Various housing options (**supportive housing and single room occupancy models**) work within a harm reduction framework, Joint funding through BC Housing and Health Authority. In addition to mental health and substance use services, there are a variety of supports available, ranging from home support to nutritional counselling, to arts.
- Phoenix Centre – provides a range of services for substance misuse in **Kamloops** including detox, youth outreach, family services, preventions services
- Luma Housing Project in Vancouver - The Luma Native Housing Society operates over **200 units of Aboriginal social housing in Vancouver**. In 2004, they opened a patient lodge that supports Aboriginal patients from across B.C. by providing them with an apartment-type setting to stay in while they are receiving medical treatment in Vancouver. The unique aspect of the lodge is that patients and their families can participate in the complex's common area, programs, social gatherings and become part of the "neighborhood" while they are recovering and receiving treatment.
- ACE Empowerment Centre and the BC Schizophrenia Society Prince George**: consumer-led initiative**, supported by the Schizophrenia Society, which provides member-driven social and recreational events, and peer support
- Broadway **Youth** Centre provides housing information, employment, counselling, Aboriginal youth services information, and community connections in Vancouver and Surrey
- Coast Mental Health: provides assistance in housing jobs, community, rehabilitative social and recreational opportunities, food, clothing and basic life skills training in Vancouver
- RainCity Housing and Support Society – serves people within a **harm reduction framework**, including people with co-occurring mental health and substance use issues who are homeless or who are at high risk of homelessness
- Crabtree Housing: offers safe transitional housing for pregnant and parenting women who are overcoming substance abuse issues. The housing community uses a harm reduction approach and connects residents to YWCA and community resources.
- CMHA Shuswap/Revekstoke Branch – supported housing complex designed as a horseshoe – one side is BC housing funded while the other side provides **home ownership options** via CMHC
- Homes for Good Society – formed as a next phase to the Mayor's Action Team on Homelessness: **Goal is to end chronic homelessness** in the region (Surrey and surrounding) in five years through a *Housing First* approach, and based on two pillars: making use of existing housing inventory where possible, and coordinating availability of existing supports

CHALLENGES IN HOUSING & RELATED SUPPORTS

- There has been **rapid development in the BC housing market** over the last five years, with a strong emphasis on people who are homeless, and people with mental illness and addictions – concurrently the closure of the Riverview

psychiatric hospital, the creation of the mental health and addictions treatment centre (Burnaby Centre), and the redevelopment of specialized beds across the province has been taking place. The planning/implementation around housing and supports for people with mental illness needs should consider if the same needs will be present in the future and, if not, the degree of flexibility to change or shift models that will exist ion the system.

- Consistent with all regions across the country, **the aging population** and the needs that come with this shift need careful planning for housing/support models.
  - In the 2008 report on Home Care and Community Services, the Auditor General notes that in 2006, those over the age of sixty-five accounted for approximately 15% of the total population – by 2031, this proportion is to increase to 24% (about 1.4 million people). In a shorter time-frame, by 2011, an estimated 55,000 people will have dementia in British Columbia — an increase of 22% in just seven years.
  - Seniors who need mental health supports are becoming homeless more rapidly than in the past. They also bring their own unique challenges in determining mental health and aging related dementias. They often have chronic addictions issues, as well as physical health issues.
- **Standards' development needs to keep pace** with redevelopment of the Single Room Occupancy Hotels – support levels should be part of these standards
- There are housing options within the current system (e.g., licensed care facilities, family care homes) that are meeting housing needs – need a better understanding of how to support these models in being **recovery-oriented**
  - Licensed residential care facilities have regulations that can make it very difficult to incorporate recovery oriented elements into the model. While there are reasons for these regulations, more work is needed to look at how the application could be more flexible
  - There are a number of people with primary health issues in addition to mental health issues – this is often the reason that they access RCFs
- A **greater degree of collaboration is needed** between health services and housing – recognize that sometimes more informal processes work best on the ground. There are opportunities to look at how funding could be tied to partnership and innovation.
- **System flow**: need to build in more ability to help people move to more independent options if this is what they desire, thereby freeing up the higher supports models for people who are waiting/need them – right now, there are wait lists at every point in the continuum, making it difficult for people to move
  - There are wait-lists for social housing across the province. Detailed data on tenants and length of stay (or "turnover") in BC Housing units and other social housing is not readily available. Average length of stay varies somewhat by client group but generally is about five years. BC Housing continues to improve the application process for social housing, to better match the applicants with appropriate housing and level of supports.
  - There are significant **geographic differences across BC**: Urban versus Rural versus Vancouver Census Metropolitan Area – all require different planning lenses
- **Food security is a major issue** – need to make sure people's basic needs are addressed
- **Portable housing benefit could be of great use** for some people
- Concern that Burnaby Centre not re-institutionalize people – having adequate housing and supports in the community is key to this, coupled with early intervention services
- Interest in looking at how **Assertive Community Treatment Teams can be more flexible** in the way supports are provided
- **Ongoing operating funding for housing is crucial** – not just capital dollars to build
- Many people with mental illness are living in regular BC housing stock: there is a range in providers' understanding of how to meet people's mental health needs

- Making connections to local mental health teams and how accessible these are can vary – it seems that the smaller the community, the better the connections with the mental health providers
- Similarly, there can be a high percentage of people with mental illness living in seniors' care facilities – as high as 30%

- There has been a **lengthy wait for the provincial mental health plan** which has created a kind of limbo within the mental health system
- Many people that fall through the cracks are people with complex mental health and addictions, and issues that stem from long histories of trauma and marginalization. They do not fit clearly into the categories of the mental health system
- There is a huge unmet need for new immigrants with histories of trauma, abuse, torture, and illness – stigma issues are significant - they are a part of the hidden homeless, they often double up with families so they do not come to the forefront as quickly as some other groups
- These points are strikingly similar to what we are experiencing with Indigenous people in terms of mental health being heavily stigmatized or not acknowledged, and special housing support is extremely difficult.

FUTURE DIRECTIONS: TRENDS IN HOUSING & RELATED SUPPORTS

- BC has had a fairly significant policy focus on the issues of housing and homelessness, together with significant resource allocations (although resources for supports have been smaller and this is a concern)
- There has been a focus on congregate options – tends to be more specific to Vancouver and larger urban centres – which appears to be premised on some assumptions about what serves people best. Significant work has been done on developing supports needed for the Single Room Occupancy model and these supports need to be funded – future work should incorporate models that provide greater flexibility (i.e., current trends focus significantly on bricks and mortar but future population may not need the congregate models to the extent that they are being created today)
- General trend is about moving more towards client-centered housing options
- Major area of focus now/for the future is building much closer partnerships and linkages between Housing and Health at all levels – between government departments, between BC Housing and Regional Health Authorities, between providers

MANITOBA

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of Manitoba is approximately 1,148,400 (Statistics Canada, 2009) with an unemployment rate of 5.6% compared to a rate of 8.1% across Canada (Statistics Canada, 2010). Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of 2.6%** since 2001, lower than the national average of 5.4%.
- An **aging population**, consistent with all other regions across Canada, where 14.0% of the population is aged 65 and over (compared to 13.6% nationally).
- The census enumerated 175,395 people reporting **Aboriginal identity** in Manitoba in 2006, representing 15% of the national total (only Ontario and British Columbia had more), and equivalent to 15.3% of the total population of Manitoba.
- The **Aboriginal population is becoming increasingly urban**. In 2006, 54% lived in an urban centre, an increase from 50% in 1996. Urban areas include large cities, or census metropolitan areas, and smaller urban centres. In comparison, 81% of non-Aboriginal people were urban dwellers in 2006. The difference between the two proportions is due mainly to the large share of First Nations people who live on reserves.
    - Aboriginal people have much lower incomes compared to the population as a whole in Manitoba – a difference of about $9,000 in median annual income, and over $10,000 in median household income.
    - The Aboriginal population, particularly renters, represents one of the most poorly housed segments of Manitoba society: home ownership was 20-25% less among Aboriginal people in 2006, compared to the overall population, and the likelihood that dwellings required major repair or were overcrowded was much higher in dwellings occupied by Aboriginal people.
- Roughly 2.6% of households in Manitoba lived in band housing in 2006, up from 2.4% in 2001.
- A relatively **high percentage of households in Manitoba** (just over 10%) reported that their dwelling was **in need of major repairs**. In the province's band housing, the need for major repairs was much higher, representing about 55% of the dwellings.
- About 2.8%, or 31,200, of the **1.1 million newcomers to Canada** settled in Manitoba from 2001 to 2006. In total, the census enumerated 151,200 foreign-born individuals in Manitoba. They represented 13.3% of the province's population, the fourth highest proportion in Canada
- The population of foreign-born people in the census metropolitan area (CMA) of Winnipeg grew by 10.5% between 2001 and 2006. This is in comparison to the total growth of the CMA which increased by 2.8%. About 1 in 5 foreign-born residents of Winnipeg arrived in Canada between 2001 and 2006, predominantly born in Asia and the Middle East with nearly 3 out of every 10 newcomers having been born in the Philippines.
- Of the 448,780 households in 2006, **68.9% owned the dwelling** they lived in (consistent with the national average). This represents an increase of 5.5% since 2001 (about half the growth seen nationally). Of owner households, 54.6% held a mortgage, on par with the national average of 57.9%.
- The census counted 281,760 households in the census metropolitan area of Winnipeg. Of these, two-thirds (67.2%) owned their accommodation and 32.8% rented it.
- The proportion of households **spending 30% or more of their income on shelter was well below the national average** of 24.9% at 18.6% (down from 19.4% five years earlier)
    - One-fifth (20.0%) of households in Winnipeg spent 30% or more of their income on shelter. Among the households that owned their accommodation, only 11.6% spent 30% or more of their income on shelter, compared to 37.3% of renters.

- While the median household income increased by 12.4% from 2001 to 2006, the average rent for a two-bedroom unit in the province rose by 16%

The Canadian Council on Social Development, in its social development series in 2009, noted that Manitoba's economy is one of the most diversified in Canada, but labour shortages are a continuing concern. One of the positive aspects of the shortage, however, is that shortages combined with strong economic conditions prior to the recession, have driven up average wages (although Manitoba is still considered a low wage economy, ranking ahead of only Nova Scotia and PEI). Manitoba has tended to outperform national figures on a number of economic indicators including housing investment. The strength of the Canadian dollar in relation to the American dollar has presented some challenges, given that the United States is the province's major importer – the future performance of the U.S. economy will have a significant effect on Manitoba's economy

While Manitoba's economy has been stronger compared to the national economy in recent years, median household incomes are about $6,000 less than the national median, and have increased at a slightly lower rate compared to Canada overall. The incomes of people in the top fifth of the income distribution in Manitoba have been increasing much more rapidly than the incomes of those in the bottom fifth. This is consistent with national trends. Incomes of low-income households have not kept pace with inflation. A single person working full-time in Winnipeg would need to work 50 hours per week at minimum wage to reach the poverty line. Manitoba has also fallen behind the national average in terms of job creation in sectors that pay good salaries. For example, jobs in mining, oil, and gas extraction industries increased by 8% in Manitoba between 2001 and 2006, compared to a national increase of 46%. In addition, middle-income families have not seen earnings keep pace with increases in basic costs of living such as housing, utilities and food. Over the last twenty years, for every dollar gained in income by the poorest 10% of families with children, the richest 10% gained $27.68 (Social Planning Council of Winnipeg, 2009, p.11).

Manitoba, based on after-tax income in 2005, had the second highest poverty rate in Canada at 13% (only behind B.C. at 13.6%). In 2005, 12.6% of Canadians living in the major Census Metropolitan Areas (CMAs) experienced low incomes compared to 8.4% of those living in other areas - the highest rates of low income were found in Winnipeg (15%), Vancouver (15%), and Montréal (14%). Food bank users represent 3.4% of the provincial population, the second highest level of food bank use in Canada (Food Banks Canada, 2008). It is estimated that as many as 10,000 people in Winnipeg, most of them Aboriginal, are part of the "hidden homeless." That is, they live precariously or temporarily with friends or family (Distasio et al., 2005).

According to the Canada Mortgage and Housing Corporation, some Manitoba communities have some the lowest vacancy rates in the private rental housing market across the country: for example, 0.2% in Thompson and 0.1% in Brandon as of April 2009. The province's housing strategy "HOMEWorks" identifies that there were 3,300 fewer rental units in Winnipeg in April 2009 compared to 1992 (p. 8).

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

The Department of Housing and Community Development (HCD) is a new department created through government reorganization in November 2009[101]. HCD consists of the **Manitoba Housing and Renewal Corporation (Manitoba Housing)**, and three other program delivery and operating divisions, including the Community Places Program, Neighbourhoods Alive!, and Cooperative Development:

- Community Places (funding and planning assistance to non-profit agencies to construct, acquire or renovate new facilities)
- Cooperative Development (advice and support for emerging and existing housing co-operatives)
- Neighbourhoods Alive! (supports community organizations in designated neighbourhoods to revitalize their neighbourhoods)

[101] Prior to this, the housing portfolio fell within the Department of Family Services and Housing (which is now the Department of Family Services and Consumer Affairs).

Manitoba Housing is a Crown Corporation created by statute (The Housing and Renewal Corporation Act) in 1967. The legal name of the corporation is Manitoba Housing and Renewal Corporation. Manitoba Housing is mandated under The Housing and Renewal Corporation Act and is governed by a Board of Directors with policy direction provided by government. Manitoba Housing:

- Owns the Province's housing portfolio and provides subsidies to approximately 34,900 households under various housing programs. Within the portfolio, Manitoba Housing owns 17,600 units of which 13,100 units are directly managed by Manitoba Housing and another 4,500 units are operated by non-profit/cooperative sponsor groups or property management agencies.
- Provides subsidy and support to approximately 17,300 households (including 4,700 personal care home beds) operated by cooperatives, Urban Native and private non-profit groups.
- Manages undeveloped land held in the provincial Land Bank. Through land development activities, Manitoba Housing contributes to the development of suburban neighbourhoods and reinvests the profits in areas of identified need in a manner that supports the province-wide housing initiatives.

The Department of Health has primary responsibility in establishing policy and overall strategic direction for mental health in the province (e.g., development and roll-out of the new provincial mental health strategic plan); management and delivery of services is the responsibility of **Regional Health Authorities** throughout the province. There are some mental heath programs and agencies which are funded by and accountable to the department, such as mental health self-help organizations and other non-profit mental health agencies (or specific agencies) with a provincial mandate. The department also manages the direct operation of Selkirk Mental Health Centre. As part of a restructuring of portfolios, the previous Department of Manitoba Health and Healthy Living became two separate departments: Manitoba Health and Manitoba Healthy Living, Youth and Seniors, whereby mental health falls within Manitoba Health and addictions falls within Manitoba Health Living, Youth, and Seniors.

The Department of Family Services and Consumer Affairs (formerly the Department of Family Services and Housing) is the lead department in implementation of the province's "ALL Aboard" poverty reduction and social inclusion strategy. Among other responsibilities, this department also administers income assistance programs, including those for people with disabilities, provides assistance in tenant and landlord rights and responsibilities and dispute resolution.

Cross-Departmental Coordination Initiatives Division (CDCI) is a partnership of the Departments of Health, Housing and Community Development, Family Services and Consumer Affairs, and Healthy Living, Youth and Seniors. Created in 2007, the CDCI works in collaboration with government and community partners to coordinate approaches and service delivery with respect to housing and supports for the seniors population, individuals with mental health issues and individuals who are homeless or at risk of being homeless. The office works with regional health authorities and communities to improve policy co-ordination, integrate service provision, improve collaboration and co-ordinate strategies. The CDCI has had a number of successes already, and is more fully profiled under the promising practices section.

PROGRESS TO DATE: KEY INITIATIVES

POVERTY REDUCTION STRATEGY

Manitoba's poverty reduction strategy (ALL Aboard), announced in May 2009, identified four pillars to reduce poverty and promote prosperity:

- Safe, affordable housing in supportive communities
- Education, jobs and income support
- Strong, healthy families
- Accessible, co-ordinated services

The Government committed to $212 million in new spending in the 2009-2010 fiscal year. ALL Aboard identified the importance of economic growth to the success of its plan. It also created an interdepartmental working group to report to a new Ministers' Poverty Reduction Committee, to monitor and report on progress.

In June 2009, the Province introduced the **HOMEWorks! Housing Strategy and Policy Framework for Manitoba,** which outlined the principles, priority areas of investment, and strategic goals that will guide provincial housing activities over the next decade. The vision of the strategy is "creating stronger communities through housing solutions" and its mission is "to provide housing leadership that contributes to the health, social and economic well-being of all Manitobans." The strategy is premised on the following principles:

1. Housing issues are interrelated to health, social, education and economic issues.
2. HomeWorks! promotes efficiency and effective use of resources.
3. Housing is a shared responsibility across individuals, communities, the housing industry and all levels of government.
4. Partnerships strengthen the housing environment: Provincial housing initiatives help local people meet local needs and priorities.
5. HomeWorks! Supports increase independence and self-reliance in housing.
6. Housing activities strive to promote inclusion (i.e., support economic and social independence, personal accountability, and individual choice).
7. People require a range of housing options.
8. HomeWorks! supports the effective functioning of the housing market.

HomeWorks! Homeless Strategy with a Focus on Mental Health Housing (May 2009) is the interdepartmental strategy to reduce and prevent homelessness with a targeted approach to connecting homeless people and those with mental-health challenges to stable, secure housing and support services. Ten new initiatives are currently in development to address the creation of a range of housing options with related supports with a focus on addressing the needs of emergency shelters, the development of Outreach mechanisms, housing with services and prevention activities.
Initiatives include:

- Stabilizing funding to homeless shelters and adding capacity to the homeless shelter system.
- The introduction of Emergency Homeless Shelter Standards.
- The Salvation Army Service Coordination Project.
- The Cold Weather Shelter Strategy.
- The Homeless Outreach Mentor Team.
- Housing with Services: 285 more integrated mental health housing units with supports ranging from independent living with supports to 24 hour supportive housing units.
- The Portable Housing Benefit; Manitoba Housing Community Wellness Initiative.

In Spring 2010, the Department of Housing and Community Development released a two-year investment plan in housing, making the following commitments (totalling $378 million from the provincial and federal governments) to further the HomeWorks! Strategy:

- 600 new affordable household units over two years ($123 million) with a total of 1,500 new units within five years.
- 1,500 households will benefit from renovations to their homes; 12,000 households will benefit from building improvements through a $226 million investment in social housing renovations.
- 800 households will receive renovation assistance for privately owned housing with a $15 million investment.
- 600 households will receive assistance to help them pay less than 30 per cent of their income on rent.

- 200 households will be able to afford to buy their own home as a result of a $7 million investment in new home ownership.
- 275 households will be supported with a $5 million investment for housing development in areas of need.
- 600 households will benefit from an investment of $2 million in supports and supplements for people who are homeless or have mental health issues.

HOUSING AND SUPPORT SERVICES FOR PEOPLE WITH MENTAL ILLNESS

Struck by the provincial government's Department of Health and Healthy Living in the fall of 2007, a representative committee developed a position paper articulating the range of housing and supports for people living with mental illness, findings of a literature review of evidence-based practice, and **recommendations to move the housing and supports agenda forward**.

HOUSINGFirst is a four pillar strategy for housing that was announced in April 2007:

1. HOMEWorks! targets affordable housing for low-income Manitobans;
2. BUILDINGFoundations focuses on the revitalization of existing public housing;
3. Project: A Roof Over Each Bed, which will invest in emergency and transitional shelter for homeless people; and
4. The extension of the basic renovation programs, including the Residential Rehabilitation Assistance Program (RRAP).

Manitoba is in the process of developing a comprehensive five-year provincial mental health strategic plan, building on the 2002 **Manitoba Health's Vision Statement for Mental Health Renewal**. This vision statement was developed to articulate the direction the system was moving towards and highlights the following:

1. Mental health services are developed based on the knowledge that people can recover from mental illness.
2. Individuals with mental health problems have the opportunity to live in integrated housing that they have selected in their community.
3. All new initiatives and programs are based on the latest relevant knowledge, reflect best practices and are oriented toward successful coping, empowerment, self-direction and recovery.
4. Individuals have supports and services available to them that they have had a central role in developing, selecting and evaluating. These services are focused on successful living in communities. Local community resources and the responsibility to include all citizens are seen as integral within the framework of support.
5. Family members and other natural supports are included in the planning and evaluating of services and initiatives.
6. Self-help groups play a significant role in the mental health system and in the lives of consumers, family members and other natural supports.
7. A primary health care approach that encompasses population health principles is used to address people's diverse health needs and includes a focus on prevention, health promotion and early intervention. It involves holistic, community-based strategies and coordinated, integrated approaches. Services are offered along a continuum of care.
8. Manitobans understand and are comfortable with mental health issues and are comfortable exploring and accessing these supports. Efforts to change negative public attitudes and their resulting behaviours, such as discrimination, are in place across the province (Government of Manitoba, n.d.).

RANGE OF HOUSING ACCOMMODATIONS

Table 1. *Overall Range of Housing Options in Manitoba.*

Dedicated Mental Health Housing	▪ Supported Housing ▪ Supportive Housing ▪ Portable Housing Benefit (Supported Housing) ▪ Residential care facilities
Non-Dedicated Affordable Housing	▪ Social/Public Housing Program ▪ Not-for-profit Sector Housing ▪ Rural and Native Housing Program ▪ Co-operative Housing ▪ Single Room Occupancy Hotels and Rooming Houses (privately operated) ▪ Manitoba Shelter Benefit ▪ Rent Supplement Program ▪ School Tax Assistance for Tenants 55 Plus ▪ Complementary Assistance Program
Additional Facilities or Housing Options	▪ Emergency and transitional shelters ▪ Personal Care Homes ▪ Supported Living Program

The "All Aboard" Poverty strategy has also developed a summary of housing and supports available for people with mental health and homelessness issues, as reproduced in Table 2[102]:

Table 2. *Types of Housing and Levels of Health and Social Supports for Manitobans with Mental Health and Homelessness Issues.*

Level of Support for Mental Health Issues	Types of Housing			
	Emergency/ Crisis	Interim	Long-Term Housing	
			Supports Attached to the Facility	Supports Attached to the Individual
No Supports	Living on the Streets	Couch-Surfing Family and Friends	Social Housing Subsidized Rental Costs	▪ Manitoba Shelter Benefit / Rent Supplements
Low	Homeless Shelters	Transitional Shelters	Social Housing Tenant Services Coordinators	▪ Rooming Houses/ Board & Room ▪ Single Room Occupancy Hotels
Moderate	Hospital Emergency Wards Crisis Stabilization Units	Interim Housing for Youth	Board & Room - Care & Supervision Community Wellness Initiative (CWI)	▪ Portable Housing Benefit ▪ Permanent Housing with Supports ▪ Housing for the Chronically Homeless ▪ CMHA Supported Housing Projects ▪ Eden Supported Housing Projects
High	Hospital Psychiatric Wards Mental Health Centres Selkirk, Eden	Mental Health Centres Selkirk, Eden	Licensed Residential Care Facilities Mental Health Supportive Housing	▪ Program of Assertiveness Community Treatment (PACT) Teams

[102] http://www.gov.mb.ca/fs/allaboard/housing_first.html

DEDICATED MENTAL HEALTH HOUSING

The Provincial Advisory Committee on Mental Health Housing and Related Support Services outlined the types of housing which can be dedicated for people living with mental illness in its report to Manitoba Health and Healthy Living in June 2008. These are:

Supportive Housing: Supportive independent living which can include group homes, and congregate housing Supports are generally tied to the housing rather than to the individual. Some examples of this type of dedicated housing in Manitoba include Eden's Linden Place Program, the Bell Hotel Supportive Housing Project, Carriage Road, and Canadian Mental Health Association (CMHA) Thompson.

- Low barrier housing: provides stable housing and support services to individuals who may not yet be engaged in any treatment and does not require sobriety. The focus is on helping people to achieve greater self-sufficiency and housing stability.

Supported Housing: Housing scattered throughout the community including *Housing First* options, as well as dedicated or non-dedicated options in the non-profit, co-op housing and private rental markets. Supports are generally tied to the individual, regardless of what type of housing they live in. Some examples of this scattered-site model are provided by CMHAs and Regional Health Authorities (RHA), as well as Eden's Supported Housing Projects.

- *Housing First*: emerged to meet the special challenges of providing service to disengaged, homeless, and/or co-occurring disorders populations. The focus is on rapid re-housing of people who are homeless as the first priority, then providing services as needed with a focus on services that sustain housing. Housing is not contingent on compliance with external services and participants do sign lease agreements.

At the present time, regional health authorities frequently use private market housing (where rent supplements or portable benefits may or may not be available), as well as public or social housing options, when assisting clients to secure housing, in addition to frequently accessing public and social housing options. Consistent with other urban centres across the country, vacancy rates are very low in urban centres, it is smaller urban and rural centres in Manitoba which have some of the lowest vacancy rates across the country; for example, both Brandon and Selkirk often have vacancy rates of 1% or less. As required, RHAs will also use hotels and residential care options as temporary housing measures (Employment and Income Assistance is often the program that funds the shelter component in these situations). According to the report from the Provincial Advisory Committee, recent consultations with consumers and families have indicated that mental health crisis stabilization units and emergency shelters are now 'housing options' that they rely on due to a lack of housing options. One of the challenges for people with mental health issues is that, in some cases, individuals receive employment and income assistance (EIA) on the basis of a mental health disability (and may therefore be eligible for specific mental health housing supports) but may not meet the criteria regarding severity of mental illness for accessing RHA mental health services, requiring them to look for other service options. This challenge is more predominant in urban areas and is seen in some provinces where the focus is on people whose functioning is most significantly impacted across all life domains.

Of the dedicated mental health housing available in the province, the majority is provided by mental health non-profit organizations. Table 3 provides a summary of existing capacity.

During the first 'push' of mental health reform in the early 1990s, there was expansion of residential models of support, crisis units, and small (2-3 people) foster homes. As the mental health community has evolved, and psychosocial rehabilitation practices have become more prevalent, there has been a **new focus on developing more supported housing options** to reflect consumer choice. Health authorities began receiving an average of $35,000 each (starting in 2003/04) that was to help in expanding these options, and work with consumers in securing housing. Some health authorities opted to provide this funding to local CMHA branches to provide this function.

The **most common types of dedicated housing options are provided via CMHAs and other community-based mental health organizations**. Generally, the mental health organization approaches both the federal government for Homelessness Partnering Strategy funds, as well as the provincial government for housing funding (for example, through HomeWorks! Initiatives). The mental health organization assumes the property management function and provides

supports as well. In some areas, partnerships have been established with RHAs for funding support as well; the RHAs are able to access housing units for clients with mental illness, while the community-based organization manages the property and provides supports. In general, where there is 'congregated' dedicated mental health housing, these **units are mixed with non-dedicated mental health units**. This type of mental health housing has been developing primarily since 2003, when RHAs were provided with funding to assist clients in finding housing as noted above.

Community-based organizations have played the largest role in expanding actual housing stock: for example, Eden Health Care Services, in addition to providing an inpatient setting and a range of community supports, have secured four buildings in different parts of Manitoba, providing dedicated mental health housing together with supports with a focus on integrated settings. Funding to purchase the buildings was secured through government sources, but a great deal of funding was also leveraged through faith communities. As another example, when the Brandon Mental Health Centre closed (as part of the deinstitutionalization movement), much of that funding was maintained in the community, allowing for an expansion of community mental health and housing options.

Most recently, the **government has committed to establishing an additional 285 units of dedicated mental health housing** through the redevelopment of existing social housing stock and new capital development (Table 3 provides a breakdown of the units).

One of the most promising developments within the dedicated housing sector has been the establishment of a **portable housing benefit**. Rather than the more traditional rent supplement programs, where the rent supplements are generally attached to specific units, this subsidy is attached to the person who can then secure private rental market housing. The portable housing benefit can be accessed by people who are receiving EIA and who have been assessed as having mental health issues (although a psychiatric diagnosis is not necessarily required). In addition to the portable benefits, there is one staffing position for each fifty benefits (for a total of 8 FTE) to provide support to people in securing and sustaining their housing.

In addition to these supported and supportive housing options, there are dedicated **residential care facilities** for people living with mental illness, people with disabilities, or people with other special needs. These facilities are licensed by the province – generally through the Residential Care Licensing Program of Family Services and Consumer Affairs, which has a mandate for licensing residential care facilities for adults with mental illness, developmental disabilities, and adults requiring care due to frailty or aging-related cognitive impairment across the province. By March 2009, six of the 11 RHAs had accepted the delegated licensing responsibility for approved homes for their program (Mental Health) from the Supportive Living Program (SLP; which sits within the Department of Family Services and Consumer affairs). Residential Care Licensing staff from the SLP provide training and policy interpretation, as required. They are typically home settings for a small number of residents with private owners/operators. These operators provide 24-hour supervision and support, including meals and laundry. Regular inspections are made by the licensing authority (i.e., the SLP or RHA).

Two additional initiatives, falling within the Homelessness Strategy with a Focus on Mental Health Housing, provide enhanced models of housing outreach and support services for individuals with mental health needs:

- The province has created a **"Homeless Outreach Team"** to provide support to homeless individuals through various service providers in Winnipeg, Thompson, The Pas and Brandon. The team works with a ***Housing First* approach** that provides better access to health, social services and housing for individuals currently experiencing homelessness.
- Finally, the **Community Wellness Initiative** (CWI) was launched in 2005, to provide supports to people living in Manitoba Housing who were experiencing mental health issues. This partnership between Manitoba Housing and the Regional Health Authorities operates in fourteen Manitoba Housing sites as of 2009/10 (within and outside Winnipeg) and focuses on housing support, life skills and wellness activities including providing information on such topics as menu planning, the benefits of exercise and a healthy lifestyle, the identification and management of stress, dental and vision wellness, and the roles of the tenant and property managers.

Table 3. *Dedicated Housing Options in Manitoba.*

Program	Description	Capacity
Supported Housing (Portable Housing Benefit)	Provides a **rent supplement** of up to $200 per month to low-income individuals with mental health issues so that they can secure private rental market housing. People must have an unstable housing situation that is interfering with their treatment, and with their ability to fully participate in their community. **Support workers** (8 full time staff attached to mental health agencies) are available to provide housing supports. The Portable Housing Benefit (PHB) is administered by the Winnipeg RHA, the CMHA Winnipeg and Sara Riel Inc within the City of Winnipeg. In areas outside of Winnipeg, the PHB is administered by the CMHA in Thompson and Brandon, together with the RHAs. In the Central Region, the PHB is managed by CMHA in the Northern area, and Eden Health Care Services in the Southern area. Funding is for people on employment and income assistance program (who have been enrolled on the basis of a mental health disability) and is provided via Manitoba Family Services and Consumer Affairs. The program began in Winnipeg, Brandon and Thompson and is in the process of rolling out across the province.	600 benefits of up to $200 per person per month and 8FTE support staff Allocation of $1.940M in 2009/10
Supported Housing	Brandon RHA – 88 supported housing placements including 33 placements with the PHB (note that capacity states 55 total so as not to double count PHB data).	55 placements
Supported Housing	CMHA Brandon/Westman – mixture of 1-bedroom and 2-bedroom, as well as 3 emergency units.	39 units
Supported Housing	CMHA Selkirk – all 1-bedroom with 50% receiving rent supplements.	22 units
Supported Housing	CMHA Dauphin – 5 studio apartments, 8 1-bedrooms, 5 2-bedrooms and 3 emergency units.	21 units
Supported Housing	CMHA Swan River – 8 studio apartments, 11 1-bedroom, 1 2-bedroom and 2 emergency units.	22 units
Integrated Supported Housing	20 units dedicated for people with complex mental and/or physical health needs: 10 in Winnipeg (Carriage Road) and 10 in Brandon (Princess Park).	20 units
Supportive Housing	Friends Housing Incorporated – 28 units and 15 townhouses dedicated for mental health.	43 units
Supported Housing	Eden Health Care Services has four buildings: Steinbach/Penfeld Court has 24 units with 14 units receiving rent supplements dedicated for mental health; Steinbach/Ashwood-Birchwood has 12 units each with approximately half dedicated for mental health housing all with rent supplements; Enns Courts East and West in Winkler has 38 units with 19 units dedicated for mental health. Note that Eden also administers six residential care facilities.	45 units
Supportive Housing	Sara Riel Inc. provides transitional (two to three years in general) housing and support services to people with mental health issues graduating from their residential program. There are three 1-bedroom and eight 2-bedroom units located in the same apartment block. Eden Health Care Services provides a transitional housing and support program through Linden Place in Winkler.	11 units 8 units
New Initiatives: Housing with Supports (Supported and Supportive)	The government has recently announced 285 more mental health housing units with supports, predominantly created through conversion of existing Manitoba Housing – these include: ▪ 50 privately owned or converted Manitoba Housing units redeveloped into permanent housing with supports ▪ 30 units with on-site supports for individuals with persistent mental illness ▪ 40 units in downtown Winnipeg converted to housing with supports for individuals who are chronically homeless ▪ 74 additional CMHA integrated housing units	285 units – in development

Program	Description	Capacity
	▪ 87 existing units at Madison Lodge that will receive enhanced support services ▪ Four Manitoba Housing units converted into interim housing for youth with support from Resource Assistance for Youth (RaY)	
Supportive and Transitional Housing	CMHA Thompson has a Transitional Housing Unit (4-bedroom unit), McGill House (a two duplex unit with one 3-bedroom and one 4-bedroom unit). Hope House, providing crisis and stabilization services, is discussed under the mental health services section.	11 bedrooms
Residential Care Facilities	Provide accommodation, care, and supervision to people with mental illness. Services include up to 24-hour supervision, meals, assistance with personal care, medication administration, laundry, and assistance with personal finances as required. Private owners/operators are licensed (or "approved" for 3 beds or less) by the province or RHAs. ▪ Brandon RHA has 36 dedicated beds under residential care, 16 of which are staffed by RHA resources, 16 through private owners, and 4 through non-profits.	510 beds

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

The primary focus of Manitoba Housing is to provide independent housing options to people living on low incomes. While the proportion of tenants with mental illness assisted by Manitoba Housing is difficult to estimate, the province has provided subsidies at different times to a small number of organizations or facilities specifically for the purpose of expanding housing options for this population. Manitoba Housing have **tenant service coordinators** that assist tenants living in units within the provincial portfolio. Coordinators do provide extra support to buildings where they are aware that there is a larger concentration of people living with mental health issues and the focus is on helping tenants secure supports they need to maintain their housing (not on coordinators directly providing health and social services). On-the-ground experience has shown that buildings with higher concentrations of people with special needs tend to experience more problems and this creates issues because Manitoba Housing does not have responsibility to provide these types of services and support.

In the past, people with mental health issues tended to access Manitoba Housing as a last resort, in part due to the greater focus Manitoba Housing had on families and seniors (as mandated by the province). In the most recent Manitoba Housing strategic plan, a priority has been placed on assisting people with multiple issues (including mental health) to secure housing within Manitoba Housing. A key initiative of the Cross Departmental Coordination Initiatives Division is to work with the housing system to identify a range of housing units to which people with mental health issues can access.

In addition to housing provided via the Manitoba Housing Authority and non-profit community-based organizations, there is also a significant **"Single Room Occupancy" (SRO) hotel and rooming house market** – particularly in the Winnipeg area. While the goal of this mapping process did not include this type of privately funded housing option, many people live in SROs and rooming houses and they are part of the affordable housing market. In addition, a good proportion of people who use SROs and rooming houses are receiving some form of income assistance and/or shelter benefit so they are, in effect, a kind of public option.

SROs are located in what used to be regular hotels and, over the past century or so, have transitioned to become a form of affordable rental housing. A 2005 analysis of SROs identified that about 1,000 people live in SROs in Winnipeg, the majority of which are located in downtown (Distasio et al., 2005, p.2). They pay an average of $250 monthly 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 a house with at least several private bedrooms where tenants share a common bathroom. Residents are considered tenants in rooming houses, but not in SROs. Because they are 'hotels' they fall under the Manitoba Liquor Control Act rather than the Tenants' Act.

The number of rooming houses and tenants is unclear: the most recent analysis (Distasio et al., 2002) suggests that there are approximately 1,000 rooming houses in Winnipeg, serving around 5,000 tenants. Based on an estimate that about 70% of people are receiving income assistance, the authors believe that about 3,500 tenants are receiving shelter supplements to assist in paying for the rooming house; this ultimately means that government was spending somewhere in the region of $825,000 on a monthly basis five years ago for people to live in rooming houses. We must emphasize that the number of SROs, and to a greater extent rooming houses, can vary greatly (some can close in a month, others open) so these numbers are provided to emphasize that SROs and rooming houses are a significant part of the market from the perspective of tenants, not to provide exact figures. The report to the Mental Health Commission includes more detailed discussion on how SROs and rooming houses can be maximized as healthy, safe housing options for people. SROs and rooming houses are vitally important as a housing option when there are few other available options to people living with mental illness – the question is how to ensure that these models can be tailored/supported to support the people who live in them.

Table 4. *Non-Dedicated Affordable Housing Options in Manitoba.*

Program	Description	Capacity
Social/Public Housing	Includes 13,100 housing units directly managed by the Manitoba Housing through its agent, the Manitoba Housing authority, with the remainder provided through non-profit community-based agencies.	34,900 units[103] with transfer payments of roughly $58 million
Rural and Native Housing Program	Provides a subsidy to ensure that low-income tenants and homeowners living in rural areas pay no more than 25 per cent of their family income on housing.	Roughly 1,500 units in communities across Manitoba
Co-operative Housing	Between 1973 and 1991, CMHC participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme, however, is that all of these co-operatives provide some type of financial support. Housing co-ops are member-owned and controlled organizations. The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. The federal government ceased funding new development at the end of 1991, but continues to honour its operating agreements with existing co-operatives, which house **over 92,000 members across Canada** under these legacy programs. In 1999 Manitoba housing co-ops decided to receive local services through a Winnipeg-based office of the Co-operative Housing Federation of Canada (rather than a regional federation). The CHF local office assists Manitoba housing co-ops in linking with each other through an Advisory Forum, linking with the broader CHF, provides local education, bulk purchasing and advocacy with government.	2,756 units in 33 co-ops in Winnipeg and 13 co-ops outside of Winnipeg104
Manitoba Shelter Benefit	Provides a monthly benefit of: ▪ $210 per household (for families not receiving employment and income assistance, seniors, or people living with a disability); or ▪ A flat rate of $50 for people who rent, receive Employment and Income Assistance, and who have a disability or adults without dependent children (the maximum is $30 per person who pay room and board) This benefit is intended to enable low-income households to secure private rental market housing. Funded via the Department of Family Services and Consumer Affairs.	21,225 recipients with $9.098M spent in 2009/10
Rent Supplement Program	Funded by Manitoba Housing but delivered through Provincial Services, provides supplements to low- and moderate-income families and elderly households to rent in private rental market or non-profit housing projects. Government enters agreement with owners/operators of private rental stock to subsidize the different between market rental rate and rent-geared-to-income rate. Subsidy costs are shared by the federal and provincial governments (50/50) for units committed pre-1985 and on a 75% federal/25% provincial basis for units committed post-1985.	1,172 units, average $309 supplement paid, $4.348M in 2009/10
School Tax Assistance for	Provides an annual grant of up to $175 to private rental market tenants aged 55 years or older living on lower income, to offset the school tax portion of rental costs. Applications are made by tenants This program is funded by Manitoba	1,815 rebate cheques totaling

[103] Number of units and funding where available is based on interviews with government contacts, the Conference Board of Canada (March 2010, p.84-86), the Department of Family Services and Housing 2008/09 Annual Report, and the Department of Housing and Community Development 2009/10 Annual report.
[104] Co-operative Housing Federation of Canada.

Program	Description	Capacity
Tenants 55 Plus	Housing but delivered through Provincial Services on behalf of the Department of Finance. Program expenditures are recovered from the Department of Finance.	$0.24M for 2009/10
Complementary Assistance Program	Funded by Manitoba Housing but delivered through Provincial Services, provides grant assistance to housing co-operatives to lower housing charges for income-tested occupants. Co-ops submit monthly statements to claim assistance on behalf of eligible clients. Closed to new applications at this time.	41 households in 6 co-ops for total of approximately $88,000 in 2009/10

ADDITIONAL INITIATIVES

Affordable Housing Initiative (AHI)/Canada-Manitoba Affordable Housing Program Agreement: Based on the housing framework agreed to in November 2001 by federal, provincial/territorial housing ministers. 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 a grant, a stream of ongoing subsidies or the value of in-kind contributions (e.g., land). Within these terms and 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. The Program was intended to create around 2,500 units of affordable housing for households on social housing lists, or those eligible to be on such lists. The two phases of the agreement meant a total investment of $73.86 million ($36.9 million from each of the federal and provincial governments)[105]: As of June 30, 2010, virtually all of this funding had been committed and/or announced for 2,571 units[106] and the 2009/10 Annual Report from the Department of Housing and Community Development noted that all commitments from the first two phases of the AHI had been finalized. The two-year extension ("Phase III") of AHI provides $9.06 million from each of the federal and provincial governments.

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 period the initiatives were to be reviewed and funding allocations for the following three years were to be determined. All three program extensions were part of the federal government's September 2008 announcement of $1.9 billion over five years.

Homelessness Partnering Strategy (HPS): Launched on April 1, 2007 by the federal government, building on the foundation of its predecessor program, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five year commitment (see box). Of the sixty-one "Designated Communities" funding component under the strategy, Manitoba has three: Brandon, Thompson and Winnipeg. A key focus of the HPS is a housing-first approach and focuses on transitional and supportive housing as important ways to move individuals out of homelessness. **Manitoba receives about $14 million from the HPS** and this is delivered through the **Winnipeg Housing and Homeless Initiative**.

Residential Rehabilitation Assistance Program (RRAP) Suite of Programs: First introduced in 1973 by the federal government to provide assistance to low-income homeowners and landlords who rent to low-income households to repair properties to acceptable health and safety standards. Now includes an emergency repair program (for rural area residents), the Home Adaptations for Seniors Independence (one-time, non repayable contribution of up to $3500 for low-income seniors), and the Shelter Enhancement Program (repair or rehabilitation of shelters for victims of family violence). Jointly funded by federal and provincial governments (75/25 cost sharing), the two-year extension of RRAP (see box) provides $11.64 million in federal funding and $3.88 million in provincial funding. For 2009/10, funding was as follows[107]:

Homeowner RRAP	$2,572,179
Disabled RRAP	$643,750
Rental RRAP	$2,098,000
Emergency Repair Program	$112,500
Home Adaptations for Seniors Independence	$41,570
Shelter Enhancement Program	$1,890,000
Total	**$7,358,000**

[105] Department of Family Services and Housing 2008/09 Annual Report
[106] Canada Mortgage and Housing Corporation (June 30, 2010), National Afford Housing Initiative Funding Table. http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm
[107] Department of Housing and Community Development 2009/10 Annual Report

Canada's Economic Action Plan (CEAP): The CEAP has had a significant impact on the provision of new housing stock in the province. A total of $78.94 million in federal funding (matched by the province), over a two-year period, provides for $14.52 million for housing for low-income seniors, $2.72 million for Housing for Persons with Disabilities and $61.7 million for Renovation/Retrofit of Existing Social Housing. The Renovation/Retrofit funding was not only used to upgrade public housing stock as noted later in the document but also non-profit housing, cooperative housing and urban Aboriginal housing under social housing agreements. In addition, CEAP provided $30.14 million in additional funding to build new housing and $20.48 million in additional funding to renovate existing housing in Manitoba First Nation communities[108].

Winnipeg Housing and Homelessness Initiative (WHHI): A one-stop approach for community organizations to access housing and/or homelessness programs provided by all three levels of government in the City of Winnipeg; the WHHI maximizes cooperation amongst the partners. The current WHHI Memorandum of Understanding between Canada, Manitoba and Winnipeg extends until 2013. While the WHHI itself has no funding, funding from partner contributions (through the Affordable Housing Initiative, the Homelessness Partnering Strategy or provincial initiatives) has enabled collaborative approaches. From November 2000 through to March 31, 2010, over $8.9 million in Neighbourhood Housing Assistance funding (up to $10,000 per unit to organizations or individuals for homeownership and renovation in specific neighbourhoods)[109] has been leveraged through partners.

Progress on the HomeWorks! strategy (Part of the HOUSINGFirst strategy announced in 2007): This included $104.5 million over three years for the HOMEWorks! strategy focusing on inner-city revitalization with a focus on: refugees and immigrants; older Manitobans; urban Aboriginals; northern Manitobans, and homeless Manitobans. As of March 31, 2010, the Province has committed or allocated all funding available from the original $104.5 million. Construction is complete on 252 units and another 215 units are in development under HOMEWorks! Programs developed under this initiative include the following:

- **Home Ownership Program**: Provides low to moderate income households with a one-time contribution to reduce the capital cost of their house and offers down payment assistance.
- **Rental and Cooperative Housing Program**: Provides access to capital funding for private developers and non-profit and cooperative organizations to develop a new supply of rental or cooperative housing to increase supply for lowto moderate-income households.
- **Northern Remote Renovation Program**: Provides renovation options for low- to moderate-income households in Northern communities with incomes at or below the HOMEWorks! maximum household income limit.
- **Cooperative Housing Program**: Co-op members purchase equity shares in a housing project and collectively become owners of the building. Subsidies are available for low-income members.
- **Homebuyer Down Payment Assistance Program**: Provides down payment assistance, ranging from 5 per cent to 10 per cent of the sale price, and a closing cost allowance to low- to moderate-income renters so that they can afford a mortgage down payment to purchase their first home.
- **Manitoba Tipi Mitawa Program**: Provides mortgage payment subsidies and contributes 5 per cent of the purchase price toward a down payment for Aboriginal people living off reserve.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, but aren't dedicated to serving this population. Within Manitoba this includes: **shelters, transitional housing** not specifically targeted to people with mental illness, and **Personal Care Homes (PCHs)**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity.

EMERGENCY SHELTERS AND TRANSITIONAL HOUSING

[108] Funding levels provided by the regional office of the Canada Mortgage and Housing Corporation.
[109] Department of Family Services and Housing 2008/09 Annual Report

According to figures from Human Resources and Skills Development Canada (HRSDC), there were **approximately 1.560 beds** in Manitoba's emergency and transitional shelters in 2007[110], or 5.8% of known shelter beds across Canada. There were **132 shelter beds per 100,000** population, significantly over the 82 shelter beds/100,000 people national average. The **number of shelter beds is likely an underestimate** because:

- It is based on the number of known shelters – there may be additional shelters not captured in this data set,
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available,
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007.

Also according to HRSDC, **of the known 1,020 shelters** identified across Canada as of March 2007, 723 or **71% were emergency shelters**, providing temporary and short-term accommodation for homeless individuals and/or families. Such shelters typically also offer essential services such as food, clothing and counselling. Transitional shelters offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. Transitional shelters numbered 291 and represented a little more than 28% of the total. There were, in addition, 6 shelters providing both emergency and transitional services, representing less than 1% of the total."

There are **ten women's shelters providing emergency accommodations and support** to women and their children who are victims of family violence. In addition, there are four Residential Second-Stage Housing Programs providing affordable long-term housing and services for women leaving an abusive relationship who have extensive needs. These programs also provide comprehensive emotional and practical support including individual and group counselling, parenting support and information. A total of 352 clients were served in Residential Second-Stage Programs in 2008/09 ($0.548 million in 2008/09), and there were a total of 38,725 bed nights in women's shelters in 2008/09 ($7.1 million in 2008/09).

There are a small number of transitional housing programs for people with substance use issues that are discussed under the Mental Health and Related Supports section as they are a form of treatment-based program.

Table 5, provided by the Department of Housing and Community Development, includes emergency shelters and transitional housing facilities across the province. The majority have been funded through the Shelter Enhancement Program since 2007.

Table 5. *Emergency Shelters and Transitional Housing Facilities in Manitoba.*

Name of Facility	Type of Facility	Location
New Directions for Children, Youth, Adults & Families	Crisis	Winnipeg
Alpha House	Second Stage Housing	Winnipeg
L'Entre Temps,	Second Stage Housing	Winnipeg
Osborne House	Shelter	Winnipeg
Women in Second Stage Housing WISH Inc.	Second Stage Housing	Winnipeg
Ma Mawi Wi Chi Itata	Emergency	Winnipeg
Ikwe Widdijiitiwin	Emergency/Transitional	Winnipeg
Holy Names House of Peace	Second Stage Housing**	Winnipeg
Safe Haven	Emergency	Flin Flon
Nova House	Shelter	Selkirk
Thompson Crisis Centre	Shelter	
South Central Committee on Family	Shelter	Winkler

[110] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

Violence		
The Pas Committee for Women in Crisis	Shelter	The Pas
Parkland Crisis Centre	Shelter	Dauphin
Westman Women's Shelter Inc	Shelter	Brandon
*Samaritan House	Second Stage Housing	Brandon
Eastman Crisis Centre Inc.	Shelter	Steinbach
Portage Family Abuse Prevention Centre	Shelter	Portage la Prairie

*Samaritan House has not received funding through SEP

**Second Stage Housing provides conditional housing to its occupants. This means that occupants must adhere to certain circumstances (i.e., counselling services before they are housed).

PERSONAL CARE HOMES (PCH)

PCH programs are managed by Regional Health Authorities (RHAs) and provide 24-hour professional nursing services to eligible individuals who can no longer manage independently at home with family support and/or community services like Home Care. In general, PCHs serve seniors and are not designed to serve people with mental illness. Services include: 24-hour nursing, personal care services, physician services, food and nutrition services, medications and pharmacy, housekeeping and laundry, as well as access to allied health workers. Access centres determine eligibility through a multidisciplinary assessment process. Costs are based on resident income and range from $29.70 to $69.70 per day. Personal Care Homes can be targeted to specific needs. For example, within the Winnipeg area, there are 5,697 beds[111] – the majority are identified as general personal care beds, but there are a small number identified as behavioural special needs, young disabled, deaf or hearing impaired, behavioural treatment, interim beds and respite beds. It's important to understand that there are no formalized mental health services in place for people residing in PCHs.

There are **approximately 9,830 PCH beds across the province** (provided by Manitoba Health and reported in CUPE, 2008, p.25) located in 124 homes (Department of Health 2008/09 Annual Report) representing a 1% increase from 2001 to 2008. During the same time period, there was an 8.4% increase in the population aged 75 and over. As of March 31, 2008, there were an additional 150 non-licensed interim beds which were to be phased out. Roughly three quarters of beds are located in "non-proprietary" facilities (non-profit) with the remainder being "proprietary" (for-profit). In a 2001 analysis, PriceWaterhouseCoopers estimated that 41% of Manitobans living in primary care homes were experiencing dementia or Alzheimer's.

RESIDENTIAL OPTIONS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES: THE SUPPORTED LIVING PROGRAM AND THE MANITOBA DEVELOPMENTAL CENTRE

This program falls under the Department of Family Services and Consumer Affairs, and is responsible for the planning, development, maintenance, overall direction and management of programs and resources that support and enhance the quality of life of adults with a mental disability (developmental disability) living in the community. Core components include: day services, residential services, support services and residential care licensing. **Residential services** can include provision of support in family homes, independent living (with or without supports), and residential care facilities (also discussed in the dedicated housing section). Residential care licensing applies to residential care facilities funded by the Supported Living Program (SLP) and includes residences in the community which serve people with mental illness or adults requiring assistance related to frailty or aging-related cognitive impairment. Total funding for the SLP in 2008/09 was about $196.9 million; this includes the full range of supports, not those specifically tied only to residential care settings. In 2008/09, there were 208 licensed residential care facilities providing 1,336 beds, and 868 approved residential care facilities (3 beds or less) providing 1,579 beds. The SLP also identified 722 people living independently with support as part of their program, and 178 people in independent living situations. The remainder lived with parents, extended family or in alternate care (e.g., hospitals, personal care homes).

[111] Winnipeg Regional Health Authority. http://www.wrha.mb.ca/ltc/pch/inde.g.php

Programming is focused on the developmental issues and for **people with co-occurring mental health issues**, there can be challenges in securing additional mental health services.

Manitoba Developmental Centre

- An accredited **residential care facility** for adults with a mental disability.
- Residential units are organized based on resident needs: the Extended Care Program (people whose mental disability or complex medical conditions require intensive, long-term care) and the Geriatric Program, (for people experience age-related changes that affect daily living) and the Habilitation/Specialty Program (for people whose behaviours present a risk to themselves, to others or to their environment and for residents to increase their independence and participate more fully in community life).
- Focus on enhancing quality of life.
- Provides services including medical, pharmaceutical, nursing, dental, physiotherapy, psychiatric, special diet, recreational, psychological and occupational therapy.
- Provides developmental program supports, including client assessment, communication, literacy, art, pottery, music, personal development programs, chaplaincy services and vocational training.
- Provides respite care and outreach services to assist community care providers in transitioning and maintenance of discharged residents in the community.
- Average daily resident size is 325 people.
- Annual budget in 2008/09 of approximately $32.5 million.

Table 6. *Additional Facilities or Housing Options in Manitoba*.

Program	Type	Program Description	Capacity
Emergency and Transitional Shelters	Emergency/ Transitional Shelters	Homeless individuals and/or families. Emergency – approximately 70% of all shelters across Canada providing temporary and short-term accommodation for homeless individuals and/or families. Transitional shelters offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities.	1560 emergency/ transitional shelter spaces (likely an underestimate)
Personal Care Homes	Long Term Care	Provide 24-hour professional nursing services to eligible individuals who can no longer manage independently at home with family support and/or community services like Home Care. In general, PCHs serve seniors. Access centres determine eligibility through a multidisciplinary assessment process. Roughly three quarters of beds are located in "non-proprietary" facilities (non-profit) with the remainder being "proprietary" (for-profit). Licensed and inspected by Manitoba Health.	9830 beds in 124 homes ($29.70 to $69.70 per day)
Supported Living Program	Supported Housing (for people with developmental disabilities) and Residential Care Facilities	Lead for planning, development, maintenance, overall direction and management of programs and resources that support and enhance the quality of life of adults with a mental disability (developmental disability). **Residential services** can include provision of support in family homes, independent living, and residential care facilities. Responsible for all residential care facilities licensing except for mental health designated facilities in some RHA areas. Manitoba Developmental Centre: is an accredited **residential care facility** for adults with a mental disability – residential units vary depending on people's needs. ▪ Average daily resident size is 325 people ▪ Annual budget in 2008/09 of approximately $32.5 million	208 licensed RCF for 1,336 beds, 868 approved RCF (3 beds or less) for 1,579 beds 900 independent living/supports 325 people – Manitoba Developmental Centre

MENTAL HEALTH SUPPORTS

Table 7: Range of Mental Health Supports in Manitoba

Range of Mental Health Supports*	
Community Connections	▪ Peer Self-Help ▪ Proctor Programs ▪ Family Support ▪ Services Focused on Psychosocial Model of Rehabilitation and Recovery ▪ Vocational and Employment Supports ▪ Housing and Community Living Programs ▪ Social and Recreational Programs
Community Mental Health Services	▪ Community Mental Health Teams ▪ Intensive Case Management ▪ Program for Assertive Community Treatment ▪ Forensic Community Service ▪ Provincial Special Needs Program ▪ Mobile Crisis Units ▪ Crisis Stabilization Units ▪ Safe Houses ▪ Crisis Lines, Help Lines, Farm and Rural Stress Line ▪ Critical Incident Stress Debriefing Teams ▪ Outpatient Services
Inpatient Services	▪ Acute and Specialized
Other	▪ Prevention, Promotion and Public Education Services ▪ Mental Health Education Resource Centre of Manitoba ▪ Office of the Chief Provincial Psychiatrist ▪ Mental Health Review Board ▪ Ombudsman

* Note: not all supports are available in all regions.

FUNDING LEVELS

According to a recent analysis by the Institute of Health Economics (Jacobs et al., 2010), the following were the total expenditures on mental health and addictions services[112] in Manitoba for 2007/08:

- $128.9 million for inpatient care[113] ($106.9 million in general hospitals and $22 million in psychiatric hospitals)
- $38.9 million for physician services ($3.1 general practitioners – fee for service, $23.9 specialists – fee for service, and $11.9 million for psychiatrist on alternative payment schemes)
- $90.8 million for community and social services ($44 million for community mental health, $2.4 million for employment support, $22.3 million for addictions, and $22.1 million for First Nations mental health and addictions services)

Mental health programs are generally delivered at the regional health authority level (reflected above), but there are some programs which are directly funded by Manitoba Health.

- The majority of addictions sections are funded provincially, not through the regional health authorities. In 2008/09, 22.981 million was provided for addictions programs and services through Manitoba Health.[114] In addition, some

[112] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.
[113] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.
[114] Department of Health, 2008/09 Annual Statistics

addictions agencies receive provincial funds from Family Services and Justice as well as from Manitoba Lotteries Corporation.

- $2.950 million was provided in 2008/09 directly by Manitoba Health for mental health, including $1.691 for self-help organizations.[115]
- The Selkirk Mental Health Centre (Selkirk) is a provincial mental health facility, providing long-term mental health inpatient and rehabilitation to residents in Manitoba.
  - Treatment and rehabilitation services in all programs are provided by multi-disciplinary teams. Selkirk Mental Health Centre has in five inpatient treatment programs:
    - Acute Program (43 beds)
    - Rehabilitation Program (86 beds and 8 community residence beds)
    - Geriatric Program (75 beds)
    - Forensic Program (18 beds)
    - Acquired Brain Injury Program (30 beds and 5 community residence beds)
  - The cultural and spiritual needs of Manitoba First Nations, Métis, and Nunavut patients are met by Aboriginal services staff, such as elders, proctors, and a coordinator, and include conducting sweat lodge, smudging and pipe ceremonies, making sacred items, and sharing traditional stories.
  - Selkirk has a formal agreement with the government of Nunavut, to provide inpatient services to residents of Nunavut experiencing mental illness.
  - Selkirk received $31.417 million in funding in 2008/09 and roughly $37.04 million in 2009/10.

RANGE OF MENTAL HEALTH SERVICES

Primary responsibility for delivery of mental health services rests with the regional health authorities. The following outlines the main types of services as per Manitoba Health (however, not all RHAs will have all services)[116]:

1. **Ongoing Community Support**

- **Community Mental Health** programs are operated by RHAs and provide a combination of comprehensive assessment, case management, rehabilitation/ treatment, supportive counselling and crisis intervention, community consultation and education, varying somewhat by RHA. Community mental health workers can include Adult Workers, Child and Adolescent Workers, and Psychogeriatric Workers.
- **Intensive Case Management Programs (ICM)** work with individuals who have clearly identified goals in areas like school, work, home or their social life. This program provides more intensive and continuous support than the community mental health worker model, and has a strong emphasis on psychosocial rehabilitation.
- **The Program for Assertive Community Treatment (PACT)**, operated by the Winnipeg RHA, works with persons who have a persistent and severe mental illness and experience serious difficulties in meeting basic daily needs in the community. These individuals frequently have co-occurring disorders (both a mental health and substance abuse diagnosis) and are at high risk of hospitalization and homelessness.
- **Cross-Cultural Mental Health Specialists** provide community mental health assistance to persons with mental health difficulties that have difficulty accessing and using community resources because of language and cultural differences. This is a Winnipeg RHA position.

[115] Ibid.
[116] Excerpted from the Department of Health website at http://www.gov.mb.ca/health/mh/system.html

- **The Forensic Community Service**, operated by the Winnipeg RHA, provides specialized services to individuals under the auspices of the Criminal Code Review Board. It has a varied mandate, including case management in the Winnipeg area and consultation with mental health agencies and health care providers throughout the province.
- **The Provincial Special Needs Program** (directly funded by the province) offers highly individualized services to persons with a mental health disorder or disability who pose a high risk to themselves and are not eligible for other existing services. Services include in-depth assessment, consultation, case management, and coordination of community-based program and support options.

See also the Community Wellness Initiative, the Homeless Outreach Team, and the Portable Housing Benefit program discussed under the Dedicated Mental Health Housing section.

2. Crisis/Urgent Services

- **Mobile Crisis Units** provide crisis intervention and suicide prevention services to persons experiencing emotional or mental health crises. Services are provided in the community, usually within individuals' residences and include screening and psychiatric assessment, crisis intervention and counselling, referral and short-term follow-up with other mental health and social services. This service is provided by various RHAs.
- **Crisis Stabilization Units** are short-term community-based settings that provide mental health intervention to persons who require specialized mental health supports but not hospitalization. Crisis stabilization units usually have a nurse on shift that is able to assist with medication management and other medical and psychiatric issues. Individual stays in crisis stabilization units vary considerably, but usually do not exceed two weeks. There are 16 beds in the Winnipeg RHA, 8 beds in the Brandon RHA and 8 beds in the Interlake RHA.
- **Crisis Response Centre** consults with the Winnipeg RHA around the development of the crisis response centre for mental health.
- **Safe Houses** are short-term residential settings for individuals who require a caring, supportive environment to help them manage an emotional or mental health crisis. Safe houses are often staffed by consumers, and usually do not have the nursing expertise to manage acute psychiatric crises.
- **Crisis Lines** provide telephone crisis intervention and suicide prevention services by trained volunteers and staff. These services provide immediate and short-term interventions, and can serve as referral links to other community mental health services. Most mobile crisis units and crisis stabilization units also provide telephone crisis intervention.
- **Help Lines** are peer support telephone services that provide basic support, practical assistance, and information to persons struggling with emotional or mental health issues. These are not crisis lines, although they may make referrals to crisis lines and other mental health services.
- **The Manitoba Farm and Rural Stress Line** (directly funded by the province) provides province-wide phone support, counselling, practical assistance and information to people whose lives are in any way affected by farming, agriculture, and rural living. The line also maintains a website which provides up-to-date information about services and resources available to rural Manitobans.
- **Critical Incident Stress Debriefing Teams** provide immediate and short-term interventions to persons who have experienced a potentially traumatic event. Critical events can include suicides, murders, major accidents and other emergencies. Critical incident debriefing teams provide post-trauma debriefings, education, and referral to longer-term community resources.

3. Community Connections

- **Proctor Programs** provide supportive services to assist individuals to develop community living skills and other social, recreation, and/or educational interests and goals. Proctors are usually casual paraprofessionals who work under the

direction of community mental health workers (CMHW or ICM), usually in accordance to an established rehabilitation plan.

- **Self-Help and Family Supports** (directly funded by the province) are most often provided through formal associations of people, many of whom are either living with a mental illness or have family member with a mental illness. Self-help activities include mutual support, public education, advocacy and consumer-oriented services that promote the needs and priorities of people with mental health difficulties.
- **Vocational and Employment Supports** provide assistance to persons wanting to pursue and secure employment. Services include career guidance counselling, education and training, referral and job finding assistance, and employment placement. Programs vary from pre-vocational education and on-site job training to casual employment placement.
- **Housing and Community Living Programs** are available to persons who may experience difficulties living independently because of mental health difficulties. Supported housing (non-facility based) assists people to choose, obtain, and keep housing in the community. Other housing service options vary from residential care facilities (which provide a full range of services including meal preparation, medication administration, laundry, and assistance with daily living skills) to supportive housing options (which focus on rehabilitation and the development of independent community living skills).
- **Social and Recreational Programs** offer a variety of supports and skill development activities for persons interested in becoming involved in social and leisure activities. These activities are structured to assist people with mental health difficulties to pursue individual interests and develop meaningful social and living roles within their community.

Some mental health service providers, such as CMHA Winnipeg, provide a comprehensive rehabilitation and recovery model of service (based on a psychosocial rehabilitation model) where individuals work on self-identified goals. CMHA Winnipeg's model provides a lower staff to client ratio (i.e., less than 20 people per staff) and the service tends to last about two years.

4. Hospital Services

- **Acute-Care Treatment Facilities** provide psychiatric care and treatment in inpatient psychiatric units of general hospitals or community health centres operated by RHAs.
- **Outpatient Services** are provided at many community hospitals and health centres. These services include identification, assessment, treatment, and case management services for persons with mental health difficulties.
- **The Selkirk Mental Health Centre** (described above)
- **The Eden Mental Health Centre** is operated by representatives of Manitoba Mennonite churches, and the community in conjunction with the Central RHA. The Centre provides inpatient treatment, outpatient psychiatric assessment and treatment, and community mental health services including consultation to other agencies and caregivers.
- **The Manitoba Adolescent and Treatment Centre** provides mental health services to children, youth and families. Services range from brief intervention to intensive long-term treatment and include hospital-based residential, day and follow-up services, youth forensic services, neurodevelopmental services, early psychosis prevention and intervention, educational psychiatric services, and an early childhood clinic.

5. Other Services

- **Prevention, Promotion and Public Education Services** are advisory and education services to the public and professional groups, often provided by RHA mental health programs and self-help organizations.
- **The Mental Health Education Resource Centre of Manitoba** is a lending library providing educational information to providers, consumers, caregivers, educators and the general public.

- **The Office of the Chief Provincial Psychiatrist** (directly funded by the province) is responsible for numerous legislated and non-legislated functions for the province of Manitoba. These functions include administering The Mental Act of Manitoba and the Orders of Committeeship program.
- **The Mental Health Review Board** works on behalf of Manitobans in need of mental health services. The Board hears appeals regarding any aspect of the admission or treatment of a patient in a psychiatric facility. Legislation also requires that there be an automatic review of all involuntary patients after the filing of the third certificate of renewal and annually, thereafter.
- **The Ombudsman** provides formal individual advocacy for all government-operated services, including the operations and hospitals of RHAs. The Ombudsman investigates complaints from persons who feel they have been unfairly treated by government departments or agencies, and promotes the principles of fairness, openness and accountability.

ADDICTIONS SERVICES

Table 8 provides a summary of transitional housing for people with problematic substance use. Because these are transitional housing units with support services, we have included these under the services section, rather than the housing sections. It's important to note that some of these sites have very limited on-site housing or counselling support.

Table 8. *Addictions Transitional Housing in Manitoba.*

Name	Description	Capacity
Programs Directly Funded by the Province		
Tamarack	60-day co-ed program with potential for extension (for people who have completed an initial addictions treatment).	12 beds
Two Ten Recovery	Length of stay 3-18 months.	16 beds (for men) – 9 beds (women)
Addictions Recovery Inc.	Two buildings (both for men): length of stay 3-12 months with possibility for extension.	14 beds
Esther House	For women. Length of stay ranges from 1-12 months depending on individual.	6 beds (for women)
Behavioural Health Foundation	Five community transition houses. No maximum length of stay.	20 beds
Programs Funded Indirectly by the Province (through the Regional Health Authority)		
Mainstay Residence	Receives funding from Family Services and Consumer Affairs, the Winnipeg Regional Health Authority, and other sources such as the United Way to provide co-ed residents with harm-reduction oriented services.	34 beds
Union Gospel Mission	Provides separate residential programming for men (25+) and women/children (60 rooms). Receives per diems from the province for income assistance participants.	85+ spaces
Program not Funded by Government		
Two Ten Recovery	One building (for men) with a focus on independent housing.	6 spaces (for men)

INCOME SUPPORTS

The Department of Family Services and Consumer Affairs administers the Employment and Income Assistance (EIA) program. Key legislation includes the Employment and Income Assistance Act and its Regulation which governs the EIA.

Basic assistance covers basic allowance and a shelter allowance. Basic allowance covers the cost of food, clothing, and household needs. Some of this information may be out of date given the ongoing poverty reduction strategy in the province.

Maximum basic allowance rates are based on both the household's composition (e.g., persons with disabilities; able-bodied employable persons) and the number of children in the household and their ages.

EIA has made significant changes in recent years to allow all recipients to retain assets and earnings, ease the transition to work, and promote quality of life:

- As of January 2009, all EIA participants are allowed $4,000 liquid assets per family member at the time of application and while enrolled, up to a family maximum of $16,000.
- Earnings exemptions apply to each employed person in the household.
- As of February 2008, all EIA clients may retain $200 plus 30% of the net remainder for monthly exemptions on **earned income**.
- Established a monthly volunteer benefit to help with the cost of volunteering.
- Increased the Income Assistance for Persons with Disabilities benefit by $25 per month.
- Increased the combined exemption of the provincial disability trust and the federal Registered Disability Saving Plan to $200,000.
- Extended health benefits for non-insured health services to all single parents and persons with disabilities who are moving from EIA to work for up to two years.
- Persons with disabilities on EIA can receive contributions of up to $500 per month from families or others without affecting their benefits.
- Two pilot programs focused on mental health supports and employment training for persons with disabilities.
- In July 2010, total income for a single individual with a disability was estimated at $9,516 (includes basic social assistance, other provincial/territorial benefits and GST credit).

According to the Social Assistance Statistical Report, 2007 (Federal-Provincial-Territorial Directors of Income Support, August 2010, pp. 74-79):

- In March 2007, there were a reported 57,700 recipients (31,500 total cases) of Employment and Income Assistance[117] (note that this does not include municipal program caseloads):
  - Approximately 57% of all EIA cases were due to disability (17,800 cases)
  - Approximately 12% of all disability-related EIA cases had been receiving assistance for one year or less, 30% for more than one year to five years, and 58% for over five years

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

The Manitoba map has highlighted a number of promising practices, including the extensive work and funding investments attached to its poverty reduction and housing strategies. This section provides more information about the **Cross Departmental Coordination Initiatives division** (CDCI) of the provincial government, as well as the Winnipeg Inner City Research Alliance. Reference should also be made to the site visit summaries.

Partners have noted that the work of the CDCI division has had a significant impact on the landscape for housing dedicated to people with mental health issues. The CDCI division plays a leadership role in working with a variety of stakeholders to address issues of housing and homelessness for Manitobans. The CDCI liaises within provincial

[117] Federal-Provincial-Territorial Directors of Income Support, May 2010. *Social Assistance Statistical Report, 2007.*

government departments, with RHAs, with housing authorities and with community-based organizations and research initiatives. Created only three years ago, the CDCI is seen to have played an integral role in the creation of the Portable Housing Benefit (PHB) for people with mental health issues. This benefit, combined with attached housing support services delivered by mental health agencies, has already had on-the-ground 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 (e.g., *Housing First*), ensuring people weren't being discharged 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 enhancement of the "**Community Wellness Initiative**," providing supports to people with mental health issues living in Manitoba social housing units. This was another example of CDCI facilitating coordination across multiple provincial departments including the Department of Housing and Community Development, the Department of Family Services & Consumer Affairs, the Department of Health & Healthy Living and Manitoba Housing. 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 Housing and Community Development and generate the funding solution required.

The **Winnipeg Inner-City Research Alliance** brings together researchers, government representatives, health authorities, community-based organizations and others to conduct research projects that are identified as most important by the community. This local research which considers neighbourhood and individual social needs is designed to improve policy and program development impacting Winnipeg's inner city. The partnership approach has fostered research, training and related activities to harness development of Winnipeg's inner city communities. Topics include housing, community development, cross-cultural approaches to education, child and youth issues, health and economic development, while drawing people together to build partnerships, build ideas, and strengthen community capacity. Although the focus is on Winnipeg's inner city, this type of research is relevant to many other Canadian cities as well. Funding sources have included the Social Sciences and Humanities Research Council and the Canada Mortgage and Housing Corporation.

Currently under construction, the **Crisis Response Centre** will be a new 24-hour community crisis response centre in Winnipeg scheduled to open in the fall of 2012. The new facility will reduce pressure on the region's emergency services and better serve people seeking help for an emotional crisis. The response centre will be a 27,370 square foot, two-storey building that will offer an array of crisis services, including walk-in mental health assessment and treatment and crisis intervention 24/7. Should people be in need of admission to hospital, the Crisis Response Centre is situated in a close proximity of the Health Sciences Centre. The response centre will serve adults who are experiencing any of the following:

- Personal distress and who are at risk of harm associated with the immediate crisis, including suicide.
- Symptoms of a mental health condition which requires assessment and treatment.
- Circumstances which require de-escalation to prevent relapses.
- Mental health problems that if dealt with, may prevent hospitalization.
- Emotional trauma, where assessment, crisis intervention and links to longer-term services can be made.
- Difficulty obtaining on-going services after a crisis.
- Difficulty obtaining help after hours when mental health service providers are unavailable.

CHALLENGES IN HOUSING AND RELATED SUPPORTS

- **Availability of low-cost housing** is very limited and this requires federal leadership to address – the flip side of this coin is the **accessibility of existing housing**. Future work needs to consider the barriers to being housed that people, and in particular people from vulnerable groups, face. These barriers could include stigma and discrimination, knowledge of existing housing options, and criteria people need to meet in order to access existing housing (e.g. committing to receiving certain services in order to receive housing.)
- While the PHB has had a positive impact for people with mental health issues, it has also highlighted the real **housing stock** challenges the province has experienced for a number of years – there simply aren't enough units for people to access, even when they're able to consider options in the private rental housing market. For example, the vacancy rate in Winnipeg is consistently around 1%, and the vacancy rate in Brandon is often as low as 0.1%. These pressures will not be addressed by the PHB.
- There is more funding available for housing at the moment with the federal government's stimulus package, and the provincial housing commitment – **ensuring the right supports are available** and funded appropriately is equally important to facilitate success in maintaining housing.
- While there is a range of mental health services and supports available, the capacity (i.e., number of clients per staff, waiting lists) of these services is a tremendous challenge.
- People who engage with the mental health supports available tend to experience success in maintaining their housing – the challenge can be for people who don't want to (or feel they are not able to) comply with **providers' terms for provision of service**. This higher risk population often has co-occurring mental health and problematic substance use issues.
- **Income assistance programs** have not kept pace with inflation or increasing shelter costs.
- An agreed on **funding formula** is needed for mental health services and housing where specific investments are tied to specific models of housing and support identified in the provincial position paper on housing and supports for people with mental illness.
- The **residential care system** was developed in the late 1970s and work is needed to look at how to further strengthen the way mental health residential care facilities are utilized in a client's recovery process. A cross-departmental approach engaging Health, Housing, Family Services and CDCI may provide a mechanism through which a broader array of housing and support options become available, and through which residential care facilities (RCFs) can be supported to focus more on psychosocial rehabilitation and work from a recovery perspective.
- Ultimately, people end up living in places that they can afford to live in including RCFs, single room occupancy hotels and rooming homes. Our focus needs to be on how we **support existing housing and support options to be safe, healthy, and empowering environments**.
- Having sufficient data availability to do accurate estimations of housing and homelessness issues, mental health issues, cost/benefit analyses, and evaluations of existing programs is crucial.
- There needs to be better understanding of **the role of housing providers** in service delivery and the interface with health and mental health providers.
- There are specific **capacity and critical mass issues in rural and remote areas** that need consideration in the development of housing and support models. Housing stock can be an even greater issue in the more rural areas and people are often left with few options but to share dwellings where there isn't sufficient space.
- 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).
- Existing public housing is in **poor physical condition**: there has been limited to no capital investment over the last three decades. This is beginning to be addressed through recent provincial and federal investments.

- Linkages between hospitals and housing providers are needed so that people can be **discharged/ transitioned from hospital** when they are ready to do so, into a safe and supportive housing environment.
- There needs to be a much greater **integration of mental health and addictions services** – currently, most mental health services are funded and delivered via RHAs while the majority of addictions services are directly funded through the provincial government.

The Provincial Advisory Committee, which identified the range of housing and support options for people living with mental illness, identified a number of housing challenges including: "the special circumstances of the First Nations, Métis and Inuit populations, the vast and varied geography of the Province, a lack of affordable housing across Manitoba, particularly in the larger urban centres, restrictive municipal zoning by-laws and low vacancy rates for private rental apartments throughout Manitoba". They further identified support-related challenges including recruitment, appropriate remuneration for para-professionals, and a lack of consistency in specialized mental health and addictions services offered across RHAs.

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

- There is an increased focus on Supported Housing models and *Housing First* approaches that serve people with mental health issues (broader application than people with serious mental illness and the barriers this can create).
- 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 there is recognition in government that housing is a key part of the solution.
- There is 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 looking at how to provide appropriate supports in what used to be seen as inappropriate settings (e.g., single room occupancy hotels and rooming houses) – there is potential to work within and improve existing housing options.

Manitoba's Provincial Advisory Committee for housing/support options identified a number of considerations to guide future development of the system (see also "Key Initiatives" section), as part of their submission to the government:

1. A new permanent mechanism is needed to plan and ensure coordination between health services and housing services. Development of a plan for this mechanism at the provincial planning level as well as the service delivery level.
2. Development of a range of housing and supports to meet the diverse and changing needs of consumers and to allow individual choice.
3. Based on a recovery model, all efforts should be made to promote the least restrictive housing and supports possible for each individual.
4. It is recognized that some individuals will require intensive supports in more restrictive settings at some times. To ensure a recovery focus, development of segregated settings with a maximum of 6 people or not more than 40% of the total units in a building.
5. Development of more affordable housing stock throughout Manitoba.
6. Development of a financial mechanism to ensure that individuals have adequate funds to obtain safe housing. To augment the present rent subsidy system a portable rental subsidy attached to the individual must be developed.
7. Providing housing alone is ineffective for individuals with mental illness and therefore adequate supports must be provided. Development of a funding mechanism to address the need for these supports that is equitable to other vulnerable groups (e.g. individuals with intellectual disabilities).

8. Development of a provincial Mental Health plan addressing the need for the full range of coordinated integrated mental health services throughout the province.
9. Develop an inter-sectoral, inter-departmental First Nations engagement process in the provincial Mental Health & Housing mandate that is respectful and inclusive of traditional ways & medicines and cultural diversities.
10. Development of provincial and federal policies, programs and procedures for Mental Health and Housing in collaboration with First Nations in a comprehensive manner for both on and off-reserve members. This would include:
    - Inter-jurisdictional policy and financial barriers, cultural importance and competence;
    - Ensure seamless continuum of mental health and housing systems and support services that are accessible, high-quality and coordinated; and
    - Ensure holistic approach is taken that addresses trauma, poverty, and lack of employment, relocation, residential schools and intergenerational impacts.

- Winnipeg is one of the five sites of the Mental Health Commission's Homelessness Demonstration Project – the *Housing First* approach, with a focus on the Aboriginal community, should produce findings that can help to inform future directions as well.

NEW BRUNSWICK

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of New Brunswick is approximately 730,000 (Statistics Canada, 2009) with an unemployment rate of 9.8% compared to a rate of 8.1% across Canada (Statistics Canada, 2010).

Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of 0.1%** since 2001 – which is low compared to the national average of 5.4% but consistent with growth patterns in Atlantic provinces.
  - Moncton is the only census metropolitan area in the Atlantic provinces whose growth rate surpassed the national average between 2001 and 2006. It now has a larger population than any other urban area in New Brunswick.
- An **aging population**, consistent with all other regions across Canada, where 14.7% of the population is aged 65 and over (compared to 13.6% nationally).
  - The population of Atlantic Canada (Newfoundland and Labrador, Prince Edward Island, Nova Scotia and New Brunswick) was the oldest in the country with more people aged 65 and older and fewer people aged 14 or less compared to the rest of Canada.
- A **small number of people identifying as having Aboriginal identity** (17,655 or 2% of the total population across Canada). There are about 13,000 Aboriginal households living off-reserve (New Brunswick Housing Corporation, 2010).
- A significant proportion of the population (29.4%) identifying **French as the primary language** spoken in the home.
- The male labour force has held steady or declined from 1996 – 2006 while the female labour force grew by 10%, with gains across the province. New Brunswick has had the **largest increase in employment rates among women** of all the provinces over the last 30 years.
- There has been a **steady urbanization of the population** over the last ten years: urban 'centres' have seen a 9.2% increase in population from 1996 to 2006, while the remaining rural areas of New Brunswick have seen a significant decline of 14.4% over this same period.
- Of the 295,965 households in 2006, **75.5% owned the dwelling** they lived in (compared to about 68% nationally); this represents an increase of about 5.7% since 2001 (compared to 11.8% nationally). Of owner households, 52.3% held a mortgage. This high rate of home ownership relative to the national average is typical of the Atlantic provinces.
- The **proportion of households in core housing need stood at 10.3%** in New Brunswick, one of the lower rates across the country.
  - Of owner households, 5.7% were in core housing need, compared to 25.4% of renter households.
- Median annual household income rose 13.4% from 2001 to 2006 to $45,415 (nationally this figure stood at $53,870) and median annual household costs during the same period of time increased by 16.9%, below the national rate of 18.5%
  - The average New Brunswick worker earns close to 20% less per hour than the Canadian average.
  - Minimum wage is the second lowest amongst provinces and territories.

While the overall percentage of low-income New Brunswickers dropped somewhat between 1990 and 2005, it remained essentially the same in a number of counties, and in the county of Charlotte, the percentage actually increased (Canadian Council on Social Development, 2009):

- Saint John County has one of the **highest rates of child poverty in the country** at 28.3% (compared to the provincial 16.2% rate).
- Unilingual Francophones and First Nations communities both have a higher incidence of low-income than the New Brunswick average.

The 2009 Report Card on Child Poverty in New Brunswick notes, "Despite continued economic growth, **poor families have seen no real improvement in their situation**, while wealthy families have typically had increases in their incomes. The **income ratio** between the wealthiest and poorest 10% of families with children in NB has **risen from 8 to 1 in 1989 to 11 to 1 in 2007**" (p.8). While household income nearly doubled in the 20 years between 1961 and 1981, it grew less than 8% in the 1980s and 90s. In fact, in 2006, household income actually declined in constant (real) dollars (New Brunswick Housing Corporation, 2010, p.10).

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

Department of Social Development is the primary department responsible for: social assistance, children's services, housing, and seniors' care. The **Economic and Social Inclusion Corporation** is responsible for community initiatives to combat poverty and for monitoring the progress of the provincial economic and social inclusion plan (Overcoming Poverty Together: The New Brunswick Economic and Social Inclusion Plan). The deputy minister of Social Development serves as the president of the corporation, with members of the board representing government, business, community non-profit organizations and persons having experienced poverty[118]. The **New Brunswick Housing Corporation** is responsible for the administration and management/delivery of social housing in the province. It was created through the New Brunswick Housing Act. The underlying foundation of the department's work is a focus on building **self-reliance**.

Department of Health – provides overarching direction on mental health policy and oversees implementation of government mental health policies. The Addictions, Mental Health and Primary Health Care Division of the Department is responsible for planning, funding and monitoring of services through the two **Regional Health Authorities** (RHA). A Mental Health Services Advisory Committee, established through legislation, also advises the Minister of Health on a broad spectrum of issues relating to mental health services. Services are provided through four distinct operational sectors:

1. Community mental health centres
2. Psychiatric units;
3. Psychiatric hospitals;
4. Non-profit organizations that serve persons with mental health problems and consumer-run programs.

The bulk of mental health services are provided directly by the two RHAs in the province, or by providers who have service contracts with the RHAs (of which there are two total in New Brunswick). Psychiatric units, psychiatric hospitals, and Community mental health centres are all under the authority of the two RHAs.

PROGRESS TO DATE: KEY INITIATIVES

Overcoming Poverty Together: The New Brunswick Economic and Social Inclusion Plan: After a province-wide consultation process under leadership of government, business and community officials, this comprehensive strategy for poverty reduction was adopted by the government in November 2009. The key target is to reduce income poverty in the province by 25 percent and deep income poverty by 50 percent by 2015. Core goals include:

- Move from rules based to outcome based system.

[118] Government of New Brunswick (May 3, 2010). News Release: Economic and Social Inclusion Corporation vice-chairs and president named. http://www.gnb.ca/cnb/news/fcs/2010e0659sd.htm. Retrieved December 28, 2010.

- Move from passive assistance to employment orientation.
- Move from focus on income poverty to social and economic inclusion.
- Restructure and increase social assistance rates including a new regime more appropriate for persons with disabilities.
- Significant overhaul of household income policy.
- Introduction of vision and dental care for children in low-income families by April 1, 2011.
- Provide more opportunities to keep earned income as individuals transition to work.
- Reform wage exemptions to include a working income supplement.
- Raise allowable asset exemption.
- Link benefits such as child care, home heating, and health to household income to the extent possible.

Coinciding with the release of this strategy was the release, by the New Brunswick Housing Corporation (NBHC), of a provincial housing strategy, **Hope is a Home: New Brunswick's Housing Strategy**. The vision is that "All New Brunswickers have access to safe and affordable homes as a prerequisite for economic and social inclusion" (p. 1). Reflecting the broader social inclusion and poverty reduction direction of the government, the NBHC Board of Directors now includes six deputy ministers of key provincial departments. The Housing Strategy considers the full continuum of housing need: from homelessness to affordable rental housing to homeownership. The primary focus is ensuring New Brunswick's most vulnerable citizens have improved access to housing assistance. The key objectives are:

- Reduce core housing need in New Brunswick by 10% over the next five years from the 10.3% identified in the 2006 Housing Census (Statistics Canada)
- Reduce chronic homelessness in New Brunswick significantly over the next five years
- Improve the Energy Efficiency of housing occupied by low income households
- Ensure the transparent and effective delivery of provincial housing programs

Investments will be made in:

- Making quality housing more affordable
- Ensuring the sustainability of government assisted housing
- Increasing rural housing opportunities
- Creating homeownership opportunities
- Strengthening housing supports
- Supporting government's commitment to energy efficiency
- Accessibility for persons with disabilities

The government has also supported the creation of a New Brunswick Homelessness Framework (contained within the NBHC Housing Strategy) which aims to end chronic homelessness over the next five years.

Finally, the Department of Health recently issue a provincial mental health strategy, **the Action Plan for Mental Health in New Brunswick 2011-18**, which builds on the report of the Minister's Task Force on Mental Health (McKee, 2009). This Task Force provided a series of recommendations on moving the provincial mental health policy framework from its last iteration in 1988, which focused attention on system reform and the deinstitutionalization process. The new action plan for mental health focuses on patients at the centre of treatment, and includes new targets and a plan to increase access to specialized services across New Brunswick. Core goals of the action plan are:

- Transforming service delivery through collaboration
- Realizing potential through an individualized approach
- Responding to diversity
- Collaborating and belonging: family, workplace, and community
- Enhancing knowledge
- Reducing stigma by enhancing awareness
- Improving the mental health of the population

RANGE OF HOUSING ACCOMMODATIONS

Table 1. *Overall Range of Housing Options in New Brunswick.*

Dedicated Mental Health Housing Options	▪ Some dedicated options as part of the non-profit housing program
Non-Dedicated Affordable Housing Options	▪ Non-profit housing ▪ Public Housing ▪ Rent Supplement ▪ Rural/Native and Basic Shelter Program ▪ Affordable Rental Housing Program ▪ Housing Cooperatives
Additional Facilities or Housing Options	▪ Emergency Shelters for the homeless and Transitional Housing for the youth ▪ Special Care Homes ▪ Community Residences ▪ Nursing Homes ▪ Transition Housing and Second-stage housing for women leaving relationship violence

NON-DEDICATED HOUSING PROGRAMS AND SERVICES

The following information has been gathered through a combination of interviews with government sources, information from the New Brunswick Housing Strategy (New Brunswick Housing Corporation, 2010, pp. 26-29), information from the 2008/09 Annual Report from the Department of Social Development, and Building from the Ground Up (Conference Board of Canada, 2010, Appendix A). In discussion with government contacts, it was noted that there may be some adults with a mental health condition who are eligible for, and accessing, the following non-dedicated housing resources, however this is not something that is tracked. It is also possible that some people may be receiving subsidized home support services (up to 215 hours per month or, if the person is eligible for nursing home services to prevent institutionalization, up to 336 hours per month) under the provincial Long Term Care Program.

Approximately 16,700 units are subsidized by the government across the province – about a quarter of these units (4,211 units) are public housing units owned and managed by the province, the remainder are owned by non-profit providers or they may be 'non-owned' stock that is available through rent supplements in the private rental market. All housing is expected to meet certain health and safety standards – where housing isn't directly owned and operated by New Brunswick Housing, there are agreements in place with landlords. There were approximately 4,300 people on the waiting list in January 2010. The Department of Social Development's 2008/09 Annual Report records an $82.63 million in funds spent on housing (this does not include costs associated with long term care residential options).

Part of the assessment process for access to any of these units includes criteria to identify if people have mental health issues (or any other type of special need). While New Brunswick Housing does not provide any supports to tenants (as it's

not part of their mandate), there are a number of ways in which people with mental illness may be served through affordable housing programs, for example:

- Rent supplements: In some situations, rent supplements are provided to non-profit mental health organizations to secure housing through the private or non-profit housing markets. In general, for the Rent Supplement Program, New Brunswick housing has agreements in place with private landlords to ensure that the units are maintained at a certain level, and there are periodic inspections to ensure this is the case. All rent supplements are provided directly to the landlord (either by New Brunswick Housing or by non-profit organizations who receive the rent supplements from New Brunswick Housing). In some cases, rent supplements are 'dedicated' for people with mental illness. This is not part of the provincial mandate of the program, but something that has evolved over time, and typically happen 'on the ground' between housing authorities and non-profit providers.
- Dedicated units in a congregate setting: In a very small number of situations, New Brunswick Housing has provided homes with self-contained units to mental health organizations. New Brunswick Housing maintains the units and sets the rent based on a 30% income target, while the mental health organization provides support services and manages access to the units for their clients.
- Affordable Housing Rental Program: Under the cost-sharing agreement with the federal government, New Brunswick Housing provides a portion of the construction costs in terms of capital grants, as well as rental subsidies for the operating budget. The mental health (or other health or social service organization) organization would finance the remainder of the capital cost of the new building.

One of the innovations in New Brunswick includes the "Community Involvement Program" through the Department of Social Development. This program provides support for the establishment of tenant associations in public housing communities. Community involvement coordinators work with associations to help tenants gain access to resources, and organize community building activities within their housing communities. As of 2008/09, there were a total of 14 active tenant associations (and 6 communities in development) across the province.

Table 2. *Non-Dedicated Housing Programs and Services in New Brunswick.*

Program	Type	Program Description	Capacity
Public Housing	Housing	Provides safe, affordable rental accommodations for low income households who experience difficulty in obtaining adequate and affordable private sector housing. The Province of New Brunswick owns the buildings and provides the property management.	4,211 senior and family housing units
Non-Profit Housing	Housing	Assists non-profit groups to address the housing needs of low income households within their communities. There are a total of 4,999 rental units and 3,628 nursing home beds funded under this program.	4,999 rental units 3,628 nursing home beds 2008/09: $11.5M for subsidies[119]
Rent Supplements	Housing	Enable low-income households to obtain rental units in the private market by providing subsidies (operating agreements with owners of existing rental properties) – seniors, persons with disabilities, persons with special needs, families, and non-elderly singles are assisted through this program (provided they meet the lower income criteria). Note that, of the 403 new rent supplements created in 2008/09, 346 went towards the Affordable Rental Housing Program – part of the federal-provincial Affordable Housing Initiative.	3,008 rent supplement units

[119] Government of New Brunswick, 2008/09 Annual Report, Department of Social Development, p.27

Rural/Native and Basic Shelter Program	Housing	Addresses the lack of private market rental housing in rural areas of the province. These units are typically single or duplex units owned and managed by the province.	878 units $3.6M in 2008/09
Housing Cooperatives	Housing	Between 1973 and 1991, CMHC participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme that all of these co-operatives provide some type of financial support. Housing co-ops are member-owned and controlled organizations. The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. The federal government ceased funding new development at the end of 1991, but continues to honour its operating agreements with existing co-operatives, which house **over 92,000 members across Canada** under these legacy programs.[120] Brunswick Co-operative Housing ("BRUNCH") is an incorporated body founded in 1995 with the signing of an agreement between the Cooperative Housing Federation of Canada and its New Brunswick members. BRUNCH represents and provides limited services for about 20 BRUNCH member co-ops.	807 units in 22 co-operatives across the province
Affordable Rental Housing Program	Housing	Provides assistance to private entrepreneurs, private non-profit corporations and co-operatives for the construction, acquisition and rehabilitation of rental housing projects. Under the Affordable Rental Housing Program approximately 750 new affordable rental housing units will be developed under the current agreement with the Government of Canada (expiry date March 31, 2011). Assistance has been in the form of a forgivable loan, with rent supplements available (as noted above).	n/a

ADDITIONAL INITIATIVES

Homelessness Partnership Strategy (HPS): Launched on April 1, 2007 by the federal government, building on the foundation of its predecessor program, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five year commitment. A key focus of the HPS is a housing-first approach and focuses on transitional and supportive housing as important ways to move individuals out of homelessness. Under the Federal Homelessness Partnering Strategy, New Brunswick organizations are allocated $1,295,905 per year for the designated, Aboriginal and outreach communities. Each of the four designated communities has established a Homelessness Community Group comprised of non-profit organizations, community members and representatives from all three levels of government.[121]

Affordable Housing Initiative (AHI)/Canada-NB Affordable Housing Agreement: Based on the housing framework agreed to in November 2001 by federal, provincial/territorial housing ministers. 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 a grant, a stream of ongoing subsidies or the value of in-kind contributions (e.g. land). Within these terms and 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. New Brunswick has a commitment (through Phase I and II of funding) for a **total of $27.89 million – to date, there have been a total of 1,192 units that have been committed or announced for a total of $25.68**

[120] Co-operative Housing Federation of Canada.
[121] New Brunswick Housing Strategy, 2010, p.36

million.[122] The federal government's Economic Action Plan builds on this existing commitment, extending the AHI to March 31, 2011 through a $1.9 billion investment over five years, and providing a further one-time investment of $1.525 billion in housing stimulus measures to build new and renovate existing social housing. This funding is being delivered through amendments to existing cost-sharing and delivery arrangements with provinces and territories through the AHI.

Residential Rehabilitation Assistance Programs:

- Federal/Provincial Repair Program: Assists low income homeowner households who occupy substandard housing requiring major repair or lacking basic facilities. In 2010/11 it is anticipated 800 homeowner households will receive financial assistance to bring their homes up to an acceptable standard of health and safety.
- Federal/Provincial Repair Program for Disabled Persons: Provides assistance for the modifications of existing homeowner or rental units to improve the accessibility of the dwelling for disabled occupants. In 2010/11 it is anticipated 100 disabled households will be provided with financial assistance to improve accessibility of the dwelling for disabled occupants.
- Federal/Provincial Emergency Repair Program: Provides financial assistance to low income households to undertake emergency repairs that are required for the continued safe occupancy of their homes. In 2010/11 approximately 500 homeowners will receive assistance.
- RRAP Conversion Program: Assistance is offered to convert non-residential properties into affordable self-contained rental units and/or bed units to be occupied by low income households. For 2010/11, 10 units will receive assistance.
- Rental and Rooming House RRAP Program: Assistance is offered to private sector landlords occupied by low income tenants for repairing or improving the property to an acceptable standard of health and safety for the occupants. In 2010/11, 70 units occupied by low income tenants will receive assistance.
- **Aboriginal Trust Programs**: Developed and implemented in October 2007 by the Department of Social Development: Off-Reserve Aboriginal Home Ownership Program, Off-reserve Aboriginal Shelter and Transitional Housing Program, and Aboriginal Affordable Rental Housing Program.
- **Social Assistance Emergency Repair Program**: Provides financial assistance to social assistance recipients (homeowners) to undertake emergency repairs that are required for the continued safe occupancy of their homes. In 2010/11 approximately 620 homeowners will receive assistance.
- **Housing Adaptations for Senior Independence Program**: Provides assistance for minor adaptations for low income seniors who have difficulties with daily living activities in the home. For 2010/11, 20 low income seniors will receive assistance.
- **Energy Efficiency Retrofit Program**: Assistance is provided to improve the energy efficiency of housing occupied by low income homeowners and owners of rental properties occupied by low income tenants. In 2010/11 it is estimated that 1,300 homeowner and rental households will receive assistance in order to improve the energy efficiency of their homes.
- **Shelter Enhancement Program**: Provides financial assistance to sponsors of existing shelters for victims of family violence or youth for repairing the property to an acceptable standard of health, safety and security for occupants and/or accessibility modifications for persons with disabilities. Funding is also available to increase the number of emergency shelters or second stage housing units available to women and youth who are victims of family violence. In 2010/11, 40 units will receive assistance.
- **Homeownership Assistance Program**: Provides assistance in the form of a second mortgage and an interest write-down subsidy based on income to modest income households who can obtain financing such that when combined with New Brunswick Housing Corporation funding results in the purchase or construction of a modest first home. In 2010/11 it is anticipated that 45 households will benefit from the program this year.

[122] National AHI Funding Table, Canada Mortgage and Housing Corporation website. http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm

- **Home Completion Loans Program**: Provides assistance in the form of a loan and an interest write-down subsidy based on income to low and modest income households to complete their partially constructed home. In 2010/11, five households will receive assistance.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, but aren't dedicated to serving this population. Within New Brunswick, this includes: **shelters, transitional housing** not specifically targeted to people with mental illness, and **Long-Term Care (Adult Residential Facilities and Nursing Homes)**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity.

EMERGENCY SHELTERS AND TRANSITIONAL HOUSING

The first New Brunswick Report Card on Homelessness, released in July 2009, estimates that 2,374 people who were homeless stayed at a shelter at some point in 2008. As part of the development of the New Brunswick Homelessness Framework (one component of the provincial housing strategy), the following information was reported with respect to shelters and transitional housing (New Brunswick Housing Corporation, 2010, p. 39):

Table 3. *Homeless Shelters and Transitional Housing in New Brunswick.*

Name	Location	Target Population	Number of Beds
Nazareth House	Moncton	Men, Women, Youth	30
Harvest House	Moncton	Men, Women, Youth	30
Coverdale Emergency Shelter	Saint John	Women	10
Salvation Army Booth Residential Services	Saint John	Men	26
Fredericton Homeless Shelters	Fredericton	Men Women (Grace House)	40 9
Miramichi Youth House	Miramichi	Youth (age 16-19)	1
Emergency Homeless Shelter	Bathurst	Men, Women, Youth	9
Salvation Army Miramichi Community Resource Centre	Miramichi	Men	4
Total Emergency Beds: 159			
Transitional Housing for Youth			
Miramichi Youth House	Miramichi	Youth (age 16-19)	6
First Steps Housing Inc.	Saint John	Pregnant and parenting women (age 16-29)	8 rooms for mother and babies and 4 prenatal beds
Youth in Transition	Moncton	Youth	6 (3 for young men and 3 for women)
Youth in Transition (Chrysalis House)	Fredericton	Young women (age 16-19)	8
Total Transitional Housing Beds: 32 Designated for Youth			

According to Human Resources and Skills Development Canada, in 2007, there were about 67 shelter and transitional beds per 100,000 population in New Brunswick, which is **significantly less than the national average** of 83 beds per 100,000 population[123].

In addition to emergency shelters and transitional housing for the homeless population, the Department of Social Development has contracts with 13 transition houses to provide up to 30-day stays for women, with or without children, who are fleeing relationship violence. Approximately 785 women and 491 children were served in 2009/10 – there are a total of about 170 emergency beds for women fleeing relationship violence, as well as 34 "Second Stage Housing" units which offer longer-term housing and support services to women, with or without children, up to one year, who are leaving abusive relationships. There are five second stage housing facilities in New Brunswick.

LONG-TERM CARE PROGRAM[124]

In addition to a range of home support services, the Long-Term Care Program (which falls under the Department of Social Development) includes Adult Residential Services and Nursing Homes.

Adult Residential Facilities
Targeted for adults who have significant functional limitations (regardless of their medical diagnosis). These facilities provide residents with:

- Support in the activities of daily living
- Emotional and behavioural supports
- Supports focused on maintaining optimal level of functioning, self care and independent
- Opportunities to participate in community life

Four levels of care are provided by Adult Residential Facilities. These care levels range from 1 to 4 with Level 4 being the highest degree of support and care provided. These levels of care are determined by the frequency and complexity of care and supervision required by the resident.

For government assistance in these facilities, a financial assessment is carried out. Room and board is provided, as well as required supervision and assistance with activities of daily living.

Special care homes and community residences must be approved by the Minister. These Special Care Homes and Community Residences are privately owned and operated, but licensed and monitored by the department on an annual basis: there are unannounced visits to each home and residence during the year. There were a total of 493 Adult Residential Facilities with 6,145 beds across the province[125] according to the 2008/09 Annual Report of the Department of Social Development. As of November 30, 2010, approximately 6,000 residents were receiving services in special care homes or community residences[126].

Clients pay according to their ability to do so; subsidies from the province are available. As of October 2006, their contribution is determined in relation to their net family income. Assets are no longer considered.

a) Special Care Homes

[123] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2
Provided by Department of Social Development staff, last updated January 5, 2010
[125] Department of Social Development, Government of New Brunswick, 2008/09 Annual Report, p.39
[126] Communication from Barbara Lemieux, Provincial Consultant, Housing and Homelessness Unit, Ministry of Social Development, December 20, 2010.

There are approximately 425 special care homes providing residential services for approximately 5,500 adults and seniors. Special Care Homes usually provide residential services to clients assessed as requiring Level 1 or 2 care. Effective April 1, 2007, the per diem rates for subsidized clients is $74 for those with level 1 care needs and also $74 for those with level 2 care needs.

b) Community Residences

There are approximately 65 community residences providing services to approximately 410 adults under 65 with high needs, but not requiring regular nursing care. These facilities have rotating staff and are administered by Boards of volunteers. The average number of residents per facility is 6. Effective April 1, 2010, the per diem rates for subsidized clients is $118.71 for those with level 3 care needs and $149.56 for those with level 4 care needs.

Nursing Homes

Nursing home services are intended for those individuals who are medically stable and who need nursing care. There are 65 nursing homes in New Brunswick, providing 4,325 beds. Almost all nursing homes are non-profit organizations that are privately owned, and are operated by a volunteer board of directors. The maximum rate paid by clients in nursing homes is $83 per day.

As well as providing regular nursing care, the nursing home system provides specialized care services. New Brunswick currently has four nursing homes with specialized units.

The long term care assessment process is used to assess the long-term care needs of individuals over the age of 19. The assessment process employs standardized eligibility criteria for nursing home admission. Once eligible, an applicant's name is placed on the waiting list.

Table 4. *Additional Facilities or Housing Options in New Brunswick.*

Program	Description	Capacity
Homeless Shelters	Provides emergency shelter and basic supports across New Brunswick	159 beds
Transitional Housing	Provides a longer-stay transitional housing and support arrangement dedicated to homeless youth	32 spaces
Transition Houses and Second Stage Housing Facilities for Women	Department of Social Development has contracts with 13 transition houses to provide up to 30-day stays for women (and their children) who have been abused by their partners. "Second Stage Housing" units offer longer-term housing and support services to women, with or without children, up to one year, who are leaving abusive relationships. There are five second stage housing facilities in New Brunswick, managed by the Women's Issues Branch.	170 beds in 13 transition houses, as well as 34 second-stage housing units
Adult Residential Facilities – Special Care Homes and Community Residences	Special Care Homes usually provide residential services to clients assessed as requiring Level 1 or 2 care. Effective April 1, 2007, the per diem rates for subsidized clients is $74 for those with level 1 care needs and also $74 for those with level 2 care needs. Individuals in community residences general require level 3 or level 4 care needs, but not nursing care. These facilities have rotating staff and are administered by Boards of volunteers. The average number of residents per facility is 6. Effective April 1,2010, the per diem rates for subsidized clients is $118.17 for those with level 3 care needs and $149.56 for those with level 4 care needs.	5,500 adults and seniors in 425 special care homes Around 410 adults under 65 with high needs in community residences
Nursing Homes	Nursing home services are intended for those individuals who are medically stable and who need nursing care. These nursing homes are non-profit organizations that are privately owned, and are operated by a volunteer board of directors. The maximum rate paid by clients in nursing homes is $83 per day. As well as providing regular nursing care, the nursing home system provides specialized care services. New Brunswick currently has four nursing homes with specialized units.	4,325 beds in 65 nursing homes

MENTAL HEALTH SUPPORTS

Table 5. *Overview of Mental Health Supports in New Brunswick.*

Range of Mental Health Supports	
Community Connections	▪ Consumer-run activity centres providing social, vocational, recreational and advocacy activities (tailored to local need). ▪ Clubhouses providing pre-vocational and vocational activities that are provided through partnerships between consumers and mental health professionals. ▪ Adult Long-Term Service (Community Mental Health Centres; CMHC): Facilitating development of natural community connections and participation.
Community Mental Health Services (includes Addictions Services)	CMHC Services include: ▪ Screening and assessment ▪ 24-hour crisis intervention ▪ Short-term therapy ▪ Navigation to other services ▪ Case management Service ▪ Community Support Service ▪ Rehabilitation Service ▪ Suicide Prevention Service ▪ Services for the Elderly ▪ Psychiatric Units provide day hospital services, 24-hour emergency and consultation services, and consultation/liaison to other hospital medical and surgical units. ▪ Psychiatric Hospitals provide consultation/education for mental health services, evaluation, research and mental health training, televideo and telepsychiatry, and onsite support for people with mental illness who are seniors or who have co-occurring developmental disabilities. ▪ Addictions services provide inpatient detoxification, short-term inpatient rehabilitation, long-term residential rehabilitation, outpatient services, methadone clinic, Portage Facility for youth/young adults.
Inpatient Services	▪ Acute and specialized beds
Other	▪ Mental health promotion and prevention services (CMHC) ▪ Consultation/education to partners (CMHC) ▪ Child and adolescent services (CMHC) – generally, this project focuses on services for adults, but these have been included as they are integrated in the adult service delivery structure of the CMHCs. ▪ Adult-Long Term Service (CMHC): client advocacy and rights protection ▪ Critical Incident Stress Response Teams ▪ Suicide Prevention Program

FUNDING LEVELS

According to the Department of Health's annual report, funding for addiction and mental health services **totalled $94 million in 2008/09** (or 4.2% of the total health budget). Roughly $88 million was allocated to regional health authorities ($17.08 million for addictions services and $70.99 million for mental health services), with the remainder used to provide corporate and other services related to mental health and addictions.

An analysis by the Institute of Health Economics (Jacobs et al., 2010) identified the following expenditures on mental health and addictions services[127] in New Brunswick for 2007/08:

- $78.2 million for inpatient care[128] ($68.1 million in general hospitals and $10.1 million in psychiatric hospitals),
- $23.2 million for physician services ($4.2 million general practitioners – fee for service and $5.8 million for specialists – fee for service, and $13.2 million for psychiatrists working under alternative payment schemes),
- $49.2 million for community and social services ($32.4 million for community mental health and $16.8 million for addictions services), and
- $1.2 million for non profit organizations excluding the provincial government.

RANGE OF MENTAL HEALTH AND WELLNESS SERVICES

There have been significant changes in the mental health sector across Canada, and within New Brunswick, over the last 30 years, with an increasing emphasis on community-based delivery of services. In 1988, New Brunswick's mental health policy was implemented with a focus on deinstitutionalization. The New Brunswick model has been recognized as one of the most successful examples of broad-based mental health system reform in Canada (Review of Best Practices in Mental Health Reform, report by the Clarke Institute of Psychiatry, 1997; cited in McKee 2009). Most recently, the advisory report to the Minister of Health (McKee, 2009) noted that the policy has since taken on an additional dimension, with **increasing emphasis on early intervention with young people and their families**.

From a broader perspective, the New Brunswick health system has recently undergone a shift in its RHA structure, moving **from eight authorities to two**, in an effort to enhance a more standardized approach to health services across the province. The RHAs will continue to deliver health services, including having patient advocates to assist people in navigating the health care system. Each RHA will have a board of directors appointed by the Lieutenant Governor in Council.

The Addictions, Mental Health and Primary Health Care Division of the Department of Health is responsible for ensuring the provision of the following mental health services across the province:

- Long-term support
- Child and adolescent services
- Acute services
- Quality management and executive support

Functionally, mental health services include:

- A range of community-based mental health services provided by Community Mental Health Centres (CMHC) across the province which report directly to the RHAs.
- Inpatient services provided by psychiatric units in general hospitals and psychiatric hospitals (the Addictions, Mental Health and Primary Health Care Division of the Department of Health contracts with the RHAs for provision of these services by hospitals).
- A range of services provided by non-profit organizations that serve persons with mental health problems including consumer-run programs (which are managed by a Board comprised of consumers and community representatives).

[127] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.
[128] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.

COMMUNITY MENTAL HEALTH CENTRES

There are thirteen Community Mental Health Centres who deliver core community-based mental health services in catchments across the province as part of the RHAs: seven of the thirteen centres' directors are Regional Directors who work to maximize the use of regional mental health resources and ensure services are coordinated across the region. Every centre has a Community Advisory Committee made up of consumers, family, and advocacy representatives. Core community-based mental health services include:

- **Acute Services**: For adults who have mental or emotional issues that interfere with their psychosocial functioning. Multidisciplinary teams provide screening, assessment, 24-hour crisis intervention, short-term therapy, prevention, consultation and service delivery coordination, and navigation to other community and mental health services as needed.
- **Child and Adolescent Services**: For children and youth to age 18, these services focus on mental health promotion and enhancement, treatment and recovery. Includes individualized assessment, treatment and evaluation services, crisis services, consultation and education to partners (including family). According to the Department of Health's 2008/09 annual report, in the 2008-09 fiscal year, the Child and Adolescent Community Mental Health Program provided a total of 18,273 services to 7,091 children and adolescents.
- **Adult Long Term Services**: For people in need of treatment and rehabilitative mental health services and who present a combination of factors relating to diagnosis, duration of illness and level of disability. Includes treatment and monitoring of services, psychosocial rehabilitation services and supports, facilitating community integration and improved quality of life, facilitating people's development of natural social networks, client advocacy and rights protection, supporting client recovery by increasing capability to manage stress and difficulties related to mental illness, ensuring client participation in all phases of service planning and delivery.

According to the 2008/09 Department of Health Annual report, in the 2008-09 fiscal year, there were:

- **15,298 new referrals to CMHCs across the province**: 39% were either self referral or referral by a parent, and 30% were referral from a general practitioner or physician specialist.
- A total of **27,763 distinct individuals** served in the three core programs (representing 37.2 individuals for every 1,000 population).
- Of this total, 23,716 services were provided and 15,872 distinct individuals received services within acute services program; and 73,722 services to 4,800 adults in the long-term adult program.

PSYCHIATRIC UNITS AND PSYCHIATRIC HOSPITALS

There are eight regional hospital facilities across the province and each includes a psychiatric unit that provides **acute in-patient and day hospital services** for voluntary and involuntary patients. In addition, these units provide: 24-hour emergency and consultation services to patients referred by physicians and CMHCs; consultation/ liaison to other hospital medical and surgical units; and mental health education to a range of hospital clinical staff and other professionals. There were a total of 48,517 inpatient days in the psychiatric units in 2008-09.

There is a **Child and Adolescent Psychiatric Unit** (CAPU), a six-bed tertiary resource, located in the Moncton Hospital, providing inpatient care and outreach services. There were a total of 1,785 inpatient days in 2008/09.

There are **two provincial psychiatric hospitals** one in Saint John (Centracare) and one in Campbellton (Restigouche Hospital Centre) providing specialized treatment and rehabilitation services to adults. The Restigouche Hospital Centre also provides specialized observation and assessment for forensic cases for the entire province. The two hospitals function as: specialized, tertiary, in-patient resources for other mental health services; support centres for evaluation, research and mental health training; and providers of psychiatric telephone / videoconference consultation and on-site support to other agencies for psychogeriatric patients and individuals with developmental handicaps. During the 2008-09 fiscal year, Centracare had 15,293 inpatient days, and RHC 62,683 inpatient days.

MENTAL HEALTH PREVENTION/PROMOTION INITIATIVES

Consumer-run activity centres are managed and/or supported by the Addiction, Mental Health and Primary Health Care Services Division of the department of health, and focus on prevention and promotion activities. Centres promote community integration by providing social, vocational, recreational and advocacy activities. They help people become more independent of formal services by means of peer support, education, and mutual self-help. According to the Department of Health's 2008/09 Annual report, during the 2008-09 fiscal year, the activity centres received 1,633 distinct attendees, which represents a 3% increase in the number of individual attendees from the previous fiscal year.

There are two **clubhouses** (Fredericton and Saint John), where mental health consumers work in partnership with professionals to provide meaningful, structured, pre-vocational and vocational activities.

The **Critical Incident Stress Response Program** assists people to deal with the stress that accompanies trauma. The regionally-based teams provided services to 601 individuals in 2008/09, and were involved in 47 debriefing sessions.

The department also funds a **Suicide Prevention Program** providing prevention, intervention, and post-vention. A Provincial Suicide Prevention Committee advises the Addiction and Mental Health Services Division with regard to suicide prevention activities. There are 14 regional suicide prevention committees with representatives from various government departments, non-profit, and private agencies.

ADDICTION SERVICES

These prevention and treatment services are delivered through the regional health authorities across the province:

- In-patient detoxification for alcohol, drugs, and/or gambling; 2,284 people served in 2008/09.
- Short-term rehabilitation services within an inpatient setting including group therapy, education, stress management and self-awareness. There are two 3-4 week programs available which served 1,642 individuals in 2008-09.
- There is a long-term residential rehabilitation service for men (3-6 months) which served 1,263 individuals in 2008-09.
- The Departments of Health, Public Safety and Education have partnered with Portage Atlantic to provide services for youth who need intense in-patient treatment. Portage Atlantic, a not-for-profit organization, operates a long term residential adolescent treatment facility for youth aged 14-21. There were 46 new admissions and six readmissions to the Portage facility in 2008-09. There are also outpatient services available (assessment, consultation, and counselling).
- Four methadone clinics provided medical treatment and psycho-social counselling services to 1,076 distinct individuals in 2008-09.

INCOME SUPPORT PROGRAMS

The Department of Social Development is responsible for the delivery of the Social Assistance program. Key legislation includes: The Family Income Security Act and the Family Income Security Regulations govern New Brunswick's Social Assistance program. Basic assistance includes the cost of food, clothing, shelter, routine transportation, fuel and utilities, and personal and household items. For clients with disabilities, liquid assets may not exceed $3,000 at the time of application to be eligible for the Social Assistance program.

The Social Assistance program has two rate programs upon which maximum basic assistance rates are based: the Transitional Assistance Program and the Extended Benefits Program. Each of the two programs employs different levels of earnings exemptions:

- **Transitional Assistance Program (TAP):**
  - Financial assistance to individuals and families with 'intermittent foreseeable needs.'

- A category of financial assistance for individuals and families with 'the potential to achieve self-sufficiency once barriers to their employment are addressed.'
- Monthly exemptions on earned income is $150 for singles and $200 for families.
- In 2006, there were a reported 36,100 recipients of TAP.[129]

- **Extended Benefits Program (EBP):**
  - Financial assistance to individuals and families certified by the Medical Advisory board as blind, deaf, or disabled.
  - A category of financial assistance for those with 'long-term predictable needs.'
  - Monthly exemptions on earned income is $250 for singles and $300 for families.
  - In 2006, there were a reported 6, 700 recipients of EBP.[130]
- In addition to the two programs (outlined above), New Brunswick also has an Extended Wage Exemption (EWE) available which is separate from the earnings exemptions of TAP and EBP. The duration of the benefit is two years. The amount of exemption changes are in line with three different time frames within this two year period. The first two time frames (six months duration each) give clients the option of having a percentage of their salary exempted (resulting in a higher earnings exemption). The last time frame (e.g., months 13-24) earnings exemptions revert back as per usual.
- In September, 2005 the province put in place the provision of an extended drug coverage for a duration of thirty-six months for clients that leave social assistance for employment.
- **Total income** for a single individual with a disability was estimated at $8,496 (includes basic social assistance and GST credit).[131]

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

New Brunswick has made significant progress in recent years in setting out clear goals and targets relating to poverty reduction and housing and homelessness as noted in the Key Initiatives section – the mental health provincial framework is expected shortly. The integrated vision for health, income and housing is reflective of the work of the recently created New Brunswick Health Council. The Council is tasked with developing mechanisms of meaningful community engagement, and the measurement, monitoring a devaluation of:

- Population health
- Health service quality
- Population satisfaction with health services and health service quality
- Sustainability of health services in New Brunswick

The Council, among other achievements, issued a provincial Population Health Snapshot in 2009/10 – which was reflective of the social determinants of health – as well as developing/issuing a Health Systems Performance Report Card. These types of practical tools, combined with the targeted provincial frameworks noted above, may be of great value in identifying the needs of housing and mental health services.

[129] Federal-Provincial-Territorial Directors of Income Support, August 2009. *Social Assistance Statistical Report, 2006.* Note that more recent figures were not available in the May 2010 release of the *2007 Social Assistance Statistical Report.*
[130] Federal-Provincial-Territorial Directors of Income Support (May 2010). *Social Assistance Statistical Report, 2007.* Note that more recent figures were not available in the May 2010 release of the *2007 Social Assistance Statistical Report.*
[131] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability,* Bulletin Number 2.

CHALLENGES IN HOUSING & RELATED SUPPORTS

- New Brunswick has a high level of "adequacy" need (when considering the Canada Mortgage and Housing Corporation definition of core housing need based on adequacy, suitability and affordability). This is related to four main factors: the age of New Brunswick's housing stock; the preponderance of homeownership units owned by low-income households; the absence of province-wide building code enforcement; and the rural nature of New Brunswick.
- A number of demographic shifts are causing/will cause the need for appropriate housing planning (i.e., significant increases in aging population, growing Aboriginal population).
- Youth homelessness is a growing issue in New Brunswick – consistent with trends seen across the country.
- Aboriginal communities in New Brunswick and in the country are faced with a multitude of complex social issues both for First Nation people living on reserve and those off reserve.
- Rising energy costs and deteriorating buildings: consistent with other provinces and territories across the country, this is creating significant challenges from an affordability perspective for both tenants and owners of social housing and private market housing.
- The New Brunswick Housing Framework also highlights the importance of having an information system that would allow rapid access to data about existing housing, access, and maintenance needs.
- The concept of "*Housing First*" can be challenging for some providers to understand – there has been a lot of discussion in how this is operationalized.
- While many good models are discussed and planned, there aren't sufficient initiatives actually "on the ground." This requires more funding to actually move to implementation.
- A greater understanding of ideal "mixed housing" approaches/proportions are needed.
- There is a particular need for apartments for single people.
- A trend identified is the need for ongoing housing supports after the actual housing is secured (i.e., budgeting, housing maintenance, tenant's rights, etc.).
- There is often stigma against people with mental health issues by landlords, and then consumers often do not assert their own rights as tenants or may be unaware of these rights.
- Landlords also could benefit from education on mental illness and what to expect from clients, to reduce stigma and biases.
- For example, in the Salvation Army homeless shelter in Saint John, there are some strong partnerships with housing providers; providers make units accessible for people coming from the shelter, and Salvation Army continues to provide the supports and will follow-up with them if they don't hear from the client.
- It used to be that landlords could evict people with mental health issues more rapidly than the general population but now all tenants are afforded the same protections and a longer time frame for the eviction process. The unintended effect of these legislative changes has been a decreased willingness on the part of private landlords to rent to people with mental health issues. There is some protection for roomers and boarders through the Residential Protection Act.

FUTURE DIRECTIONS: TRENDS IN HOUSING & RELATED SUPPORTS

- There is increasing interest from aging parents on development of secondary suites for 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.

- There is a significant focus on homelessness and poverty reduction in the province right now which is very promising from a housing development perspective – the end of federal funding for a number of programs is a significant concern.

The government, through its provincial frameworks, has emphasized the linkages across housing, self-sufficiency, and poverty reduction. To this end, the New Brunswick Housing Corporation's housing strategy identifies that housing policy and programs must:

- Be coordinated and consistent with other public policy.
- Promote economic and social inclusion, personal accountability, and individual choice.
- Include benefits which promote transition to the extent possible.
- Be responsive and flexible to the varying specific needs of vulnerable individuals and households and to the broader needs arising from changing demographics.
- Help communities meet local needs and priorities.
- Recognize the shared responsibility of all levels of government, individuals, communities and the housing industry for good safe housing outcomes.
- Support the strengths of the private, public, and non-profit sectors in meeting the needs of low-income New Brunswickers.
- Be flexible.

The strategic objectives outlined include:

- Reduce core housing need in New Brunswick by 10% over the next five years from the 10.3% identified in the 2006 Housing Census (Statistics Canada).
- Reduce chronic homelessness in New Brunswick significantly over the next five years.
- Improve the Energy Efficiency of housing occupied by low income households.
- Ensure the transparent and effective delivery of provincial housing programs.

NEWFOUNDLAND AND LABRADOR

CONTEXT

The population of Newfoundland and Labrador is approximately 508,925 (Statistics Canada, Demography Division, February 2010). Within the Metropolitan Area of St. John's the population is 187, 596 (Statistics Canada, Demography Division, February 2010), as such many specialized services are located in St. John's.

Newfoundland and Labrador consistently had one of the highest rates of child poverty in Canada from 1998 to 2004, peaking at more than 20%. By 2006, Newfoundland and Labrador was fourth lowest at about 9%, compared to 11% nationally (measured after income tax). In 2003, after six years of offshore oil production, revenues had begun to flow into the provincial treasury. By 2005-06 there were budget surpluses and oil became the province's biggest revenue source. While economic well-being in Newfoundland and Labrador was improving by 2005, there were, and are still, many challenges (Locke & Rowe, 2009, p.4-6). The Provincial Government's 2005 consultation document, Reducing Poverty in Newfoundland and Labrador: Working Towards a Solution, stated that:

- 44% of those below the low-income cut-off (LICO) were income support recipients
- Children of income support recipients were 3.5 times more likely to receive income support before age 30, and less likely to graduate from high school
- 22% of poor families had a poverty gap in excess of $6,000 below the LICO, and single women aged 18-65 had the highest gap of all groups analyzed
- Persistence of poverty was greatest for 55-64 year olds and those without a high school education
- About one-third of those receiving income support were people with disabilities. Income levels for Aboriginal peoples were not available but on average are thought to be lower than for non-Aboriginals

Within Newfoundland and Labrador progress has been made within the last 5 years in expanding housing and related supports options for adults with mental health issues and mental illness. This has resulted from a growing awareness in the province that there needs to be a more clear integration of services for vulnerable populations. However, approximately 80% of mental health services in Newfoundland are located in St. John's, outside of which, services are deemed 'piecemeal'.

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

Newfoundland Labrador Housing (NL Housing): NL Housing is the housing arm of the provincial government. NL Housing is a crown corporation whose mandate is to develop and administer housing assistance programs for the benefit of low to moderate income individuals and families throughout the province including seniors, single parents, single people, Aboriginal people, and persons with disabilities. The corporation oversees the following housing programs: the **Rental Housing Program, the Rental Supplement Program and the Provincial Home Repair Program**.

Human Resources, Labour and Employment (HRLE): The Department of Human Resources, Labour and Employment works in cooperation with other provincial departments and federal and municipal governments to serve individuals with disabilities (and other populations) as well as organizations and community groups that support individuals with disabilities. The department is responsible for the delivery of the **Income Support** program to adults in Newfoundland and Labrador. Basic assistance consists of individual/family benefits and a shelter allowance.

The Department of Health and Community Services: The Department of Health and Community Services provides policy direction, funding and operational standards to the Regional Health Authorities. Programs funded by the Department of Health and Community Services include: residential options (e.g., Cooperative Apartment Program**,** Alternative Family Care Home Program, Board and Lodging Supplement, Individualized Living Arrangements**,** and Shared Living Arrangements), intervention services (Direct Homes Services Program and Community Behavioural Services Program), Provincial Home Support Program, therapeutic and professional services, Special Assistance Program – Medical

equipment and supplies, Newfoundland and Labrador Prescription Drug Program, and the Special Child Welfare Allowance Program.

Regional Health Authorities: Mental health programs are offered through four Regional Health Authorities (RHAs) throughout the province, who deliver programs and services to individuals with disabilities and their families. Funding is provided by the Department of Health and Community Services.

PROGRESS TO DATE: KEY INITIATIVES

- *A Housing Strategy for Newfoundland and Labrador*
- *A Social Housing Plan for Newfoundland and Labrador – Secure Foundations 2009*
- Poverty Reduction Strategy
- Provincial Healthy Aging Policy Framework
- Provincial Policy Framework for Mental Health and Addictions

RANGE OF HOUSING ACCOMMODATIONS

DEDICATED MENTAL HEALTH HOUSING IN NEWFOUNDLAND

The Ministry of Health has regulated 15 privately owned boarding homes (45 placements) in St. John's for individuals with mental health issues. These homes operate a shared bedroom model (e.g., 3-4 individuals per room) where the focus is on integration and rehabilitation. Staff support and education is provided by the Ministry of Health. The Regional Health Authority (Eastern Health) is responsible for community care, including case management services. The Ministry of Health also regulates Access Home – 1 boarding home (10 beds).

Please refer to the "non-dedicated" housing section below for further discussion on housing and support models provided by Stella Burry Community Services, Choices for Youth and the Tommy Sexton Centre.

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

Newfoundland Labrador Housing (NL Housing): As the provincial housing provider NL Housing assists low income households through the 5, 500 social housing rental units it operates and 1, 400 rent supplements for households that rent in the private and non-profit sectors. In the last 2 years NL Housing has used provincial funding to earmark 78 rent supplements for people with complex service needs. These needs are inclusive of mental health needs but encompass a wide array of need across vulnerable populations. The Canadian Mental Health Association (CMHA) Newfoundland and Stella Bury Community Services (SBCS) have partnered with NL Housing to identify individuals with complex service needs that would benefit from rent supplements. Approximately 45% of these rent supplements are allocated to CMHA Newfoundland and 55% to SBCS.

In addition, there are a number of rent supplements and social housing units that are dedicated for those with mental health issues. One example is the 20-year-old partnership NL Housing has developed and sustained with Pleasant Manor – a supervised setting for four residents who have been diagnosed with mental illness. NL Housing works closely with Pleasant Manor to arrange access to public housing units or rent supplements when clients of Pleasant Manor are ready to move into more independent housing. There are 18 clients supported by Pleasant Manor who are assisted through these social housing programs. NL Housing has also allocated five units to Choices for Youth, a NGO that focuses on supportive living options for young persons with complex service needs.

Outside of these partnerships with community organizations that provide supportive living services, it is difficult to estimate the percentage of individuals with mental health issues/illnesses living in social housing since applicants to NL Housing are solely assessed based on their housing need.

The provincial poverty reduction strategy has allocated $1 million to the Provincial Homelessness Fund which is administered through NL Housing. Capital dollars have been allocated for development of space for provision of support services that promote housing stability for persons at risk of homelessness.

NGOs – Housing and Supports: Stella Burry Community Services, Choices for Youth and the Tommy Sexton Centre are the three main NGO housing providers which combine significant support services with housing provided.

Stella Bury Community Services (SBCS): SBCS is the largest NGO housing provider in Newfoundland and provides affordable housing to low income individuals in St. John's. SBCS owns/operates 17 buildings, which provide 67 rental units, 24 units managed by SBCS. Overall, SBCS provides housing and related services to approximately 80-90 tenants (including people with complex mental health needs). SBCS operates using a *Housing First* approach. Applicants do not require a diagnosed mental illness to access services. It's important to note, however, that many people who access SBCS services have a range of mental health needs.

The organization acquired several properties (including federal government surplus properties), refurbished them, and used the equity from their first few homes to buy other private market homes. The organization then received funding to renovate these private market homes to create more affordable housing. SBCS is also working in partnership with St. John's Housing to provide landlord services and support to tenants for properties that St. John's Housing is having difficulty maintaining.

SBCS currently operates 3 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 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 counselling, 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. Referrals are typically made through health care providers, family counselling agencies, The Department of Human Resources and Employment, family and peers, and self-referral. On-site supports include counselling and assistance with education and employment needs, life skills instruction, and housing.

Carew Lodge is one of several supportive housing locations for low income, single individuals and 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. An on-site community development workers provides tenants and other clients with assistance with education and employment needs and advocacy support with regard to income. Carew Lodge is the location of a 'one-stop-shop' housing resource centre. This is the only housing resource center in the province.

Choices for Youth, a shelter for young men approximately 16 years of age and older (has housed men up to the age of 29), opened its doors in 2004. Since then, it has housed 300 young men but the percentage of youths who cycle back through the shelter has reached over 50%. To combat this cycle, Choices for Youth is launching a program that will combine a supportive housing environment with on-site support. The program has recently received funding by the federal and provincial governments to fill a significant housing gap within St. John's. The program will combine 14 safe, affordable housing units (one- and two-bedroom apartments) with on-site support, a basic literacy and math skill program, and an employment preparation program. This program will address the housing and employment needs of this youth population.

The Tommy Sexton Centre offers housing (apartments) for people living with HIV/AIDS and also has four shelter beds open to the rest of the community.

Capital funding and operational funding for housing in Newfoundland and Labrador is provided by the following sources:

1. Federal/provincial funds allocated to: social housing, and the **Affordable Housing Agreement** (funds allocated per unit for development of new housing)
2. The new **2009 Provincial Homelessness Fund** (capital funds for development of support services space for the provision of on-site and outreach services that promote housing stability for persons at risk of homelessness)
3. **Homelessness Partnership Initiative** (HPI)
4. Operating funding from the **Supportive Living Community Partnership** for supportive living services that promote housing stability for persons with complex service needs

Table 1. *Non-dedicated affordable housing options in Newfoundland and Labrador.*

Program	Description	Capacity
Housing with Supports	Stella Bury Community Services (SBCS) is the largest NGO housing provider in Newfoundland, providing affordable housing and supports to people living on low incomes with complex needs (including mental health). Uses a *Housing First* approach and people do not need a diagnosed mental illness to access services. In addition, Stella Bury provides additional transitional housing options: ▪ Emanuelle House – 16 bed therapeutic residential setting for men and women on parole ▪ Naomi Centre – short term residential setting for young women ▪ Carew Lodge – 12 self-contained units with shared kitchen facilities together with 2 transitional housing units	67 units in 17 buildings
Housing with Supports	Choices for Youth – provides a shelter for males aged 14+. New program will provide affordable housing together with support in 1 and 2 bedroom units	14 units
Housing with Supports	Tommy Sexton Centre – permanent housing for people living with HIV/AIDS and 4 shelter beds	4 units
Rental Housing Program	▪ Newfoundland Labrador Housing is responsible for the delivery of the program ▪ Assists low-income households to obtain suitable and affordable rental housing in the private sector ▪ Provides subsidized, self-contained apartments ▪ Rent is 25-30% of household income	5, 511 units
Rental Supplement Program	▪ Newfoundland Labrador Housing is responsible for the delivery of the program ▪ Assists low-income households with obtaining suitable and affordable rental housing in the private sector ▪ Landlords set aside apartments within their property portfolios to rent to low-income households ▪ Rent is 25-30% of household income	1,005 units
Lower End Market Units	▪ This housing is operated by the City of St. John's and is available to low and moderate income earners and is rented on the basis of gross family income ▪ Tenants pay the lower end of market rent as determined annually by Newfoundland and Labrador Housing Corporation	268 units

Rent Geared to Income	▪ This housing is operated by the City of St. John's and is available to low and moderate income earners and is rented on the basis of gross family income ▪ RGI units are targeted specifically at individuals and families of low income ▪ Rents in these units are based between 25 and 30% of household income (depending on number of family members and monthly income)	156 units
Housing Co-operatives	The Newfoundland-Labrador Federation of Co-operatives (NLFC) is the central agency representing the collective interests of the co-operative business sector in the province	414 units

ADDITIONAL INITIATIVES

- **Affordable Housing Program**: This program is designed to provide funding in the form of a one-time capital grant for the construction of major repair of affordable housing units for low to moderate income households. Rents for affordable housing units are set at or below average market rents in the community. The tenant is only required to pay 25-30% of their total monthly income towards rent. Federal and provincial subsidies make up the difference, and are paid directly to the landlord.
- **Provincial Home Repair Program**: Newfoundland Labrador Housing is responsible for the delivery of this program designed to assist low income homeowners who require essential repairs to their homes. NL Housing provides funding to eligible homeowners in the form of grants and repayable loans to cover the cost of repairs. Grant funding ranges from $5,000–$6,500 and funding in the form of repayable loans range from $10,000–$13,000.
- **Provincial Home Repair Program – Adaptation**: This program is designed to provide seniors and individuals with physical disabilities who require accessibility changes to their residence the ability to carry out these renovations, which allow them to remain in their homes for a longer period.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

SHELTERS

According to figures from HRSDC, there were **approximately 215 beds** in Newfoundland & Labrador's emergency and transitional shelters in 2007[132], or 0.8% of known shelter beds across Canada. There were **44 shelter beds per 100,000** of the population, **significantly below the 82 shelter beds/100,000 national average**.

This number of shelter beds is likely an underestimate because:

- It is based on the number of known shelters – there may be additional shelters not captured in this data set
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007

Also according to HRSDC, of the known 1,020 shelters identified across Canada as of March 2007, 723 or 71% were emergency shelters, providing temporary and short-term accommodation for homeless individuals and/or families. Such shelters typically also offer essential services such as food, clothing and counselling. "Transitional shelters offer services

[132] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. Transitional shelters numbered 291 and represented a little more than 28% of the total. There were, in addition, 6 shelters providing both emergency and transitional services, representing less than 1% of the total" (Government of Canada, Human Resources and Skills Development Canada, 2011).

NURSING HOMES AND PERSONAL CARE HOMES

People access long term care through nursing homes (long-term care homes) or personal care homes. Nursing homes are publicly operated and provide on site professional health care and nursing services while personal care homes are privately owned and operated facilities and provide assistance with personal care and activities of daily living and avail of visiting health professional from the regional health authority.

Nursing homes:

- All facilities provide 24 hour nursing care together with a variety of health and social supports (the level of which varies by type of home)
- There are some facilities with specialized programs and units for groups of individuals with special needs (i.e., Alzheimer disease)
- Admission is based on assessment by staff of the regional health authorities
- The maximum amount of rent a resident pays to live in a nursing home is $2,800/month – subsidies may be available to pay the full or a partial amount

There were a total of 2,643 nursing home (long-term care) beds in Newfoundland as of 2008 (CUPE, 2009, p. 8). While the population aged 75+ has increased by 12.8% between 2001 and 2008, the rate of beds per 1,000 for this population has actually decreased by over 16% during the same time period. Unlike other provinces where there is a mix of public and private ownership, all beds are publicly owned and operated.

Personal care homes

- Privately owned and operated residential homes for seniors and adults requiring assistance with daily living activities
- Individuals do not require on-site health or nursing services but may require services from visiting professionals
- Homes are licensed by regional health authorities
- The amount of rent a resident pays varies depending on the home – there are subsidies available from the province

People living in personal care homes live in these residential settings due to a variety of personal care and supervision needs. People living with mental illness or mental health issues often live in these personal care homes and community care homes. There are 81 personal care homes and 21 community care homes in the province. 1,855 clients receive care in these homes[133].

RESIDENTIAL OPTIONS FOR PEOPLE LIVING WITH INTELLECTUAL DISABILITIES

As described by the Department of Health and Community Services[134]:

1. **Cooperative Apartment Program**: This program offers a private residential setting operated by an incorporated community board of directors and staffed by a live-in supervisor and relief staff. The private residences are usually rented houses and are shared by up to three adults with intellectual disabilities. The main emphasis is on skill

[133] Government of Canada, Canadian Heritage, Newfoundland and Labrador, Article 6:Right to Work. http://www2.pch.gc.ca/pgm/pdp-hrp/docs/escr/nf-eng.cfm

[134] http://www.health.gov.nl.ca/health/personsdisabilities/fundingprograms_hcs.html#ro

teaching and support to enable more independent living rather than providing a permanent residence. Provincial standards exist for this model.

2. **Alternative Family Care Home Program**: This program offers private homes which have been approved by the Regional Health Authority for the purpose of providing room and board, supervision and personal and social support for up to two unrelated adults with intellectual disabilities in a family atmosphere. Supports and services are available as necessary. Monitoring and supervision is provided by the social worker assigned by the Regional Health Authority. Provincial standards exist for this model.
3. **Board and Lodging Supplement**: As described under the 'dedicated housing' section, this supplement is also available for people with physical and/or intellectual disabilities who reside with relatives or non-relatives. These adults have identified needs and require a higher board and lodging rate to live in these arrangements than is usually allowed. The supplement is available through the regional health authorities.
4. **Individualized Living Arrangements**: An individualized living arrangement (ILA) is established when no other service option is available or appropriate for an adult with an intellectual disability, meeting home support criteria and unable to reside with their natural family. While this program usually supports one client per home, there may be situations approved where the living arrangements are shared by individuals who wish to reside together. The funding for basic income support is provided by the Department of Human Resources Labor and Employment with additional funding for home support and other related costs provided by the RHAs. Once established, the ILAs are managed by the individual, family, or operations committee.
5. **Shared Living Arrangements**: In some instances individuals with disabilities who require high level of home support may choose to share the cost of a living arrangement and home support staff. Funding may be provided from several sources such as the Department of Human Resources, Labour and Employment (HRLE) and the Regional Health Authorities (RHA). As in an individual living arrangement all benefits of income support including rent and heat and light supplements, and any other benefits available, are obtained from HRLE and supplemented as per policy by RHAs.

MENTAL HEALTH SUPPORTS

FUNDING LEVELS

According to a recent analysis by the Institute of Health Economics (Jacobs et al., 2010), the following were some of the expenditures on mental health and addictions services[135] in Newfoundland for 2007/08:

- $55.9 million for inpatient care[136] ($24.9 million in general hospitals and $31 million in psychiatric hospitals)
- $14.8 million for physician services ($1.1 general practitioners – fee for service, $5.2 specialists – fee for service, and $8.5 million for psychiatrist on alternative payment schemes)
- $12.6 million for First Nations mental health and addictions services

The level of funding on community mental health and addictions services provided via Regional Health Authorities is not reportable at this time.

RANGE OF MENTAL HEALTH SERVICES

Stella Burry Community Services (SBCS) operates a community support program which has 40 participants to date and approximately 35 individuals on a waitlist. The community support program is targeted for individuals with complex mental illnesses and a history with the criminal justice sector (e.g., probation, parole, NCR, and long-term supervision

[135] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.
[136] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.

orders). The program has 16 community mental health workers, 4 case managers, and 2 relief workers. Community mental health workers are responsible for the coordination of services and provide specific services such as teaching life skills. As previously mentioned, SBCS operates a housing resource centre at its Carew Lodge location. The organization also developed the Hungry Heart Café – a program where clients receive training in food preparation. In addition to these services, SBCS offers employment services (e.g., training, education, employment maintenance services, 'workplace support workers,' etc.). The Stella's Pride Program is a service where an individual is provided with support to continue to work. Other services include: an income support program, counselling, residential programs, intense life skills and employability coaching, ABE Level 1 program (literacy and numeracy program), and outreach clinical services to women in prison.

There is one psychiatric hospital in Newfoundland, the Waterford Psychiatric Hospital in St. John's. Outside of St. John's there is a general hospital in Cornerbrook and one in Labrador, both with dedicated psychiatric beds. The Health Sciences in St. John's will have a 10 bed psychiatric unit, however, these beds will not be used for individuals in critical crisis.

Assertive Community Treatment (ACT) was introduced in Newfoundland two years ago. Newfoundland has three ACT teams located in St. Johns, Cornerbrook, and Grand Falls-Windsor[137]. ACT teams provide 24/7 support to individuals with a diagnosis of schizophrenia and bipolar disorder. The professional supports within ACT teams include peer support, a mental health worker, occupational therapists, a psychiatrist, and nurses. Generally ACT teams include 6-8 professional team members.

In mental health and addictions, the Early Intervention and Outreach Program was introduced in the 2008/09 fiscal year. Twenty workers from health authorities work directly with youth in their communities to address emerging mental health issues.

Crisis services in Newfoundland are limited. To date, only 1 mobile crisis team exists in St. John's which is currently under development with policing services. There are no respite beds for people with mental health issues; however, a short stay unit exists at the Waterford Hospital wherein individuals in crisis may stay for up to a 4 or 5 day maximum.

OVERVIEW OF MENTAL HEALTH SERVICES PROVIDED BY REGIONAL HEALTH AUTHORITIES

Eastern Health:

- Eastern Health is the largest integrated health authority in Newfoundland and Labrador
- Eastern health offers the full continuum of health and community services, including public health, long-term care, community services, hospital care and unique provincial programs and services
- The geographic catchment area for Eastern Health is the part of the province of Newfoundland and Labrador east of, and including, Port Blandford. This area includes the Avalon, Burin and Bonavista Peninsulas as well as Bell Island
- Health and community services are offered through community-based offices, medical clinics, nursing homes and hospitals

Central Health:

- The geographic catchment area for Central Health extends from Charlottetown in the East to Baie Verte in the west (this includes Gander and Grand-Falls Windsor)
- Provides acute-care services, tests, treatments and procedures, community health services, long-term care, and pastoral care
- There is a Mental Health Unit (20 beds) located at the Central Newfoundland Regional Health Centre in Grand Falls-Windsor

[137] The ACT team in Grand Falls-Windsor is not yet full staff complement

- Community health services include: mental health and addictions services, community supports, child, youth and family services, long-term care, and residential services

Western Health:

- Western Health's geographical boundaries are from Port aux Basques southeast to Francois, northwest to Bartlett's Harbour, and on the eastern boundary north to Jackson's Arm.
- All mental health services (Corner Brook, Stephenville, Deer Lake, Port Saunders, Burgeo, Norris Point, Port aux Basques) provide promotion, education and prevention services, consultation, assessment and counselling services to children, adults, families, groups and communities for mental health/mental illness-related issues.
- The authority offers community based programs and acute and long term care services
- The Mental Health Unit is a 23 bed Acute Care Service at Western Memorial Regional Hospital that serves as the only Mental Health Unit in the Western region of Newfoundland
- The Mental Health Rehabilitation outpatient service provides supportive care to individuals with mental illness and their families.
- The community based programs provide health promotion, health protection, mental health and addictions, community corrections, child youth and family services, child care services, community support programs, intervention services, and community health nursing
- Primary health care, secondary acute care, adult rehabilitation and long term care services are provided through the Authority's many health centres

Labrador-Grenfell Health:

- Labrador-Grenfell Health provides quality health and community services to the communities north of Bartlett's Harbour on the Northern Peninsula and all of Labrador
- They deliver both primary and secondary health services to the residents of the region, including acute care, diagnostic services, continuing and long term care, health promotion, mental health and addictions, family and rehabilitation services, child protection and intervention services, youth services, adoptions, child care services, residential services and community health nursing
- Mental health services are provided through hospitals within the region (Captain William Jackman Memorial Hospital in Labrador City, Labrador Health Centre in Happy Valley, Goose Bay and Curtis Memorial Hospital in St. Anthony). Services are also provided in Flower's Cove, Roddickton, Forteau, Port-Hope-Simpson, Cartwright and Churchill Falls
- Outpatient counselling services include individual counselling, family counselling, couple counselling, youth work, and case management for chronic and persistent mental illness

INCOME SUPPORTS

In Newfoundland and Labrador, the provincial social assistance program is known as Income Support and is governed by the *Income and Employment Support Act* and the Income and Employment Support Regulations. The Department of Human Resources, Labour, and Employment is responsible for the delivery of the Income Support program to adults within the province. Basic benefits are only provided to adults (children's basic benefits are provided through the provincial child benefit). Clients who leave social assistance for employment are provided with an extended drug card for six months. Basic assistance includes a shelter allowance, as well as benefits to cover basic needs of food, clothing, utilities, etc.

Maximum shelter allowance rates are based on the number of people in the household and the type of accommodation.

- Employment and Income Assistance clients are eligible for the following monthly exemptions on **earned income**:

- Clients without disabilities may retain $75 plus 10% of income over $75 to a maximum total exemption of $150 a month
- Clients with disabilities may retain $95 plus 10% of income over $95 to a maximum total exemption of $150 a month
- Families without disabilities may retain $150 plus 10% of income in excess of $150 to a maximum total exemption of $275 a month
- Families with disabilities may retain $190 plus 10% of income in excess of $150 to a maximum total exemption of $275 a month

- Total income for a single individual with a disability was estimated at $10,997 (which includes basic social assistance, other provincial/territorial benefits and GST credit)[138]
- In 2007, there were a reported 43,000 recipients (25,900 cases) of Employment and Income Assistance[139]
  - Approximately 22 % (or 5,600 cases) of all Employment and Income Assistance cases were due to disability[140]

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

THE SUPPORTIVE LIVING COMMUNITY PARTNERSHIP

This interdepartmental government initiative, the Supportive Living Community Partnership, was introduced in 2009 and attempted to overcome two major problems that the non-profit sector was having:

1. Non-profit organizations relied on multiple government programs for money and had to fit their requests within the parameters of all of those programs, which often meant non profit organizations were often compromising on what they really wanted to do
2. Due to a lack of operational funds, a number of good ideas/projects that had capital money but could not get off the ground

The program was developed by provincial government departments (e.g., 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 their financial resources and put a single request into Cabinet. The request was approved and one of the regional directors was seconded to implement the initiative with funds being managed by the one director/department.

The Supportive Living Community Partnership is tasked with developing programs, assessing need, and responding to the need of communities by supporting the provision of a range of supportive housing/supportive living options. This allows for non-profit, community-based groups to work closely with the government while providing funds to operate supportive living. Supportive housing (within this initiative) is defined as 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-based, broad-based perspective not at the individual level (e.g., those requiring a high level of individual support). Programs that require a home-support program (e.g., 24-hour a day one-on-one support) are restricted from funding.

The overall goal of the initiative is to fund community groups that will develop a model of services and staffing for individuals that do not require a high level of support. The program can fund a range of community services that are individualized for the needs of the community. The focus of funding is for those individuals who are in and out of institutions, health care, and emergency shelters. Furthermore, it is not focused on supporting congregate living but

[138] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability,* Bulletin Number 2.
[139] Federal-Provincial-Territorial Directors of Income Support, 2010. *Social Assistance Statistical Report, 2007.*
[140] Ibid.

looking more to developing scattered units from a *Housing First* model; however, funding is available for clustered on-site services, scattered sites housing, and more flexible community services and supports. All funding is dedicated 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
- Funds to sponsor a conference on meeting the needs of individuals with complex needs (held in St. John's in October 2009)
- To create a full time position to support capacity building within the system
- To obtain on site support services offered at Choices for Youth (transitional housing for youth)
- To co-fund a housing development worker position in Labrador (monies are to be used for operational costs only)
- Choices for Youth
- A replication of the "Eva's Phoenix" model in Toronto –supportive housing units for 12 youth; on-site supports, with flexible services and an educational and employment readiness program
- Transitional housing for youth
- Funding on site support (ICM model)
- Community Advisory Boards established in 5 communities
- Created community plans

The hope is that through this program more scattered units and out-reach services will be developed (*Housing First*). The amount of funding and funding level by the Supportive Living Community Partnership depends on the target population, and the program utilizes a general assessment tool to determine funding. This depends on the level of program, services, and staffing. This process was implemented to allow for flexibility in program development and to ensure that funding can meet the needs of the community.

NAVNET

NAVNET is an innovative cross system 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. NAVNET co-sponsored "From the Outside In," a Fall 2009 conference where speakers from Australia profiled innovations in service delivery for people with complex needs. Building on these learning's, NAVNET has been engaged in a wide variety of activities aimed at coordinating our response to individuals with complex needs. Some of these activities have included:

- The completion of a comprehensive cost analysis to determine the costs associated with providing services and support to 10-12 clients who use multiple government and community systems
- In development is an information sharing protocol in line with existing Privacy Legislation. This will allow NAVNET Member Departments and Agencies to share relevant information to ensure that services are individualized, coordinated, and that duplication does not occur. It is expected that this protocol will include a client consent form as well as a Memorandum of Understanding between NAVNET Members
- A client identification project which quantified for NAVNET the number of individuals in St. John's who meet their definition of "complex needs"
- Exploring ways to facilitate development/increase in housing system capacity that will address gaps and meet the needs of (future) NAVNET clients
- Enhancing communication through use of specific tools including a webpage (www.navnetnl.ca), newsletters (the "Navigator" provides progress updates on the work of NAVNET) and electronic bulletins (shares information and

upcoming events between the government and community sectors). Other strategies such as creative networking ideas (workshops, brown bag lunches; lunch and learns) are in progress

- Through knowledge transfer initiatives, the NAVNET Project Coordinator has presented at a wide variety of forums, including the National Health Care Leadership Conference in Winnipeg in June 2010 and at a Roundtable organized by the Mental Health Commission of Canada and the CMHA (National Office) in Ottawa in November 2010
- NAVNET has submitted a funding submission for a one year demonstration project of a new coordinated service model

CHALLENGES IN HOUSING AND RELATED SUPPORTS

Traditionally, the major challenge in housing individuals with mental illness has been a lack of funding. NGOs have had to spend time cobbling together resources to create and sustain housing. The Supportive Living Community Partnership is thought to counter this issue.

Within mental health dedicated housing, there exists a mismatch with regard to client need and available housing models. Specifically, housing models/stock, such as the boarding room model from the time of deinstitutionalization, continues to exist.

Another challenge is the development of affordable housing in Newfoundland. There are issues with the availability of low income housing, and permits are given to private developers without expectations that they provide affordable housing. There is a low vacancy rate and landlords are able to 'cherry-pick' tenants.

There is currently no incentive for developers to develop housing for people with mental illness. In addition, due to the oil industry and other spin off industries, the price of real estate in the province has increased dramatically in the last couple of years, especially in St. John's. The trend in housing development has been towards building 'lifestyle' condos for the baby boomer generation or condos for off-shore oil company employees.

An additional challenge is the fact that there are a limited number of long-term care facilities in Newfoundland and Labrador, so housing for the older adult population will continue to be an issue as the population ages. Furthermore, more seniors are migrating to St. John's to be closer to specialized services. This trend has contributed to the housing shortage in St. John's.

Given the lack of adequate and affordable housing options in Newfoundland, many individuals with mental illness remain in hospital for extended periods of time.

FUTURE DIRECTIONS: TRENDS IN HOUSING & RELATED SUPPORTS

Traditionally, services in the province have worked in silos, with the exception of some formal (e.g., The Supportive Living Community Partnership) and informal partnerships. It is hoped that the New Supportive Housing Initiative will help tackle this issue.

Coinciding with the implementation of the provincial housing strategy, there has been a recent trend for the provincial social housing provider (e.g., NL Housing) to earmark rent supplements for persons with mental health issues/mental illness. The social housing plan included funding for 400 new rent supplements through the poverty reduction strategy. The overall goal is to support living for individuals that need more integrated/aligned services.

With regard to specific models, the government and community philosophy has leaned toward a *Housing First* model, which provides rapid access to more permanent housing. Historically, funding has been allocated to congregate housing; however, this has been the resultant effect of a lack of housing development rather than a preference toward the model.

The Ministry of Health and Community Services has downsized the boarding home stock by approximately 20-30%. Currently, *Housing First* models are being funded. The Ministry of Health and Community Services has placed priority on

getting people into housing from institutions with a provincial government commitment to fund dedicated housing. Dedicated housing sites that are both clustered and scattered continue to receive funding. In regard to housing support, funding is varied.

With regard to specific complex populations, there is a strategic approach to better serve those with involvement in the criminal justice system.

Transportation to services is also an issue in Newfoundland. As the population in Newfoundland is scattered, individuals need to travel to St. John's for services.

NORTHWEST TERRITORIES

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of the Northwest Territories (NT) is approximately 41,464 (Statistics Canada, 2009). The Aboriginal identity population in NT is approximately 20,635 (Statistics Canada, 2009). In 2006, the unemployment rate in NT was 10.4% in comparison to the rate of 6.6% across Canada (Statistics Canada, 2009).

Approximately half of the population in the NT resides in the territory's capital city of Yellowknife; as such the majority of services are located in the capital city. There exist an additional thirty-three communities in NT, all with scarce services.

The Health Status Report (2005) indicated that by 2008 most of the population in NT would be in need of mental health services. According to the NWT Addictions Report 2006, approximately one-third of the NT population is engaged in hazardous drinking practices. Furthermore, the majority of the NT population reported using cannabis in their lifetime. Overall, the proportion of lifetime users increased from 53 per cent to 60 per cent.

As indicated in the Yellowknife Homelessness Report Card (2008) there are some specific characteristics unique to the North that should be considered. These include:

- Remote geography
- Harsh climate
- High cost of living
- High rates of social issues (e.g., addictions, domestic violence and intergenerational dependency on income support)
- Underdeveloped infrastructure
- Inability to access market housing
- Small population base
- Lack of accessible and affordable transportation systems between communities
- High cost of labour and materials to increase housing stock
- Cross-territorial migration with minimal funding to supply adequate social housing and other services to migrants
- Cultural transformations and urbanization

Furthermore, the Report Card highlighted that couch surfing is an issue within the North that puts already vulnerable populations at risk to predators involved in criminal activities (e.g., theft, sex trade or drug trade).

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

Within the NT various organizations provide housing and related community supports. These organizations range from government and non-governmental organizations to for-profit and non-profit as well.

Northwest Territories Housing Corporation: The Northwest Territories Housing Corporation is the Crown Corporation of the territory. NT Housing Corporation offers a program structure named Housing Choices whereby four programs offer flexible delivery options to assist NT residents to become more independent and successful homeowners. The four programs are described below in the following section.

Non-Governmental Organizations: Support programs, such as transitional housing and shelter support programs, for individuals with mental health issues and mental illness are provided through various NGO agencies. Some examples include The Centre for Northern Families, Side Door, The Salvation Army, YWCA Yellowknife, Aurora Oxford Foundation, Canadian Mental Health Association, Food Bank, Food Rescue, Healing Drum Society, John Howard Society, Literacy

Council, Native Women's Association, NWT Council of Persons with Disabilities, Religious Organizations, Tree of Peace Friendship Centre, Wellness Coalition: Community Service Patrol and Citizens on Patrol, Women's Society, and Yellowknife Community Foundation.

Department of Health and Social Services: The Department of Health and Social Services works in partnership with the eight territorial Health Authorities to plan, develop, evaluate and report on program and service delivery that supports health and well-being. The major responsibilities of the Department of Health and Social Services include: securing funding, developing legislation, setting policies and standards, monitoring and evaluation and strategic planning. Health and Social Services is responsible, within their mandate, to provide support to people with both social and health issues, as well as people that suffer from physical, emotional, or mental health problems.

Health and Social Services Authorities: There are eight Health and Social Services Authorities (HSSA) in NT. Key responsibilities of the HSSAs include the planning and delivery of health and social services and day-to-day management and administration of program and service delivery. Each HSSA creates independent strategic plans that align with the overall HSS system plan.

The NWT Council of Persons with Disabilities provides financial assistance to regional groups that provide support services to persons with disabilities in Inuvik, Hay River and Fort Smith. Financial assistance, training opportunities and workshops to newer groups in the Tłı̨cho and Sahtu regions is also provided. The NWT Council of Persons with Disabilities is the only cross-disability, territory-wise, non-governmental association that works with persons with disabilities.

FUNDING

- Northwest Territories government receives $28.7 million per annum by the **Canada Mortgage Housing Corporation** to support social housing
- The **Department of Health and Social Services** provides approximately $1.75 million to the Regional Health Authorities for the five NWT family violence shelters. This is the main source of funds for all shelters[141]. In addition, the Department of Health and Social Services, in partnership with the Council for Persons with Disabilities provides support for various programs to support people with disabilities in communities. The Department also announced a four-year contribution agreement (2006-2010) for funding of $100,000 per annum to enhance and develop options for senior-specific community outreach programs
- Emergency shelters are funded by the Government of Northwest Territories based on the number of emergency beds and the number of days the beds were used
- NGOs receive funding by the **Government of Northwest Territories** to cover capital costs for housing with supports for individuals with mental health issues/mental illness; however, programs are fragmented and the amount of government funding for supported housing is difficult to ascertain
- The **Homelessness Partnering Strategy** provides capital funding
- **Small Community Homelessness Fund** (SCHF) provides funding for the development of local projects to address emergency shelter and community homeless issues outside of Yellowknife, Fort Smith, Inuvik and Hay River. This funding became available in 2007/2008 and is overseen by a steering committee led by **Health and Social Services** with representation from **Education, Culture and Employment, Justice**, and the **NWT Housing Corporation**

[141] Northwest Territories Health and Social Services. Northwest Territories Health and Social Services System Annual Report 2007/2008. pp 23

PROGRESS TO DATE: KEY INITIATIVES

This section will present various initiatives in the NT that have influenced housing and related supports. The initiatives described included both policy and planning initiatives.

FRAMEWORK FOR ACTION 2008-2011, NORTHWEST TERRITORIES HOUSING CORPORATION (NWTHC)

The NWTHC's Framework for Action 2008-2011 (Northwest Territories Housing Corporation, 2008) identifies the strategic actions required over the next three years to deliver on their mandate and to address the housing expectations of the Government of the Northwest Territories (GNWT) and all residents. The intention is for the framework to be a living document to ensure that changing needs will continually be addressed and met. The purpose of the framework is to provide an awareness of the undertakings of the NWTHC and to provide a basis for further strategic and business planning activities.

The eight plans of action are based on the corporate responsibilities contained in the *Northwest Territories Housing Corporation Act* and guided by principles that have been informed by stakeholders, as well the actions are recommended through the Mandate consultation. The eight plans of action are as follows:

1. Provide access to affordable, adequate, and suitable housing
2. Ensuring the long-term sustainability of the existing stock
3. Improve energy efficiency and reduce environmental impacts
4. Secure and protect our investments
5. Contribute to safe, healthy and sustainable communities
6. Provide training opportunities in housing
7. Foster partnerships
8. Communicate with those we serve

NWT ACTION PLAN FOR PERSONS WITH DISABILITIES, FEBRUARY 2008

The Disability Steering Committee Partnership was tasked with developing an interdisciplinary and multi-dimensional framework that would serve to "guide the development of effective programs and services, and promote the full inclusion of persons with disabilities throughout the NWT" (The NWT Disability Framework, 2004). The five priority areas or core building blocks are as follows:

1. Education
2. Employment
3. Income
4. Disability Supports
5. Housing

Within the priority of housing the framework identifies the need to ensure that persons with disabilities will be provided with a range of housing options that are affordable, accessible and that maximize independence; accommodations to ensure safe and adequate housing; that special features in housing are provided; and that independent living supports are in place so that persons with disabilities can remain in his or her home as long as possible and still be independent.

2009 NWT COMMUNITY SURVEY – HOUSING NEEDS COMPONENT

The NWT Bureau of Statistics conducted a survey in all communities in the Northwest Territories between January and March in 2009 with the purpose of measuring and analyzing housing conditions in the Northwest Territories. Housing conditions were reviewed based on nationally accepted indicators such as suitability, adequacy and affordability. Housing that did not meet one or more of these indicators was deemed to have a 'housing problem.' In circumstances where a dwelling is deemed to have a housing problem and a total income below the Core Need Income Threshold, the dwelling is considered to be in 'core need.' Overall, it was found that 19% of dwellings in the Northwest Territories were in core need. This figure has increased from 2004 to 2009, with the greatest contributor being the increase in the percent of households with adequacy problems, particularly with those in need of major repairs. The Nahendeh district was found to have the highest proportion of core need, with over 36% of dwellings in core need. Table 1 depicts key findings from the survey.

Table 1. *Key Findings of the 2009 NWT Community Survey – Housing Needs Component.*

Housing Indicators		
Suitability	**Adequacy**	**Affordability**
Having an appropriate number of bedrooms for the characteristics and number of occupants as determined by the National Occupancy Standard Requirements	Adequate housing must have running water, an indoor toilet, bathing and washing facilities, and must not require major repairs	Affordable housing costs less than 30% of household income where shelter costs include utilities, water, heat, insurance, property taxes land lease costs and rent or mortgage payments
Findings by Housing Indicator		
▪ Approximately 7.6% of households in the NWT showed suitability problems ▪ In the NWT, 1,291 households were considered overcrowded (9% of total number of households in NWT)	▪ Approximately 16% of households in the Northwest Territories require major repairs ▪ Smaller communities showed greater need with a range of 29-61% ▪ Regional centres varied between 10-15% ▪ Only 4.3% of dwellings in Yellowknife required major repairs ▪ Housing adequacy was mainly an issue for owned homes and public housing units ▪ Private market rentals required the least amount of maintenance ▪ 19% of owned homes and 24% of public housing units required major repairs	▪ 14% of households in the NWT were found to have affordability issues ▪ Approximately 48% of the dwellings in the NWT are rental properties, with 52% being private market and 33% are public housing units (the remaining 15% are staff housing)

SHAPING OUR FUTURE 2006-2010

This action plan was organized around the six core services of the Integrated Service Delivery Model. It also contains actions that support improved management and accountability for the delivery of health and social services. The eight priority actions outlined in the plan are as follows:

1. Promoting and Prevention Services
2. Protection Services
3. Diagnostic and Curative Services
4. Rehabilitation Services
5. Continuing Care Services
6. Mental Health and Addictions Services
7. System-Wide Management and Accountability
8. Human Resources

Several actions highlight key issues and related deliverables at the community level. These are outlined below:

- **Improving community capacity to support rehabilitation** services was highlighted as an action to ensure that assessments and recommendations can be followed up at the community level. The development of a training program for rehabilitation aides was the deliverable related to this action.
- **Expanding services for identified target groups (e.g., seniors, persons with disabilities, and victims of family violence)** was an action outlined within continuing care services to address the issues of improving services in conjunction with other Social Envelope Departments for targeted groups, and increasing support for people with disabilities. The resultant deliverables included the implementation of the Seniors Action Plan and the Disability Action Plan. In addition, multi-year funding agreements that consolidate individual contribution agreements was a stated deliverable.
- The **development of supported living options for people with disabilities or mental illness** as well as **respite programs for parents with difficult-to-manage children** was another action highlighted within continuing care services. This action was put forth to prevent the long-term institutional placement of people living with disabilities or mental illness. Key deliverables included: pilot supported living enhancements and the development of an implementation plan.
- Within Mental Health and Addictions Services, a key action was the **implementation of community-based prevention, treatment and counselling for addictions and mental health** through initiatives such as:
  - Increasing the skill level of staff working in the mental health and addictions fields
  - Developing next steps in the implementation of year 3 of the strategy (this includes initiatives to support increased treatment services through Natsejeke, the Salvation Army and mobile treatment and on-the-land programs)
  - NWT addictions awareness campaign
  - Children and youth mental health promotion

These actions were highlighted to address the issue of services needing to be provided closer to where clients live and developing additional treatment options (e.g., mobile treatment and on-the-land programs), particularly for youth. The main deliverables to address this action included: a 'Next Steps' work plan; stakeholder consultations; an implementation plan; preliminary analysis of a 'Communications Plan' with recommendations on approaches for a mass media campaign on addictions; and a RFP to design the NWT addictions awareness campaign.

RANGE OF HOUSING ACCOMMODATIONS

Table 2. *Overall Range of Housing Options in the Northwest Territories*[142].

Range of Housing Options	
Dedicated Mental Health Housing	n/a
Non-Dedicated Affordable Housing	Social Housing Programs Rent Supplement Program Co-operative ILM Housing Program Rural and Native Rental Housing Rural and Native Homeownership Programs
Additional Facilities or Housing Options	Supported Living[143] Transitional Housing[144] Emergency Shelter Assisted Living & Half-Way Housing

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

The estimated percentage of the population in social housing experiencing mental health issues is not known and it is especially challenging to estimate in communities outside of Yellowknife.

The NT Housing Corporation manages 2,650 units across the territory, some of which are dedicated for individuals with physical disabilities. For individuals with mental health issues living in social housing, supports are not provided through the housing provider or through partnerships with community-based organizations.

Table 3. *Non-Dedicated Housing Options in NWT.*

Region	Program	Type	Description	Capacity
Various	Social Housing Programs	Housing only	Federal and Territorial governments share operating subsidies. Rents are calculated according to rent-geared-to-income	2,650 (297 -Yellowknife)
Various	Rent Supplement	Housing only	These programs provide subsidy assistance for social housing projects or units owned by private landlords, non-profit organizations and cooperatives	541

[142] Note that the range of options is not intended to imply an adequate supply of each option, as accessibility issues exist in various options

[143] In the NWT Supported Living refers to longer term 24/7 support to people with disabilities

[144] Transitional Housing refers to housing that is shorter term and provides life skills support

Region	Program	Type	Description	Capacity
Fort Smith Yellowknife	Co-operative ILM Housing Program	Housing only	These co-ops operate under the Federal Co-operative Housing Program and are funded with index-linked mortgage loans. These are long-term loans (30 to 35 years) in which the lender is guaranteed a real rate of interest after inflation and the borrower's payments are adjusted up or down each year in accordance with changes in the Consumer Price Index.	130 (Fort Smith - 30 units) (Yellowknife - 100 units)
Various	Rural and Native Rental Programs	Housing only	Program provides subsidized housing units for households in need of rent-to-income support in rural areas. Also available for housing projects by private or non-profit associations	590
Various	Rural and Native Homeowners hip Programs	Housing only	Program provides households in rural areas with assistance in acquiring affordable, adequate and suitable accommodation.	46

Canada – Northwest Territories Affordable Housing Program Agreement, 2009: This joint investment between the Government of Canada and the Northwest Territories has been implemented to build new affordable housing and to assist low-income households with renovation costs for their homes. Both governments signed an amendment to the existing agreements (Canada-Northwest Territories Affordable Housing Program Agreement and the Housing Renovation Program Agreement) which has resulted in an investment of $59 million by the federal government and $58 million by the Government of the Northwest Territories over the next two years. This is an additional combined investment of $7 million by both levels of government for a two-year extension to each of the original agreements.

Providing Assistance for Territorial Homeownership (PATH): PATH is a program which helps individuals to become homeowners by assisting in the construction or purchase of a home in the form of a forgivable loan. Individuals obtain additional funding from sources such as an approved financial institution. Additional assistance is available for improving the accessibility of homes for persons with disabilities.

Contributing Assistance for Repairs and Enhancements (CARE): CARE is a program that provides assistance to existing homeowners for repairs to their home to ensure a safe and healthy residence and to increase the useful economic life of their home. Assistance is provided in the form of a forgivable loan. Additional assistance is available for improving the accessibility of dwellings for persons with disabilities.

Homeowner Entry Level Program (HELP): HELP is a program which provides assistance to prospective first-time homebuyers who are unable to secure mortgage financing or are unsure of their responsibilities as homeowners. Clients of this program are provided with the opportunity to experience homeownership commitments before purchasing a home. Assistance is provided through a lease on an NT Housing home and applicants pay 20% of their gross income toward the lease (rent) payment and shelter costs. After successfully completing a two-year lease (rental) period, clients are eligible to receive an equity contribution that would be used towards the purchase of a home

Solutions to Educate People: STEP is a program that provides education and counselling assistance to prepare participants for the requirements of homeownership. The aim of the program is to increase financial skills, knowledge of the home purchase process, and basic home maintenance repairs. Assistance is provided in the form of four courses.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

In the NT, housing options are limited to emergency options and housing with supports (e.g., transitional housing) that are not specifically dedicated to individuals with mental health issues. In any case, persons with mental illness often occupy beds/units in the various shelters and transitional homes. With regard to funding, Bailey House is the only NGO that receives operational money. Operated by the Salvation Army, Bailey house has received funding through the Homelessness Partnering Strategy.

A major crisis with regard to housing options in NT is the lack of capacity to serve youth (aged 16-19). Overall, housing is provided in the form of emergency shelters. This poses a risk as there is the potential for violence and predatory behaviour for this vulnerable population.

Family violence and housing for families are other priority areas in NT. Currently, the Department of Health and Social Services provides funding for five family violence shelters throughout the NT including: the Family Support Centre (Hay River); Tuktoyaktuk Women and Children's Shelter; Inuvik Transition House; YWCA Alison McAteer House (Yellowknife); and YWCA Sutherland House (Fort Smith).

There have been several initiatives to increase the housing options available to various vulnerable groups in NT. Three supported living homes and a building for day programming will be constructed in Hay River for individuals with moderate to severe cognitive disabilities. There will be a total of 12 beds, two of which are designated for respite clients.

In addition, the Yellowknife Association of Concerned Citizens for Seniors is planning to have a 24-bed Territorial Dementia Facility to be operational in early 2010, with the support of HSS and a partnership with Diavik Diamond Mines

Furthermore, Supportive Living Services for residents of the South Slave Region (funded by the Hay River Health and Social Services Authority) will be constructed and will consist of three group homes. The main purpose of the program is to provide assisted living for individuals with an intellectual or developmental disability to live in NT; many such residents are living in long-term care facilities in the South.

Table 4. *Additional Facilities in the Northwest Territories.*

Region	Program	Type	Description	Capacity
Yellowknife	Centre for Northern Families	Emergency	Emergency shelter for single women offering a community advocacy program and a daycare within the facility	23 beds
Yellowknife	Centre for Northern Families	Housing with Supports	Transitional housing program	3 beds
Yellowknife	Sidedoor	Emergency	Emergency drop-in center for youth. Provides an after school program, evening drop-in center, and overnight drop-in	
Yellowknife	The Salvation Army	Emergency	Emergency shelter for single men	40 beds

Yellowknife	Bailey House (SA)	Housing with supports	Supports include skills for independent living (e.g., life skills support including tenancy skills), community drop-in medical clinic, community advocacy, daycare, some crisis services capacity, withdrawal management services	32 beds
Yellowknife	YWCA – Rockhill	Housing with supports	Transitional housing for families. Supports include crisis support, life skills support, including tenancy skills	27 units
Yellowknife	YWCA – Alison McAteer House	Emergency	Emergency housing for women and children of family violence	32 beds
Yellowknife	Aurora Oxford Foundation	Housing with Supports	Housing for Aurora Oxford House Foundation is a non-profit organization providing housing and services to individuals recovering from alcohol and drugs in Yellowknife. This foundation has been in existence since 2005. It runs a house for men and just recently opened up an Oxford House	

MENTAL HEALTH SUPPORTS

Table 5. *Range of Mental Health Supports in the Northwest Territories*[145].

Range of Mental Health Supports	
Community Connections	Generally provided by organizations with broader mandates to serve people with mental health, addictions, FASD issues
Community Mental Health Services (includes addictions' services)	▪ NWT Counselling Program – wellness workers ▪ Outpatient psychiatric services ▪ Addiction Treatment Facility ▪ Withdrawal program ▪ Outpatient addictions program
Inpatient Services	Inpatient psychiatric services (Stanton Regional Hospital)
Other	Prevention and education initiatives (NWT Community Counselling Programs)

FUNDING LEVELS

A review of mental health and addictions services in 2005 identified that a total of $7.1 million dollars was allocated for community-based mental health and addictions services in 2005-06. This does not include funding for psychiatry services or residential programs that cross-over with addictions and mental health[146]. It was estimated that there were approximately 77 full-time equivalent wellness workers.

[145] Note the range of mental health supports does not imply an adequate capacity/level of resources and funding in the various services
[146] Chalmers et al, December 2005, p.31.

RANGE OF MENTAL HEALTH SERVICES

In the Northwest Territories various organizations provide mental health and addiction services including, but not limited to, Stanton Regional Hospital, Mental Health Clinic, Yellowknife Health and Social Services Authority, Tree of Peace Friendship Centre, and Healing Drum Society. In general, services are provided through regional authorities, or through community-based non-profit organizations that have agreements in place with regional authorities to deliver services

Mental Health and Addictions Services are identified as one of six core services in the Department of Health and Social Services Integrated Services Delivery Model. The NWT Community Counselling Programs provide support and counselling for addiction, mental health and family violence issues, make referrals to addictions treatment programs or other services as needed, and provide prevention and education initiatives. Services are primarily provided through community wellness workers.

Addictions services are limited, however, some options exist. For example, there is an addiction treatment facility in Hay River and a withdrawal program at The Salvation Army for men and women in Yellowknife. Children and youth access residential treatment programs in southern Canada. There is also a Matrix Intensive Program funded by the Fort Smith Health and Social Services Authority which consists of a locally delivered 16-week outpatient addictions treatment program to accommodate individuals who do not want to leave their families and community for addictions treatment.

Mental health and addictions services are a core service of regional health authorities. Key services are designed to respond to mental health and addiction issues, family violence problems through education, prevention, treatment, and aftercare. These services are delivered as an integrated program, and are targeted at individuals with a mental illness, mental health issue, addiction, or concurrent disorder.

Four hospitals and 28 health centres deliver insured hospital services to both in and out-patients. Where available, these facilities offer psychiatric and psychological services under an approved program.

Other Non-governmental Organizations that provide related supports include:

- Healing Drum Society
- Canadian Mental Health Association
- John Howard Society
- Native Women's Association
- Wellness Coalition: Community Service Patrol and Citizens on Patrol

INCOME SUPPORT

The territorial social assistance program is known as Income Assistance and the program is governed by the *Social Assistance Act* and delivered by the Department of Education, Culture and Employment. Assistance includes allowances for food, accommodation, utilities and fuel (the actual amount of fuel and utilities is paid). An enhanced benefit is also available for persons with disabilities, seniors and for applicants who participate in a program, such as employment or volunteering. The enhanced benefit provides allowances for clothing, education expenses, furnishings, security deposits, emergency and day care.

According to the 2007 Social Assistance Statistical Report (Federal, Provincial, Territorial Report released May 2010, pp. 119 – 121), when applying, people with disabilities are entitled to retain $5,000 in assets as are aged persons. Single clients with or without disabilities receiving income assistance can have earning exemptions of up to $200 per month plus 15% of any earned income in excess of $200. Families may retain $400 per month plus 15% of any earned income in excess of $400. In March 2007, there were 1,817 recipients (total of 1,046 cases) receiving income assistance, with 34% of all cases being for reasons related to a disability. Of this group, fewer than 10% had been receiving assistance for one

year or less, 40% for more than one year to five years, and about 34% of cases had been receiving benefits for one year or less, and nearly 50% for more than five years.[147]

The following was discussed as part of the Canadian Council on Social Development's series on poverty policies and programs (Canadian Council on Social Development, 2009e, p.13):

> Problems in the income security system and efforts by civil society groups working to eliminate poverty prompted a review of Income Security programs in 2004. That review process led to the development of an Income Security Policy Framework for Self-Reliance (Canadian Council on Social Development, 2009e). This new framework set out the Territory's vision for the development of policy and promoted consistency across income support programs. It was significant in that it formally reflected a transition in the view of income support programs from being "programs of last resort" to "programs aimed at increasing self-reliance." It also signaled that the Government was monitoring efforts in other jurisdictions as it began to use the language of poverty reduction.

Ultimately, the new framework has generated concern that without setting measurable outcomes and specific targets, it falls short of being a comprehensive poverty reduction strategy.

CHALLENGES IN HOUSING & RELATED SUPPORTS

- All tenants of subsidized housing in NT are subject to 3-month lease terms
  - The government does not have to have the grounds to evict a tenant after the 3 month period, which makes it extremely difficult to house vulnerable populations in social housing
  - If an individual wishes to challenge an eviction, they must do so in supreme court
- 90% of the housing stock is owned by the territorial government
- If an individual owes money to the housing authority, they cannot gain access to housing in another community until all arrears are paid (includes all damages)
- Vulnerable populations have better luck with private landlords as they do not have 3 month lease terms and housing tenure is more secure in the private market
- Social housing providers do not make accommodations for vulnerable populations
- Individuals resort to 'roaming' from house to house and will often stay with elders as they will not be kicked out of the home
- It is common for up to 5 families to live in one house do due the lack of stock and rigid lease terms
- Addictions workers were made 'Wellness Workers' wherein they could only make referrals to services
- Regional Mental Health Workers deliver formal mental health services. However, most of these positions are not filled. Thus, the end result has been a loss in resources
- Psychiatrists are typically visitors to the North (i.e., do not reside there) and are not well aware of the situation in the North. Therefore, an individual's context is typically not considered when diagnosing a client. Most diagnoses are addictions-related so that individuals can gain access to services in the community
- Mental health services are typically focused on First Nations. Differences among Inuit and First Nations cultures are not acknowledged. This poses an issue for individuals receiving services as they are perceived as incompliant with treatment when they do not participate in rituals that are not a part of their culture
- Additional issues identified in a recent review of mental health and addictions programs included[148]:

[147] Federal/Provincial/Territorial Report on Social Assistance, 2007, released May 2010 http://www.hrsdc.gc.ca/eng/cs/sp/sdc/socpol/publications/reports/sd10-3-2004e/page16.shtml

- Changing socio-economics – improving economies and employment opportunities, notably the gas pipeline project in the Mackenzie valley, which concurrently will create a need for more health and social services
- Drug usage patterns are changing and being influenced by improved economics, drug availability, etc. with a resultant concern that there is a need to address education and prevention for "hard" drugs (i.e., cocaine, crack cocaine, methamphetamines/crystal meth)
- Role of self-government and Aboriginal land claims
- Role of residential school programs and healing services
- The aging population – addictions and mental health issues with elders, older adults and those with chronic health conditions such as diabetes. Prevalence of dementia, depression, suicidal ideation and gambling in older adults
- Adults living with FASD (Fetal Alcohol Spectrum Disorder)
- Child/youth early intervention – there's a demand for services and expertise
- Primary Community Care Teams (PCCT) and role of Nurse-Practitioners
- Reduced reliance on specialties such as psychiatry and more mental health diagnoses/treatment interventions given by general practitioners and family physicians
- Increased regulation of human service providers (counsellors, social workers, psychologists) with legislated scopes of practice

- Jeffrey Wilson, as part of the CCSD Poverty Reduction Policy and Program review for NWT, noted that there is a critical lack of affordable, safe, and secure housing in NWT and identified the following issues related to housing:
  - Home ownership in NWT is 53%, well below the national average of 68%
  - Rental housing is in short supply thus rents are extremely high, and applicants must go through an invasive screening process
  - Landlords are able to evict people without cause or recourse
  - The most severe shortages in housing are in public housing with minimum residency requirements placing real burdens on people (e.g., people arriving in Yellowknife or Inuvik must live in the community for at least six months before applying for housing)
  - Addictions have been identified as being at the core of housing insecurity and homelessness
  - Hidden homelessness is thought to be much more prevalent than visible or absolute homelessness
  - Women's homelessness with estimates that up to 5% of the entire female population is homeless

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

Assisting Small Communities to Prevent and Reduce Homelessness and Related Impacts

- The Small Community Homelessness Fund is available to communities outside of Yellowknife, Fort Smith, Inuvik and Hay River for the development of local projects to address emergency shelter and community homeless issues
- A steering committee led by Health and Social Services with representation from Education, Culture and Employment (ECE), Justice and the NWT Housing Corporation, oversees implementation of the SCHF

[148] Chalmers et al, December 2005, p.6-8

- The Pehdzeh Ki First Nation in Wrigley received funding to renovate a church basement into an overnight shelter, as well as to facilitate a life skills workshop for the homeless
- The Deh Gah Got'ie Council in Fort Providence was funded to renovate two bachelor units as emergency housing
- The Katlodeeche First Nation in Hay River was assisted in renovating a three-bedroom house into two bachelor units to provide homeless accommodation on the Hay River Reserve
- The Acho Dene Koe First Nation in Fort Liard received funds to implement their Winter Warm-Up Program. This program includes a weekly hot nutritious meal, a clothing bank and an emergency vouchers program

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

- Historically in NT, supportive-type housing services were in the form of emergency beds/shelters only.
- A 'bottle-neck' effect was occurring wherein persons requiring support would go from emergency beds/shelters to whatever type of shelter they could find (and have no services attached)
- Transitional housing (e.g., Bailey House) is the newest investment towards supportive housing (within the last five years)
- Historically, in order to receive mental health services in NT, individuals had to have an addiction issue. There has been a recent shift wherein mental illness and addiction services are moving in the same portfolio of service provision; however, this has not yet translated 'on the ground' as of yet
- Currently, there are no services for mental illness outside of the hospital
  - All individuals discharged from hospital into community services are discharged into addictions/FASD services

NOVA SCOTIA

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of Nova Scotia is approximately 960,500 (Statistics Canada, 2009) with an unemployment rate of 9.8% compared to a rate of 8.1% across Canada (Statistics Canada, 2010). It is the second most densely populated province in the country. Nova Scotia's economy has diversified from the fishing industry over recent years with significant sectors in small business; mining; offshore oil and gas; the military; information, communications, and technology; and tourism and entertainment.

Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of 0.6%** since 2001 – well below the national average of 5.4% but the highest among Atlantic provinces.
- An **aging population**, consistent with all other regions across Canada, where 15.1% of the population is aged 65 and over (compared to 13.6% nationally); this **ranks Nova Scotia second among all provinces and territories**.
- Slightly less than 4% of the population of Nova Scotia identify their native tongue as French
- About 2% of Nova Scotia's population identifies as having an Aboriginal identify – roughly 24,175 people in 2006.
- 6,900 of the **1.1 million newcomers to Canada** settled in Nova Scotia from 2001 to 2006. In total, the census enumerated 27,400 foreign-born individuals in Halifax – home to the largest foreign-born population in the Atlantic Provinces. Halifax received 5,100 new immigrants, or 0.5% of all newcomers to Canada in 2006. Slightly more than half (51.4%) of the newcomers were born in Asia and the Middle East.
- Of the 376,840 households in 2006, **72% owned the dwelling** they lived in – this represents an increase of 6.5% since 2001 (compared to an 11.8% increase nationally). Of owner households, 52.5% held a mortgage.
- The **share of owner households in urban areas was 57.4%** in 2006 – this is well below the national average of 81.1% but consistent with the low percentages seen in other Atlantic provinces.
- The **proportion of households spending 30% or more of their income on shelter was below the national average** of 24.9% at 22.6% (representing a modest decrease of 0.3% from 2001). However, **rental households in Nova Scotia have the highest rate of core housing need in Canada** (in both 2001 and 2006). 45.1% of all rental households were spending 30% or more of their income on shelter.
- Nova Scotia households had median, annual household shelter costs of $7,588 in 2006 – an 18.1% increase from 2001, consistent with the national average increase of 18.5%.
- In 2006, **fewer than 7% of Atlantic Provinces' households lived in a dwelling that was less than five years old**. The one exception was Prince Edward Island, where 8.3% of households lived in a new dwelling, virtually on par with the national average

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

- The **Nova Scotia Housing Development Corporation** is governed by the Nova Scotia Housing Development Corporation Act.
- Three federal-provincial agreements form the cornerstone of the Corporation's operations:
  - Social Housing Agreement (1997)
  - Affordable Housing Agreement (2002, 2005)
  - Housing Renovation Program Agreement (2003)

- These agreements allow the Corporation to support the province in providing safe, adequate, affordable, and sustainable housing to low and modest income Nova Scotians.
- The Corporation also manages the province's social housing assets, negotiates funding agreements, and provides financing tools for a variety of housing solutions. In addition, the Corporation fills a gap in lending needs as it can borrow long term funds at fixed interest rates.
- The Minister of Community Services is the Corporation's Chairperson and the Deputy Minister is the President.
- The staff of the **Department of Community Services** carry out the management and administration functions of the Corporation, but are not direct employees and receive no remuneration from the Corporation.
- Direct service delivery, including functions such as tenant and property management, is carried out by **seven housing authorities** and their employees.
- In carrying out its business, the Corporation and its agents perform a number of roles, including those of land owner, landlord, administrator, and developer.
- Other corporation activities include the administration of the **Canada Mortgage and Housing Corporation's (CMHC)** mortgage/loan portfolio for Nova Scotia and working with other program units within Community Services and with the Department of Finance to provide direct lending to housing related projects for long-term, interest rate risk reduction.
- The **Department of Health** provides leadership for the overall policy and planning of mental health services in the province. **Nine district health authorities** are responsible for the management and delivery of mental health services, including contracting with non-profit community organizations for service delivery.

PROGRESS TO DATE: KEY INITIATIVES

- Nova Scotia is one of the few provinces with a poverty reduction strategy **Preventing Poverty: Promoting Prosperity** (2009) identifies the vision for 2020: “to break the cycle of poverty by creating opportunities for all Nova Scotians to participate in the prosperity of the province and enjoy a better standard of living” (p. 16). This strategy:
  - Identifies four goals: (1) enable and reward work, (2) improve supports for those in need, (3) focus on children, (4) collaborate and coordinate – with short-, medium-, and long-term actions attached to each goal
  - Cites partnerships with federal programs (Affordable Housing Program Agreement, Affordable Housing Trust, Aboriginal Off-Reserve Trust) and successes to date with respect to housing (i.e., 1,100 affordable housing units created or preserved since 2003)
  - Commits to $59 million for affordable housing over the following three years with a focus on people who have difficulties in accessing housing – single adults, often with disabilities
  - Identifies the need to adjust income assistance personal allowances, review existing provincial housing policies in the context of poverty reduction, and the need for the **development of a long-term housing strategy linked to the goals of the poverty reduction strategy**
- The Government of Nova Scotia committed to development of a mental health strategy in March. The Minister of Health recently created the Mental Health Strategy Advisory Committee. Composed of researchers, clinicians, and people living with or affected by mental illness, the committee intends to make recommendations for mental health and addictions services in the province.

RANGE OF HOUSING ACCOMMODATIONS

Range of Housing Options
▪ Subsidized Home Ownership
▪ Public Housing for Seniors
▪ Public Housing for Families
▪ Rent Supplements
▪ Co-operative and Non-profit Housing
▪ Dedicated Mental Health Housing and Supports - Supported and Supportive
▪ Long-Term Care Homes
▪ Homes for Special Care
▪ Small Group Options
▪ Licensed Group Homes
▪ Emergency Shelter
▪ Transitional Housing
▪ Addictions Treatment/Housing Options

DEDICATED MENTAL HEALTH HOUSING OPTIONS

There are a number of non-profit providers as well as a private housing organization involved in the delivery of dedicated mental health housing in Nova Scotia. The following table summarizes the organization and type of housing provided. Housing with supports available is typically characterized as being supportive in nature, and for the purposes of this project the following distinction is made:

- **Supportive housing** arrangements are located in blocks together with (on-site) supports linked to the housing.
- There are a total of **70 self-contained apartments** with a supportive arrangement.
- **Supported housing** apartments are scattered across various sites with mobile supports available.
- There are a total of **48 self-contained apartments** with a supported arrangement.
- In addition there are **14 beds in a group home setting (Homes for Special Care)** that specifically target people living with developmental disability and/or mental illness. Further discussion on HSC is included under the Additional Facilities section.

Table 2. *Dedicated mental health housing options in Nova Scotia.*

Organization	Type	Capacity
Supportive Housing for Individuals with Mental Illness - New Dawn, Cape Breton Mental Health Program, Canadian Mental Health Association, Crossroads Clubhouse	Housing and supports	13 supportive apartments
Connections Clubhouse	Housing and supports	45 supported apartments
Canadian Mental Health Association	Housing and supports	Range of supportive housing options in various communities
Metro Non-Profit Housing Association*	Housing and supports	Two buildings – one for males and one for females

Killam Properties and Private Landlord/ Capital District Mental Health Program	Housing and supports	47 supportive housing apartments (one to three bedrooms)
Affirmative Industries Association	Housing and supports	10 supportive housing apartments (eight 1-bedroom, two 2-bedroom)
Shelburne Association Supporting Inclusion	Residential care	Homes for Special Care 8-bed group home 6-bed residence
Shelburne Association Supporting Inclusion	Housing and supports	Three supported housing apartments
Metro Community Housing Association	Residential care	Licensed group homes Small Option Homes
Metro Community Housing Association	Housing and supports	Supported Apartment Program

The following provides additional detail on the organizations involved in the provision of the housing models – further detail on service models is contained in the Housing-related Mental Health Supports section.

- **Supportive Housing for Individuals with Mental Illness (SHIMI)**: A private landlord in Sydney (Cape Breton) who has 13 apartments where rent is kept at a flat rate, and will not be increased unless the social assistance rate is increased as well. This initiative (SHIMI) is a partnership between New Dawn Enterprises, the Cape Breton District Health Authority (CBDHA) Mental Health Services Program, the Cape Breton Mental Health Services Charitable Foundation, and the Canadian Mental Health Association (CMHA). Provides a total of 13 apartments in three buildings. New Dawn provides property management, while the CBDHA and the CMHA provide tenant support and referral services. Income support is provided by the Department of Community Services. The first tenants were members of Crossroads Clubhouse, which also provides employment counselling, food services, and counselling, in addition to the mental health and health supports provided by CBDHA and CMHA.
- **Connections Clubhouse**: Located in Halifax, Community Outreach and Housing Program has a strong focus on connecting people with the housing type of their choice, with a range of community and peer supports available. Tenants are provided with a range of clubhouse oriented supports, including access to 24/7 crisis prevention/intervention.
- **Metro Non-Profit Housing Association**: Focuses on people who are homeless or at risk of homelessness in Halifax – over 85% have a diagnosis of mental illness and/or addictions and so they have been included as part of the dedicated housing stock. Staff are on-site during the daytime and use a community development approach, providing referrals to other services as required. Tenants are engaged in community life of the buildings, and at the Board of Directors level. Model is premised on a holistic approach oriented towards harm reduction.
- **Metro Community Housing Association**: Provides support and residential services to persons who have experienced mental health issues. There are three main residential programs: licensed group homes (24-hour staff support for 8-10 residents per home), Small Option Homes (three clients and one staff person per 4-bedroom home), and a Supported Apartment Service which provides mobile supports to people living in independent apartments.
- **Canadian Mental Health Association**: Some of the eight branches across Nova Scotia provide supportive housing
- **Killam Properties** is one of Canada's largest residential landlords, and is based in Halifax. Holdings include 118 apartment properties in Atlantic Canada's six major urban centres and has 55 manufactured home communities across Canada. Killam Properties has provided dedicated units at their sites where a housing worker can live and provide supports on an ongoing basis. Killam has contributed 31 units for clients of the Capital District Mental Health Program (CDMHP) in Halifax (first piloted in 2007) and a second landlord has since contributed an additional 16 units. CDMHP provides tenant support, who also have access to a 24/7 mobile crisis team. Subsidies ranging from 5% to 22% of market rents are provided by Killam as a corporate donation (worth $46,000 in 2009).
- **Affirmative Industries Association**: Developed "Building for Independence" in Halifax, a housing and supports model which assists people living with mental illness to earn equity in their apartment which is then available to help the person buy a home, return to school, etc. Tenants pay into Individual Development Accounts (IDAs) and are provided

with matching grants. There is a total of 10 supportive housing units (eight 1-bedrooms and two 2-bedrooms) for people with mental illness.

- **Shelburne Association Supporting Inclusion**: Located in Sherburne and serves people with disabilities (developmental disability and/or mental illness). There are three programs providing residential services and supports: an 8-bed group home (including one respite bed) in Shelburne, a 6-bed developmental residence (Level 2) in Barrington Passage, and a Supported Apartment/Independent Living Program for individuals living in their own apartments (total of three). The residential supports are individualized and geared toward activities of daily living, budgeting, community awareness, relationships, etc. Both the group home and developmental residence are designated and licensed as Homes for Special Care by the Department of Community Services.

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

Table 1. *Non-Dedicated Affordable Housing Options in Nova Scotia*[149].

Program	Description	Capacity
Public Non-Profit Housing for Seniors	This program is designed to provide adequate, affordable housing to low income seniors (aged 58 and over) in need. Residents are charged rent based upon income. The rent paid is for a fully serviced unit. The units are self contained, and include a stove, refrigerator, heat, and hot water. Some units are designed for the physically challenged. Units are located throughout Nova Scotia. Special consideration is given for people with special needs such as a physical disability.	7,700 units
Public Non-Profit Housing for Families	This program is designed to provide adequate, affordable rental housing to families in need. Residents are charged rent based upon income. The program is managed by the housing authorities. The operating losses are cost shared by the Province of Nova Scotia and CMHC. Priority is given to victims of family violence, applicants whose homes have been condemned, applicants who need to be near a hospital, and applicants who have special needs (e.g., a physical disability).	3,700 units
Rent Supplement Program	This program is designed to assist those needing adequate, affordable rental housing. A rental subsidy is paid to private landlords or cooperative/non-profit housing projects, allowing individuals to pay rent based upon income.	800 units
Rural and Native Housing	Program provides rent-geared-to-income housing and homeowner units for low to moderate income families.	1,200 units
Co-operative and Non-profit Housing	Co-operative and non-profit housing projects programs provide modest, affordable housing for lower- and moderate-income families, seniors, and individuals. Co-operative housing is owned and managed by the resident members while non-profit housing projects are owned and managed by the non-profit sponsors. Depending on the type of co-operative or non-profit housing program under which the housing was developed, and your household annual income, your monthly housing payment may be market rent or less. A member with low-income may be eligible to receive subsidy from either the co-operative's subsidy pool (income tested assistance) or through a rent supplement provided by the Department (Index-Linked Mortgage Co-ops[150]). Most Boards of Directors of co-operative housing projects undertake subsidy reviews annually and distribute rental subsidies based on the amount available to the co-operative.	1,761 units in 74 Housing Co-operatives[151]
Lone-Parent Student Affordable Rental Housing	This program provides a limited number of subsidized rental housing units in privately owned apartment buildings, or cooperative housing projects for to low-income, single parents attending university. These rental units are offered under the existing Rent Supplement Program which is administered by the housing authorities.	70 units included within Rent Supplement Program

[149] Unless otherwise noted, number of units were obtained via the Department of Community Services, Government of Nova Scotia website at http://www.gov.ns.ca/coms/housing/
[150] Information on index-linked mortgage co-operatives can be found here: http://www.fhcc.coop/eng/pages2007/ilm.asp
[151] Co-operative Housing Federation of Canada. http://www.fhcc.coop/eng/pages2007/about_3a.asp?Prov=NS

OTHER INITIATIVES[152]

Homelessness Partnering Strategy (HPS): Launched on April 1, 2007 by the federal government, building on the foundation of its predecessor program, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five year commitment. Halifax and Sydney (Cape Breton) both qualify under the "Designated Communities" funding component. A key focus of the HPS is a *Housing First* approach, and focuses on transitional and supportive housing as important ways to move individuals out of homelessness.

Affordable Housing Initiative (AHI)/Canada-Nova Scotia Affordable Housing Agreement: Based on the housing framework agreed to in **November 2001** by federal and provincial/territorial housing ministers, each province/territory developed **"Affordable Housing Agreements" in 2003**. 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 a grant, a stream of ongoing subsidies or the value of in-kind contributions (e.g. land). Within these terms and 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. Nova Scotia has a commitment (through Phase I and II of funding) for a **total of $28.09 million; to date $27.93 million has been committed/announced for a total of 1,211 units**.[153] The Federal Government's Economic Action Plan builds on this existing commitment, extending the AHI to March 31, 2011 through a $1.9 billion investment over five years, and providing a further one-time investment of $1.525 billion in housing stimulus measures to build new and renovate existing social housing. This funding is being delivered through amendments to existing cost-sharing and delivery arrangements with provinces and territories through the AHI.

New Rental Housing: This program is component of the Canada-Nova Scotia Affordable Housing Agreement and is for developers who are interested in building new affordable rental units in areas where the population is growing or there is a shortage of housing. Provides up to $25,000 in capital funding and $25,000 in rent supplement funding per unit over 10 years. Property developers (public or private) must sign an agreement committing to providing the housing to low-income households, and that the unit will remain affordable for 10 years. CMHC is involved with the program and 553 units currently exist.

Rental Housing Preservation: This program is a component of the Canada-Nova Scotia Affordable Housing Agreement and is intended to create more affordable rental units in areas with a demonstrated need by converting buildings not currently being used for residential purposes. It provides up to $25,000 per unit in rent supplement funding over 10 years. CMHC is involved with the program and 118 units currently exist.

Shelter Enhancement Program: The objective of this program is to assist in the acquisition, construction, repair and rehabilitation, and the improvement of shelters and second stage housing for women and children as well as youth who are victims of family violence. Clients are non-profit corporations or charities who operate the housing. Funding is limited to fully forgivable capital loans. Sponsor groups must obtain assurance of operating assistance for emergency shelters. Second stage housing occupants are expected to make modest contributions to offset the project's operating costs. Contribution of up to 100% of newly developed projects capital cost may be available (maximum loan per unit is $24,000). CMHC is also involved in this program.

Rental Assistance Program: The program has been closed to new applicants since 1995.

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[152] Unless otherwise noted, funding levels and units identified for each type of initiative were obtained through: Conference Board of Canada. (March 2010). *Building from the ground up: enhancing affordable housing in Canada,* Appendix A, p.91-*93.*

[153] National AHI Funding Table, Canada Mortgage and Housing Corporation website. http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm

Seniors Property Tax Rebate: Administered by the Government of Nova Scotia and designed to help eligible home seniors remain in their homes by providing them with an annual rebate on their municipal property taxes.

Residential Rehabilitation Assistance Program (RRAP) Suite of Programs: This is a federal-provincial cost-shared (75/25) program administered by the Canada Mortgage and Housing Corporation:

- Homeownership RRAP – provides assistance to low income homeowners to bring their property up to minimum health and safety standards.
- RRAP for Disabled Persons – provides assistance to homeowners or landlords of apartments or rooming houses that need to make specific modifications to accommodate persons with disabilities. Maximum loan forgiveness: $16,100 for homeowner or rooming house and $24,000 for self-contained unit.
- Homeowner RRAP – provides assistance for mandatory repairs to meet basic requirements of health and safety. Maximum is $16,000.
- Rental RRAP – provides assistance to landlords to make major repairs, or mandatory repairs to meet basic requirements for low-income units. Maximum per unit is $24,000.
- Rooming House RRAP – provides assistance to landlords of rooming houses in urban or rural areas to make major repairs or address basic facilities' issues. Maximum per bed is $16,000.
- RRAP Conversion – provides assistance to convert existing commercial buildings or buildings not used for housing, into new housing units for low-income tenants. Post RRAP rents must be equivalent to 60% of market rents in that area. Assistance is in the form of a fully forgivable loan. Maximum per unit converted is $24,000, per bed converted is $16,000.

New Home Purchase Program: Non-profit and private sector developers may access funding to help moderate-income households move from rental housing to homeownership in designated urban areas. Average funding of $40,000 per household. Six units.

Off-Reserve Aboriginal Housing Trust Fund Programs: Provides funding for housing development programs delivered through various Aboriginal off-reserve groups.

Family Modest Housing Program: Provides mortgage funds of up to $70,000 for lower-income households to build or buy modest housing. Interest rates are fixed for a five-year term and the loan must be repaid within 25 years.

Home Ownership Preservation Program: Provides financial assistance to help low and moderate income homeowners repair major defects involving the home's structure, framework, plumbing, electrical system, heating system, or fire safety system. 250 units.

Small Loans Assistance Program: Provides a low-interest loan of up to $20,000 for home renovations, additions, or repairs to low-income homeowners. There are a portion of the 2,600 loans made per year for all home improvement programs in Nova Scotia.

Housing Coordination: Sydney has recently hired a housing coordinator

Other programs: Access a Home Program (home adaptation for wheelchair use), Emergency Repair Program (emergency repairs for homeowners in rural and remote areas), Home Adaptations for Seniors Independence (adaptation to keep seniors aging in place), Parent Apartment Program (renovations to enable low-income seniors to live with family members), Provincial Housing Emergency Repair Program (assists with cost of emergency repairs), and Senior Citizens Assistance Program (assists low-income seniors with forgivable grants for necessary repairs).

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, but aren't dedicated to serving this population. Within Nova Scotia, this includes: **shelters, transitional housing not specifically targeted to people with mental illness, licensed Homes for Special Care (residential care facilities, group homes and developmental residences, adult residential centres, and regional rehabilitation centres), small options homes, long-term care options, and addictions treatment programs**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity.

SHELTERS

- Shelters typically rely on per diem payments from municipalities to support a significant percentage of their budget. Fundraising is another core component of operating funding.
- The majority of shelters are located in the Halifax/Dartmouth area.
- Barry House provides a shelter for homeless women using a harm reduction approach. Operated by the Saint Leonard's Society of Nova Scotia.
- Metro Turning Point Centre – year-round, 24/7 centre providing high support, 'harm reduction' model for men who may have faced barriers in accessing other resources.
- Adsum House provides 24/7 emergency shelter for women and children. They receive the majority of their funding from municipality per diems, government grants, and donations. Much of the per diems to Adsum House cover the costs of sheltering clients.
- Bryony House is a shelter for abused women
- Phoenix Youth Shelter is a 20-bed shelter for youth that is one component of Phoenix Youth Programs which offer services such as counselling, supportive housing, street front walk-in services, learning and employment program, and follow-up supports.
- Salvation Army provides an overnight shelter in addition to Addictions Services, Community and Family Services, Family Tracing Services, and Rehabilitation Services
- Men's Homeless Shelter – Sydney
- Almost Home Women's Shelter – Sydney

According to figures from Human Resources and Skills Development Canada (HRSDC), there were **approximately 618 beds in Nova Scotia's emergency and transitional shelters in 2007**[154], or 2.3% of known shelter beds across Canada. This is consistent with Nova Scotia being home to approximately 2.9% of the nation's population (some provinces and territories have a larger discrepancy between these figures). There are **62 shelter beds per 100,000** people in Nova Scotia, compared to the 83 shelter beds/100,000 people national average. This is **likely an underestimate** because:

- It is based on the number of known shelters and there may be additional shelters not captured in this data set
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007

Also according to HRSDC, "of the known 1,020 shelters identified across Canada as of March 2007, 723 or **71% were emergency shelters**, providing temporary and short-term accommodation for homeless individuals and/or families. Such

[154] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

shelters typically also offer essential services such as food, clothing, and counselling. Transitional shelters offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. Transitional shelters numbered 291 and represented a little more than 28% of the total. There were, in addition, six shelters providing both emergency and transitional services, representing less than 1% of the total."

TRANSITIONAL HOUSING

Halifax/Dartmouth area:

- Adsum Court is a long-term supportive housing option for women and children with 23 self-contained apartments for women where rent is held to a maximum of 30% of gross income – rent covers the cost of maintaining the development and the mortgage payments. Staff are on-site approximately 35 hours/week to provide advocacy, referrals, group programming and individual supportive counselling.
- Adsum Centre provides 24/7 staffed support and programming, in a residential setting, to 16 women and their children who are trying to address barriers which have led them to experience homelessness. Range of length of stay is typically 6-12 months.
- Phoenix Youth transitional housing programs include:
    - Phoenix House – 10-bed long-term residential facility for males and females focused on skill-learning for independent living
    - Supervised Apartment Program – three homes which can each house three youth with a live-in support person
- Alice Housing – provides second-stage housing for abused women and their children. Nineteen housing units are available throughout Halifax Regional Municipality and families can stay up to two years.
- Saint Leonard Society of Nova Scotia: provides a halfway house for women released from prison (Nehiley House) and men (Sir Sanford Fleming House).

LICENSED HOMES FOR SPECIAL CARE

- Includes a range of residential settings as part of the Services for Persons with Disabilities Program (administered by the Department of Community Services). All of the models provide support and supervision in homes with four or more beds. The options for placement in any particular Home for Special Care are limited to the level(s) of care/program they provide as per their licensed mandate under the Homes for Special Care Act.
- **Residential Care Facilities (RCFs)**: RCFs provide a residential support option to four or more adults with disabilities who require minimal support and supervision with routine personal-care activities, community skills and activities, and illness supervision. Individuals are provided with limited direct support and do not have major health or behavioural support needs. RCFs were created in the early 1960s as 'boarding homes' for mobile, younger adults who were expected to be out and about in the community. Minimal services and supports were put in place.
    - Currently, **25 RCFs support a total 518 individuals**[155], many of whom are living with a long-term mental illness. The average age of individuals supported in this setting is 55.5 years.
    - High prevalence of communal bedrooms, limited programming.
    - Lack of capacity in the system has made it very difficult to transfer residents to either higher or lower support settings when the support needs of residents change over time.
    - No standards other than licensing requirements are in place for RCFs.

[155] Department of Community Services, Government of Nova Scotia (June 2008). *Residential Review Report.* Provides capacity data for the licensed and unlicensed home options for persons with disabilities, p.10-15.

- **Group Homes / Developmental Residences**: Group Homes and Developmental Residences provide a continuum of developmental rehabilitation programs for individuals with disabilities within a 4-12 person residential setting. Developmental Residences and group homes emphasize the development of interpersonal, community oriented skills, and activities of daily living. Group Homes primarily serve younger persons with one or more of the following types of disabilities: intellectual disability, long-term mental illness, or physical disability. Developmental Residences primarily serve younger adults with an intellectual disability or dual diagnosis. Developmental Residences are categorized as levels one to three depending on the supports provided (level three provides the highest degree of support).
    - A total of 77 Group Homes and Developmental Residences support 460 persons with disabilities.
    - All Group Homes and Developmental Residences are non-profit and the physical premises are either owned or leased by the operator.
    - Residents are supported to attend appropriate day programs in the community.
    - Group Homes and Developmental Residences are located in all regions and the infrastructure appears to be in a better physical state than many of the Residential Care Facility settings.
- **Adult Residential Centres (ARCs)**: ARCs provides long-term, structured supports and services to adults with disabilities to enhance their development of interpersonal, community-oriented skills and activities of daily living. Approved staffing is provided 24-hours and seven days a week by on-site professional staff.
    - This setting is intended to support those individuals with more complex behavioural and skill development challenges.
    - Due to the high level of ARC capacity in some regions, other residential settings such as Group Homes for persons living with a mental illness have not been created.
    - Due to the large resident base, several ARCs have been able to establish their own adult day programs, including sizable vocational enterprises.
    - At present the **seven ARCs support 492 persons with disabilities, mainly with complex needs along with mental health issues**; the largest ARC in Nova Scotia supports 115 residents and the smallest supports 32 individuals.
- **Regional Rehabilitation Centres (RRCs)**: RRCs provide both rehabilitation and developmental programs to adults with disabilities who require an intensive level of support and supervision related to complex behavioral challenges and skill development needs. Approved staffing is provided 24-hours and seven days a week by on-site professional staff.
    - Clients have access to a number of professional services including medical services, nursing, psychological and psychiatry services, social work, speech-language therapy, physiotherapy, and occupational therapy.
    - Day programming is intensive. Pre-vocational, vocational, and life skills development are a major component of RRC organizations.
    - Collectively the **three RRCs support 154 individuals**. All are non-profit and two of the agencies have a dual ARC/RRC role.
- The **Licensing Services unit of the Department of Community Services** (DCS) licenses all day care facilities, residential child-caring facilities, children's small option homes and homes for special care facilities in Nova Scotia. Facilities are inspected at least twice a year. Facilities that are non-compliant with licensing requirements in some area(s) receive more frequent inspections.

SMALL OPTIONS

- In addition to the above licensed options, **211 small options** provide a residential option for up to three adults with disabilities.
- Unlicensed Community Based Options provide supports to three individuals or less. This group includes Small Option Homes. The programs of alternative Family Support (formerly known as Community Residences), and independent Living Support (formerly known as the Supervised Apartment Program) are also defined as community-based options.
    - **Independent Living Support Program** provides support up to 21 hours/week to people in their own apartment or home.
    - **Alternative Family Support Program** – up to two individuals live in an approved, private family home (unrelated to the family). People receive support with basic routine activities and are linked to relevant community programming.
- Small options were developed in the mid-1980's by a number of municipal units as a way to move persons with disabilities more quickly into residential settings without working under the confines of The Homes for Special Care Act.
- Appealing to families and individuals due to a low number of residents and higher probability of private bedrooms.
- Administered based on individual municipal by-laws, standards, and policies; the responsibility for all residential settings serving persons with disabilities was transferred to the province in 1996.
- Operate within the framework of "**Interim Standards**" released by the Department of Community Services in 1996. All three-population groups are served (**developmental disability, mental illness, and/or physical disability**). **People's needs may range from very complex to low support**.

LONG-TERM CARE FACILITIES

- The Department of Health inspects and approves three types of long-term care facilities. They are:
    - **Community Based Options** – accommodation, supervision and non-nursing level personal care for one to three people in each home. These are unlicensed, but are inspected and approved by the Department of Health.
    - **Residential Care Facilities** – homes for people who need supervision and limited help with personal care. These are licensed and inspected by the Department of Health. **Total of 782 beds and eight respite beds as of April 2010**.
    - **Nursing Homes or Homes for the Aged** – homes for people who need help with personal care and professional nursing care. These are licensed and inspected by the Department of Health. **Total of 6,672 regular beds and 70 respite beds as of April 2010**.
- Long-term care is paid for jointly by the provincial government and by long-term care residents.
    - Government pays health-care costs for resident care. These costs may be related to the salaries, benefits, and operational costs of nursing and personal care; social work services; recreation therapy; and physical, occupational, and other therapies. These costs will only be covered for residents who enter long-term care homes that participate in the provincial Single Entry Access system.
    - Residents pay accommodation charges, which include: salaries, benefits, and operational costs of maintenance; dietary services; housekeeping; management and administration departments; capital; and return on investment. This charge is collected by the long-term care facility.
- Each year, the Department of Health sets the standard accommodation charge for the three types of long-term care homes. These rates are based on average operating costs.

- Nursing Homes = $94.75 per day
- Residential Care Facilities = $54.50 per day
- Community Based Options = $48.00 per day
- Respite Charge = $30.90 per day

- Residents are not expected to pay more than 85% of their assessed income toward accommodation charges.

ADDICTIONS TREATMENT PROGRAMS

- Alcare Place: 13-bed transitional program for men recovering from addictions. Operates 24/7 with clients' average lengths of stay around five and a half months.
- Marguerite Centre: 12-bed, long-term residential facility for women in recovery from addictions and abuse. Centre provides 24/7 staffing.

Table 3. *Additional Facilities in Nova Scotia.*

Location	Name	Type	Description	Capacity
Halifax	Barry House	Shelter	Women	618 spaces (Human Resources and Skills Development Canada, 2007)
Halifax	Metro Turning Point	Shelter	Men	
Halifax	Adsum House	Shelter	Women and children	
Halifax	Bryony House	Shelter	Abused women	
Halifax	Phoenix Youth Shelter	Shelter	Youth	
Halifax	Salvation Army	Shelter	Men	
Sydney	Men's Homeless Shelter	Shelter	Men	
Sydney	Almost Home Women's Shelter	Shelter	Women	
Halifax	Adsum Court	Transitional Housing	Women and children	23 apartments
Halifax	Adsum Centre	Transitional Housing	Women and children	16 beds
Halifax	Phoenix Youth	Transitional Housing	Youth	10 beds
Halifax	Phoenix Youth	Transitional Housing	Youth	9 beds in three homes
Halifax	Alice Housing	Transitional Housing	Abused women and children	19 apartments
Halifax	Nehiley House	Transitional Housing	Halfway house for women released from prison	
Halifax	Sir Sanford Fleming House	Transitional Housing	Halfway house for men released from prison	
Sydney	Every Woman's Centre	Transitional Housing	Women – second stage housing	
Across Nova Scotia (NS)	Residential Care Facilities (RCF)	Licensed Homes for Special Care	People with disabilities with minimal support and supervision requirements	25 RCFs provide 518 beds
Across NS	Group Homes (GH) and Developmental Residences (DR; levels 1-3)	Licensed Homes for Special Care	GH: Younger adults with: intellectual disability, long-term mental illness, and/or physical disability DR: Younger adults with intellectual disability or dual diagnosis (co-occurring mental illness)	77 GH and DR provide 460 beds
Across NS	Adult Residential Centres (ARC)	Licensed Homes for Special Care	Adults with disabilities who have more complex behavioural and skill development challenges along with mental health issues.	7 ARCs provide 492 beds
Across NS	Regional Rehabilitation Centres (RRC)	Licensed Homes for Special Care	Adults with disabilities who require an intensive level of support and supervision related to complex behavioral challenges and skill development needs requiring access to intensive professional services	3 RRCs provide 154 beds

Location	Name	Type	Description	Capacity
Across NS	Small Options	Community-based Unlicensed Homes	Each home provides a residential option for up to three adults with disabilities (intellectual, physical, and/or mental illness)	211 homes
Across NS	Alternative Family Support	Community-based Unlicensed Homes	Provides support up to 21 hours/week to people with disabilities in their own apartment or home	
Across NS	Independent Living Support	Community-based Unlicensed Homes	Up to two individuals with disabilities live in an approved, private family home (unrelated to the family)	
Across NS	Nursing Homes/Homes for the Aged	Long-term Care Facilities	Homes for people who need help with personal care and professional nursing care. These are licensed and inspected by the Department of Health	6,672 beds and 70 respite beds
Across NS	Residential Care Facilities	Long-Term Care Facilities	Homes for people who need supervision and limited help with personal care	782 beds and 8 respite beds
Across NS	Community Based Options	Long-term Care (unlicensed but inspected and approved by Department of Health)	Accommodation, supervision, and non-nursing level personal care for one to three people in each home	
Halifax	Alcare Place	Addictions	Transitional program for men recovering from addictions	13 beds
Halifax	Marguerite Centre	Addictions	Long-term residential facility for women in recovery from addictions	12 beds

MENTAL HEALTH SUPPORTS

Table 4. *Range of mental health supports in Nova Scotia.*

Range of Mental Health Supports	
▪ Community Connections	Clubhouse Programs Employment and Housing Supports Peer Support
▪ Community Mental Health Services	Emergency Mental Health and Crisis Response Case Management Psychosocial Rehabilitation Outpatient Outreach Services Seniors Mental Health Early Psychosis Eating Disorders Specialty Services
▪ Inpatient Services	Acute and Specialty

FUNDING LEVELS

According to a recent analysis by the Institute of Health Economics (Jacobs et al., 2010), the following were some of the total expenditures on mental health and addictions services[156] in Nova Scotia for 2007/08:

- $62.0 million for inpatient care[157] ($46.2 million in general hospitals and $15.8 million in psychiatric hospitals)
- $19.9 million for physician services ($0.3 million general practitioners' fee for service, $7.3 million specialists' fee for service, and $12.3 million for psychiatrists – alternative payments)
- $26.0 million for addictions services
- $2.3 million for non profit organizations excluding the provincial government and $118 million for educational mental health services

RANGE OF MENTAL HEALTH SERVICES

- There are **nine district health authorities** across the province each of which has a mental health program serving adults, as well as children and youth. The health authorities do not provide housing but do provide mobile mental health supports to people in housing. The main types of services provided include emergency mental health services and crisis response; acute inpatient care; case management; psychosocial rehabilitation; clubhouse programs; employability and some housing supports; outpatient outreach services; and specialty services. These specialty services are provided in centralized areas of the province by multidisciplinary team members with clinical expertise in specialty areas (e.g., eating disorders). There are three networks in Nova Scotia: Early Psychosis; Eating Disorders; and Seniors Mental Health. In addition, there is a housing coordinator with rehabilitation mental health services.
- Delivery of these services are guided by a set of **system-level standards**[158] for mental health services from the Department of Health, developed by the Core Programs Standards Working Group of the Mental Health Steering Committee. These standards will be updated every five years in consultation with consumers, practitioners, and researchers.

[156] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans, and income support programs.
[157] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.
[158] Department of Health, Government of Nova Scotia (July 2009). Standards for Mental Health Services In Nova Scotia

- The District Health Authorities also provide **addictions services** which generally include medically supervised detox; individual and group counselling, prevention and health promotion services; addiction education; adolescent/school-based services; problem gambling; and women's programming.
- The Capital District Health Authority provides a wide range of mental health services to Halifax/Dartmouth and some surrounding areas including a 24/7 mobile **mental health crisis team** (mobile to Halifax, Dartmouth, and Bedford), the Nova Scotia Early Psychosis Program, emergency assessment, eating disorders clinic, sleep disorders program, mental health day treatment, seniors day services, outpatient and community services, and a dual diagnosis program (mental illness and developmental disability) which includes an 18-bed inpatient unit.
- Two other District Health Authorities have crisis services: Cape Breton Health Authority (emergency crisis service) and the IWK Health Centre (Mobile Crisis Intervention Service from 9 a.m. – 5 p.m.).
- There are a range of community mental health providers within the province, including:
  - Clubhouses – provide a range of supports to members living with mental health issues in the areas of employment, education, housing supports, crisis prevention and interventions, delivery of medication, access to respite options, and peer support.
    - Friendship Club, Truro
    - New Hope, New Glasgow
    - Crossroads Clubhouse, Sydney
    - New Beginnings, Dartmouth
    - Connections Clubhouse, Halifax
  - Community-based programs and organizations that offer adult mental health services:
    - Self Help Connection – acts as a resource centre/clearinghouse for hundreds of self-help/peer support groups in Nova Scotia (including abuse, anxiety, stress, depression, manic depression, addictions, bereavement, eating disorders, care giving, divorce, and cancer)
    - Canadian Mental Health Association (eight branches) – range of services available depends on branch. Usually includes education, advocacy, and some range of employment and housing supports
    - Laing House is a peer support organization for youth with mental illness between 16 and 30 years of age. This is a youth-driven, community-based organization where young people who are living with a mental illness can get a variety of supports (e.g., education, employment, independent living skills)
    - Metro Community Housing Association – range of flexible supports to promote housing tenure including 24-hour emergency service, assistance in finding employment, and social opportunities
    - Missing Lint Cooperative – a not-for-profit business whose mandate is to employ individuals who have had difficulty obtaining or maintaining employment due to mental illness. Provides photocopying and printing services, as well as other office and maintenance services.
  - Employment skill development and support:
    - Affirmative Industries: Affirmative Industries is a not-for-profit organization supporting people with disabilities achieve economic independence. Employment projects include a pet supply business, dollar store, The Next Step (includes mentoring and employment training), and "Building for Independence" (explained in the upcoming "Promising Practices in Housing and Related Supports" section).

- Lakecity Woodworkers
- Consumer Initiative Centre

- Schizophrenia Society of Nova Scotia: four chapters provide support groups, education, and advocacy across the province

- **Acute psychiatric units**:
  - Abbie J.Lane
  - Additional units: Short-stay unit (Capital District), Community Focus Living Unit
- **Specialized psychiatric units**:
  - Nova Scotia Hospital
  - East Coast Forensic Hospital - two rehabilitation units with 30 beds each and a 24 bed Mentally Ill Offender Unit where court ordered assessments are performed and treatment is provided to offenders diagnosed with mental illness. The hospital also manages the Provincial Sex Offender Program located on the Nova Scotia Hospital site, and provides primary health care to the Province's corrections population through our Offender Health Services Program.

INCOME SUPPORT PROGRAMS

The Department of Community Services administers the provincial "**Employment Support and Income Assistance**" program. The program is guided by the Employment Support and Income Assistance Act and the Employment Support and Income Assistance Regulations. The Employment Support and Income Assistance program provides financial assistance and employment supports to help people maximize their self-sufficiency by increasing their employability and their independence. Basic assistance consists of a personal allowance (food, clothing, and miscellaneous essentials) and shelter (actual amount for rent/mortgage, fuel and utilities, up to the allowed maximum).

Children's basic benefits are provided through the Nova Scotia Child Benefit.

- The Child Benefit is a non-taxable, monthly amount paid to low-income families. This is provided as an integrated payment (with the Canadian Child Tax Benefit and the National Child Benefit Supplement) by the Canada Revenue Agency.
- Transitional drug coverage for twelve months is provided to clients who leave social assistance for employment.
- At the time of application, single applicants with or without disabilities may have no more than $500 in liquid assets ($1,000 for a family).
- Recipients are eligible for the following monthly exemptions on **earned income**: Singles and families with disabilities may retain $150 plus 30% of the remaining net wages (singles and families without disabilities may retain 30% of net wages).
- **Total income** for a single individual with a disability was estimated at $9,140 in 2008 (includes basic social assistance and GST credit).[159]

According to the 2007 Social Assistance Statistical Report (Federal-Provincial-Territorial Directors of Income Support, 2010), an estimated:

- 45,400 people received the ESIA as of March 31, 2007; this equated to a total of 28,500 cases.

[159] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability*, Bulletin Number 2.

- The primary reason in 46% of all cases was long-term disability, and short-term disability in 11%.

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

Killam Properties is one of Canada's largest residential landlords, and is based in Halifax. Holdings include 118 apartment properties in Atlantic Canada's six major urban centres and has 55 manufactured home communities across Canada. Killam Properties has provided dedicated units at their sites where a housing worker can live and provide supports on an ongoing basis. Benefits to Killam include access to supports for everyone in that particular setting, not just people formally part of a treatment system.

- Killam has contributed 31 units for clients of the Capital District Mental Health Program (CDMHP) in Halifax (first piloted in 2007) and a second landlord has since contributed an additional 16 units.
- Killam and the second landlord make the final decision on tenant selection, but CDMHP conducts the initial screening and referrals process.
- CDMHP provides tenant support, who also have access to a 24/7 mobile crisis team.
- Subsidies ranging from 5% to 22% of market rents are provided by Killam as a corporate donation (worth $46,000 in 2009).

Supportive Housing for Individuals with Mental Illness (SHIMI) – New Dawn – a private landlord in Sydney (Cape Breton) who has 13 apartments where rent is kept at a flat rate, and will not be increased unless the social assistance rate is increased as well. This initiative (SHIMI) is a partnership between New Dawn Enterprises, the Cape Breton District Health Authority Mental Health Services Program, the Cape Breton Mental Health Services Charitable Foundation, and the Canadian Mental Health Association.

- Provides a total of 13 apartments in three buildings.
- New Dawn provides property management, while the CBDHA and the CMHA provide tenant support and referral services. Income support is provided by the Department of Community Services.
- The first tenants were members of Crossroads Clubhouse, which also provides employment counselling, food services, and counselling in addition to the mental health and health supports provided by CBDHA and CMHA.

Affirmative Industries Association: developed "Building for Independence" in Halifax, a housing and supports model which assists people living with mental illness to earn equity in their apartment which is then available to help the person buy a home, return to school, etc. Tenants pay into Individual Development Accounts (IDAs) and are provided with matching grants (provided by the Department of Community Services on a pilot-project basis).

- A total of 10 supportive housing units (eight 1-bedrooms, two 2-bedrooms) for people with mental illness.
- The building site was donated by Halifax Regional Municipality and the project received capital assistance from CMHC, the government of Nova Scotia (through the Affordable Housing Initiative), and through a capital campaign (raised 15% of total capital costs).
- Because there is no mortgage, the rental price is set to the maximum welfare entitlement for people on disability, while Affirmative Industries is still able to generate an operating surplus which can then fund the matching grants to the IDAs.
- Tenants are able to access their built-up equity when they move (maximum tenancy in the building is expected to be five years) or under special circumstances.
- Affirmative Industries was a recipient of the Canadian Institute of Planners National Award for Planning Excellence in Housing for the IDA concept and the community engagement process used during project planning. Affirmative Industries did not set up the IDAs until late 2008, so the evaluation of the effectiveness of a five-year tenancy and savings horizon will take place in 2013–2014.

Coordinated fundraising: Mental Health Foundation of Nova Scotia

- The Mental Health Foundation of Nova Scotia is a registered charitable foundation that was established in 1987 to create a higher level of awareness of mental health and support organizations to deliver the highest level of mental health care throughout Nova Scotia.

CHALLENGES IN HOUSING & RELATED SUPPORTS

- Lack of income security (and resulting issues relating to housing and food security) creates dependence on the system. It is critically important to have action on the Poverty Reduction Strategy released by the government. Currently awaiting timelines, targets, and resources.
- Significant housing stock issues – particularly outside of Halifax.
- Recovery approach is not prevalent in some types of residential settings. There can be subtle disincentives with what people see as their mandate, their mission, and their approach to people.
    - There are policies in some assisted living options that impact people's ability to exercise a full scope of rights, freedoms, and personal choice; for example, being able to live together, having access to a living space at anytime (not just during set hours when staff are available), and being able to direct their goals, lives.
- Federal infrastructure funding is not accessible for most of the current residential settings.
- Provincial contributions to affordable housing development are largely dependent on the federal government making contributions.
- The province has had success in building and renovating housing but providers also need financial resources to provide flexible, mobile supports to people in individual apartments.
- Working from a recovery perspective, if people feel they can't move because they're concerned about losing their support, then there needs to be shifts in the models available, and options around 'delinked' support. Employment supports and non-punitive policies on earned income for people on social assistance could play an important role in this process.
- Health and community services need to invest to provide flexible, appropriate, fluid housing supports that are individualized.
- Investments from municipal governments are needed.

FUTURE DIRECTIONS: TRENDS IN HOUSING & RELATED SUPPORTS

- Government recently announced development of a mental health strategy (in March 2010); there may be opportunities that can be leveraged through this process.

NUNAVUT

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of Nunavut is approximately 29,475 (Statistics Canada, 2009) with an unemployment rate of 14.2% in the third quarter of 2010 compared to a rate of 8.1% across Canada (Statistics Canada, September 2010). This is in contrast to unemployment rates in the Yukon and the Northwest Territories that are amongst the lowest in the country. Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of 10.2%** since 2001 (second only to Alberta across the country), almost double the national average of 5.4%. This is mostly due to birth rates that are significantly higher than the Canadian average.
- The census enumerated 24,920 people reporting **Aboriginal identity** in Nunavut in 2006, representing about **85% of Nunavut's population**. Most people identify themselves as Inuit (83.6% of the total population).
- A **young population** where only 2.7% of the population is aged 65 and over (compared to 13.6% nationally) – the lowest rate in Canada.
- Across Canada, the Aboriginal population is much younger than the non-Aboriginal population. In 2006, the median age of the Aboriginal population was 27 years, compared with 40 years for non-Aboriginal people, a gap of 13 years. Across Canada, the Aboriginal population was youngest in Nunavut at 20 years in 2006.
- More than 80% of Nunavut's population aged 20 to 29 is Aboriginal, and the proportion is expected to grow.
- Close to 70% of the population identified Inuktitut as their mother tongue in the 2006 census.
- Of the 7,855 households in 2006, less than 23% owned the dwelling they lived in (the lowest rate in Canada where the national average is 68.4%) – this represents an increase of 1% since 2001 (significantly less than the national average). Of owner households, 66.3% held a mortgage (national average of 57.9%). By 2010, **of the 8,550 occupied dwelling, about 20% owned it**.
- Similar to the other territories, a **very high proportion of households** reported that their homes needed **major repairs** (20.2% compared to 7.5% nationally).
- Close to 1 in 5 households reported that there was less than one room per person
- The proportion of households **spending 30% or more of their income on shelter was well below the national average** of 24.9% at 9.6%. Median household shelter costs were $6,065 in 2006 compared to $8,966 nationally.
    - Lower shelter costs are due to a high rate of government subsidization (according to the Survey of Household Spending, 57% of households in Nunavut reported living in a dwelling subsidized by the government) through the 10-year housing plan.
    - While the median household income increased by 32.6% from 2001 to 2006 ($60,248 in 2006 compared to $45,440 in 2001), the annual household shelter costs increased by 16%.

Most recently, the Nunavut National Housing Needs Survey (conducted from November 2009 through to June 2010) identified that:

- Slightly more than half of all dwellings were public housing[160], about two in ten dwellings were owner occupied, and the balance of housing was staff or other rental dwellings.
- In about half of all crowded dwellings (about 35% of total dwellings), the living room is being used as a sleeping area,

[160] The terms "public" and "social" housing tend to be used interchangeably in Nunavut

- Public housing had the highest proportion of dwellings below standard (about 63%) – slightly more than half of people living in dwellings below standard would move out if more units were available,
- Just over 1,200 people identified that they did not have a usual home at the time of the survey (about 4% of the population) – about 3,780 people aged 15 and over were on the waiting list for public housing (nearly one in five of the population).

Nunavut is the largest federal territory in Canada – it separated from the Northwest Territories on April 1, 1999 pursuant to the Nunavut Act and the 1993 Nunavut Land Claims Agreement Act. The capital, Iqaluit, is home to roughly one quarter of the population, with Rankin Inlet and Arviat as the next largest communities. It is also almost one quarter of Canada's land mass with all but one of the twenty-five incorporated communities (Baker Lake) located on the sea, with few road links between communities. Many of these communities are relatively new as permanent settlements. According to the Conference Board of Canada's report (2003):

- The need to address the serious shortage of housing throughout the Territory has been identified as a top priority by the government – many of the health, social and economic issues appear to be linked to this shortage
- Housing issues are linked to the high cost of having land serviced and in building, maintaining and operating homes – operating costs are the biggest obstacle to public housing, including utilities
- The high costs of housing creates a significant disincentive for employment for people living in public housing – having a job can result in substantial increases in rent
- Many residents must travel out of their home communities, and often out-of-territory, to access health services they need
- Very few communities have access to physicians - access to mental health services is seen as a very high priority
- Nunavut has a "mixed" economy – both land-based (or non-wage activities including hunting, trapping, sewing, informal child care) and wage-based economies which are not mutually exclusive
- The land-based economy was estimated to range from $40 million to $60 million
- The economy is very dependent on the government sector for wage economy employment and this is not a sustainable option for their growing population – growth in the government sector will eventually slow in relation to population growth, thus economic diversification is crucial

"A unique set of factors intersect in Nunavut that complicate the current housing crisis. A harsh climate, remote geography, extremely small population base, lack of road or rail access, underdeveloped infrastructure systems and the high costs of labour and materials combine to prevent the development of the kind of housing market which encourages private investment in southern Canada. Consequently, the creation of new housing supply is heavily dependent on public sector involvement" (Nunavut Ten-year Inuit Housing Action Plan, 2004, p.i).

"Key challenges in the development of Nunavut's economy include the development of transportation infrastructure, the development of a robust community-based entrepreneurial sector, the orderly development of mineral and petroleum resources, the cost of reaching suppliers and markets, and the need to build capacity in the workforce. Continuing economic problems include the high cost of doing business, low employment rate, and economic leakages and distortions. Nunavummiut need to be in a position to participate in all aspects of economic growth in the territory. The primary objective of government in this area is to help transform Nunavut's enormous potential into economic benefits for Nunavummiut" (Government of Nunavut, 2010, p.3-4).

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

The Nunavut Housing Corporation[161] (NHC) is a public agency of the government, created through the Nunavut Legislature by the Northwest Territories Housing Corporation (Nunavut) Act. The NHC reports to the Legislative Assembly through the Minister Responsible for the Nunavut Housing Corporation. The NHC is responsible for the delivery of targeted housing solutions which includes:

- Providing funding, education, training, and support to **Local Housing Organizations**
- Providing homeowner services (e.g., down payment assistance, home renovation assistance, and technical assistance)
- Providing, administering, and maintenance of staff housing units
- Coordinating housing-related advocacy
- Funding for over 4,500 public housing units

The current Minister responsible for the NHC is also the Minister of Health and Social Services and the Minister responsible for homelessness.

The Nunavut **Health and Social Services Department** provides a wide range of programs and services to residents, including mental health services, addiction services, and social work services. Regional Health and Social Services Authorities carry out the delivery of mental health and addictions services with local staff.

PROGRESS TO DATE: KEY INITIATIVES

The Nunavut Government has recently approved the "**Addictions & Mental Health Strategy**"[162]. The government, together with non-government organizations and other government departments and agencies, implement a wide range of new and enhanced programs and services. The Department of Health & Social Services has started the implementation priorities and the accountabilities.

Regional Health & Social Services carry out the delivery of addictions and mental health programs and services with local staff. These programs and services include, but are not limited to:

- Counselling clients
- Group healing sessions
- Community wellness workshops
- Screening and referring clients to treatment programs
- Case-management
- Crisis management

Nunavut residents may request to be referred to a residential treatment center outside of Nunavut, as there are no centers in Nunavut. This request can be made to a Wellness Counsellor/Addiction Worker or if this kind of resource does not exist within the respective community, through the local Health Centre.

The **Nunavut Ten-Year Inuit Housing Action Plan** (2004) calls for a sustained ten-year intervention into social housing that will bring overcrowding down to national standards, requiring immediate construction of 3,000 units, immediate renovation of 1,000 existing units, and construction of 2,730 units between 2006-16. Total projected funding requirements at that time were $1.9 billion. The Action Plan was based on consultations with

[161] See http://www.nunavuthousing.ca/ for additional information
[162] http://www.gov.nu.ca/health/promo.shtml#addictionsmentalhealth

communities in every corner of Nunavut, and was a joint effort of Nunavut Tunngavik Inc. (NTI), Inuit Tapiriit Kanatami (ITK), and the NHC. The Plan resulted in securing $200 million in Nunavut Housing Trust funds from the Government of Canada for affordable social housing across the entire Territory, allocated over a three-year period.

Tamapta: Building Our Future Together sets out the government's vision for 2030 together with priorities and actions for the next three years. Tamapta identifies poverty reduction, housing options, and people at risk as priorities for 2009-13.

RANGE OF HOUSING ACCOMMODATIONS

Table 1. *Overall range of housing options in Nunavut.*

Dedicated Mental Health Housing	Akausisarvik Centre
Non-Dedicated Affordable Housing	Public Housing Program (owned units and rent supplements) Staff Housing Program Home Ownership Programs
Additional Facilities or Housing Options	Emergency and Transitional Shelters Residential Facilities Medical Boarding Homes

DEDICATED MENTAL HEALTH HOUSING

Located in Iqaluit, Akausisarvik Centre is the only organization that specifically houses people with serious mental illness. Maximum capacity is 13 spaces with a length of stay that is usually 30-90 days. There are a small number of clients that have stayed over a period of years. Many clients are housed in Akausisarvik as part of their transition from receiving treatment at the Centre for Addiction and Mental Health in Toronto, Ontario. People often do not return to their home communities due to stigma and discrimination. Akausisarvik Centre is fully funded by the Ministry of Health and Social Services with an annualized operating budget (not on a per diem basis) and its operations were assumed by the Ministry in 2004 (it was previously run by non-governmental organizations). Characteristics of the model include: 24/7 staffing, Life-skills support (e.g., cooking, laundry), employment/education support, and day programming. The model is still evolving, and is moving towards incorporating crisis services as well. There is access to a psychiatrist; however, there is only one psychiatrist in the territory.

NON-DEDICATED AFFORDABLE HOUSING OPTIONS AND PROGRAMS

There are three main programs of the Nunavut Housing Corporation (NHC):

1. Public Housing
2. Staff Housing (for government employees)
3. The Home Ownership Programs

A primary focus of the NHC has been construction of approximately 725 new units of social housing, funded through the Nunavut Housing Trust in 2006 (in the amount of $200 million) in response to the territory's ten-year action plan on housing. Nunavut received an additional $100 million in funding for housing under the 2009 federal budget which will be used to construct 285 public housing units – a recent release from NHC indicates this figure will be closer to $150 million[163,164].

[163] Unless otherwise noted, funding and unit numbers were obtained via the NHC 2007/08 annual report and the 2009/10 NHC Business Plan.
[164] September 20, 2010, News Release: MLAs respond to crisis at Nunavut Housing Corporation

Public Housing

The Government of Nunavut, through the NHC, currently maintains about **4,500 public housing units** (4,278 are NHC-owned, and 256 are leased through rent supplements[165]), **1,342 staff housing units** (244 owned, 1,098 leased through rent supplements), and holds mortgages for 500 homeowners – this represents more than 65% of Nunavut's total housing stock (NHC 2009/10 Annual Report, p.L-8).

The Nunavut Housing Corporation, through funding agreements with twenty-five Local Housing Organizations (LHO) community partners, delivers financial resources for public housing. The LHOs are responsible for the complete care of the portfolio of about 4,500 units, from allocating public housing to residents, rental assessment and collection, to maintenance and repair. The NHC uses a geared-to-income rent scale for public housing, to take away disincentives for people to pursue employment opportunities. New construction of public housing generally uses a five-plex housing design, which incorporates new energy efficient and more culturally sensitive features.

According to the 2007/08 Annual Report of the NHC, **expenditures on the Public Housing Program** are as follows: a total of $50,420,000 was spent to construct 577 new public housing units and repairs and maintenance for the existing 4,179 units (at that time) totalled $6.025 million. Each public housing unit requires approximately **$21,950 to operate and maintain on an annual basis**. As the funding from Canada Mortgage and Housing Corporation continues to decline (and ultimately terminates in 2037) additional resources will be needed to support these costs.

Staff Housing

The NHC also administers staff housing (leased and owned units) on behalf of the Government of Nunavut. The LHOs maintain the staff housing units at the local level. The level of leasing (85%) of staff units will need to be addressed over time. In 2007/08, costs for the Staff Housing Program were $39.5 million – revenues from staff housing rents are retained by the Government.

The Homeownership Program

The Homeownership Program assists eligible residents who can afford the cost of homeownership to secure and to maintain their own housing. Homeownership remains unattainable for most residents – in 2009, on average, it cost $976 monthly for fuel, water, garbage, power, insurance, maintenance and land lease fees (for residents to lease land from the government). Homeownership education and counselling is also available to provide support in the areas of new construction, renovation, bank financing, home budgeting, and energy conservation in the home.

- **Nunavut Downpayment Assistance Program**: provides assistance to eligible clients depending upon the community and type of home. Assistance levels are lowest in Rankin Inlet, Iqaluit, and Cambridge Bay ($30,000 for an existing unit up to $50,000 for new construction) and highest in smaller and more remote communities ($45,000 for an existing unit and $75,000 for new construction)
- **Tenant to Owner Program**: provides tenants in public housing with an opportunity to purchase the unit they're renting.

In 2007/2008, $6.148 million was spent on Homeownership Programs. Funding for these programs came primarily from the Government of Nunavut ($5,568,000) with a smaller contribution from CMHC ($580,000).

For existing homeowners, there are repair and renovation programs that provide assistance:

- Emergency Repair Program: up to $15,000 per client – jointly funded through the government and CMHC for a limited number of clients
- Home Renovation Program: up to $50,000 per client – jointly funded through the government and CMHC for a limited number of clients
- Senior Citizen Home Repair Program: up to $15,000 per client – funded through the government of Nunavut

[165] Structured as a direct agreement and payment between the NHC and the landlord

- Seniors and Disabled Persons Preventative Maintenance Program: provides a $1,500 annual grant to eligible seniors and disabled persons to undertake preventative maintenance on their homes – funded through the government of Nunavut
- Homeowner Energy Efficiency Rebate Program: provides up to a maximum rebate of $2,000 by way of a 50% rebate of eligible costs for homeowners to improve the energy efficiency of their homes – funded through the government of Nunavut

For 2010/11, the budget estimates for programs were as follows:

- For the Public Housing Program, total costs for 2010-11 were estimated to be $84,073 million (which includes contributions of $7,499 million in rental revenues and $48,204 contributions from CMHC).
- Staff Housing Program: $6,810 million for operations and $32,757 million for rent supplements (close to 1,100 units)

In March 2009, responsibility for homelessness was transferred from the Department of Education to the NHC – priorities for 2009/10 included the establishment of a policy analyst position to oversee the homelessness file and establishment of an inter-departmental working group on homelessness which is tasked with developing a Government of Nunavut Homelessness Strategy.

Table 2. *Non-Dedicated Affordable Housing Options in Nunavut.*

Program	Description	Capacity
Public Housing Program		261 leased units budgeted at $7.039 million plus 3,939 units owned by the NHC
Staff Housing Program		1,342 staff housing units (244 owned, 1,098 through rent supplements)
Housing Co-operative	Between 1973 and 1991, CMHC participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme, however, is that all of these co-operatives provide some type of financial support. Housing co-ops are member-owned and controlled organizations. The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. The federal government ceased funding new development at the end of 1991, but continues to honour its operating agreements with existing co-operatives, which house **over 92,000 members across Canada** under these legacy programs.[166]	1 co-operative in Iqaluit with 20 units

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, but aren't dedicated to serving this population. Within Nunavut this includes: **emergency and transitional shelters, medical boarding homes, and residential options for people with special needs**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity.

[166] Co-operative Housing Federation of Canada.

SHELTERS AND TRANSITIONAL HOUSING

According to figures from HRSDC, there were **approximately 349 beds in the three territories**' (Nunavut, Yukon, and Northwest Territories) emergency and transitional shelters in 2007[167], or 1.3% of known shelter beds across Canada. There were **332 shelter beds per 100,000** population, significantly above the 82 shelter beds/100,000 people national average.
The number of shelter beds is **likely an underestimate** because:

- It is based on the number of known shelters – there may be additional shelters not captured in this data set,
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available,
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007.

Also according to HRSDC, of the known 1,020 shelters identified across Canada as of March 2007, 723 or **71% were emergency shelters**, providing temporary and short-term accommodation for homeless individuals and/or families. Such shelters typically also offer essential services such as food, clothing, and counselling. Transitional shelters offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. Transitional shelters numbered 291 and represented a little more than 28% of the total. There were, in addition, 6 shelters providing both emergency and transitional services, representing less than 1% of the total."

In Iqaluit, three of these shelters include:

1. Qimaavik Women's Shelter
    - Run by the YWCA
    - Funded by the Agvvik Society
    - Houses up to 21 people with children
2. Sivummut House for Women
    - Umbrella of the Agvvik Society
    - 12-bed facility for women and their children
    - Opened in October, 2009
3. Uquutaq Men's Shelter
    - Formerly run by the Salvation Army, now run by the Uquutaq Society
    - Only provides basic shelter with a soup kitchen

RESIDENTIAL FACILITIES (FACILITY-BASED)

Residential care is provided both within and outside of Nunavut for those individuals who demonstrate a need for specialized residential care. Needs may be physical, mental or developmental in nature – there are homes for children and adults. The government estimated expenditures totaling approximately $19,515 million for residential care facilities for 2010/11. Placement options include: Elders' homes, group homes for children and adults, and facilities for Medically Fragile Children and Adults.

[167] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

Facilities that provide 24/7 staffing support and target adults with disabilities and adults with mental illness include:

- Isaccie Group Home (Iqaluit) – 8 beds designated for people with developmental and/or physical disabilities
- Funded through a contribution agreement with a service provider
- Gjoa Haven Continuing Care Centre (Gjoa Haven)
- Igloolik Continuing Care Centre (Igloolik)
- Rankin Inlet Group Home (Rankin Inlet)

A program and facility review across Nunavut which was completed in 2010 will assist in development of a strategy for residential care, with a focus on youth, for implementation in 2011-12.

Medical boarding homes are located outside of Nunavut and the Non-Insured Health Benefits Program (NIHB) of Health Canada helps to cover the costs of staying at boarding homes for eligible First Nations and Inuit who must travel out of their Nunavut home communities for medical care. The NIHB program provides funds for accommodations, meals, local transportation, and interpreter services. Locations include Churchill (MB), Winnipeg, Edmonton and Yellowknife. Most recently, an additional boarding home was opened in Yellowknife for Inuit from the Kitikmeot region of Nunavut (Larga Kitikmeot boarding home)[168].

MENTAL HEALTH SUPPORTS

According to the Government of Nunavut's three-year business plan, **mental health services** provide a continuum of care including assessment, counselling, treatment and referral services to those individuals and families experiencing emotional distress and/or psychiatric disorders. This includes providing support and assistance to communities and groups to better understand and deal effectively with primary, acute and/or emergency mental health issues, self harming behaviours, high stress, self-esteem and wellness (addictions) issues that limit personal functioning and well-being. The continuum of care is accessible at various points with the practitioner acting in a triage capacity.

Mental health professionals offer a variety of services, which differ from region to region. These include family violence councilors, community mental health specialists, child sexual abuse prevention, specialists, psychologists, alcohol and drug specialists, psychiatric nurses and social workers.

Total funding for 2010/11 was estimated at $8.5 million.

In 2009/10, a **Territorial Mental Health and Addictions Division** was established. The six positions include an addictions and treatment specialist, suicide intervention specialist, community mental health specialist and psychologist.

The **Qikiqtani General Hospital**, a joint venture between the Government of Nunavut and the project developer Qikiqtaaluk Corporation was officially opened in October 2007. The inpatient unit has 35 beds in total (both for adults and pediatrics). The former Baffin Regional Hospital, adjacent to the new hospital, houses dietetics, a pharmacy, out-patients department, support services and physicians'/specialists' clinics. There are two beds available for psychiatric admissions and support is focused on brief supervision. In general, people who require more intense, acute, or specialized admissions leave the territory. Specialized inpatient stays are frequently at the **Centre for Addiction and Mental Health** in Toronto.

[168] Government of Canada (May 29, 2010). News Release: Minister Aglukkaq shows support for Nunavut's newest boarding home. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2010/2010_85-eng.php

In addition to mental health services, **Adult Support Services** provide a range of counselling and support services to eligible adults with disabilities. Estimated budget for 2010/11 is $2.538 million.

INCOME SUPPORT

The territorial social assistance program is known as Income Support and is governed by the Social Assistance Act and the Social Assistance Regulations. Basic and extended benefits are delivered through the Department of Education. Single clients with disabilities have a monthly exemption on earned income of $200; families have an exemption of $400 per month.

Income Support consists of basic benefits (covers food, shelter and utilities) and extended benefits.
An extended benefit is also available for persons with disabilities, seniors and applicants who participate in a program, such as employment, education/training or volunteering. The extended benefit provides allowances for clothing, furnishings, security deposits, emergencies and day care. Actual cost of fuel and utilities is paid.

According to the Social Assistance Statistical Report, 2007 (Federal-Provincial-Territorial Directors of Income Support, May 2010, pp. 127-9), there were a reported 14,820 recipients (3,725 cases) of Income Supports during the year.

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

- The Department of Health and Social Services works with **Nunavut Arctic College** by supporting and funding certificate and degree programs that lead to career opportunities in health care and social services. Programs planned for delivery in 2010-2011 include: Human Services (Social Work and Alcohol and Drug Counsellor streams) in Cambridge Bay and the Nunavut Nursing (Baccalaureate) Program.
- The Nunavut Housing Corporation contracted with Statistics Canada to conduct a Nunavut Housing Needs Survey (NHNS). Results from the NHNS were released in Fall 2010 and provide reliable data relating to the housing shortage, the type of housing required to meet the demands of a growing population and the resources needed to address the crisis. The final response rate was 79% of all dwellings occupied by usual residents in Nunavut.

CHALLENGES IN HOUSING AND RELATED SUPPORTS

- Most recently, the NHC identified a $50 million shortfall for the building of the 285 units announced and funded through the 2009 federal budget (estimates now suggest it will cost $150 million compared to the initial $100 million budget). A review of the Nunavut Housing Trust by Deloitte and Touche further identified a $60 million shortfall that is required to complete construction and reach the 725 new units targeted through this $200 million initiative. Deloitte and Touche noted the following as some of the challenges identified as part of their review, recognizing that challenges can vary at different sites (p.9):
  - **Varied locations throughout Nunavut** - The project has a number of work sites in diverse geographical locations throughout Nunavut. Locations have differing community size, resource availability and access issues all of which impact the difficulty of undertaking and managing construction projects of this nature
  - **Lack of historic cost data** - NHC had not previously performed a project of this scope and scale and therefore there was a lack of historic cost data available to provide a basis for estimating likely project costs
  - **Limited construction season** - Due to the extreme weather experienced in Nunavut during the winter months, there is a limited time during the year when construction activities can be performed

- **Labour/contractor availability, retention, and productivity** - These factors are more challenging than an equivalent project in the south due to the combined impact of weather, location, access, accommodation, available facilities, pay rates, working practices and other similar issues
- **Material logistics and shipment** - Due to access and weather issues and a lack of local suppliers, for most communities, only one (1) main shipment of material is delivered from the south per year. This presents challenges in ensuring all required material reach the right destination at the right time
- **Storage and protection of materials** – Due to the isolated and diverse project locations, secure and weather protected storage is not available or is impractical at many project sites. As such, material shipments may remain outside near the project site exposed to weather, theft and other potential loss
- **Ability to replace missing, damaged or stolen material** - The diverse and remote locations of the project sites makes replacement of material challenging due to the time and cost that may be required to procure and transport replacement material
- **Continuity of management/supervision** - Areas of the north generally have significant turnover in management and supervision personnel. As such, factors such as accountability, continuity and historic knowledge of the project and processes tend to be an issue

- As identified by Nunavut Housing Corporation in their 2009/2010 Business Plan:
  - Close to half of Inuit children live in crowded dwellings (Statistics Canada, Social and Aboriginal Statistics Division, 2008) – overcrowded and inadequate dwellings are linked to health concerns such as respiratory tract infections in children, tuberculosis and Hepatitis A.
  - There is an extremely limited private market in Nunavut: most landlords/developers only respond to tenders, or initiate new development, that in turn promises long term government leases (costs to transport materials, secure land, and build/operate buildings makes profitability a challenge)
  - Nunavut's 25 communities are remote – with no road or rail access – all materials must be transported by air or sea. Local Housing Organizations struggle to store materials on a 12-month basis
- According to the NHNS, if more housing were made available to people in dwellings below housing standards, 3,580 groups across Nunavut would want to move: 1,420 singles, 490 two-person groups, 510 three-person groups, 430 four-person groups, 310 five-person groups, and 420 groups of six or more persons.
  - Of the 4,030 dwellings below housing standards, 1,270 had no desire to move out.
  - Temporary residents without a usual home elsewhere (including homeless people) made up 4% of the population in Nunavut (or 1,220 people) – this is considered a priority group within the group of respondents who lived in dwellings that were below housing standards and wanted to move (p.14).
- With respect to mental health services and other adult support services: because of limited resources within Nunavut, many of these adults are referred out-of-Territory.
- Adult Alternative Family Homes and Supported Independent Living models are two resources that are greatly needed in Nunavut.
- 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.
- More community-based facilities are required in light of the increasing proportion of aged members in the population.

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

- The NHC has identified planning and implementing the delivery of the $100 million in federal funding for housing for 2009-2011 as a key priority. Other priorities include:
  - Identifying a greater variety of housing options – meeting the needs of young families is a particular need
  - Continuing construction in Nunavut's communities beyond the investments from the Nunavut Housing Trust – seen as a key economic driver
  - Addressing the growing infrastructure requirements of the LHOs (in particular, having sufficient space to store materials etc.)
- Mental health priorities for 2010 – 2012 include:
  - Development and implementation of the **Addictions and Mental Health Framework**, including a land-based and facility-based treatment programs and services.
  - Implementation of a territorial suicide prevention strategy in partnership with Nunavut Tunngavik Inc. and the Embrace Life Council

A review of the Mental Health Act is planned for 2012/13.

ONTARIO

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of Ontario is approximately 12,160,300 (Statistics Canada, 2009) with an unemployment rate of 8.8% compared to a rate of 8.1% across Canada and a 2007 pre-recession rate of approximately 6% (Statistics Canada, 2010). The majority of the population is located in the south, primarily along the "Highway 401 Corridor" across the top of Lakes Erie and Ontario. Northern Ontario is sparsely populated with Northern Ontario accounting for 88% of land mass but only 6.5% of the province's population. Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of 6.6%** since 2001 – only surpassed by Alberta, Nunavut, and the Northwest Territories during the same time period.
- An **aging population**, consistent with all other regions across Canada, where 13.6% of the population is aged 65 and over (compared to 13.6% nationally).
- Slightly less than 5% of the population of Ontario is Franco-Ontarian (those whose native tongue is French), although those with French ancestry account for 11% of the population.
- The **number of Aboriginal people has been increasing** at rates greater than the general population of Ontario; the Aboriginal population increased by 68% in Ontario between 1996 and 2006. Eight in every 10 Aboriginal people, just over 944,000, lived either in Ontario or in the four western provinces in 2006. The census enumerated 242,495 Aboriginal people in Ontario in 2006, reflecting 21% of people reporting Aboriginal identity across Canada (recognizing that this is likely an underestimate since some people living on reserves do not participate in the census).
- More than half of the **1.1 million newcomers to Canada** settled in Ontario from 2001 to 2006. In total, the census enumerated 3,398,700 foreign-born individuals in Ontario. They represented 28.3% of the province's population, the highest proportion of all 10 provinces and the highest in Ontario's history.
- Most foreign-born Ontarians lived in the census metropolitan area of Toronto (68.3%).
- Of the 4,555,025 households in 2006, **71% owned the dwelling** they lived in. This represents an increase of just over 13% since 2001, the second largest proportional jump among the provinces. Of owner households, 59.1% held a mortgage.
- The proportion of households **spending 30% or more of their income on shelter was well above the national average of 24.9%** at 27.7% (up from 25.3% five years earlier, the fastest proportional increase in the country).
- Ontario also had the highest shelter costs of all provinces, for both owners and renters. Households that rented their accommodation spent a median of $9,644 a year on shelter, while the median for owners was $12,545. For owners with a mortgage, the median was nearly $17,952.
- Ontario had the **lowest percentage of households** who felt that their dwelling was **in need of major repair** (6.6%).

Ontario has traditionally been Canada's leading manufacturing province, but the reliance on the manufacturing and forestry sectors were particularly hard-hit by the economic recession. No other Canadian jurisdiction experienced a sharper decline in corporate tax revenues between 2007-08 and 2009-10 and the government posted a record $21.3 billion deficient for the 2009-10 fiscal year (Government of Ontario, 2010).

- Ontario posted the biggest growth in housing core need among the provinces and territories – with a 47% increase from 1991 to almost 600,000 households in 2001 (Shapcott, 2008), including home owners (Ontario Non-Profit Housing Association & Co-operative Housing Federation of Canada Ontario Region, 2009).

- One in every three Toronto households spends 30% or more of their income on housing – the highest levels among metropolitan areas across Canada (Wellesley Institute, 2009). More than 66,000 people are waiting up to 12 years for rent-geared-to-income accommodation (Housing Opportunities Toronto, 2009).

- Renters have, on average, household incomes that are half of owners. In the years from 1997 to 2005, housing spending by the median (middle) tenant household grew by 21% while the median tenant household income grew by just about half of that (12%; Shapcott, 2008).
  - In Ontario, housing costs increased by 17%, while incomes increased by 4%. Renters were four times more likely to be in core housing need than owners (Ontario Non-Profit Housing Association & Co-operative Housing Federation of Canada Ontario Region, 2009).
- Every province and territory, except Ontario, has made at least modest gains in raising housing funding since 2001. Ontario cut provincial spending by $732 million from 2001 to 2007. When combined with the $358 million the Ontario government was to have invested as part of the Affordable Housing Agreement, there was an overall deficit of $1 billion in comparing its commitments to housing versus actual expenditures from 2001 to the issuing of the 2008 National Report Card. Through its 2009 budget, however, Ontario has identified that it will invest in new housing infrastructure initiatives as part of its overall Poverty Reduction Strategy. Over the next two years, the province will invest $622 million (matched by the federal government for a total of approximately $1.2 billion) for the following:
  - $704 million for social housing rehabilitation and energy retrofitting of 50,000 units
  - $365 million to help create 4,500 new affordable housing for low-income seniors and people with disabilities
  - $175 million to extend the Canada-Ontario Affordable Housing Program, which is creating new homes for low-income families, senior citizens, persons living with mental illness, and victims of domestic violence
  - In addition, the 2009 Ontario budget identified an annualized investment of approximately $5 million for municipal rent banks across Ontario

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

- **The Provincial Ministry of Municipal Affairs and Housing (MMAH)** "works to strengthen Ontario communities by promoting a housing market that serves the full range of housing needs, protects tenants, and encourages private sector building, while supporting the creation of affordable housing for working families and Ontario's most vulnerable households."[169] The MMAH holds primary responsibility for legislation, policy, and funding decisions for affordable housing, social housing, rental housing, and property taxation/assessment. The following sections also provide information on the MMAH Housing for Off-Reserve Aboriginal Families program. The Residential Tenancies Act (2006) guides the landlord-tenant relationship, rights, and responsibilities in Ontario.
- The **Social Housing Services Corporation** (SHSC) was created in 2002 following downloading of administration of social housing to municipalities in 2000 (part of the **Local Services Realignment initiative**). Creation of this independent corporation, and devolution of housing to municipalities was legislated through the **Social Housing Reform Act** (2000). That Act designates 47 Service Managers (municipalities and strict social services administration boards) to administer social housing. In turn, service managers contract with social housing providers (including **public housing, non-profit, and co-operative housing providers**) to provide housing and support services in communities.
- The SHSC provides supportive services and information to social housing providers and municipal service managers including bulk purchasing, insurance, investment, and information services (including supporting independent housing-related research).

[169] Government of Ontario Ministry of Municipal Affairs and Housing website. http://www.mah.gov.on.ca/Page125.aspx

- One component of the SHSC is the "GLOBE" program (Green Light on a Better Environment) to increase and support energy-efficiency of social housing, created in part due to rising utility costs.
- Performance indicator systems for organizations charged with managing social housing (e.g., non-profits, co-ops) and another for service managers to compare results related to administering social housings programs.

- Each service manager has a coordinated access centre through which people apply to social housing.
- The **Ontario Non-Profit Housing Association** is an independent, member agency of housing providers that provides:
  - Research and operational information, as well as support to providers and service managers.
  - Information to tenants on how to apply for social housing, waiting lists, and subsidies.
- The Ontario region affiliate of the **Co-operative Housing Federation of Canada** is an independent, member agency of co-operative housing providers that provides advice and support to housing co-ops in the province to assist them in operating successfully under provincial housing programs and legislation.
- The **Ministry of Health & Long-Term Care (MOHLTC)** is responsible for oversight of the addictions and mental health system through funding and oversight of the regional health authorities (fourteen **Local Health Integration Networks** were created in 2006 to plan, fund, and evaluate health services across the province), setting policy, and legislative direction.
  - The MOHLTC is also responsible for funding the majority of housing that is dedicated/ specifically targets people living with serious mental illness.
- The Local Health Integration Networks (LHINs) contract with **Health Service Providers** (HSPs) to provide mental health and addictions services, including hospital and community mental health organizations.
- In addition to holding responsibility for services and housing for people with developmental disabilities, the **Ministry of Community and Social Services** funds services and supports that help people who are homeless or at risk of becoming homeless. Funding is provided to municipalities who contract with community agencies. Programs include the Consolidated Homelessness Prevention Program, domiciliary hostels, emergency hostels, and the Emergency Energy Fund (all described later in this summary).
- The **Ministry of Children & Youth Services** funds most of the community mental health services available to children and youth aged 18 and under. This work is guided by the Ministry's "A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health."

PROGRESS TO DATE: KEY INITIATIVES

Affordable Housing Strategy: The Ministry of Municipal Affairs and Housing released the province's first long-term affordable housing plan in late fall of 2010. The strategy provided the vision and principles for affordable housing in Ontario over the next 10 years. The focus of the consultations undertaken over the last two years included: roles and responsibilities in service delivery, efficiencies and access, legislative modifications to streamline and improve management of social housing, innovations, and outcome measurement. The Strategy has identified a number of priorities including providing greater flexibility in how municipalities may use funding, increasing integration, and advocating for additional funding support to the federal government.

Poverty Reduction Strategy: The province of Ontario created its poverty reduction strategy that focuses on children and families as a first priority – it targets reducing the number of children living in poverty by 25% (equal to 90,000 children) over five years. In addition to specific measures relating to education and income supports, of particular interest is initiatives relating to housing. Indicators for an "Ontario Housing Measure" are under development, which may have positive implications for the social and affordable housing sectors as a whole.

The work of the mental health and addictions systems is guided through two policy frameworks: **Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario**[170] (1999) and ***Making It Happen*** (1999). The *Making It Happen* mental health framework focuses primarily on people living with serious mental illness setting out target populations, functions and outcomes of a reformed mental health system. The MOHLTC acquired all "dedicated" non-profit housing services for people with mental illness from the MMAH at the time that Making It Happen was released. The intention was for the MOHLTC to establish a Mental Health Housing Steering Committee to oversee housing policy development and implementation (1999) but no policy framework was forthcoming. Nine Mental Health Implementation Task Forces were struck by the Minister of Health & Long-Term Care to make comprehensive recommendations on implementation of mental health reform in the context of *Making It Happen*. These reports were submitted in 2002 together with a report from the Provincial Forum of Task Force Chairs that summarized themes and recommendations across the province.

Minister's Advisory Panel on Mental Health and Addictions[171]: The Minister of Health & Long-Term Care created this Advisory Group of consumers, family members of individuals with mental health and addiction issues, health care providers, and researchers from across the province. The Advisory Group released its report, Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy, in December 2010 and their advice will help the Minister of Health and Long-Term Care lay the foundation for a 10-year mental health and addictions strategy.
The Advisory Group has identified two main areas of focus:

1. How to redesign mental health and addictions services – including family care, community, and hospital care – to best meet the needs of individuals.
2. How to create the necessary conditions in communities to reach optimal mental health and well-being.

In order to address these issues, the Advisory Group focused on five goals to help shape a 10-year Strategy:

1. Improvement of Mental Health and Well-Being
2. Creation of Healthy Communities
3. Stigma and Discrimination Cessation
4. Early Identification and Intervention
5. Provision of Integrated, High-Quality Services.

ALL-PARTY SELECT COMMITTEE ON MENTAL HEALTH & ADDICTIONS[172]

An all-party committee formed by the Ontario legislature to help develop ways to improve access to mental health and addiction services in the province. Representatives from all three parties worked with consumers/survivors, providers, experts and other interested parties to determine the mental health and addiction needs that currently exist. The committee recently released its report in August 2010, recommending:

- The creation of an umbrella agency (Mental Health and Addictions Ontario) to design, manage, and coordinate the mental health and addictions system, and to ensure the consistent delivery of programs and services across Ontario. Consolidate all mental health and addictions programs and services in the MOHLTC.
    - The committee noted that one of the main problems in Ontario's mental health and addictions system is that services are funded or provided by at least 10 different ministries. In addition, there are many agencies involved in service provision: 440 children's mental health agencies, 330 community mental

[170] Ontario Substance Abuse Bureau. (1999). *Setting the Course: A Framework for Integrated Addiction Treatment Services in Ontario.*
[171] http://www.health.gov.on.ca/english/public/program/mentalhealth/minister_advisgroup/minadvis_faq.html
[172] http://www.health.gov.on.ca/english/media/news_releases/archives/nr_09/feb/nr_20090224.html

health agencies, 150 substance abuse treatment agencies, and approximately 50 problem gambling centres.

- The availability of a core basket of services in all regions of Ontario.
- Access to system "navigators" who can connect people with the appropriate treatment and community support services.
- Mental Health and Addictions Ontario ensure, coordinate and advocate for the creation of additional affordable and safe housing units, with appropriate levels of support to meet the long-term and transitional needs of people with serious mental illnesses and addictions.
- Increased respite care to provide more support for families and caregivers.
- The creation of a task force to examine Ontario's mental health legislation.

The Committee further noted the crucial importance of housing, peer support, employment, and support for family caregivers in recovery.

RANGE OF HOUSING ACCOMMODATIONS

Ontario funds more than 20 programs, involving three ministries: Ministry of Municipal Affairs and Housing (MMAH), Ministry of Community and Social Services (MCSS) and Ministry of Health and Long-Term Care (MOHLTC). Table 1 provides a list of provincial housing and homelessness-related programs. At a high-level, current capacity is as follows:

1. Dedicated mental health housing:
    - There are approximately 7,900 units of dedicated mental health housing funded by the MOHLTC for people living with serious mental illness. This includes 3,300 physical units and 4,600 rent supplement units generally located in the private rental market (Auditor General Report – Community Mental Health, 2008).[173]
    - There are 149 Homes for Special Care (with 1,758 beds) in Ontario dedicated to people living with serious mental illness (Clarke, 2010; Koegl et al., 2004).
    - Approximately 930 people are served through Habitat Services in Toronto who contract with private boarding homes and rooming houses to provide on-site housing support and mental health services.
2. Non-dedicated housing:
    - There are a total of 260,000 units of social housing in Ontario – consisting of 100,000 public housing units and 160,000 non-profit and co-operative units. Within non-profits, there are approximately 11,000 supportive housing units targeting a number of special needs including people living with mental illness. The Auditor General's Report on social housing noted that the asset value of the province's social housing stock was estimated to be approximately $40 billion (Auditor General of Ontario, 2009).
    - There are 4,700 beds in domiciliary hostels in Ontario, cost-shared between the municipalities and the MCSS. It's estimated that 75% of tenants experience mental health issues and 50% have serious mental illness (Hwang et al., 2009).
3. Additional facilities:
    - Human Resources and Skills Development Canada, through the Homelessness Partnering Secretariat, estimates that there are approximately 9,700 shelter beds in Ontario as of March 2007. This accounts for

[173] Note that this is consistent with findings from Durbin et al. (2005) and Clarke (2010) given the levels of funding investment in new units since 2005.

approximately 36.1% of shelter beds across Canada.[174] This is likely an underestimate given that it does not include overflow or seasonal beds.

- There are just under 76,000 long-term care beds (Canadian Union of Public Employees, 2009; Clarke, 2010)[175] and 43,380 retirement residence units (Canada Mortgage and Housing Corporation, 2009).[176]

Table 1. *Housing Programs in Ontario*[177].

Program Name	Program Description	Lead Ministry
Affordable Housing Programs		
Social Housing	Subsidized rental housing for people with low to moderate incomes provided in a public, non-profit, or co-operative housing development, or in private rental units through a rent supplement agreement. Most social housing tenants receive rent-geared-to-income assistance.	MMAH
Canada-Ontario Affordable Housing Program (AHP)		
Rental and Supportive	Funding to create new, affordable housing for low and moderate income households, persons living with mental illness, and victims of domestic violence.	MMAH
Northern Housing	Renovation and development of affordable housing units for low-income households in Northern Ontario.	
Homeownership	Assists rental households to purchase affordable homes.	
Housing Allowance/Rent Supplement	Temporary housing allowances to make rental housing more affordable for low-income tenants in markets with high vacancy rates. Assistance is provided for up to five years.	
Strong Communities Rent Supplement Program	Long-term, rent-geared-to-income, subsidized rents in private, non profit and co-operative units.	MMAH
Strong Communities Housing Allowance – Toronto Pilot	Pilot project to create temporary housing allowances to improve housing affordability in Toronto – approximately 400 units targeted to low-income senior, and urban Aboriginal households.	MMAH
Rental Opportunity for Ontario Families (ROOF)	Temporary housing allowances to make housing more affordable for low-income working families with children. Provides up to $100/month to families for a maximum five years.	MMAH

[174] Homeless Individuals and Families Information System (HIFIS) Initiative, 2006-07 Annual Report. (Homelessness Partnering Secretariat). Ottawa, Human Resources and Social Development Canada, 2007.
[175] Canadian Union of Public Employees (October 2009). Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care and Clarke, D (June 7, 2010) Health Capital Investment in Ontario *Presented to: Design & Health Canada 2010 June 7, 2010 by Ministry of Health & Long-Term Care.*
[176] Ontario Retirement Communities Association, http://www.orcaretirement.com/master.php from National Seniors' Housing Survey (2009) Canada Mortgage and Housing Corporation
[177] Note that the range of options is not intended to imply an adequate supply of each option, as accessibility issues exist in various options. This table was reproduced from the Ministry of Municipal Affairs and Housing website: http://www.mah.gov.on.ca/Page6458.aspx with some modifications.

Program Name	Program Description	Lead Ministry
Aboriginal Housing Trust	Funding provided for new rental and ownership housing, and repair/ rehabilitation, targeted to Aboriginal communities.	MMAH
Rural and Native Housing	Subsidized rental and ownership housing in rural and remote areas.	MMAH
Homelessness & Eviction Prevention		
Emergency Hostels	Board, lodging, and money for personal needs to homeless adults, families and youth, on a short-term and infrequent basis. Funding is provided under the Ontario Works Act, 1997.	MCSS
Ontario Works - Hostels to Homes Pilot (H2H)	Pilot project consisting of six sites that provide supports to assist chronic users of hostel services to find and maintain stable, affordable, and appropriate housing.	MCSS
Consolidated Homelessness Prevention Program	Funding for homelessness prevention programs administered by municipalities.	MCSS
Provincial Rent Bank	Emergency loans/grants to tenants facing eviction due to short-term rental arrears.	MMAH
Emergency Energy Fund	Financial assistance to low-income Ontarians experiencing an energy-related emergency (e.g., hydro cut-off).	MCSS
Housing with Supports		
Dedicated Supportive Housing (MOHLTC)	Subsidized rental accommodation and support services to help people with special needs live independently (includes frail seniors, physically disabled, acquired brain injury, addictions, serious mental illness, HIV/AIDS).	MOHLTC
Dedicated Supportive Housing (MCSS)	Subsidized rental accommodation and support services to help people with special needs live independently.	MCSS
Homes for Special Care	Room, board, supervision, and assistance with daily living to people with serious mental illness.	MOHLTC
Habitat Services	Permanent residential care housing provided in Toronto to improve the quality of private-sector boarding homes.	MOHLTC
Mental Health Supportive Housing Rent Supplements	Subsidized rental accommodation and support services for people with a serious mental illness who are homeless or at risk of homelessness.	MOHLTC
Domiciliary Hostels	Provides permanent housing with limited supports for vulnerable adults who require some supervision and support with activities of daily living but who are not eligible for long-term care.	MCSS
Violence Against Women (VAW) Emergency Shelters	Shelters offer a range of services to help women achieve increased safety and increased well-being and empowerment.	MCSS
Second Stage Housing	Safe, affordable, transitional housing with ongoing support services for women who have experienced abuse and their children. MMAH supports the housing component and MCSS funds the support services.	MCSS MMAH

DEDICATED HOUSING OPTIONS

Typically, this is funded via the Ministry of Health & Long-Term Care (MOHLTC) but there are exceptions. There are two main types of dedicated MOHLTC housing:

1. Housing with Supports: Includes both "Supported" and "Supportive" Housing Options

Common attributes of supported and supportive housing are:

- Low-cost housing combined with some type of support
- Consistent population: Both models are funded to serve people living with serious mental illness as defined in *Making It Happen*
- A common philosophy: Providers of both of these options tend to focus on the importance of empowerment, independence and recovery in how they provide housing and supports
- Tenancy: People living in either supported or supportive housing are tenants, and sign leases with private landlords or mental health or social housing providers – depending on how that particular housing is managed and organized

The support usually includes:

- Mental health clinical services, such as case management, assertive community treatment, or a multi-disciplinary team. These services are always funded via the MOHLTC and delivered by mental health agencies, and/or
- Housing support services which focus on skill-building and empowerment to help maintain housing stability and tenure (e.g., finances and budgeting, setting life goals, addressing issues which are impacting housing stability, helping people to connect to natural supports and activities in their communities). These services may be funded via the MOHLTC and delivered by mental health agencies, but they may also be funded via municipal or federal initiatives, or other ministries provincially and delivered by, for example, social housing providers or other support service providers (including providers who serve people living with mental illness, perhaps as part of a broader population, but don't receive MOHLTC funding to do so and, as such, are not designated "Health Service Providers" overseen by the Local Health Integration Networks).

The challenge in defining the support component lies in the cross-over in functions between mental health clinical services and housing support services that can exist depending on how various organizations or sectors have evolved to meet the needs of their clients or tenants. For example, a person may have a case manager who not only provides mental health services to them, but also incorporates a variety of activities that are more closely tied to housing support services such as learning household skills like meal preparation, grocery shopping, or budgeting). Conversely, a key component of a housing support worker includes linking people to services in the community to help to address issues (such as substance use, mental health issues, physical health issues) that could impact housing stability, which is similar to functions also provided by a case manager.

For the purposes of the mapping, however, it is sufficient to identify this issue and how it impacts the definitions of supported and supportive housing options. Typically:

- Supported housing - there is a delinking of support from the housing in which the person lives (i.e., 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 provide at least some aspects of housing support services in addition to mental health clinical services
    - Apartments are 'scattered site' (i.e., integrated within regular private market owned or rented housing)
- Supportive housing – at least 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. This could include 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 where there are private bedrooms and baths, but shared common spaces

There are about 7,900 dedicated mental health units providing housing and supports across the province, managed by 86 organizations (Auditor General of Ontario, 2008; Sylvestre et al., 2007; Clarke, 2010):

- About 3,300 are units that have been funded for purchase and/or purpose built construction by providers, usually in the form of houses and apartment-style buildings. Units are owned and operated by providers with subsidies from the MOHLTC to cover operating costs
- About 4,600 are rent supplement units located in private apartment buildings whereby providers work with private landlords to secure units for their clients. The MOHLTC provides rent subsidies to the providers
- The Auditor General estimated that, if the Kirby report (Kirby & Keon, 2006) recommendation of 57,000 units required over the next 10 years was implemented, approximately 23,000 units would be needed in Ontario (consistent with the population)

These figures are consistent with a 2005 review by Durbin et al., which cited a total of 6,300 dedicated units. This total was based on:

- 2,421 units were transferred to the MOHLTC from the MMAH in 1998
- 238 units were transferred from the MMAH in 2002; these were originally managed by the Canada Mortgage and Housing Corporation
- 3,600 new units were developed through the Homeless Initiatives Program, which allocated $45 million, starting in 1999, for creation of new housing units with support for people with serious mental illness who were homeless or at risk of becoming homeless. Funds were used for both capital acquisition and rent supplement components, and in some cases were enhanced through access to a federal program to alleviate homelessness – the Supporting Communities Partnership Initiative and the Residential Rehabilitation Assistance Program

Since that time, additional investments have been made via the provincial-federal Health Accord agreement, the MOHLTC Service Enhancement Initiative for people with serious mental illness and criminal justice involvement, and through additional MOHLTC supportive housing investments.

The MOHLTC central Supportive Housing Unit provides housing agencies with operating and rent subsidies to cover "bricks and mortar" costs, while the LHINs provide mental health agencies with funding to deliver supports both on- and off-site.

As of 2004, the provincial allocation from the MOHLTC was approximately $30 million for the housing component and $100 million for support (Sylvestre et al., 2007). Since that time, there has been an increase of 1,600 units and so this budget has increased. According to the Auditor General (2009), expenditures on Supportive Housing (i.e., Housing with supports as discussed above) were $55.8 million in 2006/07 (this was for the bricks and mortars components only), 9% of the total community mental health envelope of funding. This would be below expenditures today, given that there have continued to be some small investments in housing since then.[178]

[178] MOHLTC, as cited in the Auditor General of Ontario 2008 Annual Report – Section 3.06, Community Mental Health. Original source, MOHLTC 2006/07 fiscal year

2. Residential Care Housing

- Usually offered in for-profit board and care setting with limited to no rehabilitation support.

Homes for Special Care (HSC)
HSCs were established in 1964 to provide long-term and permanent residential care to persons discharged from Provincial Psychiatric Hospitals, who needed supervision or assistance with activities of daily living. With the divestment of the Provincial Psychiatric Hospitals beginning in March 1998, administration of the HSC beds was also divested to the receiving specialized hospitals in the community.

- Private, for-profit home operators are licensed to provide residents with a bedroom (sometimes shared) together with personal support needs (i.e., housekeeping, meals, laundry etc.). Homes are typically 6-10 beds in size.
- The HSC programs are administered by regional specialized mental health hospitals across the province.
- An assessment of residents of HSCs in 2004 (Durbin et al.) found that there was a considerable range in level of need: more than half of the people were assessed as being able to live independently with intensive support while almost 40% required more support than they were currently receiving. This represented a significant mismatch between the person's level of need, and what the HSCs offered.
- The degree to which clinical and rehabilitative services are available in the HSC setting tends to be small; although, there are increasing examples of partnerships with clinical services which further the 'recovery orientation' of this model.

There are currently 149 HSCs across the province, with a total of 1,758 beds, with annualized funding from the MOHLTC in the amount of $28.9 million (or 5% of the total expenditures for Community Mental Health Services in Ontario).[179]

MOHLTC Habitat Services
Habitat Services[180] was established in 1987, in response to concerns raised about the living conditions in boarding homes where people with mental illness were living. Boarding homes funded by Habitat have a contract with Habitat which outlines the services to be provided including meals, 24-hour supervision, and housekeeping. They are provided with a subsidy in addition to tenants' rents. Homes differ in size, but there are some common themes:

- Intended to be permanent housing. The length of stay is indefinite and residents are tenants.
- There are shared common spaces, and bedrooms are often shared by tenants.
- House rules are developed with tenant input.
- Visitors are permitted during the hours that tenants, owners, and operators agree upon.
- On-site services are available from Habitat or COTA Health (a mental health services provider).
- Boarding home staff prepare meals and do housekeeping.

The Habitat service model involves attaching two or more staff from Habitat or COTA Health to each boarding home or rooming house. These workers promote community development by:

- Providing opportunities for tenants to interact and socialize with one another and build a sense of community in their housing

[179] Cited in Auditor General of Ontario 2008 Annual Report – Section 3.06, Community Mental Health. Original source, MOHLTC 2006/07 fiscal year
[180] www.habitatservices.org

- Supporting tenants to acquire and practice skills which will enable them to participate in the community
- Supporting tenants to assert themselves and exercise their rights in housing and other areas

In addition to these housing supports, tenants may have their own case managers or connections with other mental health (or allied health) services.

Habitat has also established a Rooming House Pilot Project for consumers who would like more independence and the ability to prepare their own meals. Elements of the Rooming House model include:

- Single room occupancy – each house has common area; cooking and washroom facilities are sometimes shared and sometimes personal
- Tenants prepare their own meals
- On-call superintendent from 7 p.m. to 7 a.m. (24-hour/day response to housing-related emergencies available by contacting the superintendent)
- Habitat Services provide site support workers for tenants

Tenants' rents depend on income sources (shelter portion of ODSP or Ontario Works, or rent-geared-to-income if they receive other types of income).

Habitat Services is funded by the MOHLTC and the City of Toronto. The program provides a housing subsidy for up to 931 units of private and not-for-profit boarding homes and rooming houses[181].

Comprehensive Assessment Projects

The Comprehensive Assessment Projects were undertaken from 1998 through 2002 to better understand the needs of clients of provincial psychiatric hospitals (PPH; note that all but one of the PPHs have since been divested to specialized hospitals across the province) and community mental health agencies, and to describe the current system and its capacity. In total, the collected data represented over 12,000 PPH patients and over 41,000 recipients of community services. **Information was collected about 4300 clients receiving services from community mental health housing programs from across Ontario**. Durbin et al. (2005) identified **three types of housing support** these clients received: 24 hour on-site support (31%), day staff (20%), and support as needed from off-site staff (49%). Of the clients who received support from off-site staff, 15% lived in residential programs, with the remainder living independently in the community. Support was mainly provided by case managers. All types of support were offered by a nurse, physician, allied health profession, or support worker.

- People in programs with **24-hour staffing** were mainly living in congregate settings
  - Of note, 45% were in a rooming house/boarding house, 10% were in an approved home/Home for Special Care, 27% were in a co-op/group home, and 12% were in a private home or apartment.
  - There was a higher proportion of people with a diagnosis of schizophrenia living in 24-hour settings.
- People in programs with day staff lived in a mix of apartments and congregate settings
  - Of note, 64% were in a private home or apartment, 33% in a co-op/group home, with the remainder in rooming houses/boarding houses or approved home/HSC dwellings.
- The vast majority of those receiving support from off-site staff (most often case managers) were living in apartments in the community.
  - 79% lived in a private home/apartment, 8% in a co-op/group home with the remainder in rooming houses/boarding houses or approved home/HSC dwellings.

[181] City of Toronto (2009), 2010 Per Diem Rates for the Purchase of Service Shelter System and Related Matters, p.7. http://www.toronto.ca/legdocs/mmis/2009/cd/bgrd/backgroundfile-24920.pdf

- In residential programs, supports were more commonly provided by non-clinical staff. 98% of clients in 24-hour settings and were receiving support from non-clinical staff, 93% in day-staff settings. In 24-hour settings, 29% of clients were receiving supports from clinical staff (note that there is overlap in terms of receiving supports from both clinical and non-clinical staff), while 15% in day-staff settings received the same supports.
- Almost half of all clients had physical health problems.

Table 2. *Dedicated Housing Options in Ontario.*

Program	Program Description	Capacity
MOHLTC Supported and Supportive Housing	Housing with Supports ▪ Supported housing – 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 – at least some component of support is linked to the housing in which the person lives, ▪ 3,300 units have been funded for purchase and/or purpose-built construction by providers, usually in the form of houses and apartment-style buildings. Units are owned and operated by providers with subsidies from the MOHLTC to cover operating costs ▪ 4,600 units are rent supplement units located in private apartment buildings. Providers work with private landlords to secure units for their clients. The MOHLTC provides rent subsidies to the providers	7,900 units (2008); $55.8 million for housing component (2006/07), $100 million for supports (2005)
MOHLTC Homes for Special Care	Residential care housing ▪ Private, for-profit home operators are licensed to provide residents with a bedroom (sometimes shared) together with personal support needs (i.e., housekeeping, meals, laundry, etc.). Homes are typically 6-10 beds in size. ▪ Administered by regional specialized mental health hospitals ▪ The degree to which clinical and rehabilitative services are available in the HSC setting tends to be small; although there are increasingly examples of partnerships with clinical services which further the 'recovery orientation' of this model.	149 Home; 1,758 beds, $28.9 million annually (5% of community mental health envelope)
MOHLTC Habitat Services	Residential care housing ▪ Works with privately owned boarding homes and rooming houses to increase quality of living conditions. Funds boarding homes and rooming houses in City of Toronto. Habitat and COTA Health Services provide on-site housing support. Boarding homes provide meals, housekeeping, and supervision. Rooming houses do not provide meals. ▪ Tenants' rents depend on income sources (shelter portion of ODSP or Ontario Works, or rent-geared-to-ncome if they receive other types of income).	931 units; $8.76 million annually

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

Building from the overview in Table 1, Table 3 provides a brief description and capacity of housing options which are generally not dedicated to people with mental illness, but are commonly used housing options. Below is some additional information and discussion on some of the initiatives.

Social housing in Ontario is provided by local housing corporations, non-profit housing providers, supportive housing providers, co-operative housing providers (community and federal), affordable rental housing providers, and emergency and transitional housing providers.[182] The Social Housing Services Corporation describes the following breakdown of the approximately 260,000 units of social housing by type of provider (December 2008)[183]:

1. **Local Housing Corporations (LHC)** – 47 corporations own and operate approximately 127,000 units across the province. Sole shareholders of the LHCs are the individual service managers (were owned by the province prior to devolution of housing to municipalities)
    - Some LHCs enter into third party agreements with support providers (e.g., Associations for Community Living, Canadian Mental Health Association) to set aside a certain number of units for their clients

2. **Non-profit Housing Providers** – there are 83,227 housing units owned and operated by non-profit housing providers
    - Providers with community-based volunteer Boards of Directors
    - Non-profit housing providers accommodate a range of households requiring rental assistance, but may also accommodate households paying full market rent
    - Some non-profits enter into third party agreements with support providers (e.g., Associations for Community Living, Canadian Mental Health Association) to set aside a certain number of units for their clients
    - Approximately 5% of non-profit housing units have been modified to meet the needs of persons with physical disabilities
    - Within the non-profit sector are **supportive housing providers**. Of the 83,227 private non-profit units in the province, 11,317 are supportive housing units
        - Supportive housing is defined as housing that is occupied by individuals receiving formal support services to maintain their tenancy and live independently in the communit. Units have different target populations including frail and/or cognitively impaired elderly persons, persons living with physical disabilities, persons with developmental disabilities, **persons with mental illness**, people with acquired brain injuries, and those living with HIV/AIDS.
        - Tenants usually have health or other services visit them on-site
        - Most supportive housing providers own and manage small projects in a group home setting (4- to 5-bedroom home) or small apartment complex (under 20 units). Some supportive housing providers have larger portfolios, which include a mix of households requiring support services, and those who do not. These larger portfolios are usually found in an apartment building.
        - Generally funded by the MOHLTC and MCSS (note that supportive housing dedicated to people with mental illness is captured within the dedicated housing section); some housing providers also receive funding from their local service manager
    - There are approximately 2,660 units of emergency and transitional housing in Ontario – again, this is a subset of the 83,227 private, non-profit units
        - Provide short term accommodation for a range of households including abused women and their children, and homeless men, women and families.

[182] Types of providers as identified in Ontario Social Housing Primer, Social Housing Services Corporation (December 2008) , Co-operative Housing Federation of Canada – Ontario Region website and cross-referenced with total social housing units provided in the 2009 Auditor General's report on Social Housing in Ontario

[183] Note that the SHSC last updated unit numbers in December 2008, accounting for the discrepancy of approximately 6,000 units between this breakdown, and the Auditor General's total number of units in its 2009 report.

- Emergency shelter housing and temporary housing is usually for a period not to exceed six weeks.
- Transitional housing is usually provided to qualifying households for a period up to two years.
- Emergency shelters, temporary, and transitional housing may be owned and managed by a non-profit housing provider, supportive housing provider, or local municipality.
- Generally funded by the MCSS and local service managers

3. **Housing Co-operatives**: Between 1973 and 1991, the Canada Mortgage and Housing Corporation (CMHC) participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program). The underlying theme is that all of these co-operatives provide some type of financial support.

   - Housing co-ops are member-owned and controlled organizations. There is no outside landlord.
   - The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs.
   - Typically, 25-75% of households in a co-op pay a reduced monthly charge, based on their income. Others pay the full monthly charge set when members approve the co-op's yearly operating budget.
   - Approximately 5% of co-op housing units have been modified to meet the needs of persons with physical disabilities.
   - There are approximately 125,000 people living in 44,000 units across 550 co-operatives in the province.
   - The Federal Government ceased funding new development at the end of 1991. About half of the co-ops in Ontario were developed under federal government programs. They operate under rules contained in an operating agreement signed with CMHC.
   - The Agency for Cooperative Housing is the not-for-profit administrator of federal co-operative housing programs in P.E.I., Ontario, Alberta, and B.C., under a contract with CMHC. The remaining co-ops were developed under provincial housing programs and follow operating rules in the Social Housing Reform Act. The Act is administered by municipal service managers.
   - The Ontario region affiliate of the **Co-Operative Housing Federation of Canada** is an independent, member agency of co-op housing providers that provides advice and support to housing co-ops in the province to assist them in operating successfully under provincial housing programs and legislation.

Affordable Housing Initiative (AHI)/Canada-Ontario Affordable Housing Program Agreement: Based on the housing framework agreed to in **November 2001** by federal and provincial/territorial housing ministers, 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 a grant, a stream of ongoing subsidies, or the value of in-kind contributions (e.g., land). Within these terms and 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. In Ontario, the Program was intended to create more than 18,000 units of affordable housing for households on social housing lists, or those eligible to be on such lists and had a total funding commitment of $624 million as of March 31, 2009 ($348 million from the federal government and $276 million from the province).[184] The Ministry of Municipal Affairs and Housing reports that the Program to date has provided funding for nearly 15,000 affordable housing units and 3,700 housing allowances for low-income Ontario households.

As noted, the federal government's **Economic Action Plan** builds on this existing commitment, extending the AHI to March 31, 2011 through a national $1.9 billion investment over five years, and providing a further one-time

[184] Auditor General of Ontario (2009). 2009 Annual Report from the Office of the Auditor General – Section 3.12, Social Housing.

investment of $1.525 billion in housing stimulus measures to build new and renovate existing social housing. This funding is being delivered through amendments to existing cost-sharing and delivery arrangements with provinces and territories through the AHI. As noted in the previous section, the Ontario government is matching the federal government investment to total $1.2 billion for housing in Ontario which will create 23,000 jobs over the course of the program. Allocations are as follows:

- $87.4 million to extend the Canada-Ontario Affordable Housing Program, creating new homes for low-income families, senior citizens, persons living with mental illness, and victims of domestic violence
- $183 million to create 4,500 affordable housing for low-income seniors and persons with disabilities
- $352 million to renovate 50,000 social housing units (increasing energy efficiency)

The province is making these investments, as well as providing approximately $5 million in annualized funding to its Provincial Rent Bank Program, as part of their overarching Poverty Reduction Strategy.

Homelessness Partnering Strategy (HPS): Launched on April 1, 2007 by the federal government, building on the foundation of its predecessor program, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five year commitment. For the 61 "Designated Communities" funding component under the strategy, Ontario holds the highest number, which includes Barrie, Belleville, Brantford, Dufferin, Guelph, Halton, Hamilton, Kingston, Kitchener, London, North Bay, Ottawa, Peel Region, Peterborough, Region of Durham, Sault Ste. Marie, St. Catharines-Niagara, Sudbury, Thunder Bay, Toronto, Windsor, and York Region. A key focus of the HPS is a *Housing First* approach and focuses on transitional and supportive housing as important ways to move individuals out of homelessness.

Domiciliary Hostels: Domiciliary hostels evolved in the 1970s as an unregulated boarding house program, in part due to the province's development of more formalized policies to help support people who had housing and basic needs (e.g., Nursing Homes Act, 1974 was one such piece of legislation). The Nursing Homes Act provided subsidies for low-income, frail/elderly adults who were not yet ready, or eligible, for a long-term care home but required support with the activities of daily living. This program became the Domiciliary Hostel Program. The lack of regulation created a program that grew in an unplanned and unstructured way. The model has typically been custodial, and hostels are operated by private owners for profit. As the need for affordable housing and supports has grown, the domiciliary hostel program has also evolved. Today, they provide residential care for vulnerable adults who require some supervision and support with activities of daily living but who are not eligible for long-term care. Tenants are usually living with mental illness, developmental disability, and/or are elderly. Standards for domiciliary hostels are mandated by the municipality, and are congruent with a provincial framework introduced in 2006. Hostel owners sign agreements with municipalities to provide lodging and services in compliance with the agreement (Region of Waterloo, 2009).

While there have been many concerns with the quality of this housing and support model over the years, a more recent evaluation did have positive findings from tenants' perspectives. In addition, municipalities have played a role in improving standards of care.

- Services include 24-hour staffing with support; meals and snacks; medication management; furnished rooms (most are shared accommodation); assistance with daily living activities; housekeeping; and laundry services. They also provide access to other on-site and community based services.
- Subsidies are provided via the municipal service managers. Subsidized residents contribute to their stay and retain a small personal needs benefit. The per diem is $45.90 and is cost-shared 80/20 between municipalities and MCSS. **In addition to the per diem, eligible tenants also receive a personal needs allowance/benefit and other benefits through the Ontario Works Act**.

- According to Hwang et al (2009), size of domiciliary hostels can range in size from one to 108 beds (on average, there are 35 beds per hostel). In its 2009/10 Annual Report, MCSS notes that it provides nearly $36 million to municipalities to fund 4,900 beds in 280 domiciliary hostels (p.16). Based on cost sharing with municipalities, this means that annual funding for this program is in the order of $4.5 million.

A recent province-wide study, based on surveys with a representative, random sample of domiciliary hostel tenants, had the following findings (Hwang et al., 2009):

- Domiciliary hostel staff assist tenants in a number of ways, including helping them take their prescribed medications, accompanying them for health visits, and providing social support.
- Tenants tend to use relatively few community services and have low levels of involvement in community activities, but have a positive perception of their social connections.
- The average age of tenants is 55 (over three quarters are under the age of 65).
- **Three quarters of tenants have been diagnosed with a mental health issue – about half have a serious mental illness**. Four out of 10 tenants see a psychiatrist regularly.
- About one in five tenants have been diagnosed with a **developmental disability**.
- Most tenants said they had not used alcohol or drugs in the past three years.
- Most tenants experience **significant physical health problems**; most tenants have problems with mobility, self-care, and have chronic health problems (e.g., arthritis, high blood pressure, diabetes, anemia). Most tenants have a family doctor.
- Over three-quarters of tenants are registered with either Ontario Disability Support Program (ODSP) or Ontario Works.
- Over one-third of tenants have a history of homelessness.
- The average tenant has lived in a domiciliary hostel for five years.
- Most tenants experience personal autonomy and feel able to express their opinions about hostel life and policies. About half of respondents said there were things they disliked about living at the hostel, including problems with other tenants, the meals or size of meals, lack of freedom, lack of discipline, uncaring or unfriendly staff, and noisy/crowded living spaces.

These findings should be interpreted with caution. As sampling did not include 17 consolidated municipal service managers' areas accounting for 15% of all domiciliary hostel beds in Ontario, findings may not be generalizable to those areas. As well, 13% of individuals approached were ineligible, primarily due to an inability to converse appropriately. There may be a subgroup of tenants who have higher levels of disability or illness and/or cognitive impairment meaning a potential underestimation in level of illness. Finally, 28% of eligible individuals declined to participate in the study. Thus, there may be differences between this group and from those who enrolled.

Hostels 2 Homes (H2H) Pilot Project[185]

- Created to assist chronic hostel users in attaining safe, appropriate, affordable and stable accommodation. There are three main elements to help homeless people quickly access and then sustain housing: (1) crisis intervention and needs assessment; (2) re-housing to more permanent; and (3) accommodation.
  - "Wrap-around" supports based on individualized case management (assumes that people will be more willing to engage in accessing supports once they are housed but housing is the first priority)
- Rolled out in two phases with expected completion of the project in June 2010.

[185] Nguyen, T (2009). From Hostels to Homes: Presentation to the National Housing Research Committee, May 4, 2009, by Thu Nguyen, Ontario Works Branch, Ministry of Community and Social Services.

- Approximately $800 is provided on a monthly basis (in addition to the shelter portion of Ontario Works). This is equal to about what it would cost for that person to be in an emergency shelter for the month. Providers use funding for programming for housing, mental and physical health, and addictions issues.
- Targets people with 30+ days in hostels in a one-year period and who are eligible for Ontario Works assistance.
- Intention was to provide 18 months of support with phase-out of services beginning in the twelfth month.
- Based on data pilot sites provided to the ministry, as of January 31, 2009, a total of 947 hostel residents had been housed and 48% of them had finished participating in the pilot.
    - Of those who had finished with the pilot, the vast majority (72%) were housed when they left the pilot, and 14% left due to finding employment
- Reported successes: stabilized housing situation, enhanced self-confidence, simpler system to navigate, increased knowledge of available resources, better attachment to the community, supportive relationships with service staff.
- Reported challenges:
    - The per diem funding model for hostels – based on bed occupancy rates – is inconsistent with the objectives of H2H which emphasizes transitioning hostel users into permanent housing
    - Definition of the target group (chronic hostel users) is too broad, resulting in the selection of participants who may not be suitable for the limited period of supports under H2H
    - A large proportion of participants require intensive pre-housing supports that require more resources
    - Shortage of assistance to make housing affordable

Table 3. *Non-Dedicated Affordable Housing Options in Ontario*[186].

Program	Type	Program Description	Capacity
MMAH Social Housing (three types of providers; listed below)		Subsidized rental housing for people with low to moderate incomes provided in a public, non-profit or co-operative housing development, or in private rental units through a rent supplement agreement. Most social housing tenants receive rent geared-to-income assistance.	Total of 260,000 units Total funding – unclear: $518 million in federal funding received by province in 2008 calendar year; some funds are withheld for other provincial housing programs
1. Local Housing Corporations		Local Housing Corporations own and operate these units for singles, couples, and families living on low incomes – may contract with local services to set aside a certain number of units for their clients (may include **mental health organizations**).	Approximately 127,000 units

[186] Includes source material from the Conference Board of Canada's *Building from the Ground Up* (March 2010), pp.85 – 88, Government of Québec, Societe d'Habitation du Québec (April 2007). *Inventory of Provincial and Territorial Housing Programs in Canada*. Pp.46-8.

Program	Type	Program Description	Capacity
2. Non-profit Housing Providers		Non-profit housing providers – generally provide housing to people living on low income but sometimes include people paying market rent as well. May contract with local services to set aside a certain number of units for their clients (may include **mental health organizations**). Includes 11,317 supportive housing units (of which people with mental illness are one of a number of populations of focus) - Generally funded by MCSS and MOHLTC – sometimes by municipal service managers. The MOHLTC estimates they fund assisted living services to 10,500 seniors in social housing. Also includes 2,660 emergency (up to six weeks) and transitional housing (up to two years) units. Generally funded by MCSS and municipal service managers.	Approximately 83,227 units
3. Housing Co-operatives		Housing Co-operatives: member-owned and controlled organizations – no outside landlord. Monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. Typically, 25-75% of households in a co-op pay a reduced monthly charge, based on their income; others pay the full monthly charge set when members approve the co-op's yearly operating budget.	Approximately 125,000 people in 44,000 units in 550 co-operatives across Ontario
MMAH/AFP: Rental & Supportive	Housing only, housing and supports	Funding to create new affordable housing for low and moderate income households, persons living with mental illness, and victims of domestic violence. Provides a specific number of supportive units for tenants of social housing with specific needs. Service managers work with the Ministry of Health & Long-Term Care and the Ministry of Community and Social Services to ensure support services are coordinated.	10,079 units as of August 2010 at a cost of $498 million[187]
MMAH/AFP: Housing Allowance/Rent Supplement	Housing only	Housing allowances to make rental housing more affordable for low-income tenants in markets with high vacancy rates – households must be on (or be eligible for) social housing waiting lists. There is a maximum 5-year term for each housing allowance agreement between the service manager and the landlord. **Expires March 13, 2013**.	$80 million for 5,000 households ($20-300 per month) – as of March 2009, 3,721 rent supplements have been provided with 10% dedicated to victims of domestic violence
MMAH/AFP: Strong Communities Rent Supplement Program	Housing only	Long-term rent-geared-to-income subsidized rents in private, non profit, and co-operative units. Under a provincial/municipal memorandum of understanding, fixed SCRSP funding is provided to municipalities which they then use to enter into agreements with private landlords, social housing providers, or co-operatives for	$50 million per year for 20 years for 6,933 units

[187] Number of units and funding figures are a combination of information from the Ministry of Municipal Affairs (http://www.mah.gov.on.ca/Page6454.aspx and the Auditor General of Ontario (2009) unless otherwise noted

Program	Type	Program Description	Capacity
(SCRSP)		a specific number of units. The tenant pays on the basis of 30% income and the municipality pays the difference between that and market rent. Supports required are negotiated via MOHLTC and MCSS.	
MMAH/AFP: Strong Communities Housing Allowance (Toronto Pilot)	Housing only	Pilot project to create temporary housing allowances to improve housing affordability in Toronto; City of Toronto entered into a housing allowance agreement with the province in March 2005. Five year agreement, reduces rent by up to $300 per month (50% provincial funding, 50% through landlord rent reduction).	Approximately 400 units targeted to low-income senior and urban Aboriginal households. $3.6 million in provincial funding
MMAH/AFP: Rental Opportunity for Ontario Families (ROOF)	Housing only	Temporary housing allowances to make housing more affordable for low-income working families with children. Provides up to $100/month to families for a maximum five years. Note: applications are no longer being accepted as of 2008.	Investing up to $185 million to create up to 27,350 housing allowances – 21,500 clients have benefited to date[188]
MMAH/AHP: Homeownership	Housing only	Provides interest-free, down payment assistance loans and up to 5% of the home purchase price to moderate-income households to assist them in moving from rental accommodation to homeownership. The loan is expected to be repaid, along with 55% of capital appreciation if the home is sold within 20 years.	Operates as a revolving fund (total allocation of $36 million for 4,500 low/moderate income households). MMAH reporting 3,185 units as of August 2010
MMAH/AHP: Northern Housing Program	Housing only	Provides an average loan of $25,000 per unit to assist Northern Ontario (north of the French River) homeowners in repairing their unit, or landlords and developers to rehabilitate/build affordable rental units.	Provides $20 million in funding for 1,795 units as of August 2010 (reported by MMAH)
MMAH Provincial Rent Bank Program	Housing only	Short-term funding for low-income tenants who are in short-term rent arrears and facing eviction. Administered by municipal service managers. Outstanding rent paid directly to the landlord on behalf of the tenants. Initially a pilot project. As of August 2009, has invested a total of $28.8 million and helped over 20,250 Ontario families.[189]	$5 million annual funding
MMAH: Housing for Off-Reserve Aboriginal Families	Housing and Supports	MMAH is working with two Aboriginal organizations to administer this program. Provide funding for new affordable rental units, home ownership loans, repairs, together with provision of supports to close to 1,000 off-reserve Aboriginal households.	$80 million to support/house close to 1,000 households ($20 million within Greater Toronto Area, $60 million outside of GTA)
Rural and Native Housing Program	Housing	Provides rent-geared-to-income rental housing (there was a home ownership portion providing mortgage subsidies prior to 1991). Devolved to the province (MMAH) in 1999 from the CMHC. MMAH transferred full ownership and assets to the Ontario Aboriginal Housing Support Services Corporation (OAHSSC) in 2009.	Includes nearly 1,600 single family residential units and a home ownership component of 750+ units

[188] http://www.mah.gov.on.ca/Page6454.aspx
[189] http://www.mah.gov.on.ca/Page6454.aspx

Program	Type	Program Description	Capacity
MCSS: Domiciliary Hostels	Housing and Supports	Provides permanent housing with limited supports for vulnerable adults who require some supervision and support with activities of daily living but who are not eligible for long-term care. **Estimated 75% of tenants have mental health issues, 50% have serious mental illness**.	4,700 beds
MCSS: Hostels to Homes Pilot	Housing and Supports	To assist chronic hostel users in attaining safe, appropriate, affordable and stable accommodation – three main elements to help homeless people quickly access and then sustain housing: ▪ crisis intervention and needs assessment ▪ re-housing to more permanent accommodation ▪ "wrap-around" supports based on individualized case management Slated for completion June 2010	▪ Pilot sites: Hamilton, Kingston, London, Ottawa, Toronto, and Windsor ▪ 947 people housed as of January 31, 2009 ▪ Costs: shelter portion of Ontario Works plus approximately $800 (totals about $1,300; i.e., the equivalent of hostelling costs) on a monthly basis

ADDITIONAL INITIATIVES

- **MMAH Brownfields Initiative**: Addresses cleanup of brownfields sites and construction of new affordable housing on cleaned brownfields; helps to address the lack of affordable housing in older, urban areas. Brownfield sites are former industrial or commercial properties that are underutilized, derelict, or vacant. When cleaned-up, these sites make ideal locations for affordable housing projects, as they are often located in downtown cores close to transit, services, and other amenities. Projects were eligible for a number of incentives including up to $70,000 under the rental and supportive component of the Affordable Housing Program, financial incentives from municipal Community Investment Plans (e.g., grants for environmental studies, environmental remediation, and the waiving of development charges), and tax incentives. 535 units to date.
- **MMAH Delivering Opportunities for Ontario Renters (DOOR)**: Provided $127 million in 2007 to fund the creation or rehabilitation of affordable rental housing units.
- **MMAH Projects in Difficulty Services**: MMAH provides day-to-day management and financial support of social housing projects in difficulty until there is stabilization and an approved work plan to address project deficiencies.
- **Residential Rehabilitation Assistance Suite of Programs (RRAP)**: This is a Federal/Provincial cost shared (75/25) program administered by CMHC (administered by the municipality for the City of Toronto). Programs are generally targeted for people living on low income.
  - Homeownership RRAP – provides assistance to low income homeowners to bring their property up to minimum health and safety standards.
  - Rental RRAP – offers financial assistance to landlords of affordable rental housing to pay for mandatory repairs to self-contained units occupied by tenants with low-incomes.
  - Rooming House RRAP – provides support for major repairs to rooming houses for low income Ontarians in core need of housing.

- Residential Conversions – landlords must own and convert non-residential properties to create affordable, permanent accommodation.
- Persons with Disabilities – offers financial assistance to homeowners and landlords to undertake accessibility work to modify dwellings occupied or intended for occupancy by persons with disabilities with low incomes.

- **Property Tax Credit**: refundable property tax credit for people with low to moderate incomes
- **MCSS Emergency Energy Fund**: helps low-income Ontarians who are facing energy-related emergencies, such as: utility arrears, security deposits and reconnection costs for electricity, hydro, natural gas, oil, and other forms of energy.
- **The Aboriginal Healing and Wellness Strategy** is a partnership between the province, 14 Aboriginal provincial/territorial organizations, and independent First Nations. It combines traditional and mainstream programs and services to help improve Aboriginal health and reduce family violence. These community-based programs and services are available to Aboriginal people living on-reserve and in urban and rural communities. Services include:
  - Community wellness programs
  - Aboriginal Healthy Babies, Healthy Children Program
  - Counselling to address mental and emotional issues
  - Crisis intervention services
  - Healing lodges
  - Health care, health promotion, and education
  - Shelters and safe houses for women escaping domestic violence and their children
  - Pre- and post-natal care
  - Substance abuse treatment centres

According to MCSS, to date, the Strategy has created more than 460 community-based health and healing programs, generated more than 650 jobs, and trained 1,000 staff each year in health and social services on and off reserve. In a typical year, the Strategy provides direct services to more than 40,000 clients through 360 projects (Ministry of Community and Social Services, 2011, p.16). In December 2009, the government committed to continue funding for Aboriginal Healing and Wellness Strategy programs and services to March 2011 to allow for the transition to a new governance model.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, and either aren't dedicated to serving this population or aren't considered a true housing option (as is this case with shelters). Within Ontario, this includes: **shelters (emergency and transitional)**, residential care options for seniors (**long-term care homes, retirement homes**), **shelters/transitional housing for victims of domestic violence, and residential options for people living with developmental disabilities**. We summarize some key points related to each of these settings below, together with a table which summarizes the program and capacity where information was readily available.

SHELTERS

According to figures from Human Resources and Skills Development Canada (HRSDC), there were **approximately 9,700 beds** in Ontario's emergency and transitional shelters in 2007,[190] or 36% of known shelter beds across Canada. This is consistent with Ontario being home to approximately 39% of the nation's population (some provinces and territories have a larger discrepancy between these figures). There are **76 shelter beds per 100,000** people, slightly under the 83 shelter beds/100,000 people national average. This is **likely an underestimate** because:

- It is based on the number of known shelters; there may be additional shelters not captured in this data set
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007

Also according to HRSDC, **of the known 1,020 shelters** identified across Canada as of March 2007, 723 or **71% were emergency shelters**, providing temporary and short-term accommodation for homeless individuals and/or families. Such shelters typically also offer essential services such as food, clothing, and counselling. Transitional shelters offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. Transitional shelters numbered 291 and represented a little more than 28% of the total. There were, in addition, six shelters providing both emergency and transitional services, representing less than 1% of the total.

Shelter costs are cost-shared between the provincial and municipal governments – this is supposed to be 80/20 respectively. The province pays $34.26 as its per diem, meaning that the municipal share should be about $8.57 per shelter day (for a total of approximately $42.80 per day). The reality, however, is that this is insufficient to operate the shelters, and **municipalities often make up the shortfall**. For example, in its 2010 per diem rates, City of Toronto staff noted that the 2010 proposed operating budget for Purchase of Service shelters (City of Toronto, 2009, p.5) was based on an average per diem rate of $52.13, almost $10 more – of which the municipality would cover the shortfall (effectively bringing the cost share to a 66/34 split rather than 80/20). The province has put in place a process to **upload municipalities' shares of the per diem** with full cost upload expected by 2018. This could have significant impacts on the capacity of the shelter system unless an **adequate shelter per diem rate** is incorporated as part of the upload process.

In addition, many municipalities and service providers are strong supporters of the need to move from the **current provincial funding model of per diem rates** to a model that provides shelters with **annualized budgets, based on actual operating and support costs**, thereby providing the shelter system with greater capacity in helping shelter clients find and keep permanent housing.

RESIDENTIAL SETTINGS FOR SENIORS

The Ministry of Health & Long-Term Care has developed the following table, comparing residential options for seniors (note that we have removed supportive housing as this was discussed in a previous section):

[190] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

Table 4. *Seniors Care: Comparing Residential Care Options.*

	Retirement Homes	Long-Term Care Homes
Also referred to as:	Retirement Residence, Care Home, Assisted Living, Rest Home	Homes, Nursing Homes, Homes for the Aged
Levels of Care	Individuals or couples who need light housekeeping, meals, low levels of personal care, and availability of staff on a 24-hour basis to live independently.	Individuals who need higher levels of daily personal care, availability of 24-hour nursing care or supervision, and a secure environment.
Accommodation Style	Ranges from shared living to bachelor, one-, and two- bedroom apartments.	Ranges from rooms with four people to semi-private and private rooms.
Owned and Managed by :	Private corporations and in a few cases, non-profit corporations.	Municipal governments, non-profit corporations or private corporations.
Cost Ranges (Per Person)	Costs for accommodation and care can range from $1,500 to $5,000 per month for a private room.	The co-payment rates change from time to time (at a minimum, annually). The rates effective July 1, 2007 are: $1,543.95 per month for "standard or basic" accommodation; $1,787.29 for semi-private accommodation; and $2,091.45 per month for private accommodation.
Government Funding	None	Government can subsidize accommodation to the "basic or standard" rate for those who qualify for this subsidy. The MOHLTC funds the care provided in homes.
Governing Legislation	▪ Tenant Protection Act ▪ Some municipalities may also have "care home" by-laws.	▪ Homes for the Aged and Rest Homes Act ▪ Nursing Homes Act ▪ Charitable Institutions Act
Accreditation	Voluntary accreditation through the Ontario Residential Care Association.	Voluntary accreditation through the Canadian Council for Health Services Accreditation.
How to Select and Apply	Select and apply directly to the provider organization.	Apply via the local Community Care Access Centre and if eligible, the resident selects top three choices (except for short-stay respite or if immediate admission is required).

Source: Ontario Ministry of Health & Long-Term Care
http://www.health.gov.on.ca/english/public/program/ltc/16_options.html

- **In 2008, there were 75,958 long-term care beds across Ontario**
  - 47% were owned and operated by non-profit providers, the remainder by private providers – nationally this is a 65/35 split (Canadian Union of Public Employees, 2009, p.73).[191]
- **As of 2010**, it was reported that there were over 600 long-term care (LTC) homes with over 76,000 beds in Ontario; there was a total of **$2.8 billion** allocated for 2009/10 LHIN-funded beds (Clarke, 2010).

[191] Based on a national compilation where Ministry representatives in each province were asked to provide total number of beds, and breakdown between not-for-profit and for-profit owners/operators. Information on Ontario LTC beds came from Health System Information Management and Investment (HSIMI), July 31, 2008, Health Data Branch, Ministry of Health and Long-Term Care.

- There were **91.5 beds per 1,000 people aged 75+ as of 2008** (compared to a national average of 90 beds per 1,000). Ontario was the only province across Canada which had an increase in the bed rate from 2001 to 2008 of 3.8% (Canadian Union of Public Employees, 2009, p.25).
- Oldest LTC homes have been rebuilt over last 10 years. There are approximately 35,000 older LTC beds that require redevelopment over the next 10-15 years.
- CMHC, in its Seniors' Housing Report for Ontario (2010), noted that the **retirement home industry added 11,800 new spaces for 2005 to 2009** (almost 25% of the current stock), and that there were a total of about 43,380 spaces in retirement homes in Ontario in 2009 with a 13.2% vacancy rate.

RESIDENTIAL OPTIONS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

There have been significant changes in Ontario's developmental services sector over the last decade as there has been a push to close remaining institutions serving people with developmental disabilities. The final three developmental institutions were closed in March 2009. The Ministry of Community and Social Services did provide funding attached to people as they transitioned to the community and the government has commissioned a review to examine, in part, how people have been able to access services and supports.

Community Living Ontario has been closely monitoring this process to ensure that people not be 'reinstitutionalized' in the community by living in housing/support settings that don't promote integration.

MCSS supports children and adults with developmental disabilities with funding for day programs, residential supports, clinical supports, and personal services. This system serves more than 40,000 people annually, with a budget of $1.5 billion.[192] Roughly 16,000 people receive residential support which would include all types of residences, group homes, and supported apartment living situations. Some highlights around the funding include:

- Creation of nearly 1,300 spaces in the community for adults with a developmental disability to live
- Establishment of four Community Networks of Specialized Care across the province
- To provide linkages to specialized clinical supports for people who have some of the most complex care needs, including co-occurring developmental and mental health issues
- Provides approximately $100 million for the Special Services at Home – enables close to 30,000 individuals and families by providing funding directly to individuals and families to purchase services and supports allowing them to live at home with their families. Serves 8,400 more families through the Special Services at Home Program
- Has included an investment of $276 million to help transition nearly 1,000 people into new homes with supports as part of the final institution closure

[192] Government of Ontario. News Release - McGuinty Government Ends the Era of Institutionalization, March 31, 2009, available at http://news.ontario.ca/mcss/en/2009/03/ontario-closes-institutions-for-people-with-a-developmental-disability.html

Table 5. *Additional Facilities or Housing Options in Ontario.*

Program	Type	Program Description	Capacity
Emergency and Transitional Shelters	Emergency/ Transitional Shelters	For homeless individuals and/or family emergencies; approximately 70% of all shelters across Canada providing temporary and short-term accommodation for homeless individuals and/or families. Transitional shelters offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. ▪ 80/20 cost shared between province and municipalities ▪ Municipalities generally contract with non-profit providers ▪ Per diem approximately $42.80 per day (municipalities make up for regular shortfalls in funding; e.g., average shelter per diem of $52.13) Province has put in place a process to upload municipalities' shares of the per diem with full cost upload expected by 2018.	9,700 emergency/transitional shelter spaces (likely an underestimate)
Long-Term Care (LTC) Homes	Long-Term Care	For individuals who need higher levels of daily personal care, availability of 24-hour nursing care or supervision, and a secure environment. ▪ Can be wards, semi-private or private rooms ▪ Residents are not tenants Residents may be subsidized by MOHLTC. The minimum disposable income allowance (amount subsidized residents may retain for personal expenses) is $122 per month	Over 600 LTC homes with approximately 76,000 beds (47% non-profit, 53% for-profit); $2.8 billion MOHLTC allocation for 2009/10; co-payment rates for residents range from roughly $1,500 to $2,100 monthly in 2007
Retirement Homes	Long-Term Care	For individuals or couples who need light housekeeping, meals, low levels of personal care, and availability of staff on a 24-hour basis to live independently. ▪ Can be shared living or apartments ▪ Residents are tenants Generally run by private corporations	43,380 spaces – generally provided by for-profit private corporations; costs for accommodation and care can range from $1,500 to $5,000 per month for a private room.
MCSS - Violence Against Women	Emergency/ Transitional Housing with Supports	These two programs are one part of the ministry's overarching 2005 Domestic Violence Action plan. In total, MCSS provides $140 million annually to support this range of programs. (Ministry of Community and Social Services, 2011, p.17).	2,012 beds in 97 emergency shelters Transitional and Housing support program serves more than 20,000 women $140 million for full range of programs annually
MCSS Supportive Housing	Housing and Supports	MCSS supports children and adults with developmental disabilities with funding for day programs, residential supports, clinical supports and personal services. Some highlights around the funding include: ▪ Creation of nearly 1,300 spaces in the community for adults with a developmental disability to live	Total developmental services budget of $1.5 billion service 40,000+ people – number of residential spaces unclear. There are approximately 1,480 units provided by MCSS, funded supportive housing providers who are

Program	Type	Program Description	Capacity
		▪ Provision of approximately $100 million for the Special Services at Home which enables close to 30,000 individuals and families purchase services and supports allowing them to live at home with their families. Serving 8,400 more families compared to 2004 ▪ Has included an investment of $276 million to help transition nearly 1,000 people into new homes with supports as part of the final institution closure	members of ONPHA; these are primarily units for people with developmental disabilities

MENTAL HEALTH SUPPORTS

Range of Mental Health Supports	
Community Connections	▪ Peer Supports ▪ Vocational ▪ Social Recreation ▪ Support within Housing
Community Mental Health Services	▪ Case Management ▪ Assertive Community Treatment ▪ Counselling/Treatment ▪ Crisis Services (including short-term crisis beds) ▪ Court Support/Diversion ▪ Early Intervention in Psychosis ▪ Psychogeriatric Services ▪ Acute and Specialized Outpatient Services
Inpatient Services	▪ Acute and specialized
Other	▪ Other programs including medical resources and health promotion/education

FUNDING LEVELS

Funding for community mental health services was about **$647 million in 2007/08** (Auditor General's Report on Community Mental Health programs, 2008, p.173).

- As noted in previous sections, as of 2006/07 $55.8 million was allocated to the "bricks and mortar" component of housing and $28.9 million for the Homes for Special Care Program. $14.5 million was allocated to services provided by ten provincial organizations and the remaining $496.3 million was allocated to community mental health services. Since that time, there have been investments in both supportive housing and community mental health services

According to a recent analysis by the Institute of Health Economics (Jacobs et al., 2010), the following were some of the additional expenditures on mental health and addictions services[193] in Ontario for 2007/08:

- $993.6 million for inpatient care[194] ($475.6 million in general hospitals and $518 million in psychiatric hospitals)
- $787.2 million for physician services ($181.2 million for general practitioners' fees for service, $320.6 million for specialists' fees for service, and $285.4 million for psychiatrists on alternative payment schemes)
- $1.4436 billion for community and social services ($661.9 million for community mental health – a small relative difference compared to the auditors' report – $506.7 million for other community and social supports, $196.4 million for addictions, and $32.6 million for First Nations mental health and addictions services)

The Auditor General noted (2008, p.174-75) that:

- While the MOHLTC "has almost reached its interim deinstitutionalization target of reducing the number of psychiatric beds to 35 per 100,000 people … the Ministry was still far from achieving its community target of spending 60% of mental-health funding to meet the needs of people with serious mental illness in the community. In the 2006/07 fiscal year, the Ministry spent about **$39 on community-based services for every $61 it spent on institutional services**."

[193] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.
[194] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.

- There are **significant differences in regional averages per capita funding**, ranging from a high of $115 to a low of $19 – the provincial average is $42.
- There is a critical shortage of supportive housing units in Ontario, with wait times ranging from one to six years.
- There is an **uneven distribution of supportive housing units** in Ontario - ranging from 20 units per 100,000 people in one Local Health Integration Networks (LHIN) to 273 units per 100,000 people in another.

According to a study released by the Centre for Addiction and Mental Health in 2006, the estimated total economic cost attributable to mental illness was about **$22 billion per year** in Ontario. While there have been a number of new funding initiatives, in the last six years, prior to 2004/05, there had been no increase to community mental health programs base funding for more than a decade (Auditor General, 2008, p.185).

OVERVIEW OF MENTAL HEALTH SERVICES AND THE SERVICE SYSTEM

- Community mental health service providers **report directly to the 14 LHINs** (regional health authorities) across the province that are responsible for management of the healthcare system at the local level.
- The Ministry provides transfer payments to the LHINs, who fund about 330 community-based providers: the **major types of services provided** include housing, case management, assertive community treatment teams, crisis intervention, consumer-survivor initiatives (peer-led peer support organizations), counselling and treatment services, vocational support, and social/recreation activities. Funding is generally targeted solely for people living with serious mental illness (as opposed to people with more moderate needs).
- ***Making It Happen*** (1999) is the policy framework guiding the mental health system and outlines what characterizes people with serious mental illness: diagnosis of mental illness such as schizophrenia, depression, bipolar disorder, or personality disorder; a long duration of illness; and a significant disability in day-to-day functioning.
- As part of mental health reform, the MOHLTC divested itself of (transferred) nine of 10 provincial psychiatric hospitals to public hospitals and community-based service providers since 1998.
- In a study released by the Centre for Addiction and Mental Health in 2004, it was noted that over half of people with serious mental illness living in the community were not receiving an appropriate level of care – there was a high rate of unmet need in the community. Conversely, it was found that over half of people in hospital could be discharged into community if appropriate services were available.
- **Provincial standards exist for Assertive Community Treatment Teams**, intensive case management, and crisis intervention.
- There are **72 Ontario hospitals** which provide primarily inpatient (average length of stay target is 14 days) and outpatient acute services. There are also a small number of designated specialized mental health hospital providers who provide regional inpatient and outpatient specialized mental health services including, but not limited to, dual diagnosis (developmental and mental health issues), concurrent disorders (substance use and mental health issues), psychogeriatric, and forensic services (criminal justice involvement).

ADDICTIONS TREATMENT PROGRAMS

The Office of the Auditor General released their audit of addictions programs in 2008, highlighting the following capacity in the addictions treatment system as of the 2006/07 fiscal year (p.50):

- More than 150 providers received $120 million to treat an estimated caseload of 117,000.
  - $28 million was allocated to withdrawal management services (caseload: 18,000)
  - $37 million was allocated to residential treatment and support programs (caseload: 10,000)

- $37 million was allocated to community-based outpatient services (caseload: 45,000)

- Provincial organizations received $9 million for specific studies or to work for the sector on behalf of the province.
- This $129 million in total funding represents a $31 million increase in funding since the last audit in 1998/99. However, the substance abuse funding received a $7 million increase, with the remainder ($24 million) going toward problem gambling services.
- There are wide variations in level of funding in different LHIN regions, ranging from $3 per capita up to more than $40 per capita (p.52).
- Over the past four years (between and including 2004/05 and 2007/08), about 200 youths seeking help for their addiction problems were sent out of country for treatment at an average cost of about $40,000 each (p.53).

The Office of the Auditor General's research indicated that every $1 spent to treat substance abuse could result in $4 to $7 of potential savings in health care, law enforcement, social services, and other costs (p.54). It's estimated that alcohol and drug abuse cost Ontario more than an estimated $8 billion annually (Canadian Centre for Substance Abuse, 2006) – includes direct and indirect costs.

INCOME SUPPORTS

The provincial social assistance program in Ontario is called '**Ontario Works**.' Key legislation includes the Ontario Works Act, 1997 and administration is guided by the Ontario Works Regulations. 47 Consolidated Municipal Service Managers and District Social Services Administration Boards as well as 109 First Nations deliver the program. Basic assistance includes basic needs allowance (e.g., the cost of food, clothing, and personal needs) and shelter allowance. In August, 2005 Ontario Works implemented extended drug coverage of up to 12 months for clients leaving social assistance for employment.

Disability supports are provided by the **Ontario Disability Support Program (ODSP)** and governed by the Ontario Disability Support Program Act and its Regulations. Supports provided by ODSP include income support and benefits (e.g., health-related benefits), as well as employment supports to people with disabilities. The Ministry of Community and Social Services administers ODSP. There are two streams of services provided through ODSP: income support (basic assistance) or employment supports. Basic assistance covers a basic needs amount (e.g., cost of food, clothing, transportation, personal, and non-shelter needs) and a shelter allowance.

According to the Social Assistance Statistical Report, 2007 (Federal-Provincial-Territorial Directors of Income Support, 2010, pp 59-72):

- Ontario Works clients are eligible for a 50% exemption on their monthly **earned income**
- In March 2007, there were a reported 382,000 recipients (201,600 cases) of Ontario Works
- Approximately 58% of all reported cases had been receiving Ontario Works for one year or less
- Approximately 35% of all reported cases had been receiving Ontario Works for more than one year up to five years
- Approximately 7% of all reported cases had been receiving Ontario Works for over five years
- In March 2007, there were a reported 315,700 recipients (228,900 cases) of ODSP
- Approximately 9% of all cases had been receiving ODSP for one year or less
- Approximately 32% of all cases had been receiving ODSP for over one year up to five years
- Approximately 59% of all cases had been receiving ODSP for over five years

- **Total income** for a single person with a disability in Ontario is $12,647 (includes GST credit and other provincial/territorial tax credits)[195]

In its 2009-10 Annual Report, MCSS (p.15) notes that the Ontario Works caseload has grown almost 27% since 2008, and the ODSP caseload has grown 5% on average in each of the last three years. Finally, 10,600 people on ODSP were earning income in 2009-10 – this is a 67% increase since 2003-04 and is, at least in part, attributable to changes in rules around retaining earnings.

In January 2010, the MCSS launched the "Don't Waste Talent" campaign, connecting employers with people using the ODSP employment supports.

CHALLENGES IN HOUSING AND RELATED SUPPORTS

- **The way "need" has been captured, and is being planned for, is disconnected from the reality on the ground** (i.e., there are many people who don't have a diagnosis per se, but they have significant mental health issues and affordable housing needs); there are emerging physical health needs; and there are migratory patterns to urban centres.
- Differentiating between **housing supports and clinical supports** is part of the "needs" equation and has not been adequately addressed in the policy context.
    - Assertive Community Treatment Teams or case management attached to housing isn't the equivalent of supportive housing – but there are synergies in bringing together "shared care" models of support (i.e., housing support workers and clinical supports).
- Understanding the **overarching housing stock in the rent geared to income market** has to be part of the planning process in housing, and is something that hasn't been addressed in previous mental health housing planning. Challenges in social housing and private rental markets impacts how we plan for mental health.
- **Cooperation and collaboration** is crucial for implementing solutions to housing needs but inadequate housing stock (within the mental health system, but also in the broader housing system) creates tremendous challenges, particularly for rural areas.
- **Lengthy wait lists and affordability issues in social housing** impact overall housing and support options. Data presented by ONPHA in its 2010 report, Where's Home, included:
    - Wait lists for social housing continue to grow (nearly 142,000 households in 2010) compared to about 129,000 households at the beginning of 2009 – this is likely an underestimate since some families in core housing need may not apply due to the lengthy wait lists.
    - Average rents increased three times the rate of inflation across the province in 2009.
    - Single people generally wait the longest for social housing – often six or more years.
    - Compounding the limited supply of social housing is the overall deficit in private rental market housing (which has significant implications for use of rent supplements in housing/support models for people with mental illness). ONPHA notes that 94% of the housing starts in the last five year period were in the ownership market, with rental accounting for only 6% - 15 years ago, the comparable figure for rental construction would have been over a quarter of the housing market.
    - A CMHC analysis indicates that Ontario will have 15,000 to 18,000 added rental households every year over the next few years – ONPHA estimates that around 10,000 rental housing units will need to be built every year from 2009 to 2018 (Ontario averaged about a third of this amount over the last 10 years).

[195] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability,* Bulletin Number 2.

- The 2006 Census showed that across Ontario, 20% or 261,225 households are paying 50% or more of their income on rent – almost all of these households would be eligible for assisted housing.
- Census data shows that over the past 20 years the percentage of Ontario tenant households living in unaffordable housing (where they spend 30% or more of income on housing) has steadily risen from 32% to 45%.[196]
- There needs to be more acknowledgement in planning that **what works well in urban areas will not necessarily transfer well to rural areas**. In fact, some of the community context factors will be reversed.
- There is a lack of recognition in planning to date that many consumers don't live in supportive housing. For example, **many consumers are homeowners** who may have issues making mortgage payments, paying property taxes, and keeping up with maintenance when they're not feeling well – this should be part of the supports continuum.
- **Many people live with their families**. As parents age, this is creating a new need within the system that hasn't been adequately quantified. These people may have always lived with their parents or other family members, and now require housing at the age of 40 or 50, but have never lived independently.
- Social housing in Ontario that charges rent-geared-to-income is a very limited resource, representing only 5% of the total housing stock and 18% of the rental units in the province. Because it has long waiting lists, social housing is slow to respond to short-term need (Pomeroy et al., 2008).
- The Province's **Special Priority Policy** for social housing states that all service managers are required to give priority to applicants that have experienced domestic violence or abuse. Service managers, at their discretion, may also prioritize additional categories such as homeless youth, youth in general, and those with chronic illness. The inadvertent result of this policy is that a large portion of people who are being housed are coming from the special priority lists, leaving people in immediate need of housing , but not on the lists, waiting for ever-lengthening periods of time which could lead to crisis situations. ONPHA's membership has endorsed an approach that would include expansion of supply in social housing to meet long-term needs of waiting lists, coupled with financial assistance for special priority households in urgent need, enabling people to obtain market rental housing immediately.
- **Private and social housing rental stock is aging** and this holds true for mental health dedicated housing as well.
    - Toronto City Council, for example, estimates that by 2020, some 60% of rental apartments will be at least 50 years old. In some parts of Toronto, low-rise rental housing is much older (Housing Opportunities Toronto, p.21).
- Costly repairs for basic components (roofs, plumbing, electrical). The least energy efficient buildings **impose an "energy burden" on low-income households and available capital dollars available are not sufficient** to meet the rehabilitation/renovation needs of existing housing (both dedicated and non-dedicated).
- Complex administrative rules and an inflexible provincial legislative framework impact municipalities' ability to take advantage of opportunities in neighbourhood redevelopments (e.g., **inclusionary zoning**).
- The shelter portions of both the Ontario Disabilities Support Program (ODSP) and the Ontario Works (OW) program fall far short of what's required to rent in the private market and the ability to secure rent-geared-to-income housing is severely impacted by small stock available. The Ontario Social Assistance Review Advisory Council recommended to the Minister of Community and Social Services that a **comprehensive assessment of income security, employment supports, and related services was needed** (May 2010).
- **As the province uploads the administration and benefits for ODSP, OW, and the Ontario Drug Benefit Program, municipalities will be able to retain cost savings** – this represents savings of $570 million in 2010 alone. The Ontario Municipal Partnership fund identifies that the net benefit to municipalities, by the time the

[196] Campaign 2000. 2009 Report Card on Child and Family Poverty in Ontario, p.5

phased upload of ODSP and OW is completed in 2018, will be about $1.5 billion annually. This figure, combined with increases to ongoing annual support to municipalities, will total more than $3.8 billion by 2018 (an increase of over 250% compared to 2003).[197] There is no framework, however, that provides any guidance or oversight to municipalities as to how these savings might be reinvested in the social environment, most particularly in housing. This could be a major missed opportunity. Additionally, there is potential that supportive housing funded via the province may now be downloaded to municipalities.

- As **federal operating agreements end for existing social housing stock**, the federal subsidy will also end. By 2036, Ontario will have lost $525 million in subsidy which must be made up by the province and/or municipalities.
  - Even though mortgages will have been paid in full, rent revenues may not be sufficient to cover costs such as capital repairs or geared-to-income subsidies on an ongoing basis.
- An **overall evaluation of the Homes for Special Care program** is needed, and how this program fits in today's context – there are opportunities to enrich existing housing options.
- The **needs of the aging population** are putting increasing pressure on the system – housing/ support models including long-term care as part of an overall continuum need to be better quantified. This is also an opportunity to look at how **people with co-occurring physical health issues** are best served in housing and support models.

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

Note that these should be considered in addition to the sites visited throughout Ontario, as well as the promising practices highlighted in previous sections of this map.

- A consumer-led initiative in Toronto, PARC, has developed a partnership with a residential (custodial) care housing provider to implement the creation of 29 new, supportive housing units as a mechanism to take existing custodial housing and convert this to be more recovery-oriented in nature. Peer support is a core element of the model, and the model helps to address some of the challenges people experience day-to-day, including food security.
- Supports for Social Housing Program – the City of Ottawa has recently allocated new annualized funding ($1 million) for five support service agencies to provide ongoing services to 100 at-risk clients in social housing.
- A pilot project in London focused on building connections between the hospital and social service systems, in order to decrease the number of people being discharged from hospital to homeless shelters. This integration dramatically diminished discharges to shelters in a two-year period.
- As part of its 2001 Affordable Housing Strategy (which was updated in 2005), the Regional Municipality of Waterloo targeted the creation of 1,500 units of affordable housing by 2008. They combined funding from the provincial and the federal governments for rental housing with its own regional grants and a series of bylaw changes to encourage for profit and not-for-profit groups to build affordable housing. Bylaw changes included: a lower property tax classification for new, multi-residential rental housing which reduce monthly operating costs by $50-100 per unit and providing grants for Regional Development Charges for private developers. Units rent at or below market level and target a range of needs (singles, families, and people with disabilities). Since achieving their 2008 goal, their goal by 2013 is to create an additional 500 units. A cost analysis demonstrated that, for every $1 invested by the municipality, an additional $13 of investment was generated from other sources.
- An evaluation of the Provincial Rent Bank Program has demonstrated very promising results to date. Established in 2004, it provides short-term assistance for rent arrears in order to avoid tenant household evictions (generally up to two months). An evaluation was conducted to assess the extent to which housing

[197] Government of Ontario, Ministry of Finance, http://www.fin.gov.on.ca/en/budget/ompf/2010/

stability was enhanced, and cost savings were achieved. While there were some limitations due to availability of data, the evaluation highlighted the following (Malatest, 2008):

- Spending $13 million through the Provincial Rent Bank has lowered emergency shelter costs to the province by over $7 million.
    - Research suggests that programs such as rent banks can provide additional cost savings to tenants and landlords through reduced evictions: estimates are that evictions cost $2,234 per tenant and between $2,500 and $6,000 for landlords.
    - Other potential cost savings can include reduced costs to social assistance, social housing, and to the landlord and Tenant Board.
- There is a high level of satisfaction among service managers with the Provincial Rent Bank's overall guidelines, and the ability to adapt to local needs and context; funding assistance is generally seen to be sufficient.
    - Almost all service managers (88%) thought that the amount of funds being provided to clients was adequate.
    - Some support to consider providing additional months of rent.
    - Some service managers noted that they would like to see funding available to provide short-term assistance for those with mortgage arrears.

- Each Municipal Service Manager is mandated to provide coordinated access to available social housing. To this end, there is a provincial body where the chairs of various social housing coordinated access networks meet periodically to share prevailing issues, identify trends, and coordinate training opportunities for staff.
- Mainstay Housing, in Toronto, is the largest dedicated supportive housing in Ontario. They own and manage 41 properties with 867 units providing affordable, low threshold access for 1000 people (singles, couples, and families with children). A formal Memorandum of Understanding is in place with 20 support agencies from mental health and social service sectors.
- Houselink, in Toronto, partnered with Toronto Community Housing to identify key strategies in integrating recovery in social housing.

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

- As noted under the Initiatives section, there are two recent mental health and addictions planning processes initiated at the provincial level: 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 imminent development of a provincial affordable housing strategy is also promising – what is less clear, is what the movement will be both within the affordable housing sector, and the mental health and addictions sector, in terms of actual new housing stock development.

PRINCE EDWARD ISLAND

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of Prince Edward Island is approximately 135,900 (Statistics Canada, 2009) with an unemployment rate of 9.1% compared to a rate of 8.1% across Canada (Statistics Canada, 2010).

Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of 0.4%** since 2001 – which is low compared to the national average of 5.4% but consistent with growth patterns in Atlantic provinces.
  - There is a steady out-migration of people aged 15 to 29 (primarily to western Canada for employment) but this has been balanced by in-migration of people from other parts of Canada and newcomers to Canada.
- An **aging population**, consistent with all other regions across Canada, where 14.9% of the population is aged 65 and over (compared to 13.6% nationally).
  - The population of Atlantic Canada (Newfoundland and Labrador, Prince Edward Island, Nova Scotia and New Brunswick) was the oldest in the country with more people aged 65 and older and fewer people aged 14 or less compared to the rest of Canada.
- A very small number of people identify as having Aboriginal identity (1,730 or 0.1% of the population)
- There is a significant movement from rural to urban centres: between 1991 and 2006, the number of farms dropped by 28%, with a 7.9% decrease recorded between 2001 and 2006.
  - The population in rural PEI still comprises a much larger proportion than compared to Canada as a whole – 44.9% lived in rural areas compared to 20.6% (CCSD, 2009, p.18).
  - There is significant variation between urban and rural populations: people living in rural areas tend to spend more on shelter, have lower median wages, are more likely to rely on income assistance programs, and housing values tend to be lower (de Peuter, J., and Sorensen, M., 2005). The 2006 Census Analysis reports that 88.8% of rural households owned their own home compared to about 58% of urban households.
- Labour force participation tends to be higher in PEI than rates in other Atlantic Provinces but much of the employment is part-time or seasonal in nature
- Labour force participation rate for PEI mothers with young children is the highest in Canada – due in large part to the large number of regulated child care spaces for children up to age 6 (this is unique in Canada – surpasses Québec)
- Of the 53,135 households in 2006, **74% owned the dwelling** they lived in (compared to about 68% nationally) – this represents an increase of about 6% since 2001 (compared to 11.8% nationally). Of owner households, 54.2% held a mortgage. This high rate of home ownership relative to the national average is typical of the Atlantic provinces.
- Between 2001 and 2006, consumer prices in the Atlantic provinces, as measured by the Consumer Price Index, rose faster than the national average, with Prince Edward Island increasing the most, at 15.5%.
- The **proportion of households spending 30% or more of their income on shelter was below the national average** of 24.9% in all four Atlantic provinces - between 2001 and 2006, it rose only in Prince Edward Island – 41% of Islanders living in rental accommodations pay more than 30% of their gross income on shelter.
- Median annual household income rose 15.6% from 2001 to 2006 to $46,604 – but median annual household costs during the same period of time increased by over 23% (almost 5 points higher than the national median

shelter costs) – **this was the biggest differential between the growth in shelter costs and income in the country**.

With respect to current industry, there are limitations made by the geography of PEI from the perspective of power generation and natural resources (forest and mineral). Conversely, much of the land is productive farm land, the fishery continues to be strong, and there is a well-established tourism industry. Income levels have also tended to be lower when compared to national levels; however, strong community and social networks often mediated the effects of poverty – but this landscape of large extended families is changing. (CCSD, Flanagan, 2009). It must be noted, as well, that a combination of economic factors have had a significant impact on farm incomes – in 2002, there were about 400 hog farmers in PEI – the current estimate is closer to 75 (CCSD, Flanagan, p.19).

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

- The **Department of Health and Wellness** is charged with providing public health services, primary care, acute care, community hospital and continuing care services to Islanders to help ensure their optimal health.
- **Canadian Mental Health Association/PEI Division** is PEI's primary dedicated housing provider for persons with mental illness. Other supports provided include (but are not limited to) employment, education, wellness, social/recreation, and advocacy.
- The **Department of Community Services, Seniors and Labour** operate housing units across the province for families and seniors who need help finding affordable, appropriate homes. Assistance is also available for seniors who need to make emergency repairs to their home. This Department is also responsible for the Social Assistance program in PEI.
- The **Prince Edward Island Housing Corporation** has the responsibility in the housing field with the Department of Social Services and Seniors and local Family Housing Authorities. The Corporation is responsible for provincial co-ordination of programs, policy management of family housing through the local **Family Housing Authorities**, in liaison with the Federal Government on housing issues, and for overseeing the administration of federal provincial agreements. The **Department of Community Services, Seniors and Labour** is responsible for the staffing and delivery of most programs and also provides technical supports to Family Housing.
- The Corporation works with a variety of partners including **Canada Mortgage and Housing Corporation (CMHC) representing the Federal Government**. The Corporation manages and delivers the Canada PEI Affordable Housing agreement signed in 2003. Other partners of the PEI Housing Corporation include many community members who serve on the nine Family Housing Authorities Boards across the province.
- The Federal/Provincial **Social Housing Agreements**, which are cost-shared, support the rental of housing needs of seniors, families, and Islanders in need of housing.

PROGRESS TO DATE: KEY INITIATIVES

- The **PEI Community Advisory Committee** is an inter-agency committee representing non-profit and public sector agencies that work with the homeless population or those at risk of becoming homeless in PEI. Most recently, the Advisory Committee issued its report card on homelessness, providing the community with information about shelter, shelter utilization, and issues related to housing and income.
- The government does not have a mental health or addictions strategy, but does have a PEI Strategy for Healthy Living, a cross-departmental initiative that has also engaged community networks and providers, including representatives from the schools of nursing and psychology at the University of Prince Edward Island. The strategy does not incorporate mental health at this time, but addresses a range of risk factors related to health.
- The PEI Youth Substance Use and Addiction Strategy was developed through a series of public consultations and work with numerous provincial staff and national experts working in the addictions and mental health fields – the implementation of program enhancements and new services (in the areas of prevention, education, early intervention, treatment, counselling, and aftercare) is based on the strategy framework released in 2007.

RANGE OF HOUSING ACCOMMODATIONS

Range of Housing Options
▪ Dedicated Mental Health Housing and Supports - Supported & Supportive ▪ Private Market Housing ▪ Public Housing for Seniors ▪ Public Housing for Families ▪ Rent Supplements ▪ Co-operative and non-profit housing ▪ Subsidized Home Ownership ▪ Garden Suites ▪ Community Care Facilities ▪ Long-Term Care Homes ▪ Emergency Shelter ▪ Transitional Housing ▪ Addictions Treatment/Housing options ▪ Residential options for people with developmental disabilities: group homes, associate families, shared care, supported apartment, supervised room and board

DEDICATED MENTAL HEALTH HOUSING

The Prince Edward Island Canadian Mental Health Association (CMHA/PEI) is the only dedicated supportive and supported housing agency for people living with mental illness in the province. The CMHA/PEI dedicated housing is provided as a part of the programming offered through CMHA/PEI's three Clubhouse programs. Dedicated housing is offered through Fitzroy Centre Clubhouse in **Charlottetown (49 units)** and through Notre Dame Place Clubhouse in **Summerside (20 units)**. Hope Centre Clubhouse in Alberton does not have any units at this time but offers assistance in finding and maintaining housing through its Clubhouse. **CMHA/PEI has a total of 69 housing units**.

Service model: CMHA/PEI operates internationally accredited "Standards Based Clubhouse" model programs which integrate housing services into the spectrum of supports and services they deliver. Clubhouse programs are founded on the realization that recovery from mental illness must involve the whole person and consider the entire range of individual needs and "determinants of heath."

The Clubhouses provide members (people living with mental illness) with opportunities to build relationships that, in turn, support them in obtaining and maintaining housing, employment, and education. They also provide wellness programs, adult education programs, skills training opportunities, social/recreation activities, advocacy, access to funding programs, transportation, thrift stores, employment preparation programs, and numerous other supports that are geared to the individual's needs and goals.

The table below identifies CMHA/PEI housing by location, number of apartments or beds per site, and type of housing. **Rent supplements or affordable housing rates** are available for all of the apartments/beds.

Table 1. *Dedicated mental health housing options in Prince Edward Island.*

Region	Type	Program Description	Capacity
Charlottetown	Supportive	▪ Longworth House is a staff-supported, nine-bedroom facility plus one self-contained training apartment	10
	Supported	▪ Fitzroy Centre Complex is a 17 unit self-contained one-bedroom apartment complex	17
		▪ Kent Street Apartments is an 8 unit, self-contained one-bedroom apartment building	8
		▪ 14 community based apartment units	14
Summerside	Supported	▪ Duke Street Apartments is a staff-supported 7 unit, one-bedroom self-contained apartment facility	7
	Supported	▪ Notre Dame Place Housing is a 10 unit self-contained one bedroom apartment complex	10
		▪ 3 community based apartment units	3

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

CMHC provides cost-sharing of provincial programs involving **1,700 units**, and directly administers **900 federally funded social housing units**. The following table breaks down units by specific programs. The majority of available units managed by the province through the PEI Housing Corporation are targeting senior citizens and families. The 2010 PEI Report Card on Homelessness noted that **401 households were on the waiting list for family units, and 410 households were on the waiting list for seniors' units**. The PEI Housing Corporation noted the following in its 2007/08 annual report:

- Demand for seniors housing is strong in urban areas but stable or declining in most rural areas
- Demand for family housing is steady with lengthy waiting lists in most communities

Table 2. *Non-Dedicated Affordable Housing Options in Prince Edward Island.*

Program	Type	Program Description	Capacity
Senior Citizens' Housing Program	Housing	The program provides self-contained apartment units to low and moderate income persons over 60 years of age – **individuals aged 55+ with disabilities may be considered depending on availability**. Rent is geared to total household income and is currently set at 25%. Seniors housing units are available in 35 communities across the province. Garden suites are a form of senior housing, which are one-bedroom units located on a host property, usually that of a relative. When no longer required, garden suites are moved to the next area need. Rents are based on 25% of income[198]. As of 2006, there were six garden suites in PEI	1152 ($5.94M in 2007/08)
Family Housing Program	Housing	The program provides rental housing to low and moderate income families. Rent is geared to total family income (usually 25% of income). People receiving Social Assistance pay a rate that is established between the Department of Community Services, Seniors and Labour and the local housing authority. Housing Authorities in nine communities across the province select tenants based on their current situation.	476 ($2.489M in 2007/08)
Rent Supplement Program	Housing	Rent supplements are provided to low income families to live in private market housing. This is a limited program available in Charlottetown and Summerside.	18 ($141,000)
Rural and Native Housing	Housing	Program provides rent-geared to income housing for low to moderate income families	8 ($61,500)
Rural Community Housing	Housing	Program provides rent-geared to income housing for low to moderate income families living in smaller centres. Rents are based on 25% of income.	11 ($74,700)
Social Housing Home Ownership	Housing/ Home Ownership	During the 1970s, 83 units across the Island were purchased and made available to low and moderate income families on a rental or lease-to own basis. Over the years most of these units were sold to occupants and, aside from the remaining units, the program is inactive.	2
Housing Co-operatives	Housing	Between 1973 and 1991, CMHC participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme, however, is that all of these co-operatives provide some type of financial support. Housing co-ops are member-owned and controlled organizations. The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. The federal government ceased funding new development at the end of 1991, but continues to honour its operating agreements with existing co-operatives, which house **over 92,000 members across Canada** under these legacy programs.[199] The **Agency for Cooperative Housing** is the not-for-profit administrator of federal co-operative housing programs in PEI, Ontario, Alberta and B.C., under a contract with CMHC.	207 units in 13 sites

[198] Number of Units and Funding from *PEI Housing Corporation Annual Report 2007/08*
[199] Co-operative Housing Federation of Canada.

INDICATORS MONITORED BY THE PEI HOUSING CORPORATION

Senior Citizens' Housing Program:

- Number of units
- Number of placements
- Number of new applications
- Number of seniors on waiting lists

Family Housing Program:

- Number of units
- Number of placements
- Number of new applications
- Number of families on waiting lists
- Turnover rates

The Government of PEI also has a **Director of Residential Rental Property**, whose office is part of the Island Regulatory and Appeals Commission. The Director, or delegate, is responsible for dealing with disputes between landlords and tenants.

OTHER INITIATIVES

Homelessness Partnering Strategy (HPS): launched on April 1, 2007 by the federal government, this strategy builds on the foundation of its predecessor program, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five year commitment. Through its "Designated Communities" funding component, the 20-member **Community Advisory Committee in PEI** reviews proposals/allocates funding for the two designated communities in PEI: Charlottetown and Summerside. A key focus of the HPS is a housing-first approach and focuses on transitional and supportive housing as important ways to move individuals out of homelessness.

- The **John Howard Society** is responsible for the administration of the HPS in PEI.

Affordable Housing Initiative (AHI)/Canada PEI Affordable Housing Agreement: Based on the housing framework agreed to in **November 2001** by federal, provincial/territorial housing ministers, each province/territory developed **"Affordable Housing Agreements" in 2003**. 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 a grant, a stream of ongoing subsidies or the value of in-kind contributions (e.g. land). Within these terms and 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. PEI has a commitment (through Phase I and II of funding) for a **total of $4.16 million – to date, $4.09 million has been committed/announced for a total of 155 units**[200]. PEI selects affordable housing projects to reflect the **provincial priorities of housing for families, persons with disabilities and persons**

[200] National AHI Funding Table, Canada Mortgage and Housing Corporation website. http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm

with special needs. The government has partnered with Habitat for Humanity for the home ownership portion. The federal government's Economic Action Plan builds on this existing commitment, extending the AHI to March 31, 2011 through a national $1.9 billion investment over five years, and providing a further one-time investment of $1.525 billion in housing stimulus measures to build new housing and renovate existing social housing. This funding is being delivered through amendments to existing cost-sharing and delivery arrangements with provinces and territories through the AHI.

Senior's Emergency Home Repair Program: This program is designed to help keep low income seniors safe and secure in their own homes. The repairs must be essential to the structure of the building and the health and safety of the resident. Applicants must be aged 60 years or older, and the combined income of the applicant and spouse must be less than $35,000 per year. The program contributes 50% of the cost of eligible repairs to a maximum of $1,500.

Social Assistance Home Repair Program: This budget benefit is used to repair homes owned by social assistance clients when such repairs are necessary to the health and safety of the family and other commercial or government financing is unavailable or insufficient.

Residential Rehabilitation Assistance Program (RRAP) Suite of Programs: This is a Federal/Provincial cost shared (75/25) program administered by CMHC Homeownership RRAP, which provides assistance to low-income homeowners to bring their property up to minimum health and safety standards. The PEI Housing Corporation's 2007/08 annual report notes that 101 units were upgraded for a total of approximately $1.035 million.

- RRAP for Disabled Persons – Provides assistance to households occupied by persons with disabilities who require special modifications to improve accessibility to their residence.
- Rooming House RRAP – provides support for rehabilitation to shelters for low-income Islanders in the core need of housing.
- Emergency Repair Program – Provides assistance to homeowners in rural and remote areas to undertake emergency repairs.
- Shelter Enhancement – Provides assistance to repair existing and create new shelters and second stage housing for women, children and youth who are victims of family violence both on and off Native Reserves.
- Home Adaptation for Seniors Independence (HASI) – Assists low-income Islanders aged 65+ to improve difficulties in daily living through home adaptations (16 applications approved for total of $52, 314 in 2007/08).
- RRAP Conversion – Provides assistance to convert existing commercial or buildings not used for housing, into housing units.

Real Property Tax Deferral Program for Seniors: This program allows eligible seniors to defer the real property tax payable on their principal residence, for the duration of their lifetime. To be eligible, seniors must be aged 65 and over and be permanent residents of PEI. The total annual household income must not exceed $21,000.

Garden Suites: This is a form of seniors housing, which involves one-bedroom units located on a host property. There are 6 garden suites in the provincial housing portfolio with annual expenditures of $20,145.

In addition, the province was also in receipt of $3,396,528 of **Affordable Trust** funding and $704,542 of **Off Reserve Aboriginal Trust funding** as of 2007/08. These funds are to be invested to address affordable housing needs (PEI Housing Corporation, p. 6).

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, but aren't dedicated to serving this population. Within PEI, this includes: **shelters, transitional housing** not specifically targeted to people with mental illness, **Community Care Facilities, Long-Term Care Homes (which includes public and private nursing care facilities), Private Nursing Homes, Addictions Treatment Programs, and Residential options for People with Developmental Delays**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity (Table 3: Additional Facilities or Housing Options in Prince Edward Island). While we recognize that there are still **foster care** arrangements in existence, we have not profiled these as they are phasing out of the system as operators age and retire.

SHELTERS

- The limited shelter resources in the province are mostly located in Charlottetown.
- The Social Assistance program has a protocol with all of the shelters to cover overnight fees where the individual cannot afford to pay.
- In addition to the resources listed in the table, some areas (particularly outside of Charlottetown) will receive some assistance from the Social Assistance program to put people up in hotels temporarily.
- In general, the shelters receive very little core funding from the province – generally it is a grants-based process that tends to cover a portion of their costs.
- Some examples of funding arrangements include:
    - Transitional Housing Association shelter program is provided with block funding from the province which covers approximately 80-90% of their costs – remainder is through fundraising.
    - Bedford House (men's shelter) primarily operates on fundraising revenue – they receive a small annual grant from the City of Charlottetown (approximately $7500) for which they reapply every year as well as some limited block funding from the province.
    - Similarly, Grandmothers' House receives an annual grant from the City of Charlottetown and sometimes receives grants from the province.
- There are a total of 44 shelter spaces which were used 5,428 times according to the PEI 2010 Report Card on Homelessness. A total of 242 people were homeless and stayed in a shelter in Prince Edward Island at some point in 2009.

The Salvation Army plays a significant role in PEI:

- In Summerside, they serve over 1,000 meals on average per month in their soup kitchen, and the Food Bank provides 150-250 food hampers monthly. They are the 'go-to' organization if someone presents at night needing shelter, helping to find a hotel or motel room for those in need. They are supported mainly through local churches, businesses and individual donations and volunteers.
- In Charlottetown, in addition to providing a year-round food bank which helps close to 200 families per month, they provide a number of other services and supports, including a 'friendship room' used by 30 to 50 people daily providing social support, food, and clothing.

The Upper Room Hospitality Ministry: provides food to about 500 households per month – equivalent to about 1800 people of whom 40% are under the age of 18. In addition to the food bank, they provide a soup kitchen serving about 3,000 meals per month. Funding is primarily through individual and business donations.

Transitional Housing

- Also referred to as second-stage housing, this is a limited program for women provided by the Transitional Housing Association as a second-stage to their shelter program.
- Residents may stay for a period of one to two years and may or may not have children with them.
- Funding is generally dependent on Social Assistance for income supports.
- While there are no on-site, full-time staff, there are some liaison workers who provide support, hold group meetings, and provide linkages to mental health and addictions services in the community.

Community Care Facilities (CCFs)

- A licensed Community Care Facility is a privately owned and operated establishment with five or more residents. Services include: housekeeping, meals, assistance with grooming and hygiene. Twenty four hour nursing care is not available at these facilities.
- There are a total of **37 licensed CCFs providing approximately 890 beds** operating across the province, all of which are licensed by the government under the Community Care Facilities and Nursing Homes Act, and which are inspected to ensure they are in compliance with existing government standards, as set out in their operating program manual.
- Paying the cost of accommodation is the responsibility of the resident though financial assistance may be available on a limited basis in certain situations. Funding received via the government is generally based on a **per diem model**.
- The primary target population is seniors – there may be some individuals with mental illness.
- Bedrooms are usually shared.
- CCFs are regulated and monitored by the government (Department of Health and Wellness).

Long-Term Care (LTC) Homes

- LTC Homes are operated by **nine public nursing facilities and eight private nursing homes**, providing a total of **997 long-term nursing care beds** (400 of which are private, which includes six temporary beds)[201].
- Private Nursing Homes:
  - A Private Nursing Home (PNH) is a privately owned and operated establishment with five or more residents that is licensed by the Community Care Facilities and Nursing Homes Board under the authority of the Community Care Facilities and Nursing Homes Act.
  - Some private nursing homes operate CCF beds as well.
  - The care required by the residents is carried out by or under the supervision of a Registered Nurse – PNH have the capacity to provide 24-hour assessment and observation.
- Admission to long-term nursing care facilities is based on a coordinated assessment and a priority needs process conducted by committees in each region made up of representatives from hospitals and Home Care, Housing and Long-term Care programs.
- Most of the residents have multiple complex diagnose, the most common being dementia (estimates as high as 80%), stroke, and diabetes. All residents require a high level of nursing care that can no longer be provided at home or in community care facilities.

[201] *Final Summary Report: Trends, projections and recommended approaches to delivery of long-term care in the province of Prince Edward Island 2007-2017* (March 2008). Prepared by Ascent Strategy Group for the Department of Health and Wellness, Government of PEI., p.6.

- Normally, residents who are admitted to these facilities are 60 years of age or older. The average age of residents is 81 years in public facilities with a ratio of 1 male to 2.5 females.
- Funding is divided into two streams: health care costs and accommodations. The Department of Health covers the health care costs to a maximum of $74.30 per day, and the resident is responsible for the accommodations cost (to a maximum of $67 per day) although financial assistance may be available.

Addictions Treatment Programs

- **The Provincial Addictions Treatment Facility** provides medically supervised detoxification from all mood altering chemicals, education regarding addiction, and motivation to further treatment. The centre in Mt. Herbert (Charlottetown) has 25 detox beds and 16 rehab beds and admits both men and women from across PEI. Adolescents in emergency situations, who require short-term observation and medication are also offered detox services.
- **Extended Care Facilities**: For clients who have completed detox and rehab but need more supervised support to regain their health and re-enter society. Programs are available at St. Eleanor's House in Summerside, as well as Deacon House, Talbot House and Lacey Residence (women only) in Charlottetown.
- In addition to these facilities, **community-based addictions' services** include assessment and referral, outpatient detoxification, adult rehabilitation program, after care program, early intervention, family support programs, adolescent rehabilitation program, student assistance program, women's addiction program (inpatient and outpatient), gambling program, and smoking cessation program. There are **office locations** in Alberton**,** Summerside, Charlottetown, Montague, and Souris.
- **New Youth Substance Abuse and Addiction Treatment Program**: Following development of a comprehensive framework, the province is moving ahead with development of this new treatment program in the province of PEI, incorporating mental health needs. The eight-week program will incorporate a variety of treatment approaches, and will include access to supervised housing as required. There are some existing addictions services for youth, including access to the Portage residential care facility in New Brunswick – generally 10-15 youth from PEI are sent there on an annual basis.

Residential Options - People with Developmental Delays

The Department of Community Services, Seniors and Labour partners with a number of non-government organizations that extend a variety of services to people with disabilities, including vocational and employment training, transportation, recreation, and residential services. The range of residential services may include:

- Group Home: Live in/live out staff support and provide a home like environment (typically 24/7 staffing)
- Associate Family: Where an individual lives and receives support with another family
- Shared Care: Living arrangements that are shared between natural families, associate families, or an agency
- Supported Apartment: Accommodations that provide a live in support person or partial supports are provided on a daily or weekly basis, depending on the need
- Supervised Room and Board: Accommodations where a person has a great deal of independence and requires minimal support
- Respite Care: Residential relief offered to families that provide for short-term care

Some of these agencies, such as Queen's County Residential Services (QCRS; Charlottetown) and Community Connections (CC; Summerside) are developing, or have recently developed, supportive housing options with funding support from the Homelessness Partnering Strategy (from among other sources).

- QCRS was just funded to develop three one-bedroom apartments with long-term supports

- Project is being funded through a combination of Homelessness Partnering Strategy (HPS) funding, provincial funding, and a mortgage; some of the ongoing funding will be via the Disability Supports program.

- CC was funded to provide a building in Summerside with long-term supportive housing.
- The majority of people with co-occurring mental health issues are served by the developmental sector.

The organizations identified below are those that are providing residential services for individuals with developmental delays, either specifically, or as part of a broader mandate:

- Camp Gencheff is a year-round facility that provides a respite care program two weekends a month in the off-season.
- Community Connections: Located in Summerside and provides a variety of living options (as well as employment and vocational supports). Options include respite, group home, associate family, shared care, support apartments, supervised room and board facilities.
- Community Inclusions: Located in PEI and administers three facilities – Tignish Group Home (24/7 staffing, five beds, Supports include: vocational, recreational, social, living, and employment), Tignish Normalization Co-op, and Maplehouse O'Leary.
    - A residential coordinator coordinates community-based residential services through western PEI including respite care, supported apartment living, independent living, room and board options and in-home care providers.
- Inclusions East Inc. provides a range of services for people with intellectual and physical disabilities through five main programs: Kingswood Centre, Employment Opportunities, Southern Kings Group Home, Alternative Residential Options, and Community Supports. Inclusions is currently conducting a housing needs survey.
- Queens County Residential Services: Located in Charlottetown and provides a range of residential supports to persons with intellectual disabilities.
    - Group homes provide 24-hour residential service and support. There are five group homes situated in the Charlottetown area (serving a total of 29 residents with one respite bed) as well as one small home in Stratford (serving three residents with one respite bed).
    - Associate Family program – compensation to families is through the PEI Social Assistance and Disability Support Programs according to client eligibility and rates.
    - Residential Coordinator assists adults with intellectual disabilities in accessing community resources and housing options. Individual and family involvement is an essential part of determining housing options.
- Souris Group Home Association: Located in Souris, provides residential services and supports to men with intellectual disabilities. Holdings include McIntyre House, serving seven men with developmental disabilities and a history of homelessness.

Table 3. *Additional Facilities or Housing Options in Prince Edward Island.*

Location	Name	Type	Target Population	Capacity
Charlottetown	Grandmothers' House	Shelter	Women (operated by Native Council of PEI)	6 beds
Charlottetown	Transition House Association	Shelter	Women from domestic violence situations	20 beds
Charlottetown	Bedford House	Shelter	Men	6 beds
Lennox Island (western PEI)	Mary Bernard Memorial Women's Shelter	Shelter	Women living on the reserve in Lennox Island	12 beds
Charlottetown	Transition House Association (THA)	Second-stage housing (Supportive housing)	Women who have been in the THA shelter setting and require additional support	8 units (7 two-bedroom apartments, 1 one-bedroom apartment)
Summerside	Transition House Association	Second-stage housing (Supportive housing)	Women who have been in the THA shelter setting and require additional support	2-bedroom duplex
O'Leary (western PEI)	Transition House Association	Second-stage housing (Supportive housing)	Women who have been in the THA shelter setting and require additional support	2-bedroom duplex
Mount Hebert (Charlottetown)	Provincial Addictions Treatment Facility	Medically supervised detox and rehabilitation services		25 detox beds and 16 rehab beds
Summerside	St. Eleanor's House	Extended Care Facilities (addictions)	For clients who have completed detox and rehab but need more supervised support to regain their health and re-enter society.	
Charlottetown	Deacon House and Talbot House			
Charlottetown	Lacey Residence	Extended Care Facilities (addictions)	For women who have completed detox and rehab but need more supervised support to regain their health and re-enter society.	
Province wide	Various	Community Care Facility (CCF)	People with care needs falling within a provincial framework of levels one – three (i.e., personal care and support)	37 CCFs with 890 beds
Province wide	Various	Long Term Care Homes – Private Nursing Homes	People with care and nursing needs falling within a provincial framework of levels four and five (higher levels of support including nursing support)	8 private nursing homes with 400 beds[202]
Province wide	Various	Long Term Care Homes – Public Nursing Homes		9 homes with 594 beds

*Table does not include data for housing options for people with developmental disability at this time due to incomplete data.

[202] *Final Summary Report: Trends, projections and recommended approaches to delivery of long-term care in the province of Prince Edward Island 2007-2017* (March 2008). Prepared by Ascent Strategy Group for the Department of Health and Wellness, Government of PEI., p.6.

MENTAL HEALTH SUPPORTS

Table 4: Range of Mental Health Supports in Prince Edward Island

Range of Mental Health Supports	
Community Connections[203]	Provided by the Canadian Mental Health Association PEI: ▪ Psychosocial Rehabilitation Clubhouse Programs ▪ Employment and Housing supports ▪ Consumer & Family Support Programs ▪ Suicide Prevention School based programs ▪ Suicide Prevention, Intervention & Post-vention supports ▪ Self-Esteem school based program ▪ Resource Libraries ▪ Health Promotion/Education Programs and activities ▪ Family Education Program ▪ Consumer Advocacy ▪ White Cross Program
Community Mental Health Services	▪ Emergency mental health and crisis response ▪ Individual, family and group therapy ▪ Case management ▪ Psychosocial rehabilitation ▪ Outpatient outreach services including assertive outreach teams ▪ Seniors mental health ▪ Early Psychosis ▪ Eating Disorders ▪ Specialty services
Inpatient Services	▪ Acute and long-term treatment and rehabilitation

FUNDING LEVELS

According to a recent analysis by the Institute of Health Economics (Jacobs et al., 2010), the following were some of the expenditures on mental health and addictions services[204] in Prince Edward Island for 2007/08:

- $15.2 million for inpatient care[205] ($10.1 million in general hospitals and $5.1 million in psychiatric hospitals)
- $4.8 million for physician services ($0.9 general practitioners – fee for service, $0.7 specialists – fee for service and $3.2 million for psychiatrists – alternative payments)
- $15.8 million for community and social services ($6.9 million for community mental health, $1.8 million for employment support, $7.1 million for addictions)
- $1.2 million for non profit organizations excluding the provincial government

[203] Note that Community Connections is one of three categories that have been used to summarize mental health services in each of the maps and is intended to reflect those services which focus on facilitating people's connections within their communities. It is worth noting that there is also a large organization called Community Connections providing services for people with intellectual disabilities and that is not what is being referred to in this table.
[204] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.
[205] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.

RANGE OF MENTAL HEALTH AND WELLNESS SERVICES

The Canadian Mental Health Association/PEI Division is a charitable organization that promotes the mental health of all Islanders and supports the resilience and recovery of those experiencing mental illness. CMHA PEI's mission is to promote mental health by enabling individuals, groups and communities to increase control over and enhance their mental health. To carry out this mission, CMHA PEI provides programs and services, education and information, research, advocacy and the development of social policy.

The association's programs and services vary widely across the Island. There are self-esteem and suicide prevention programs within many Island schools, mental health education sessions and seminars are delivered across the Island and resource libraries are located in three communities. There are **three clubhouses**: **Fitzroy Centre**, **Notre Dame Place**, and **Hope Centre Clubhouse** which provide supports such as housing, employment, education, skills development and social opportunities. The following is a brief summary of the programs and services offered by CMHA/PEI Division throughout the province to over 1,000 individuals experiencing persistent mental illness.

- **Fitzroy Centre in Charlottetown** is among the top 5% largest Clubhouse programs worldwide and has 3 year certification status with the International Centre for Clubhouse Development (ICCD). With almost 600 members and a daily attendance of 85 to 100 individuals, Fitzroy Centre provides mental health rehabilitation and recovery-focused programs and services through four work units: The Housing Unit, The Employment Unit, the Education and Culinary Unit, and the Administration Unit. Each unit offers a variety of skills development opportunities, one to one support, and group activities that help individuals overcome barriers related to their mental health. The Clubhouse works with an average of 150 members whose focus is to achieve their goals in employment and education. Employment preparation and skills assessment provide members with the tools they need to access their employment goals. Fitzroy Centre provides and maintains 49 housing units in 3 separate locations and assist members to find and maintain decent affordable housing. Staff and members work in the maintenance area to ensure that the buildings and grounds are maintained. The Clubhouse provides transportation, adult basic education, wellness programs, and a food service program that includes the provision of a daily meal service. Fitzroy Centre provides assessment, medication management supports, and intake for new members, a thrift store, a library, financial management and budgeting supports. Several group sessions focusing on areas such as employment skills, self esteem building, and communication are held throughout the year. The program is also involved in public education and advocacy.
- **Notre Dame Place in Summerside** provides an environment of support and encouragement that enables its membership to strive towards more meaningful and satisfying lives, and has three year certification status with the International Centre for Clubhouse Development (ICCD). It is a place of opportunity and of hope and members feel they are part of a community that values and respects them. Notre Dame Place has a membership of 260 individuals with a daily attendance of 35-40, and offers supports through two work units. Activities such as clerical work provide an opportunity to work in reception, cashier, photocopying, and in the production of the clubhouse newsletter. Meal preparation encourages the sharing of skills in cooking, budgeting, shopping and proper nutrition. Horticultural and maintenance provides for the care of the buildings and grounds Employment staff assess job readiness and work skills, provide counselling, training, and support, to access employment opportunities**.** Educational support is available to members to encourage participation in educational programs. Notre Dame Place also offers 10 affordable, furnished apartments, including two wheelchair accessible apartments; three community-based, subsidized apartments for individuals, couples or families as well as seven individual, staff supported apartments to help tenants develop skills for more independent living.
- **Hope Centre Clubhouse in Alberton** is a "supportive community" that offers a comprehensive approach to helping its members grow towards more independent and productive lives. Hope Centre Clubhouse has a membership of 140 individuals and a daily attendance of 10-16 members. Members have the opportunity to learn, or regain, skills necessary to live a productive and empowering life. Confidence and self-respect is gained through contributing to every aspect of the club. Hope Centre Clubhouse offers its members the

vocational, educational, recreational and social opportunities necessary to support and encourage lives of dignity and hope. Hope Centre has several different work areas such as clerical, reception, and the production of a monthly newsletter. Housekeeping does the general cleaning and maintenance necessary for the upkeep of the clubhouse. The kitchen encourages the sharing of skills in cooking, budgeting, shopping, and nutrition. The Education Area helps members to develop computer and literacy skills to participate in other community-based education programs**.** The Employment Area assists members through the assessment of job readiness and work skills, training and support, and aid in job search techniques. While Hope Centre does not currently provide direct housing units, it does offer assistance in finding and maintaining community based housing.

The following is a brief summary of the other mental health and wellness focused programs offered throughout the province:

CMHA Resource Libraries: Located in Charlottetown, Summerside and Alberton, these lending libraries provide individuals and families with information and support resources on mental health and mental illness.

I'm Thumbody Program: A self-esteem program for Grade 3 students presented in classrooms across PEI by trained volunteers.

Consumer & Family Support Program: Promotes mental health and social action through Self-Help/Mutual Aid, produces a resource directory annually, oversees With Hope in Mind Program, delivers presentations raising mental health/illness awareness and is the primary support program for the self-help community.

With Hope in Mind Program: Is a provincial family-to-family, education and support program delivered by trained family member volunteers. It is a program designed to educate and support family members of someone with a mental illness.

Consumer Advocacy: Through social action, CMHA/PEI influences government, other policy makers and funding agencies to improve legislation and services affecting the mental health of Islanders.

White Cross Program: Provides regular social-recreation programs in the Queens County area of PEI and an Island-wide Christmas gift program to people with mental and emotional disorders.

Mental Health Works: A one-day workshop designed to help managers and supervisors improve their knowledge and skills around mental illness, to enable them to better handle mental health problems encountered in the workplace and to create mentally healthy workplaces that promote positive mental health and well-being for all employees.

Changing Minds: An innovative, two-day, mental illness education program presented to front line workers to assist them to more effectively deal with clients who struggle with mental illness. The program is designed to address a community need for education, stigma reduction, and to promote a better understanding of mental health and mental illness.

Suicide Prevention Program: Coordinates and delivers the Signals of Suicide Program and provides Applied Suicide Intervention Training. The Suicide Prevention Program also promotes the coordination of suicide prevention, intervention, and postvention efforts that strengthen supports and enhance resiliency in PEI communities.

- **Signals of Suicide (S.O.S.) Program**: A suicide prevention program delivered to every Grade 9 classroom across PEI, designed to change attitudes surrounding suicide and to teach youth how to recognize the signals of suicide and how to reach out to a youth sending these signals.
- **Applied Suicide Intervention Training (ASIST)**: A two-day workshop focusing on suicide first aid, designed for caregivers who want to feel more comfortable, confident, and competent in helping to prevent the immediate risk of suicide.

PROVINCIAL PROGRAMS

Hillsborough Hospital: As the provincial in-patient psychiatric facility, Hillsborough Hospital's mission is to offer specialized acute and long-term treatment and rehabilitation to the people of Prince Edward Island who have enduring mental illness, persons with mental handicaps and psycho geriatric patients. In addition, the Hospital provides day services to former patients. The facility has 75 beds of which 57 are designated for long term care. The major specialized services offered include assessment/admission/acute and sub-acute treatment and management and behavioural management.

Queen Elizabeth Hospital (QEH): QEH is a 274-bed acute care facility that provides both community services to Queens County and specialty services provincially. At the QEH, the primary focus of psychiatry is services on Unit 9 which is an acute inpatient unit with 17 adult beds, three assessment beds, as well as 3-4 adolescent beds. Patients may have voluntary or involuntary status. Patients presenting on Unit 9 may be experiencing exacerbation in their mental illness, such as schizophrenia, bipolar disorder, depression, substance and alcohol abuse. Patients work with a variety of professionals to better understand the symptoms they are experiencing as well as the possible stressors that brought them to hospital. Patients are involved in a variety of assessment procedures, one-to-one counselling, educational sessions, group therapy, specialized programming focusing on their specific needs, and discharge planning. Staff of Unit 9 provide consultations and referrals to the community by having a community nurse liaison with the inpatient unit to facilitate referral and follow-up post-discharge. The goal of hospitalization is to provide the patient with assessment, treatment, goal- setting, structured programs, a safe environment, and stabilization of symptoms, so that timely transition can be made to outpatient treatment and/or the home environment.

Prince County Hospital: Prince County Hospital is a 102 bed acute care facility which has 14 beds in the Inpatient Mental Health unit. The multidisciplinary mental health team coordinates and implements the therapeutic interventions which respond to the needs of patient/families experiencing mental and emotional illness through an entire episode of care, from an acute phase of illness to discharge.

Services include: Assessment, diagnostic services, treatment planning/ case conferencing, implementation of therapeutic interventions and modalities (which include individual/family counselling and support, teaching, group therapy, and marital counselling). Discharge planning and integration with mental health and other community based resources is a vital component of the service provided. Outpatient services are often initiated as a means to ease transition from hospital to community and to community based resources, which includes crisis intervention, case coordination/liaison with other resources, group therapy, teaching, and support with community groups (i.e., addiction groups, schools). An overall goal is to enhance the health and well being of the individuals and families by responding with services which address mental/emotional, social, physical, and spiritual needs.

Psychiatry Summerside and West: Services provided in Summerside and Alberton by psychiatrists include: Inpatient service at Prince County Hospital (PCH) – voluntary unit; outpatient services to child, adults, geriatric, and addiction populations by two psychiatrists; consultation for adult staff at Community Mental Health on a 2-4 week basis; and psychiatry consultation services to other medical departments in PCH. Psychiatry outpatient services are provided in Alberton Clinic once a month and Alberton patients are seen in Summerside clinic once a month. Psychiatry consultation is also provided to an outreach team on a monthly basis. Direct physician referrals are accepted and scheduled on an urgency basis. Psychiatry consultations with pediatricians are provided on a monthly basis.

There are currently ten psychiatrists with the Department of Psychiatry at the Queen Elizabeth and Hillsborough Hospitals. Generally, three psychiatrists are involved at any one time at Hillsborough Hospital, however, the numbers may vary. **In** addition to inpatient services as outlined above, psychiatric services are also present at Richmond Centre, a Community Mental Health Clinic where general adult psychiatry as well as child and adolescent psychiatry services are present. Three psychiatrists provide these services with the full time equivalent being close to two psychiatrists. At McGill centre, psycho geriatric services, general and chronic adult, as well as outreach services are part of the services provided by the members of the Department of Psychiatry. There are

four psychiatrists providing services to the McGill Centre. As part of the psychogeriatric outreach services, nursing home consultations are also provided.

Richmond Centre: Provides individual, family, and group therapy for individuals who are suffering from a "moderate mental health disorder". Also, other services include Changeways (depression), Panic and Anxiety, Dialectical Behaviour Therapy for borderline personality disorder, acupuncture, MAST, forensic assessment, collaborative practice with four health centres, telehealth with IWK Health Centre, mental health crisis response, psychological assessment, co-occurring disorder group, critical incident stress management.

McGill Centre: Provides adult therapy for people with serious and persistent mental illness. Services include psychotherapy; psycho-education; supportive therapy; cognitive behavioural therapy; case management; three levels of community outreach: assertive, stepdown, and maintenance; and medication management including a Neurolyptic Injection Program, monitoring and education, and administration of oral medication to assertive outreach clients. Groups are offered in the following areas: coping skills, Changeways, discharge group, outreach group, co-occurring disorders.

Community Mental Health East: Provides screening; assessment; crisis response; outreach; short-term solution-focused, client centered, cognitive-behavioural, eclectic, and group therapies; assertiveness training; medication monitoring; psychoeducation; grief counselling; depot injection clinic; monitoring and assessment of symptom severity; psycho-dynamic therapy; cognitive, behavioural, developmental, and personality assessments; and treatment for preschoolers.

Community Mental Health West: Adult services include: medication management (neurolyptic injection program, monitoring, and education of medications) and adult therapy (case management, crisis response, cognitive-behavioural therapy, and psycho-educational therapy). Youth services include: intake/crisis intervention, individual and family counselling, parenting magic group, psychological assessments, consultation, and case conferencing.

INCOME SUPPORT PROGRAMS

The Department of Community Services, Seniors and Labour administers the provincial "**Social Assistance**" program. Key legislation includes the Social Assistance Act and administration is guided by the Social Assistance Policy Manual. Basic assistance includes a basic allowance (which is intended to cover the cost of food, clothing, utilities and personal/household items) and a shelter allowance.

Income assistance for people with disabilities is provided through Prince Edward Island's **Disability Support Program**, created in 2001, which offers both financial and case planning assistance to eligible individuals through three programs: Adult Disability Supports, Child Disability Supports, and Employment and Vocational Supports. The Disability Support Program is available to individuals under 65 years of age who have a physical, neurological, or intellectual disability that limits their ability to perform activities necessary for their independence and well-being. **Mental illness is not recognized as a disability under the Disability Support Program**. Thus, people with mental illness instead receive income assistance through the Social Assistance Program as eligible:

- People who are expected to receive benefits for less than four months (short-term assistance) and/or who are seasonally unemployed are entitled to retain $50.
- People who are expected to receive benefits for more than four months (long-term) are eligible to retain $200 (for a single individual) and up to $900 for singles with disabilities.
- People who are **transient** (no fixed address and/or no intent to establish residency) are eligible for emergency assistance limited to a meal, overnight lodging and/or bridge or boat fare - exceptions may be made in extenuating circumstances.
- Social Assistance program clients are eligible for the following monthly exemptions on **earned income**: Singles may retain $75 plus 10% of the excess, Families may retain $125 plus 10% of the excess.

- **Total income** for a single individual on Social Assistance was estimated at $6,672 in 2008 (includes basic social assistance and GST credit)[206].

According to the Social Assistance Statistical Report, 2007 (Federal-Provincial-Territorial Directors of Income Support, May 2010, pp.22), an estimated 5,800 people (for a total of 3,600 cases) were receiving Social Assistance as at March 2007.

- 53% of all Social Assistance Cases were for the primary reason of long-term disability, 6% for short-term disability, and 6% for "High Support Needs" (i.e., multiple barriers to employment) as of March 31, 2007.
- Of the Social Assistance cases where the reason for social assistance was disability, about 24% had been receiving assistance for one year or less, 52% for more than one year up to five years, and 29% for more than five years as of March 31, 2007.

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

- With the support of the Homelessness Partnering Strategy, a major study is being undertaken to establish the **housing and support needs for youth** in Charlottetown and Summerside (two of the 61 "designated communities" by the HPS across Canada). The study is particularly focused in the 16-18 year age range. The report is expected in Summer 2010 and may provide learning opportunities for other jurisdictions in the country.
- Most recently, the **PEI Community Advisory Committee on Homelessness** issued the first ever Report Card on Homelessness which identified that the shelter beds were used over 5400 times by about 240 individuals over the course of 2009[207].

CHALLENGES IN HOUSING AND RELATED SUPPORTS

- **Inadequate housing stock and funding options for ongoing operating costs**: While there are some options in securing capital funding for housing stock development, there are few opportunities to secure new annualized funding to support tenants, subsidize rental costs, and sustain the operation costs to operate buildings.
  - With the discontinuation of the CMHC Social Housing program in the late 1980's, subsidization of operational costs and rent is limited to pre-existing units. Affordability of housing units for tenants for newly created housing is based on pre-established income ceilings and is not always reflective of actual need. Also, sustainability for operating and maintaining existing facilities is often beyond the capacity of non-profit organizations ability to manage.
  - As per the Canada/PEI Affordable Housing Agreement, the Federal Government sets an expectation that matching funds will be provided by the province or through other sources for any investments made through the Affordable Housing Initiative. In PEI, the expectation is that agencies provide matching funds and in-kind support.
  - The majority of HPS funding is focused on urban areas (designated to Summerside and Charlottetown) but there are significant needs in more rural areas. In addition, HPS is a good source of capital funding, but agencies still require operating funding for ongoing supports for the person and operations of the unit. In some provinces or territories, the Provincial Government has provided some annualized funding but this does not happen in PEI.
- **Existing housing requires significant investment** to ensure physical standards are maintained; renovations and repairs are costly, and are a drain on staff and volunteer time and resources.

[206] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability*, Bulletin Number 2.
[207] Thibodeau, W. *Homelessness 'hidden problem' in Prince Edward Island*. Published in the Guardian, May 4, 2010. http://www.theguardian.pe.ca/inde.g.cfm?sid=338670&sc=98

- **Geographic centralization and lack of transportation**: The majority of supports and housing stock tend to be concentrated in Charlottetown, with some availability in Summerside; PEI's transportation system is limited to the City of Charlottetown. With limited funds available for rural development and fewer formal services and supports in rural areas, individuals often find themselves having to move outside of their social/family networks to find places to live.
- **Affordability versus need**: Qualifying rates or Income Support rent ceilings may make some individuals ineligible for Affordable Housing programs, yet the supports that are often offered by these programs can provide the much needed resource to enable these individuals to live successfully in the community, not only by reducing demands on acute services, but by contributing to the economy of the community through volunteer and work opportunities.
- **Capacity of resources to respond in PEI is limited**: The ability to respond to the range of needs that people have are not only limited around mental health and addictions services and housing options, but also around food banks, shelters, etc.
- **Low ceiling for earned income for people on Social Assistance**: individuals are only allowed to keep $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, and creates a financial disincentive for individuals to leave the social assistance system.
- **Needs of youth**: The needs of youth are a significant issue that have not been addressed.
  - The PEI Community Advisory Committee on Homelessness has identified youth between the ages of 16-18 in need of housing, support and programming as a priority.
  - With earlier diagnosis of mental illnesses and more effective medications, young people are now living in communities, are more mobile, and have greater expectations and needs for services. Conversely, as a result of their illness, many of these youth have also not reached the same maturity level as their peers and have greater needs for supports.
  - Lack of appropriate housing means that young people are living in facilities that are not age appropriate (i.e. senior care facilities), are couch surfing, or are living in high-risk conditions
- **Access to Disability Funds**: On Prince Edward Island, mental illness is not recognized as a disability in relation to specialized funds for accommodations, support worker, transportation or other disability related needs.
- **Community salaries are not at par** with those in similar positions within government (roughly 20% lower). Non-profits often hire new grads who build experience and move on to better paying jobs; have difficulty attracting qualified employees; or have employees who supplement their incomes with other part-time positions.

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

- Increase in the immigrant population on Prince Edward Island and the resulting need for cultural diversity
- Increased age of the Island's population (i.e., more seniors with mental illness)
- More youth with mental illness are now living in the community and while there is a greater demand for services, they have more capacity to be contributing members of society
- More adults with mental illness are being housed in Community Care Facilities, due to a lack of other more viable or appropriate options

QUÉBEC

CONTEXTE

Caractéristiques écologiques

Contexte historique

Diverses possibilités de « logement » sont offertes dans la province de Québec aux personnes atteintes de maladie mentale et (ou) ayant des problèmes de toxicomanie. La diversité des modèles reflète également le dynamisme et l'évolution de la transformation du système de santé et des services sociaux dans le secteur de la santé mentale.

Cet historique couvre la période où les personnes atteintes de maladie mentale vivaient confinées dans de grands instituts psychiatriques, celle de la désinstitutionnalisation qui a commencé dans les années 1960 et celle plus récente marquée par une plus grande participation des personnes atteintes de maladie mentale à la communauté et par l'augmentation des possibilités de logement à l'intention de ces dernières[208].

En analysant le contexte de cet historique, on observe deux tendances. L'une de ces tendances a été de s'éloigner du modèle d'hébergement en institution des personnes atteintes de maladie mentale pour favoriser le logement qui favorise l'insertion sociale. En parallèle, on a vu apparaître au Québec comme ailleurs une tendance à fournir des ressources financières directement à l'utilisateur plutôt que de les diriger vers les voies traditionnelles.

Au Québec, deux catégories différentes de possibilités de logement se démarquent. Chacune propose un certain nombre de modèles.

La première catégorie comprend les possibilités de logement apparues à la suite de la désinstitutionnalisation. Celles-ci ont été graduellement créées sous la gouvernance d'institutions publiques telles que les hôpitaux. La régie et la responsabilité de ces logements sont mandatées par la loi à certaines institutions publiques désignées par le terme « établissement », qui sont généralement des hôpitaux. L'enveloppe budgétaire de ces programs est fournie par le ministère de la Santé et des Services sociaux (MSSS). Ce programme héberge environ 9 000 personnes ayant des problèmes de santé mentale graves et persistants.

La deuxième catégorie comprend le logement social et, plus récemment, des logements offerts par l'entremise d'entreprises à but lucratif. Ces deux possibilités donnent droit au supplément au loyer. Leur financement est directement fourni à l'utilisateur grâce à ces programs financés par la Société d'habitation du Québec (SHQ).

Structure du système et gouvernance

Le champ d'application de la santé et des services sociaux dans la province de Québec a été entièrement intégré en un seul ministère, le ministère de la Santé et des Services sociaux (MSSS). Celui-ci compte dix-huit régies régionales responsables de l'intégration des services sociaux et de santé dans leur région respective.

La structure des services sociaux et de santé comporte cinq institutions financées par l'État : les centres de santé et de services sociaux (CSSS), les centres d'hébergement et de soins de longue durée (CHSLD), les centres hospitaliers, les centres de réadaptation et les centres de protection de l'enfance et de la jeunesse (CPEJ).

L'intégration des secteurs sociaux et de santé du ministère a été reproduite au niveau régional. Les centres locaux de services communautaires (CLSC), les centres d'hébergement et de soins de longue durée (CHSLD) et les centres hospitaliers ont tous été fusionnés en une seule entité : les centres de santé et de services sociaux (CSSS).

[208] Cette dernière période a été précédée et influencée par le mouvement Vie autonome au Canada, également présent au Québec. Le mouvement Vie autonome des années 1980, mené par des personnes handicapées du Canada, a entraîné de nouvelles initiatives de création de politiques qui ont préparé le terrain vers l'intégration dans la collectivité et la participation en tant que citoyen des personnes anciennement confinées à la vie en établissement.

On estime qu'il y a entre 150 000 et 200 000 personnes au Québec atteintes d'un grave problème de santé mentale[209]. La coordination des services sociaux et de santé, y compris le soutien résidentiel et communautaire à cette population, serait régie et planifiée par les centres de santé et de services sociaux de la province.

L'administration du programme de supplément au loyer est assurée par la Société d'habitation du Québec. Une politique intersectorielle émanant du ministère de la Santé et des Services sociaux et de la Société d'habitation du Québec régit et oriente le soutien communautaire dans le secteur du logement social[210].

Organisation structurelle du logement et du soutien connexe

Les logements pour les personnes ayant de graves problèmes de santé mentale au Québec sont fournis par deux systèmes différents. Le premier consiste en des ressources résidentielles et de logement principalement gérées par le secteur hospitalier. Dans certains cas, la régie de ces ressources a été confiée à la collectivité, ce qui s'est produit dans la région de la ville de Québec. Le second système comporte des possibilités de logement offertes par le secteur du logement social. Chacun de ces systèmes propose une gamme unique de possibilités de logement et de mesures de soutien.

Logement résidentiel communautaire structuré

Les mesures de soutien résidentiel et au logement ont été mises sur pied par le milieu hospitalier en réponse à la désinstitutionalisation des patients migrant des établissements psychiatriques vers la collectivité. Par conséquent, un continuum varié de « ressources d'hébergement communautaire structuré » a été élaboré. Ces ressources d'hébergement situées dans la collectivité ont été conçues et gérées par les hôpitaux. Il existe des lois précises (c.-à-d. LSSSS, articles 302 et 108) qui gouvernent les rôles et les responsabilités de ces ressources et de l'hôpital orienteur (c.-à-d. l'établissement public).

L'enveloppe budgétaire qui finance cet ensemble de mesures de soutien à l'hébergement résidentiel traditionnel et d'hébergement communautaire provient du ministère de la Santé et des Services sociaux. Divers modèles résidentiels ou de logement ont été élaborés avec les années. Le continuum peut comprendre des possibilités telles que le logement et les repas, les foyers de groupe, les familles d'accueil et les appartements autonomes supervisés.

Secteur du logement social

Le logement social est très développé au Québec. Ce secteur a traditionnellement fait preuve d'un fort leadership et a été très présent dans le développement de logements pour les populations défavorisées et marginalisées. Ce secteur a graduellement étoffé son expertise pour soutenir les personnes atteintes de maladie mentale afin qu'elles réussissent à vivre dans un environnement de logement social. Il faut toutefois répondre aux critères de sélection pour avoir accès au logement social; en outre, ce type de logement n'est pas toujours être accessible aux personnes atteintes de maladies mentales.

Le financement pour l'élaboration des projets de logement social provient de la Société d'habitation du Québec et des municipalités. La collaboration entre le secteur du logement social et le secteur de la santé mentale est bien établie. Par exemple, dans les régions de Montréal et de Québec, le secteur du logement social et la communauté des pourvoyeurs de services de santé mentale ont été en mesure d'élaborer des modèles réussis de logement et de mesures de soutien. Il est à noter que le Program de supplément au loyer (PSL) au Québec est géré par la Société d'habitation du Québec. (Il est également à noter que les clients pris en charge par le milieu hospitalier ne sont pas admissibles au supplément au loyer de la Société d'habitation du Québec.)

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[209] Plan d'action en santé mentale (2005-2010), p. 40.

[210] Ministère de la Santé et des Services sociaux et Société d'habitation du Québec (2007). *Cadre de référence sur le soutien communautaire en logement social : une intervention intersectorielle des réseaux de la santé et des services sociaux et d'habitation.*

PROGRÈS JUSQU'À MAINTENANT: INITIATIVES CLÉS

La planification dans le domaine du logement pour les personnes atteintes de maladie mentale a été guidée par une approche intégrée au niveau ministériel. Par exemple, le ministère de la Santé et des Services sociaux, en partenariat avec la Société d'habitation du Québec, a élaboré un document de politiques intégrées qui informe et oriente la communauté du logement social et les spécialistes du soutien communautaire sur les façons de travailler ensemble afin de bien loger les populations marginalisées qui ont besoin de soutien dans un environnement de logement social.

- **Politiques relatives au soutien communautaire et au logement social** : Cadre de référence sur le soutien communautaire en logement social : une intervention intersectorielle des réseaux de la santé et des services sociaux et de l'habitation, ministère de la Santé et des Service sociaux et la Société d'habitation du Québec, gouvernement du Québec, 2007.

Le cadre des politiques provinciales favorisant la planification concernant la santé mentale au Québec s'intitule Plan d'action en santé mentale (2005-2010). Cette politique, axée sur le rétablissement, met en évidence l'importance du partenariat et de l'intégration fluide des services sociaux et de santé visant le soutien aux utilisateurs de services et leurs réseaux naturels de soutien.

- **Politiques concernant la santé mentale** : Plan d'action en santé mentale : La force des liens, ministère de la Santé et des Services sociaux, 2005.

GAMME DE POSSIBILITÉS D'HÉBERGEMENT ET DE LOGEMENT

Au Québec, une subtile distinction est faite entre les possibilités d'hébergement et de logement. L'utilisateur d'une ressource d'hébergement est généralement un « résidant » qui n'a pas les responsabilités d'un locataire. Dans le cas des possibilités de logement figurant ci-dessous, l'utilisateur assume généralement le rôle et les responsabilités d'un locataire. La personne qui signe le bail est un bon indicateur de cette distinction[211].

Ces deux catégories offrent aux utilisateurs diverses possibilités de logement qui varient entre un environnement communautaire très structuré avec mesures de soutien et des logements indépendants et autonomes (également associés à un soutien à des degrés divers).

Logements pour personnes atteintes de graves problèmes de santé mentale financés par le ministère de la Santé et des Services sociaux

Au Québec, environ 9 000 adultes atteints de graves problèmes de santé mentale vivent dans un « logement résidentiel communautaire structuré », financé par le ministère de la Santé et des Services sociaux. Le tableau ci-après contient un résumé des différents types de logement résidentiel et du soutien communautaire connexe.

Source : Plan d'action en santé mentale (2005-2010), p. 53.

[211] Vincent, K. et Morin, P. (2010). *Le logement subventionné : dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté - Source d'inspiration pour créer des modèles innovants*. Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec, p. 25.

Tableau 1. *Gamme d'options de logement et d'hébergement et descriptions pour le Québec.*

Gamme des possibilités de logement	
Types d'hébergement	**Description**
Ressources en logement offertes par les secteurs à but lucratif ou non lucratif	
Appartements autonomes d'organismes de logement sans but lucratif (avec ou sans soutien) Appartements autonomes de sociétés à but lucratif (avec ou sans soutien)	▪ logement social ▪ coopérative de logement social ▪ logement social pour unité familiale
Appartements autonomes dans un parc de logements de sociétés à but lucratif (avec ou sans soutien) Appartements autonomes d'organismes à but non lucratif (avec ou sans soutien)	▪ financés en partie par le programme de supplément au loyer (PSL) individuel, géré par la Société d'habitation du Québec (SHQ)
Logement communautaire structuré offert par les établissements du MSSS	
Ressources d'hébergement pour soins de longue durée	▪ établissements de soins de longue durée (centres d'hébergement et de soins de longue durée – CHSLD)
Ressources d'hébergement intermédiaires	▪ ressources de logement communautaire structuré réglementées par la loi, telles que définies par l'article 302 de la Loi sur les services de santé et les services sociaux ▪ l'objectif est de prendre en charge l'intégration dans la communauté en fournissant l'hébergement et le soutien requis ▪ les ressources physiques en logement ne sont pas fournies directement par les institutions publiques (c.-à-d. les établissements) qui gèrent le programme mais données en sous-traitance à des fournisseurs dans la collectivité (la seule exception étant le secteur de la protection de l'enfance) ▪ on conclut des ententes contractuelles avec des fournisseurs pour offrir l'hébergement et le soutien connexe **Types de modèles généralement offerts :** ▪ appartements supervisés (l'utilisateur y habite mais n'a pas le statut de locataire) ▪ maison de chambres ▪ foyer de groupe mené par du personnel ▪ foyer de groupe (avec soutien offert par du personnel ne vivant pas dans la maison) ▪ modèles émergents (la loi permet la création et le développement de nouveaux modèles)
Ressources d'hébergement de type familial	- l'hébergement est fourni dans un contexte de participation en milieu familial
Appartements supervisés	- hébergement dans un appartement individuel avec divers degrés de soutien, au besoin (l'utilisateur a le statut de résidant)

Tableau 2. *Aperçu des capacités provinciales de possibilités « d'hébergement résidentiel communautaire » telles que décrites dans le Plan d'action en santé mentale (2005-2010).*

Type de logement ou de service résidentiel	Description	Gouvernance	Total provincial (nombre d'individus)
Centre d'hébergement et de soins de longue durée (CHSLD) Soins de longue durée (personnes souffrant de graves maladies mentales)			937
Ressources intermédiaires (telles que définies par l'article 302 de la LSSSS)	▪ logement (service d'hébergement) et services de soutien fournis par divers agents (individus, organismes communautaires ou entreprises privées) ▪ le soutien communautaire est offert par les professionnels liés à l'« établissement public référent » ▪ le logement peut être un foyer de groupe, une maison de chambres, des appartements supervisés ▪ directives provinciales http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2001/01-801-01.pdf ▪ Financement : Ministère de la Santé et des Services sociaux par l'entremise d'un « établissement public référent » (c.-à-d. hôpitaux généraux et hôpitaux psychiatriques ou centres de santé et des services sociaux régionaux)	contrats établis avec un hôpital pour fournir le logement ou des services résidentiels	2 967
Ressources de type familial (telles que définies par l'article 302 de la LSSSS)	▪ une famille d'accueil fournit logement et soutien communautaire 24 heures par jour, 7 jours par semaine, à un maximum de 9 résidants ▪ directives concernant la qualité des services provinciaux http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2002/02-821-01.pdf ▪ Financement : Ministère de la Santé et des Services sociaux par l'entremise d'un établissement public	contrats avec un hôpital pour fournir le logement ou des services résidentiels	4 385
Autres ressources Organismes communautaires d'hébergement (tels que définis par l'article 108 de la LSSSS)	▪ appartement autonome ou unités de logement ▪ soutien communautaire ou supervision sous-traité à l'extérieur des organismes de service communautaire		451
Unités de logement autonomes avec soutien communautaire	▪ appartements et soutien communautaire fournis par le biais de servies de gestion de cas ou d'un PACT ▪ Financement : Ministère de la Santé et des Services sociaux par l'entremise d'un établissement public		491 (nombre sous-estimé[212])

[212] Ministère de la Santé et des Services sociaux (2005). *Plan d'action en santé mentale 2005-2010*, p. 53. Tel qu'inscrit dans le Plan, ce nombre est de beaucoup inférieur au nombre prévu établi à 50 personnes par tranche de 100 000.

Tableau 3. *Options de logement spécialisé : Hébergement communautaire structuré.*

Région	Organisme	Type	Capacité
Total provincial	Institutions publiques mandatées (établissements publics)	Consulter le Tableau 2	8 331

Tableau 4. *Options de logement non spécialisé*[213].

Région	Program	Type	Capacité
Total provincial	Programs de logement municipal Office municipal d'habitation (OMH)	Nombre total d'unités	62 883
Total provincial	Coopérative et autres organismes de logement sans but lucratif	Nombre total d'unités	6 234
Total provincial	Autochtones hors réserves	Nombre total d'unités	1 926
Total provincial	Inuits	Nombre total d'unités	2 124
Total – tous les programs			73 167

Tableau 5. *Marché de la location par des sociétés à but lucratif*[214].

Région	Organisme	Type	Population cible	Capacité
Total provincial	Suppléments au loyer alloués au marché de la location par des sociétés à but lucratif	Unités de location	Population du logement social	7 174 suppléments au loyer

SOUTIEN EN SANTÉ MENTALE

Investissements financiers globaux en santé mentale

L'enveloppe budgétaire totale pour tous les services de santé mentale dans la province de Québec était de 757 121 108 dollars au cours de l'exercice comptable 2002/03. (Ce montant exclut les paiements faits aux médecins et le coût de l'assurance-médicaments). Cette somme représente 6,2 % du financement total en santé.

Selon une analyse récente de l'Institute of Health Economics[215] (Jacobs et d'autres, 2010), les montants suivants représentent le total des dépenses pour les services de santé mentale et de toxicomanie[216] au Québec en 2007-2008 :

- 737,2 millions de dollars pour les soins aux patients hospitalisés[217] (487,3 millions de dollars pour les hôpitaux généraux et 205,4 millions de dollars pour les hôpitaux psychiatriques)

[213] Vincent, K. et Morin, P. (2010). *Le logement subventionné : dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté - Source d'inspiration pour créer des modèles innovants*. Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec, p. 22.
[214] Vincent, K. et Morin, P. (2010). *Le logement subventionné : dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté - Source d'inspiration pour créer des modèles innovants*. Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec, p. 22.
[215] Institute of Health Economics (2010). *The Cost of Mental Health Services in Canada*. Alberta, Canada. p. 10.
[216] Des analyses supplémentaires ont été menées par l'*Institute of Health Economics* sur les produits pharmaceutiques, les plans d'aide aux employés et les programmes de soutien du revenu.

- 248,8 millions de dollars pour les services des médecins (51,2 millions pour les omnipraticiens / frais de service, 83,9 millions pour les spécialistes / frais de service et 113,7 millions pour les psychiatres à titre de montant compensatoire)
- 682,3 millions de dollars pour les services communautaires et sociaux (565,4 millions pour la santé mentale communautaire, 5,4 millions pour l'aide à l'emploi, 99,8 millions pour la toxicomanie et 11,7 millions pour les services de santé mentale et de toxicomanie livrés aux Premières nations)

Soutien du revenu

Le ministère de l'Emploi et de la Solidarité sociale est responsable de la prestation du programme d'aide sociale provinciale (aide financière de dernier recours). Le programme d'aide de dernier recours comprend le Programme d'aide sociale et le Programme de solidarité sociale. L'aide financière de dernier recours est régie par la Loi sur l'aide aux personnes et aux familles et le Règlement sur l'aide aux personnes et aux familles. L'aide financière consiste en une prestation de base, payée chaque mois, qui peut être accompagnée d'une allocation pour les personnes qui font face à des contraintes à l'emploi temporaires ou graves. La prestation de base couvre le coût de la nourriture et des vêtements, le logement et les articles personnels et domestiques pour les adultes seulement. Les taux de prestation de base maximaux sont calculés selon la composition de la famille. Dans le cas de prestations supplémentaires pour contraintes temporaires à l'emploi, la personne doit être âgée de 55 ans ou plus, être incapable de participer au marché du travail à cause de problèmes de santé durant une période maximale de 12 mois, avoir un enfant à charge âgé de cinq ans ou moins ou être enceinte. Pour obtenir l'allocation de solidarité (allocation versée aux personnes ayant des contraintes à l'emploi graves dans le Programme de solidarité sociale), l'état physique ou mental de la personne doit être sérieusement modifié ou déficient durant une période indéterminée ou de façon permanente.

L'allocation familiale du Québec (qui a été créée en 1997 et qui a soustrait efficacement les prestations des enfants du système d'aide sociale) était un montant non imposable versé mensuellement pour aider les familles à faible revenu à assumer les coûts associés au fait d'élever des enfants de moins de 18 ans. La Régie des rentes du Québec était responsable de gérer l'allocation familiale du Québec. Depuis le mois d'août 2004, les familles ont eu droit à un montant annuel de 625 dollars par enfant. Les familles monoparentales peuvent également recevoir un supplément familial de 1 300 dollars par année. Un montant supplémentaire de 1 431 dollars est remis pour chaque enfant handicapé.

- Les utilisateurs sont admissibles aux exemptions mensuelles suivantes sur le revenu gagné :
  - Utilisateurs n'ayant pas de contraintes à l'emploi : 200 dollars pour personnes seules, 300 dollars pour les familles
  - Utilisateurs ayant des contraintes temporaires à l'emploi : 200 dollars pour personnes seules, 300 dollars pour les familles
  - Utilisateurs ayant de sévères contraintes à l'emploi (Programme de solidarité sociale) : 100 dollars pour personnes seules et familles
- Le revenu total d'une personne seule handicapée était estimé à 10 630 dollars (y compris l'aide sociale de base, les autres prestations provinciales ou territoriales et le crédit pour TPS)[218].
- En 2007, on a signalé qu'il y avait 499 600 prestataires (soit 341 500 cas) de l'aide financière de dernier recours (environ 350 300 prestataires soit 213 800 cas pour le Programme d'aide sociale et 149 400 prestataires soit 127 800 cas pour le Programme de solidarité sociale)[219]

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[217] Prendre note que les chiffres concernant les patients internes pour 2007-2008 présentés dans le rapport de *l'Institute of Health Economics* ne sont pas réels, mais représentent des extrapolations basées sur les données de 2003-2004 de l'Institut canadien d'information sur la santé.

[218] Rapports du Conseil national du bien-être social. *Revenus de bien-être social 2008 : Personne seule handicapée*, Bulletin numéro 2.

- Le pourcentage de cas recevant la prestation de base pour l'aide sociale était de 38 %, le pourcentage de cas recevant la prestation de base et une allocation pour contraintes temporaires à l'emploi était de 24 % et 1 % des cas recevait une allocation mixte (c.-à-d. deux membres du ménage présentent des contraintes temporaires à l'emploi)[220], 36 % des cas recevaient une allocation de solidarité sociale et 1 % des cas recevait la prestation de base de solidarité sociale.

PRATIQUES PROMETTEUSES RELATIVES AU LOGEMENT ET AU SOUTIEN CONNEXE

Les visites sur le terrain menées par des chercheurs ont permis d'identifier certaines pratiques prometteuses. Prendre note que seul un petit nombre de pratiques a été recensé et que la portée des pratiques prometteuses est plus élaborée que celle permise par la longueur du rapport. Cette section ne donne que quelques exemples des innovations et de l'expertise développées au Québec concernant le logement et le soutien connexe.

Protocole pour surveiller les utilisateurs et leur permettre une auto-administration de médicaments
La Direction des services de réadaptation et d'hébergement dans la communauté de l'Hôpital Louis-H. Lafontaine de Montréal a élaboré et mis en place un outil et une approche normalisés pour l'autogestion des médicaments dans toutes ses résidences communautaires. Le processus en six étapes décrit l'objectif et les étapes de l'autogestion des médicaments par les utilisateurs. Cet outil convivial contient des directives à l'intention du personnel pour surveiller l'utilisateur et identifier les secteurs dans lesquels il progresse vers l'indépendance et permet une acquisition par étapes d'une vie indépendante. Il s'agit d'un processus graduel assurant la sécurité et la conscience de l'utilisateur lorsqu'il gère sa propre médication.

Soutien aux pourvoyeurs de services dans un contexte de transformation du système
Le programme de réhabilitation psychosociale et de ressources résidentielles de l'Institut universitaire en santé mentale Douglas a commencé à soutenir les changements transformationnels du système requis par le gouvernement pour offrir plus de logements autonomes à long terme avec services de soutien. L'équipe du Douglas travaille en collaboration avec des partenaires des secteurs privés et communautaires pour s'intégrer et s'harmoniser au nouveau paradigme du logement en santé mentale. Nous avons visité deux pourvoyeurs de services privés qui ont investi et qui ont acquis un espace pour offrir des logements autonomes à long terme avec soutien. Un engagement ferme envers les valeurs des modèles émergents et la vision des approches habilitées axées sur l'utilisateur sont essentiels pour s'assurer du succès de ce changement transformationnel. Le leadership et la souplesse requis pour sensibiliser les pourvoyeurs de services sur les bienfaits de ce modèle et les aider sont la clé du succès de ce modèle.

Cadre d'évaluation du maintien de la fidélité et de la qualité du programme
Les organismes communautaires font souvent face au défi d'intégrer des mécanismes et des processus d'évaluation qui leur permettent de maintenir la fidélité des pratiques fondées sur des faits démontrés et d'en assurer la qualité. « Le Mûrier », qui gère une vaste gamme de programmes de logement et de services de soutien offerts à différentes populations cibles, a choisi d'investir dans le développement et la mise en place d'un cadre d'évaluation afin d'améliorer constamment ses services. L'entreprise a engagé un consultant pour élaborer l'instrument d'évaluation initial et continue de le façonner pour répondre aux besoins changeants.

L'instrument d'évaluation comporte douze grilles qui évaluent les processus et les procédures du soutien des utilisateurs et des services. L'instrument est utilisé par chaque équipe de programme tous les trois ans. Les résultats sont analysés et permettent d'établir des objectifs d'amélioration organisationnelle. Les plans d'action sont rédigés et mis en œuvre au cours des deux années suivantes. Le processus continu d'assurance de la qualité permet à l'organisme d'être à l'affût des besoins des utilisateurs, de l'actif et des défis organisationnels et des réalités environnementales. L'organisme a perfectionné et façonné l'instrument au fil des années et continue d'améliorer son efficacité. L'instrument et le processus favorisent l'orientation et la formation du personnel.

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[219] Directeurs fédéral-provinciaux-territoriaux du soutien du revenu, août 2009. *Rapport statistique sur l'aide sociale, 2006.*
[220] Ibid.

DÉFIS RELATIFS AU LOGEMENT ET AU SOUTIEN CONNEXE

Estimation du besoin et du coût des logements autonomes avec soutien pour les personnes ayant de graves problèmes de santé mentale au Québec

Le point de référence au Québec, établi par Lesage (2003), qui identifie le nombre de personnes (âgées de 18 ans et plus) ayant des problèmes de santé mentale et ayant besoin d'unités de logement autonome avec soutien communautaire est estimé à 50 individus par tranche de 100 000[221]. Si on applique ce point de référence à la population du Québec en, soit 7,5 millions de personnes[222], on constate qu'il faut 3 750 unités de logement autonome avec soutien pour répondre aux besoins de logement des adultes atteints de graves problèmes de santé mentale.

Une récente étude de Vincent et Morin (2010)[223] évaluant le besoin en logements sociaux pour les personnes ayant de graves problèmes de santé mentale estime que 1 200 logements (nombre également jugé sous-estimé par rapport au besoin réel)[224] est un point de départ réaliste. L'étude a établi les frais d'un modèle réussi pour le logement des personnes atteintes de graves problèmes de santé mentale par l'entremise du programme de supplément au loyer coordonné au soutien connexe communautaire en santé mentale. Le coût par personne dans ce modèle est établi à 6 750 dollars par année (ce montant comprend le coût du supplément au loyer et du soutien communautaire en santé mentale. L'investissement total pour atteindre la cible proposée serait de 8 100 000 dollars. (Voir Annexe A pour obtenir de plus amples renseignements.)

DIRECTIONS FUTURES: TENDANCES RELATIVES AU LOGEMENT ET AU SOUTIEN CONNEXE

Nous assistons à un mouvement visant à réduire le nombre de logements supervisés (c.-à-d. les ressources résidentielles communautaires structurées).

Le Plan d'action en santé mentale (2005-2010) met en évidence le besoin de délaisser le logement résidentiel au profit de logements autonomes avec soutien. Toutefois, il existe des critères importants qui sont identifiés et qui doivent être respectés afin de bâtir cette nouvelle capacité de logements en santé mentale. Un modèle de services transformé de logement et de soutien prendrait en considération l'équilibre entre le besoin d'indépendance et de sécurité des personnes et leur choix personnel concernant les options de logement ainsi que la capacité des individus.

Les autres tendances à souligner sont, entre autres, le mouvement vers une intensité moindre des services et vers l'augmentation du rôle du soutien par les pairs et des familles d'accueil.

Rôle du pair aidant à formaliser

Au Québec, le rôle du pair aidant est formalisé par la loi. Cet important développement apportera des changements permanents grâce à la création d'une nouvelle structure qui définit le rôle des pairs aidants de façon formelle dans le secteur public.

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[221] Lesage, A. et coll. (2003). Canadian Journal of Psychiatry, *Towards benchmarks for tertiary care for adults with severe and persistent mental disorders,* vol. 48, no. 7, pp. 318-320.

[222] Institut de la statistique (2004). *Démographie: si la tendance se maintient...Perspectives démographiques, Québec et régions 2001-2051*, p. 7.

[223] Vincent, K. et Morin, P. (2010). *Le logement subventionné : Dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté – Source d'inspiration pour créer des modèles innovants,* Province de Québec avec la participation de l'Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec.

[224] Ibid, p. 53.

Services résidentiels supervisés

Une initiative d'amélioration de la qualité des services dans le secteur du logement résidentiel supervisé est actuellement mise en œuvre du côté provincial. Elle vise l'amélioration de la qualité des logements dans le milieu résidentiel supervisé.

Recherche récente pour monter un dossier concernant le modèle de supplément au loyer (Ville de Québec)
Une récente recherche de Kristalna Vincent et de Paul Morin (2010) a identifié une stratégie pour augmenter la capacité de placement dans les appartements autonomes. Une de leurs recommandations est d'augmenter l'enveloppe budgétaire de supplément au loyer afin que les personnes atteintes de maladie mentale puissent avoir accès au parc de logements sur le marché locatif privé. Ce modèle est attrayant en raison de sa portabilité et de son applicabilité à d'autres populations marginalisées qui ont besoin de soutien au logement. Ce modèle, toutefois, tient pour acquis que le soutien communautaire en santé mentale serait offert par les fournisseurs actuels de services communautaires en santé mentale.

Problèmes de dialogue – considérations et réflexions

Risques potentiels concernant la tendance vers plus d'options de logement autonome

1) Un équilibre délicat doit être établi. On doit s'assurer de ne pas imposer (par les professionnels et les organismes de service) le fait que le logement autonome est la seule ou la meilleure option pour tous les utilisateurs. L'option doit être fondée sur le choix de l'utilisateur plutôt que d'être poussée par une idéologie. Le logement autonome avec soutien doit être offert aux utilisateurs qui choisissent cette option. Cela dit, cette option peut ne pas convenir à certains utilisateurs. Le risque ici est d'imposer une solution qui répond aux besoins des organismes mais pas nécessairement à ceux des utilisateurs.

Un des risques clés est donc l'imposition « du haut vers le bas », par les organismes de service, d'options de « logement autonome » plutôt que d'offrir le choix aux utilisateurs.

2) Autre secteur de risque critique : le développement de la capacité de soutien communautaire en santé mentale peut ne pas suivre le rythme souhaité ou se développer assez rapidement, ce qui pourrait empêcher les individus de recevoir le soutien requis dans la communauté.

Que démontrent les résultats jusqu'à maintenant?

Bien qu'il existe de nombreux documents de politiques et de planification préconisant le « logement autonome » en tant que meilleure direction ou direction favorisée pour cette population, une méta-analyse du groupe Cochrane étudiant les modèles de logement pour les personnes atteintes de maladie mentale a conclu que, jusqu'à maintenant, aucun modèle de logement ne semble offrir de meilleurs résultats que les autres.

RENSEIGNEMENTS SUPPLÉMENTAIRES

Annexe A – Établissement des coûts pour les suppléments au loyer et le soutien communautaire en santé mentale

Établissement des coûts pour l'hébergement autonome et le soutien aux personnes souffrant de graves maladies mentales – perspective du Québec en logement social
La Régie régionale de la santé et des services sociaux du Québec (2002) a souligné l'importance du logement social en tant que possibilité de logement pour les personnes souffrant de graves maladies mentales. Elle affirme que

l'hébergement autonome avec soutien favorise la participation en tant que citoyen, développe le sentiment d'être à la maison, offre l'accès aux services de soutien liés au logement autonome et est abordable[225].

Logement social et soutien communautaire à 6 750 dollars par année pour les personnes ayant de graves problèmes de santé mentale

L'étude de Vincent et Morin (2010) intitulée Le logement subventionné[226] estime que le nombre de personnes ayant un problème grave de santé mentale qui répondraient aux divers critères d'hébergement dans un logement autonome avec soutien communautaire se situe à un minimum de 1 200 personnes dans la province de Québec. Le coût pour répondre à ce besoin grâce au programme de supplément au loyer serait de 4 500 000 dollars. L'estimation correspondant au soutien communautaire en santé mentale est de 3 600 000 dollars annuellement. Le montant total représente 8 100 000 dollars par année ou 6 750 dollars par personne logée atteinte d'un grave problème de santé mentale.

Établissement des coûts pour le programme de supplément au loyer dans la province de Québec

Le taux de prévalence d'une grave maladie mentale dans la population générale est estimé à 2,5 %. Cela signifie que le nombre de personnes (âgées entre 18 et 64 ans) ayant une grave maladie mentale au Québec en 2006 était de 125 123 individus.

Selon certains critères et certaines hypothèses, l'étude de Vincent et Morin (2010) suggère que le besoin minimum est de 1 200 suppléments au loyer additionnels (cela représente 10 % du besoin total qu'ils ont estimé). Toutefois, l'étude recommande comme cible initiale que la province de Québec augmente de 1 200 le nombre de suppléments au loyer pour les personnes ayant une grave maladie mentale. Au coût de 3 750 dollars par personne par année, cela représente un coût total annuel provincial de 4 500 000 dollars.

Coût du soutien communautaire en santé mentale

L'étude établit à 3 000 dollars le coût du soutien communautaire connexe en santé mentale par personne par année, pour un total annuel évalué à 3 600 000 dollars pour répondre au besoin minimal.

[225] Vincent, K. et Morin, P. (2010). *Le logement subventionné : Dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté – Source d'inspiration pour créer des modèles innovants,* Province de Québec avec la participation de l'Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec, p. 46.

[226] Vincent, K. et Morin, P. (2010). *Le logement subventionné : Dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté – Source d'inspiration pour créer des modèles innovants,* Province de Québec avec la participation de l'Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec.

QUEBEC

CONTEXT

HISTORICAL CONTEXT

A broad range of 'housing' options are available in the province of Québec for persons living with mental health and/or substance use issues. The diversity of available models also reflect a dynamic and evolving health and social service system. There has been a system transformation that is occurring in relation to persons living with mental health issues. This history dates back to the days of living within the confines of large psychiatric institutional settings, the periods of de-institutionalization which began in the 1960s, and to the more recent period marked by the development of greater community participation and living options for and by persons with mental health issues.[227]

In the context of this history two trends may be noted. One trend has been to move away from the institutional model for accommodating persons with mental health problems towards living options that promote greater integration in the community setting. In parallel, a trend to divert financial resources directly to the consumer and away from 'brick-and-mortar' has also occurred here as elsewhere.

In Québec, two different categories of living options are highlighted. Each of these categories provide a number of models

The first category consists of the living options developed as a result of de-institutionalization. These were gradually developed under the governance, and mandated in legislation to public institutions referred to as "établissement," which are in most case hospitals. The funding envelope for these programs is provided by the Ministère de Santé et Services Sociaux (MSSS). This program provides accommodation to approximately 9,000 persons living with serious and persistent mental health problems.

The second category of living options are those from the social housing sector and more recently, housing available through the for-profit housing sector. Both of these are enabled with the support from the rent supplement program. Funding for these options are linked directly to the consumer through the rent supplement programs which is funded by the Société d'Habitation du Québec (SHQ).

SYSTEM STRUCTURE AND GOVERNANCE

Jurisdiction over health and social services in the province of Québec has been fully integrated into one Ministry, Ministère de Santé et Services Sociaux (MSSS). There are 18 regional authorities under the MSSS. These are responsible for the integration of health and social services in their respective regions.

The structure of health and social services consist of five publically funded institutions: Health and social service centres (CSSS), Residential and long term care centres (CHSLD), Hospital centres, Rehabilitation centres (CRs), and Child and youth protection centres (CPEJ).

Integration of the health and social sectors at the Ministry level has been replicated at the regional health and social services level. The Local community services centres (CLSC), the Residential and long term care centres (CHSLD) and the Hospital Centres (CH) have all been merged into one new entity called the Health and social service centres (CSSS).

[227] This latest period of is one that has been preceded and influenced by the Independent Living movement in Canada which was also present in Québec. The IL movement of the 1980s, led by disabled Canadian consumers led new policy development initiatives that paved the way for increased community integration and participation as citizens by persons previously limited to institutional living.

Approximately 150,000 to 200,000 persons in Québec, which had a population of 7,546,000 in 2006 (Statistics Canada, 2010), are estimated to be living with a serious mental health problem[228]. The coordination of health and social services including residential and community supports for this population would be governed and planned by these respective CSSS across the province.

The administration of the rent supplement program is delivered by the Société d'Habitation du Québec (SHQ). A cross-sectoral policy initiative developed by the MSSS and the SHQ provides guidance and direction for the community supports in the social housing sector[229].

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

Housing for persons with serious mental health problems in Québec are resourced through two different systems. The first consists of the residential and housing resources that are managed, principally by the hospital sector. However in some instances that governance for some housing resources has been transferred to the community which has happened in the Québec city area. The second system consists of housing options available through the social housing sector. Each of these provides its own unique range of housing and support options.

Structured community-based residential housing

Historically, residential and housing supports have been developed and managed typically by the hospital sector in response to the de-institutionalization of mental health patients from psychiatric institutions towards the community. As a result, a diverse continuum of "structured community-based accommodation" resources has been developed. There is specific legislation (i.e., LSSS, articles 302 and 108) that governs the roles and responsibilities of these resources and the referring hospital entity (i.e., établissement public).

The funding envelop that supports this stream of traditional residential and community accommodation supports comes from the Ministère de Santé et Services Sociaux (MSSS). A variety of residential/housing models have been developed over time. The continuum may include living options such as room and board, group homes, foster family settings, and supervised independent apartment units.

Social housing sector

Social housing is highly developed in Québec. This sector has traditionally provided strong leadership and presence in the development of housing for disadvantaged and marginalized communities. This sector has been gradually building expertise to support persons with mental health problems to live successfully in a social housing environment. Access to social housing however is dependent on meeting selection criteria and this option may not always be available for some persons living with mental health problems.

Capital funding for the development of social housing projects has come from the Société d'Habitation du Québec (SHQ) and the municipality. Collaboration between the social housing sector and the mental health sector is well established. For example, in both Montreal and Québec city regions, the social housing sector and mental health service provider community have been able to develop successful models of housing and supports. Note that the rent supplement program in Québec, Programme de Supplement au Loyer (PSL) is administered by the SHQ. (Also of note, the hospital sector is not eligible to access any rent supplements from the SHQ for their clients).

PROGRESS TO DATE: KEY INITIATIVES

Planning in the area of housing for person living with mental health issues has been guided by an integrated approach at the Ministry level. For example, the Ministère de Santé and Services Sociaux in partnership with the

[228] Plan d'Action en Santé Mentale (2005-2010),p.40.

[229] Ministère de la Santé et des Services sociaux et la Societé d'habitation du Québec (2007). *Cadre de référence sur le soutien communautaire en logement social : une intervention intersectorielle des réseaux de la santé et des services sociaux et d'habitation.*

Société d'Habitation du Québec have developed an integrated policy document that informs and guides the social housing community and the community support specialists to work together to successfully house marginalized populations in need of support in the social housing environment.

- **Community supports and social housing policy**: Cadre de référence sur le soutien communautaire en logement social: une intervention intersectorielle des réseaux de la santé et des services sociaux et de l'habitation, Ministére de la Santé et des service sociaux et la Société d'Habitation du Québec, Gouvernement du Québec, 2007.

The provincial policy framework informing mental health planning in Québec is the Plan d'Action en Santé Mentale (2005-2010). This policy 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.

- **Mental health policy**: Plan d'Action en Santé Mentale : La force des liens, Ministère de la Santé et des Services sociaux, 2005.

RANGE OF ACCOMMODATION AND HOUSING OPTIONS

In Québec, a subtle distinction is made between residential accommodation (hébergement) and housing (logement) options. Within the range of "hébergerment" (i.e., accommodation resources), the consumer is typically a 'resident' and is likely not to have tenant responsibilities. In contrast, in the "logement" housing options listed below, the consumer usually assumes the role and responsibility of tenant. One indicator for this distinction resides in 'who' signs the lease.[230]

Together both categories of options provide consumers with a broad continuum of living options that varies from a highly structured community-based living arrangement with supports towards more independent and autonomous living options (also associated with varying degrees of supports).

HOUSING FOR THE POPULATION OF PERSONS LIVING WITH SERIOUS MENTAL HEALTH PROBLEMS FUNDED THROUGH THE MINISTÈRE DE SANTÉ ET SERVICES SOCIAUX (MSSS)

In Québec approximately 9,000 adults living with serious mental health problems are living in "structured community-based residential housing" which is funded through the MSSS. A summary of the different types of residential housing and associated community supports is provided in the table below.[231]

Table 1. *Range of housing and accommodation options and descriptions in Québec.*

Range of Housing Options	
Types of Accommodation	**Description**
Housing resources available through non-profit/for-profit sectors	
Independent apartments from non-profit housing organizations (with or without supports) Apartements autonome à but lucrative (avec ou sans soutien)	▪ Social housing ▪ Social housing co-op ▪ Social housing for family unit
Independent apartments from the for-	▪ Funded in part through individual rent supplement (programme de

[230] Vincent, K. & Morin,P. (2010). *Le logement subventionné : dans le cadre de programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté - Source d'inspiration pour créer des modèles innovants*. Agence de la santé des services sociaux de la Capitale-Nationale et la Societé d'Habitation du Québec, p. 25.
[231] Source: Plan d'Action en Santé Mentale (2005-2010) p.53.

profit housing stock (with or without supports) Apartements autonome à but non lucrative (avec ou sans soutien)	subvention au loye - PSL) administered by the Société d'habitation du Québec (SHQ)
Structured community-based housing available through the "établissements" of the MSSS	
Long term care milieu accommodation resources	▪ Long term care facilities (Centre d'Hébergement et de Soins de Longue Durée – CHSLD)
Intermediate accommodation resource Ressources intermédiaires	▪ Legally sanctioned structured community based housing resources as defined by article 302 of the Loi sur les services de sante et les services sociaux ▪ Goal is to support integration into the community by providing both accommodation and supports as required ▪ The physical housing resources and the associated supports are not provided directly by the public institutions (i.e., établissement) who are managing the program but contracted to providers in the community (the only exception to this is the child protection sector) **Types of models typically available:** ▪ Supervised apartments (client resides but does not have tenant status) ▪ Rooming house milieu ▪ Staff-run group home ▪ Group home living (with supports provided by staff not living in-house) ▪ Emerging models (the legislation allows for the creation and development of new models)
Family centered accommodation resources Ressources de type familiale	▪ Accommodation is provided in the context of participation in a family-life milieu
Supervised apartments Apartements supervises	▪ Living accommodation in individual apartment settings with varying intensities of supports as required (consumer has status of resident)

Table 2. *Overview of provincial capacities for structured "community-based residential accommodation" resource options as noted in the Plan d'Action en Santé Mentale (2005-2010).*

Type of housing or residential service	Description of housing type	Governance	Provincial total (# of individuals)
Centre d'hébergement et de soins de longue durée (CHSLD) Long term care (persons with SMI)			937
Resources Intermédiare (as defined by Article 302 of the LSSSS legislation)	▪ Housing (service d'hébergement) and support services delivered by various agents (individual, community agency or private company) ▪ Community supports are provided by the professionals linked to the "établissement public référent" ▪ Housing can be: group home, rooming house, supervised apartments ▪ Provincial guidelines ▪ http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2001/01-801-01.pdf Funding Stream: Ministère de Santé et Services Sociaux via an "établissement public référent" (i.e., general hospitals or psychiatric hospitals or regional Centre de santé et des services sociaux)	-contracts with a hospital to provide housing / residential services	2,967
Resource type familial (as defined by Article 302 of the LSSSS legislation)	▪ Foster family model provides both housing and 24/7 community support for a maximum number of 9 residents ▪ Provincial service quality guidelines: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2002/02-821-01.pdf Funding Stream: Ministère de Santé et Services Sociaux via Hospital "établissement public"	-contracts with a hospital to provide housing / residential services	4,385
Resource Autres Organismes communautaires d'hébergement (as defined by Article 108 of the LSSSS legislation)	- independent apartment/housing units; -community supports and/or supervision contracted out to community service organizations		451
Independent living units with community support	▪ Apartment units and community supports delivered through case management or PACT Funding Stream: Ministère de Santé et Services Sociaux via Hospital "établissement public"		491 (under-estimate noted[232])

[232] Ministère de la Santé et des Services Sociaux (2005). *Plan d'Action en Santé Mentale 2005-2010*, p.53. As noted in the PASM, this figure is well below the expected benchmark of 50 per 100,000 of population

Table 3. *Dedicated Housing Options: Structured community based accommodation.*

Region	Agency	Type	Capacity
Provincial total	Mandated public institutions (établissements public)	Refer to Table 2	8,331

Table 4. *Non-Dedicated Housing Options*[233].

Region	Program	Type	Capacity
Provincial total	Municipal Housing Programs Office Municipal d'habitation (OMH)	Total number of units	62,883
Provincial total	Co-operative and other non-profit housing corporations Co-op et Organismes a but Non-Lucratif (OBNL)	Total number of units	6,234
Provincial total	Aboriginal off-reserve Autochtones hors reserves)	Total number of units	1,926
Provincial total	Inuit	Total number of units	2,124
Total – all programs			73,167

Table 5. *For-profit rental market*[234].

Region	Agency	Type	Target Population	Capacity
Provincial total	Rent supplements allocated to the for-profit rental market	Rental units	Social housing population	7,174 rent supplements

MENTAL HEALTH SUPPORTS

OVERALL FINANCIAL INVESTMENTS FOR MENTAL HEALTH

The total funding envelope for all mental health services in the province of Québec was $ 757,121,108 in the 2002-03 fiscal period. (This excludes the cost of physicians and drug plans. This sum represented 6.2 % of the total health funding.

According to a recent analysis by the Institute of Health Economics[235] (Jacobs et al., 2010), the following were the total expenditures on mental health and addictions services[236] in Québec for 2007/08:

[233] Vincent, K. & Morin,P. (2010). *Le logement subventionné : dans le cadre de programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté - Source d'inspiration pour créer des modèles innovants*. Agence de la santé des services sociaux de la Capitale-Nationale et la Societé d'habitation du Québec, p. 22.
[234] Ibid.
[235] Institute of Health Economics (2010). *The Cost of Mental Health Services in Canada*. Alberta, Canada. P.10.
[236] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.

- $737.2 million for inpatient care[237] ($487.3 million in general hospitals and $205.4 million in psychiatric hospitals).
- $248.8 million for physician services ($51.2 general practitioners – fee for service, $83.9 specialists – fee for service, and $113.7 million for psychiatrist on alternative payment schemes).
- $682.3 million for community and social services ($565.4 million for community mental health, $5.4 million for employment support, $99.8 million for addictions, and $11.7 for First Nations mental health and addictions services).

INCOME SUPPORTS

The Department of Employment and Social Solidarity is responsible for the delivery of the provincial social assistance program (Last-Resort Financial Assistance). The Last-Resort assistance program includes the Social Assistance Program and the Social Solidarity Program. LRFA is governed by the **Individual and Family Assistance Act** and the **Individual and Family Assistance Regulation**. Financial assistance consists of a basic benefit, paid monthly, which may be supplemented by an allowance for individuals who are facing temporary or severe employment limitations.

The basic benefit covers the cost of food and clothing, shelter, as well as personal and household items for adults only. Maximum basic benefit rates are based on family composition. For the additional benefit for temporary limitations to employment, the individual must be aged 55 or older, unable to participate in the labour market for health reasons for a period of time no greater than 12 months, caring for a child who is aged five years or younger, or pregnant. In order to receive the solidarity allowance (allowance awarded to people with severe employment limitations in the Social Solidarity Program), the person's physical or mental state must be significantly altered or deficient for what will most likely be a permanent or indeterminate period of time.

The Québec Family Allowance (created in 1997 – effectively removing children's benefits from the social assistance system) was a non-taxable amount paid monthly to help low-income families with the cost of raising children under 18 years of age. The **Régie des Rentes du Québec** was responsible for administering the Québec Family Allowance. As of August 2004, families were entitled to receive a Family Allowance in the amount of $625 per year per child. Single-parent families could also receive an additional family supplement of $1,300 per year. An additional amount of $1,431 was provided for each child with disabilities.
Total income for a single individual with a disability was estimated at $10,630 (includes basic social assistance, other provincial/territorial benefits and GST credit)[238].

According to the Federal-Provincial-Territorial Directors of Income Support Social Assistance Statistical Report, 2007 (May 2010, p.51-57):

- Clients are eligible for the following monthly exemptions on **earned income**:
  - Clients with no limitations to employment: $200 for singles, $300 for families
  - Clients with temporary limitations to employment: $200 for singles, $300 for families
  - Clients with severe limitations to employment (Social Solidarity Program): $100 for singles and families
- In March 2007, there were a reported 499,600 recipients/341,500 cases receiving Last-Resort Financial Assistance (roughly 350,300 recipients/213,800 cases for Social Assistance Program and 149,400 recipients/127,800 cases for the Social Solidarity Program)[239].

[237] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.
[238] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability,* Bulletin Number 2.
[239] Federal-Provincial-Territorial Directors of Income Support, August 2009. *Social Assistance Statistical Report, 2006.*

- Percentage of cases receiving the basic benefit for social assistance was 38%, cases receiving basic benefit plus an allowance for temporary employment constraints was 24%, and 1% were receiving a combined allowance (i.e., two members in the household are subject to temporary employment)[240], 36% of cases were receiving the social solidarity allowance, and 1% were receiving the social solidarity basic benefit.
- Approximately 20% of cases had been receiving assistance for one year or less, and 49% for more than five years as of March 31, 2007.

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

INNOVATIONS AND EXPERTISE DEVELOPED IN QUEBEC IN HOUSING AND RELATED SUPPORTS

This section gives but a few examples of the innovations and the expertise developed in Quebec in regards to housing and related supports. Site visits conducted by researchers enabled the identification of certain promising practices. Please note this is only a small number were captured and the extent of promising practices is more extensive than what the length of the report allowed.

Protocol to Monitor and Enable Consumers' Self-administration of Medication
The "Direction des services de réadaptation et d'hébergement dans la communauté " of Montreal's Louis-H. Lafontaine Hospital has developed and implemented a standardized tool and approach for the self management of medication in all of their community residences. The six phased process describes the goal and the steps to self-administration of medication by consumers. This user-friendly tool provides guidance for staff to monitor and identify where the consumer has progressed on the continuum of independence and enables a staged acquisition of this independent life skill area. It is a gradual process ensuring consumer's safety and insight in monitoring their own medication.

Supporting Service Providers with System Change
The Psychosocial Rehabilitation and Residential Resource Program of the Douglas Mental Health University Institute have begun to support system transformational changes required by the government to offer more independent long-term housing with support services. The Douglas team is working with their partners from the private and community sectors to integrate and align to the new paradigm in mental health housing. We visited two private service providers who have invested and have acquired space to offer long-term independent housing with support. Firm commitment to the values of emerging models and the vision of the client-centered and empowered approaches are essential to ensuring the success of this transformational change. Leadership and flexibility to educate and support service providers on the benefits of these models are key to making it happen.

Evaluation Framework to Maintain Program Fidelity and Quality
Community organizations are often challenged to integrate evaluation mechanisms and processes that enable them to maintain fidelity to evidence based practices and ensure quality. "Le Mûrier" which manages a large spectrum of housing and support service programs which are delivered to different target populations chose to invest in developing and implementing an evaluation framework in order to continually improve their services. They hired a consultant for the development of the initial evaluation instrument and have continued to tailor it to meet the changing needs.

The evaluation instrument is comprised of 12 assessment grids which 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 establishing 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 with clients' needs, organizational assets and challenges and environmental realities. The organization has fine tuned and tailored the instrument over the years and continues to increase its efficiency. The instrument and the process benefit the orientation and training of all staff.

[240] Ibid.

CHALLENGES IN HOUSING & RELATED SUPPORTS

ESTIMATING NEED AND COST FOR INDEPENDENT HOUSING WITH SUPPORTS FOR PERSONS WITH SERIOUS MENTAL ILLNESS IN QUÉBEC

A Québec benchmark proposed by Lesage (2003) identifying the number of persons (aged 18 years and over) living with mental health problems and who would need independent living units with community supports is estimated at 50 per 100,000 of population[241]. Using this benchmark against the 2003 Québec population number of 7.5 million[242], a need for 3,750 independent living units with supports to address the housing needs of adults with serious mental illness is suggested.

A recent study by Vincent & Morin (2010)[243] to assess the need for social housing for persons living with serious mental illness is proposing a provincial need to be at 1200 (also noted as an under-estimate of the real need)[244] as a realistic starting point. The study has costed-out a successful model for housing persons with severe mental illness through the rent supplement program coordinated with associated community mental health supports. As such, the cost per person in this model is $6,750 per year per person (this cost includes both the cost for rent supplements and community mental health supports). The total investment to meet this initial proposed target would be $8,100,000 (see upcoming Supplementary Information section for more details).

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

There is a movement towards less and less supervised housing resources (i.e., structured community-based residential resources).

The Plan d'Action en santé mentale (2005-2010) highlights the need to transform residential mental health system towards independent housing options with supports. However there are important criteria that are identified that should be met in order to build this new capacity in mental health housing options. Namely, a transformed service model for housing and supports would consider and balance the need for independence, safety of the individual, individual choice in regards to living options, and the individuals own capacity.

Other trends to highlight include movement towards less intensity of services and the increasing role of peer support and foster families.

Peer support worker role to be formalized
In Québec, the role of the peer support worker is being formalized in legislation. This significant development will bring lasting changes through the creation of a new structure that defines peer support workers in a formal role within the public sector.

Supervised residential services
A service quality improvement initiative in the supervised residential housing sector is presently being implemented provincially which is aimed at improving housing quality in the supervised residential milieu.

Recent research to build a case for rent supplement model (Québec city)

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[241] Lesage, A. et al. (2003). Canadian Journal of Psychiatry, *"Towards benchmarks for tertiary care for adults with severe and persistent mental disorders",* vol. 48, no. 7, pp. 318-320.
[242] Institut de la statistique (2004). *Démographie: si la tendance se maintient...Perspectives démographiques ,Québec et régions 2001-2051*, p. 7.
[243] Vincent,K. & Morin,P. (2010). *Le logement subventionné : Dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté – Source d'inspiration pour créer des modèles innovants,* Province de Québec avec la participation de Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec.
[244] Ibid, p.53.

Recent research study by Kristalna Vincent and Paul Morin (2010) has identified a strategy to increase placement capacity in independent apartments. One of the recommendation is to increase the rent supplement funding envelop in order for persons with mental health problems to access housing stock in the private rental market. This model has some appeal because of its portability and applicability to other marginalized populations in need of housing supports. This model however assumes that the mental health community supports would be accessed from current community mental health service capacity.

ISSUES IN DIALOGUE: CONSIDERATIONS AND REFLECTIONS

Potential risks with the trend towards more independent housing options

1) A delicate balance will have to be achieved in order to prevent imposing (by professionals and service agencies) the idea that independent living is the sole or preferred option of all consumers. It needs to be grounded in consumer choice rather than to be ideologically driven. Independent living with supports, need to be made available for consumers who choose this option. However, this option may not necessarily be the preferred option for some consumers. The risk here is imposing a solution that serves the interest of the agency but not necessarily the interest of the consumer.

A key risk therefore is "top-down" imposition by service agencies of "independent living" options rather than the consumer coming to that choice.

2) Another critical risk area: **the building of capacity for the community mental health supports** may not follow pace or be developed fast enough which will result in persons not having the supports in the community they require.

What does the evidence say to date?

While there are plenty of policy and planning documents advocating for "autonomous housing" as a best or preferred policy direction for this population, a Cochrane meta-analysis looking at housing models for persons with mental health problems has concluded that, to date, there is not one housing model that appears to be producing better outcomes when compared to others.

SUPPLEMENTARY INFORMATION

APPENDIX A – COSTING RENT SUPPLEMENTS AND COMMUNITY MENTAL HEALTH SUPPORTS

Costing independent accommodation and supports for persons with serious mental illness – Québec perspective in social housing

The Régie Régionale de la Santé et des Services Sociaux in Québec (2002) highlighted the importance of social housing as an option for persons with serious mental illness. It outlines that independent accommodation with supports promotes more engagement as citizens, brings a sense of being at home, access to support services linked to independent housing, and affordability.[245]

Social housing and community supports for persons with serious mental illness at $6,750 per year

The Fortin & Morin (2010) study called "Le Logement Subventionné"[246] has estimated that the number of persons with serious mental illness who would meet various criteria for independent housing accommodation with

[245] Vincent,K. & Morin,P. (2010). *Le logement subventionné : Dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté – Source d'inspiration pour créer des modèles innovants,* Province de Québec avec la participation de Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec, p. 46.

[246] Vincent,K. & Morin,P. (2010). *Le logement subventionné : Dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté – Source d'inspiration pour créer des modèles innovants,* Province de

accompanying community supports to be at a minimum 1200 persons for the province of Québec. The cost to address this need through the rent supplement program would be $4,500,000. The estimates for the accompanying community mental health supports are $3,600,000 annually. The total commitment represents $8, 100,000 per year or $6,750 per person with serious mental illness housed.

Costing of the rent supplements program in the province of Québec

The prevalence rate for serious mental illness in the general population is estimated to be 2.5 %. This means that the number of persons (age 18-64) with a serious mental illness in Québec in 2006 was 125,123 individuals.

Based on a number of criteria and assumptions the Fortin & Morin (2010) study suggests that at a very minimum the need to be for 1200 additional rent supplements (this represents 10% of the total need they estimated). However the study recommends as a starting target that Québec increase the number of rent supplements to the SMI by 1200. At a cost of $3,750 per person per year, this would represent a total provincial cost of $4, 500,000 annually.

Cost for community mental health supports

The cost for associated community mental health supports per persons per year is defined in the study at $3,000 per person per year for a total estimate of $3,600,000 annually to meet the minimum need.

Québec avec la participation de Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec.

SASKATCHEWAN

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of Saskatchewan is approximately 968,200 (Statistics Canada, 2009) with an unemployment rate of 4.8% compared to a rate of 8.1% across Canada (Statistics Canada, 2010). Indeed, Saskatchewan was the only province that had significant growth in employment in 2009 (Government of Saskatchewan, 2010). Highlights from the 2006 Census Analysis Series include:

- A rate of **population growth of -1.1%** since 2001, significantly different from the positive national average of 5.4%. Saskatchewan is one of only two provinces with a negative rate of growth (with Newfoundland & Labrador at -1.5%).
- An **aging population**, consistent with all other regions across Canada, where 15.4% of the population is aged 65 and over (compared to 13.6% nationally) – the **highest rate in Canada**.
- The census enumerated 141,890 people reporting **Aboriginal identity** in Saskatchewan in 2006, representing 12% of the national total, or nearly 15% of Saskatchewan's population.
- The **Aboriginal population is becoming increasingly urban**. In 2006, 54% lived in an urban centre, an increase from 50% in 1996. Urban areas include large cities, or census metropolitan areas, and smaller urban centres. In comparison, 81% of non-Aboriginal people were urban dwellers in 2006. The difference between the two proportions is due mainly to the large share of First Nations people who live on reserves.
- Of the 387,145 households in 2006, **71.8% owned the dwelling** they lived in (consistent with the national average) – this represents an increase of 1% since 2001 (significantly less than the national average). Of owner households, 49.2% held a mortgage, which is the second lowest rate across Canada (national average of 57.9%).
- The median price Saskatchewan homeowners expected to receive for selling their home was $119,875 in 2006, well below the national median of $200,474
- A relatively high percentage of households in Saskatchewan (just over 10%) identified that their dwellings required major repair. 2.6% of households in the province lived in band housing, of which 55% of dwellings were identified as requiring major repairs.
- The proportion of households **spending 30% or more of their income on shelter was well below the national average** of 24.9% at 20.4% (up from 19.6% five years earlier).
    - Of owner households, 13.1% spent 30% or more of their income on shelter; 39.8% of renter households spent 30% or more
    - One-fifth (20.4%) of the 80,320 households in Regina spent 30% or more of their income on shelter (11.9% of owner households compared to 40.6% of renter households)
    - While the median household income increased by 2.4% from 2001 to 2006, the average rent for a two-bedroom unit in the province rose by 16%

There is an increasing income gap in Saskatchewan: in 2007, the top 10% of families with children under 18 years had an average income of $228,600 compared to the poorest 10% of families at $16,400. Over the last twenty years, the top 10% saw their incomes rise by two thirds compared to a 30% gain by the bottom 10% - low to middle incomes grew by around 20% (Douglas & Gingrich, 2009). This is set against a background of increasing costs for the rental market and the housing market in general (Huang, 2009):

- Average house prices rose to $234,600 in 2008, up 37% from 2007. Regina was one of the few jurisdictions that did not see a steep decline in housing prices. Rental units were also harder to find in Regina.
- Between 1997 and 2007, there was a **net loss of 500 rental units** in Regina and the **vacancy rate stood at 0.5%** at the end of 2008.

The Canadian Council on Social Development, in its social development series in 2009 (Holden et al.), discusses the rapid decrease in the affordability of housing in Saskatchewan in recent years:

- The economic prosperity enjoyed across the country prior to the recession had a significant impact on declining affordability
- The RBC Financial Group estimated Saskatchewanians spent 29.3% of their before-tax income on a detached bungalow at the beginning of 2006 – by the end of 2007, this had increased to 40.4% of income; similarly, the percentage of income spent for people living in a townhouse increased from 23.3% to 34.1% by the end of 2007
- Canada Mortgage and Housing Corporation data demonstrated that during the same period of time, the average price of renting a two-bedroom apartment increased 15.9% to $766

In 2008, a Saskatoon Homeless Count was conducted by the Community University Institute for Social Research. Two surveys were conducted, one that was directed to service providers to capture the number of people who were homeless but sheltered (for a total of 183 people staying in places such as emergency shelters, safe houses, and transition houses) and the second was an outdoor survey to capture people who were absolutely homeless (total of 40 people). Findings, as reported at the 2008 Saskatchewan Housing Forum, included:

- Most respondents had been homeless for less than a year.
- Most people were not on a housing waiting list
- Perceived housing affordability and availability were the main barriers to finding housing

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

- The **Ministry of Social Services**, through the **Saskatchewan Housing Corporation** (SHC), promotes self-sufficiency and independence by providing housing and housing services for families, seniors, persons with disabilities, and others who could not otherwise afford safe, secure shelter. The Ministry's portfolio also includes income support, child and family services, and supports for persons with disabilities[247].
- The SHC is a Treasury Board Crown Corporation accountable to Cabinet through the Minister of Social Services. Legislative authority is provided by The Saskatchewan Housing Corporation Act. The Act establishes a Board of Directors to conduct the affairs and business of the Corporation.
- The **Ministry of Health** oversees strategic direction and coordination of the health service delivery system in the province. The majority of services are delivered through the **12 regional health authorities** and affiliated organizations who have agreements with the regional health authorities.

PROGRESS TO DATE: KEY INITIATIVES

The **Task Force on Housing Affordability** was struck by the Minister of Social Services in 2008 to make recommendations on:

- Improving housing affordability and security for those least able to afford rising housing costs
- Increasing capacity in the housing system to encourage the creation of affordable housing
- Examining how best to facilitate the long-term monitoring, policy development, and provisions of affordable housing in Saskatchewan.

The government, in response to the Task Force, has since increased shelter allowances in all of its income support programs, amended income thresholds for rental increases, increased per-diem rates paid to emergency shelters,

[247] http://www.socialservices.gov.sk.ca/housing/

and expanded the Saskatchewan Housing Authority Board. The provincial budget for housing in 2009-10 was increased to $30 million, from $22 million in the previous fiscal year, with a commitment to increase the supply of affordable housing.

The Ministry of Health has developed a strategic plan for mental health which focuses on people with complex needs, as well as addressing waiting list issues. The plan was informed by the "Patient First" Review released in October 2009. The **broader health strategy** for the province (Healthy People, Healthy Province, 2001) identifies that primary health care teams, which include mental health and addictions as core services, would be accessible across Saskatchewan within a 10-year timeframe.

RANGE OF HOUSING ACCOMMODATIONS

Table 1. *Overall range of housing options in Saskatchewan.*

Dedicated Mental Health Housing	▪ Housing with supports: group homes and apartments ▪ Mental Health Approved Private Service Homes
Non-Dedicated Affordable Housing	▪ Affordable Housing Rental program ▪ Social Housing Rental program ▪ Special purpose units ▪ Family Housing Supplement ▪ Disability Rental Housing Supplement ▪ Co-operative housing ▪ Rent Supplement Program
Additional Facilities or Housing Options	▪ Emergency and transitional shelters ▪ Personal Care Homes ▪ Special Care Homes (Nursing homes) ▪ Residential options for people with intellectual disabilities: group homes, group living homes, supported independent living programs, supported apartment living programs, Valley View Centre, North View Home, South View Home, and Approved Private Service Homes

DEDICATED MENTAL HEALTH HOUSING

Dedicated mental health housing is provided through both non-profit organizations and through health regions. Non-profit, community-based housing providers often struggle to secure the appropriate supports for tenants living with mental health issues. One of the challenges in identifying the amount of "dedicated" housing is that organizations may have a broader mandate (i.e., independent living focus), although some of the housing options may specifically target people with mental health issues. In addition, most mental health services are delivered by the health regions and all case management services, including providing assistance in securing housing, are delivered by employees of health regions.

As detailed in the 2008/09 Community Care Branch of the Ministry of Health, there are **three main types of dedicated mental health housing**: group homes, apartments, and Approved Homes. The Approved Homes are mandated to serve people with intellectual disabilities, physical disabilities, and/or complex needs, and the population of focus depends on the funder (e.g., Approved Homes that focus on people with intellectual disabilities are funded by the Ministry of Social Services). Approved Homes, as discussed in this section and in accordance with licensing under the Mental Health Act, refers to those homes that specifically target people with mental health issues. The Community Care Branch notes the following issues:

- There has not been significant growth in residential options over the last few years which is a growing problem
- As private operators of Approved Homes retire, it can be difficult to recruit new operators
- Residential options for people with higher needs is a significant problem

- There is considerable variation in availability of residential spaces across regional health authorities (e.g., there are no residential spaces in two of the regions)

Both group homes and independent living apartments have a range of supports available to tenants (there may be some group home arrangements where people would be considered residents) – the type and level varies. In general, these housing options are delivered by "Health Care Organizations" (HCOs). There are roughly 30 such organizations across the province, a proportion of which would be providing mental health housing. Two of the larger organizations are profiled below:

- Phoenix Residential Society (Regina): Provides a variety of housing support services, including services for people with concurrent disorders and people at risk of homelessness, a supported apartments program, a psychosocial rehabilitation focused program, and a program for people with acquired brain injury. Phoenix typically negotiates agreements with landlords to rent blocks of apartments. Phoenix has a new housing project in process which would result in the creation of a 40-unit apartment building which would serve at risk people with substance abuse problems, in partnership with the city, Saskatchewan Housing Corporation, and the CMHA.
- Saskatoon Housing Coalition: Provides a range of housing options (from 24-hour staffed group home to apartment buildings). The Coalition works closely with the health region and is considered a health service provider. The Coalition owns the buildings they operate. Tenants are supported by community mental health workers. The Coalition has done a number of demonstration projects and most recently received funding to develop a service model for people with serious hoarding issues. They also have staff assigned to assist people who are coming out of acute care or the emergency room in securing needed housing and support services.

Approved Private Service Homes (APSHs) are licensed private community homes that provide a family atmosphere and daily living supports for one to four people with intellectual disabilities and/or physical disabilities (or other complex needs) of which there are a total of about 650 across the province. APSHs licensed under the Mental Health Act are designated for people with mental illness. Homes provide residents a chance to develop social, recreational, and living skills. Private owners are paid each month for caring for the people in their home. The amount they are paid depends upon the level of care and support each resident needs. There are just under 790 beds licensed under the MHA. The Government of Saskatchewan is in the process of rolling out a $6 million annualized enhancement to Approved Home Programs (split between Social Services and Health) intended to provide respite for operators and community supports to residents. There will be a total of 14 annualized projects being implemented over a three-year period – to date, four projects have been funded via Health, with an additional three projects in 2010/2011 (Ministry of Social Services 09-10 Annual Report, 2010).

The most significant **"growth" in dedicated mental health housing** has been in the independent living apartments over the last five years (from 250 spaces in 2004/05 to 291 in 2008/09). Beds in APSHs increased from 771 beds to 788 beds, and spaces in group homes decreased from 39 to 29 over the same time period.

Table 2. **Dedicated Housing Options in Saskatchewan.**

Region	Group Homes		Apartments	Approved Homes		Total Community Beds
	Number	Capacity	Capacity	Number	Approved Capacity	
Cypress				3	15	15
Five Hills			47	12	53	100
Northern						
Prairie North	1	8	8	34	134	150
PA Parkland	2	10	40	16	51	101
Regina Qu'Appelle			86	26	109	195
Saskatoon	1	5	56	81	357	418
Sun Country	1	6	25	3	5	36
Sunrise			29	19	64	93
Total	5	29	291	194	788	1,108

Source: reproduced from Ministry of Health Community Care Branch, Community Program Profile, 2008/09, Appropriateness Indicator 8 - Residential Placements by RHA 2008/09, p.35

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

The Saskatchewan Housing Corporation (SHC) subsidizes approximately 30,500 units across the province. Of these, 23,500 are owned by the province and operated directly or through **local housing authorities**. An additional 5,500 are special purpose housing units. The remaining 1,500 units are home ownership units that were delivered by SHC[248]. All units within the SHC portfolio target families or seniors, although there are a limited number of buildings for people with higher levels of need. SHC has provided capital funding support to some non-profit organizations who do serve people with mental health issues (sometimes specifically, and sometimes as part of a larger target population). Non-profit providers use a variety of different models to support ongoing operations and support of their units: they may use a mixed income or mixed health status (or some combination of these approaches) in the assignment of units so that the income and support needs of the tenants vary in such a way that affordability and support needs can be met.

The SHC's 2009/10 allocation from the Ministry of Social Services is $18.845 million – the Ministry identifies an additional budget line of $11.391 million for housing operations.

The Rental Housing Supplement is specifically geared to families and people with disabilities and is funded via income assistance programs. In addition, there are some limited partnerships with Single Room Occupancy (SRO) hotels in terms of capital grants that have been used for renovations or subsidy assistance.

There is some support available to tenants in the public housing system through the **Regional Health Authorities** (by both contracted individuals and salaried staff). Additionally, the Saskatchewan Housing Corporation provides some limited supports to facilitate the formation of **tenants' associations** in their buildings. These associations organize various social and recreational activities, and there is often some informal peer support that occurs.

[248] Ministry of Social Services 2009/10 Annual Report.

Table 3. *Non-Dedicated Affordable Housing Options in Saskatchewan.*

Program	Description	Capacity
Saskatchewan Housing Corporation	Total Housing Portfolio	30,500 [249]
Affordable Housing Rental Program	Enables eligible moderate-income families and individuals to access suitable, affordable rental accommodations. The program's objectives are to alleviate the shortage of quality, affordable housing for moderate-income families and individuals in larger-market communities and create a supply of rental housing in communities where there is limited private market rental accommodation. Rents are set at the low end of the market.	23,500 units (part of the overall total for the Saskatchewan Housing Corporation)
Social Housing Rental Program	The Social Housing Rental Program provides quality, suitable, affordable rental housing for low-income seniors, families, and people with disabilities. Rent is based on income, with priority given to lower-income households, families in crisis, and those with health and/or social needs.	
Special purpose housing units	Operated by non-profit providers, these social and affordable housing units target people with special needs and provide appropriate supports.	5,500 (part of overall total)
Family Housing Supplement, Disability Rental Housing Supplement	Benefit paid to low-income families with children or low-income individuals with disabilities to cover the gap between market rent and appropriate rent-geared-to-income level (less than 30%). Random inspections of residences are undertaken and SHC provides financial assistance to rental property owners to bring their properties to a standard so that tenants can qualify for the Rent Supplement programs. Of the initial inspections, 82% passed for 2009/2010. Of those that failed, 93% undertook upgrades to meet health and safety standards.	4,160 families received the FHS 2,040 households received DRHS
Co-operative housing	Between 1973 and 1991, CMHC participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme, however, is that all of these co-operatives provide some type of financial support. Housing co-ops are member-owned and controlled organizations. The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs. The federal government ceased funding new development at the end of 1991, but continues to honour its operating agreements with existing co-operatives, which house **over 92,000 members across Canada** under these legacy programs.[250]	841 units in 17 co-ops in Saskatoon, Regina, Moosejaw, and Moosomin

[249] Number of units and funding where available is based on interviews with government contacts, the Conference Board of Canada (March 2010, p.84-86), and the Ministry of Social Services 2009/10 Annual Report.
[250] Co-operative Housing Federation of Canada.

Program	Description	Capacity
Rent Supplement Program		1,263 units, average $282 supplement paid, $4.123M in 2008/09

ADDITIONAL INITIATIVES AND INFORMATION

Affordable Housing Initiative/Canada-Saskatchewan Affordable Housing Program Agreement: Based on the housing framework agreed to in **November 2001** by federal and provincial/territorial housing ministers, 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 a grant, a stream of ongoing subsidies or the value of in-kind contributions (e.g., land). Within these terms and 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. The program was intended to create close to 1,500 units of affordable housing for households on social housing lists, or those eligible to be on such lists. As of June 30, 2010, virtually all of this funding had been committed and/or announced for 1,466 units ($41.08 of the total $41.20 provincial share)[251].

Through **economic stimulus funding** together with funding from federal housing trusts, $102.2 million will be spent on renovating the existing social housing portfolio from 2009-2012 (cost-shared between federal and provincial governments).

In May 2009, the governments of Saskatchewan and Canada signed a multi-year extension to the **Affordable Housing Initiative**. They also agreed to one-time, two-year economic stimulus funding under **Canada's Economic Action Plan** for renovations of existing social housing units, and for development of new housing for low-income seniors and people with disabilities. The total federal-provincial investment in this initiative is **$147.6 million**.

Since 2007, SHC has committed to develop **1,830 affordable rental and homeowner units across the province**. Each new investment has a multi-year life which has the potential to serve several individuals and families.

Homelessness Partnering Strategy: Launched on April 1, 2007 by the federal government, the program built on the foundation of its predecessor, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five-year commitment. Of the 61 "Designated Communities" funding component under the strategy, Saskatchewan has three: Prince Albert, Regina, and Saskatoon. A key focus of the HPS is a *Housing First* approach and focuses on transitional and supportive housing as important ways to move individuals out of homelessness.

- Federal funding was also confirmed for a two-year extension to the **Residential Rehabilitation Assistance Program** (RRAP). Saskatchewan's funding allocation from the federal government is $10.2 million over the next two years (2009-10 and 2010-11). The provincial investment is $3.4 million (25% share).
- **Saskatchewan Rental Repair Program**: Provides a one-time forgivable grant, ranging from $6,000 to $9,000 per unit for landlords to complete major repairs. 99 units to date.
- **Encouraging Community Housing Options (ECHO)**: Provides financial assistance to help non-profit and private corporations, housing co-operatives, and municipalities determine the feasibility of a housing project and develop affordable housing. Loan of up to $10,000 for a feasibility analysis. Also provides a loan for the development of affordable housing, ranging from $5,000 to $45,000. 68 projects to date.
- **Remote Housing Program**: Assists low- to moderate-income families in the North to build their own homes (forgivable grants equal to 75% of the basic unit construction costs). 23 units to date.

[251] Canada Mortgage and Housing Corporation (June 30, 2010), National Afford Housing Initiative Funding Table. http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm

- **HomeFirst Rental Development Program**: Community-based organizations, developers, contractors, and municipal or other non-profit groups can access one-time forgivable loans to develop affordable rental units, ranging from $77,000 to $96,000 per unit. 1,256 units to date.
- **HomeFirst Northern Rental Option**: Community-based organizations, developers, contractors, and municipal or other non-profit groups can apply for one-time forgivable capital loans. 143 units to date.
- **HomeFirst Secondary Suites Program**: Homeowners and rental property owners can access forgivable loans for 50% of total construction/renovations costs to create secondary suites that low- to moderate-income households can access ($24,000 to $28,000 per suite). Three units to date.
- **Saskatchewan Emergency Repair Program (SERP)**: Provides financial assistance for emergency repairs required to ensure the continued safe occupancy of a home by low-income households in urban areas. $6,000 to $9,000 per unit. 87 units to date.
- **Saskatchewan Home Adaptations for Independence**: Provides financial assistance to low-income households to complete modifications to accommodate a household member with a disability (maximum forgivable loan of $3,500). 25 units to date.
- **Saskatchewan Home Energy Improvement Program (SHEIP)**: Provides financial assistance to low- to moderate-income homeowners and rental property owners with low-income tenants to make energy efficiency retrofits that reduce greenhouse gas emissions and make housing more affordable (tops up federal ecoENERGY Retrofit Program and SaskEnergy's EnerGuide for Houses Program). 6,200 households to date.
- SHC created partnerships with First Nations and Métis organizations to allocate the **Off-Reserve Aboriginal Housing Trust**. These partnerships provide off-reserve First Nations and Métis people in Saskatchewan with a means to access funding to improve housing conditions and expand housing options. As of March 31, 2010, 109 affordable units in nine projects are in development.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings where people with mental health problems and/or mental illness may be living, but aren't dedicated to serving this population. Within Saskatchewan this includes: **shelters, transitional housing** not specifically targeted to people with mental illness, **Personal Care Homes, Special Care Homes (nursing homes), and residential options for people with developmental delays**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity.

SHELTERS AND TRANSITIONAL HOUSING

According to figures from HRSDC, there were **approximately 670 beds** in Saskatchewan's emergency and transitional shelters in 2007[252], or 2.5% of the known shelter beds across Canada. There were **67 shelter beds per 100,000 population**, significantly below the 82 shelter beds per 100,000 people national average. The number of shelter beds is **likely an underestimate** because:

- It is based on the number of known shelters – there may be additional shelters not captured in this data set
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007

Also according to HRSDC, of the known 1,020 shelters identified across Canada as of March 2007, 723 or **71% were emergency shelters**, providing temporary and short-term accommodation for homeless individuals and/or

[252] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

families. Such shelters typically also offer essential services such as food, clothing, and counselling. Transitional shelters offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. Transitional shelters numbered 291 and represented a little more than 28% of the total. "There were, in addition, six shelters providing both emergency and transitional services, representing less than 1% of the total" (Human Resources and Skills Development Canada, 2011).

PERSONAL CARE HOMES

Personal Care Homes[253] are licensed and monitored by Saskatchewan Health but are privately owned and operated. The level and type of care varies from home to home but typically accommodate individuals with lighter care needs. Personal Care Homes operate in accordance with: the Personal Care Homes Act, the Personal Care Home regulations, and the Licensee's handbook. A home must be licensed as a personal care home if it provides accommodation, meals, and assistance or supervision with activities of daily living to an adult aged 18 and older who is not a relative. PCH consultants conduct regular inspections – as part of these inspections, they conduct an audit of random resident records to determine if level of care provided reflects care required.

Residents are responsible for paying the full cost of their own care and the government notes that subsidies are not provided because there is a publicly funded system of long-term care.

LONG-TERM CARE: SPECIAL CARE HOMES

Special Care Homes (SCHs) provide institutional long-term care services to meet the needs of individuals usually having heavy care needs that cannot appropriately be met in the community through home/community based services (also referred to as nursing homes). SCHs are designated by the Minister under **The Regional Health Services Act**. Regional Health Authorities may operate a special-care home directly or through an affiliation contract. Assessment and placement of individuals in SCHs is the responsibility of regional health authorities.

The provincial government funds SCHs through the regional health authorities – residents pay based on their income. As of October 1, 2010, the resident charge ranges from $984 to $1,871 per month depending on income. The minimum charge is $984 plus 50% of income between $1,197 and $2,972[254].

There were approximately 8,945 SCH beds in 2008. While the population aged 75 and over had increased by 5.9% between 2001 and 2008, the number of beds decreased by 3.2% leading to an overall 8.6% decrease in beds per 1,000 population aged 75 and over (Canadian Union of Public Employees, 2009, p. 8 citing Saskatchewan Health). Of the total beds, 92% were owned by non-profit entities, which compares to 65% of beds nationally (Canadian Union of Public Employees, 2009, p. 50 citing Saskatchewan Health).

RESIDENTIAL OPTIONS: PEOPLE WITH INTELLECTUAL DISABILITIES

Approximately 100 community-based organizations are funded by the Community Living Division of the Ministry of Social Services. A range of residential options and services for people with developmental disabilities are funded by the Community Living Division of the Ministry of Social Services[255]:

[253] Additional information available at http://www.health.gov.sk.ca/personal-care-homes

[254] Ministry of Health, http://www.health.gov.sk.ca/special-care-homes

[255] Descriptions from the Ministry of Social Services website, http://www.socialservices.gov.sk.ca/Default.aspx?DN=cc165a8f-c66b-443e-a7ce-ab007029e962 and the 2009/10 Annual Report

- **Group homes** – Licensed homes operated by community-based organizations (CBOs) that are staffed to provide personal care, supervision, and support for typically three to six adults with intellectual disabilities. Homes are located in residential neighbourhoods throughout Saskatchewan.
- **Group living homes** – Homes operated by CBOs for usually three to six individuals with intellectual disabilities who are responsible for paying their basic shelter costs. Often, the individuals are recipients of social assistance benefits (e.g., SAP or SAID). The Income Assistance and Disability Services division may provide funds to a CBO for personal care, supervision, and support services.
- **Supported Independent Living Programs** – Provides adults with intellectual disabilities living in their own residence with the limited support and supervision they may require to live as independently as possible. Examples of supports may include help with banking or shopping for nutritional foods. 436 people were using these programs as of December 31, 2009.
- **Supported Apartment Living Programs** – Provides an alternative for individuals who do not require the extensive supports of the group home program, but require more support than the supportive independent living program.
- **Valley View Centre** – Located near Moose Jaw, Valley View Centre provides 24-hour, seven-days-a-week residential services for 230 people with intellectual disabilities (as of March 31, 2010), many of whom have complex medical and behavioural support needs. No new admissions have been accepted since October 2002.
- **North View Home** – Located in Prince Albert and operated directly by the Ministry, the program provides 24-hour residential care in a community neighbourhood for five people with intellectual disabilities. The program also operates a provincial Crisis Support Program that provides outreach and residential supports for people in the community who have intellectual disabilities and complex needs.
- **South View Home** – Located near Moose Jaw and operated directly by the Ministry, the program provides a home for up to three people with intellectual disabilities and complex needs. One space is reserved for individuals in crisis or who are in need of respite.
- **Approved Private Service Homes** are licensed private community homes that provide a family atmosphere and daily living supports for one to four people with intellectual disabilities and/or physical disabilities (or other complex needs). Provide residents a chance to develop social, recreational, and living skills. Private owners are paid each month for caring for the people in their home. The amount they are paid depends upon the level of care and support each resident needs. See also “Dedicated Mental Health Housing” section for discussion on mental health APSHs.

In 2009-10, the Ministry continued to increase the number of residential and day program spaces to significantly reduce the 440-person waitlist for spaces through the multi-year investment announced in October 2008. In the fiscal year, $18 million was allocated, and services for 264 people from the 440 waitlist were implemented or approved. The multi-year initiative included investments to enhance services in the approved private-service home sector, an update to the funding model in the day-program sector, enhanced services for clients with complex needs, and support for recruitment and retention efforts in the CBO sector. Currently, there is a pilot project for APSHs in a specific region where the homes are receiving additional behavioural supports, training and education, after-hours crisis supports, and other supports (Ministry of Social Services 2009/10 Annual Report, 2010).

Table 4. *Additional Facilities or Housing Options in Saskatchewan.*

Type	Program Description	Capacity
Emergency/ Transitional Shelters	Homeless individuals and/or families ▪ Emergency – Approximately 70% of all shelters across Canada providing temporary and short-term accommodation for homeless individuals and/or families. ▪ Transitional shelters – Offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities.	670 emergency/transitional shelter spaces (likely an underestimate)
Long-Term Care: Special Care Homes	Institutional long term care services to meet the needs of individuals usually having heavy care needs, which cannot appropriately be met in the community through home/community based services (also referred to as nursing homes). Operated directly or contracted by Regional Health Authorities.	8,945 beds in 2008/09 Residents pay based on income (government subsidies available): $984 to $1,871 monthly
Long-Term Care: Personal Care Homes	Licensed and monitored by Saskatchewan Health but are privately owned and operated. The level and type of care varies from home to home but typically accommodate individuals with lighter care needs. A home must be licensed as a personal care home if it provides accommodation, meals, and assistance or supervision with activities of daily living to an adult aged 18 and older who is not a relative. Residents are responsible for paying the full cost of their own care and the government notes that subsidies are not provided because there is a publicly funded system of long-term care.	
Group Homes for people with intellectual disabilities Group Homes for people with intellectual disabilities	Group homes – Licensed homes operated by community-based organizations (CBOs) that are staffed to provide personal care, supervision, and support for typically three to six adults with intellectual disabilities. Group living homes – Homes operated by CBOs for usually three to six individuals with intellectual disabilities who are responsible for paying their basic shelter costs. Often, the individuals are recipients of social assistance benefits (e.g., SAP or SAID). The Income Assistance and Disability Services division may provide funds to a CBO for personal care, supervision and support services.	
Housing with supports for people with intellectual disabilities	Supported Independent Living Programs – Provides adults with intellectual disabilities living in their own residence with the limited support and supervision they may require to live as independently as possible. Supported Apartment Living Programs – Alternative for people who do not require the level of supports in group home options, but require more than is available in the SILPs.	SILPs: 436 people in 2008/09
Residential services operated by the Ministry of Social Services	Valley View Centre – Located near Moose Jaw. 24/7 supported residential services for people with intellectual disabilities, many who also have complex medical and behavioural support needs. No new admissions have been accepted since October 2002. North View Home – Located in Prince Albert and operated directly by the Ministry. 24/7 residential care in community neighbourhood for five	238 individuals with intellectual disabilities

Type	Program Description	Capacity
	people with intellectual disabilities. South View Home – Located near Moose Jaw and operated directly by the Ministry, the program provides a home for up to three people with intellectual disabilities and complex needs. One space is reserved for individuals in crisis or who are in need of respite.	
Approved Private Service Homes	Licensed private community homes that provide a family atmosphere and daily living supports for one to four people with intellectual disabilities and/or physical disabilities (or other complex needs). Private owners are paid each month for caring for the people in their home. The amount they are paid depends upon the level of care and support each resident needs.	Beds in mental health APSH – 788 as of 2008/09

MENTAL HEALTH SUPPORTS

Table 5. *Range of Mental Health Supports in Saskatchewan.*

Range of Mental Health Supports	
Community Connections	▪ Residential services ▪ Prevocational/vocational ▪ Social/recreational ▪ Family education and support education
Community Mental Health Services	▪ Intake/assessment/referral ▪ Crisis intervention ▪ Case management ▪ Outpatient services and clinics ▪ Marital, individual, and family counselling ▪ Adult sexual offender assessment and treatment ▪ Family violence support ▪ Victim support ▪ Sexual assault/sexual abuse support ▪ Problem gambling support ▪ Shared management ▪ Family support and rehabilitation program
Inpatient Services	▪ Acute and specialized
Other	▪ Promotion/prevention/education

While the Ministry of Health directs policy, establishes and monitors standards, provides funding for and ensures provision of essential services, most health services, including mental health services, are provided via the province's twelve regional health authorities and associated Health Care Organizations (HCOs). The Mental Health Program is organized by: child and youth services, adult community services, psychiatric rehabilitation services, and mental health inpatient services. The program operates in accordance with the standards and guidelines of the Mental Health Services Act and Regulations.

The Mental Health Advisory Council (MHAC) advises the Minister and senior officials in Saskatchewan Health on policies, programs, priorities, and resources aimed at meeting the mental health needs of the people of Saskatchewan.

In general, services tend to be more generic in rural areas and more specialized in urban centres. Mental health and addictions services are integrated under a single manager in all RHAs.

Adult Community Services can include direct and indirect services. Direct services include diagnosis, treatment, and counselling and support while indirect services provide consultation and support to other agencies (e.g., assessment of people involved in the justice system).

Psychiatric Rehabilitation Services assists people with mental illness through longer-term case management services which includes housing such as group homes, approved homes, and independent living options. Services can also include social/recreational programs, crisis management, family support, and education.

Inpatient services provide diagnosis and treatment services for acute mental illnesses in designated mental health inpatient units in general hospitals. There is one specialized hospital in the province (Saskatchewan Hospital at North Battleford) that is dedicated to intensive rehabilitation of people with mental illness and provision of forensic services. Not all health regions have inpatient services sited within their region (no inpatient facilities in northern regions, Kelsey Trail, or Heartland).

Table 6 summarizes the services available in each of these categories.

In addition to these service categories, the BridgePoint Centre for Eating Disorders is a provincial program that provides rehabilitation for individuals and their families recovering from eating disorders.
Since the BridgePoint Centre was established in 1997, Saskatchewan Health has provided funding to it through a partnership between the Heartland Health Region, BridgePoint Centre management board, and Saskatchewan Health's Community Care Branch.

Table 6. *Mental health services by service category.*

Service Category	Services Provided	Health Care Organizations
Adult Services	Adult services are provided by the health regions' mental health clinics (although not all services may be available in each region): ▪ Intake/assessment/referral ▪ Crisis intervention ▪ Marital counselling ▪ Individual counselling ▪ Family therapy ▪ Adult sexual offender assessment and treatment ▪ Family therapy ▪ Family violence support ▪ Victim support ▪ Sexual assault/sexual abuse support ▪ Court ordered assessments ▪ Problem gambling support ▪ Promotion/prevention/education	▪ Mobile Crisis Services Inc. (Regian Qu'Appelle Health Region) ▪ Crisis Management (Saskatoon Health Region) ▪ BridgePoint Centre Pilot Program (Heartland Health Region)
Psychiatric Rehabilitation Services	Services available through health regions to rehabilitation clients: ▪ Intake, orientation, and assessment ▪ Case management ▪ Residential services ▪ Prevocational/vocational ▪ Shared management ▪ 24-hour emergency response ▪ Coordinating councils	▪ Canadian Mental Health Association branches: North Battleford, Kindersley, Moose Jaw, Swift Current, Prince Albert, Melfort, Regina, Weyburn, Yorkton, and Saskatoon Branches and CMHA Division ▪ Edwards Society (Prairie North) ▪ Saskatoon Housing Coalition (Saskatoon) ▪ OASIS Community Centre Cooperative Ltd. (Kelsey Trail) ▪ Phoenix Residential Society (Regina)

Service Category	Services Provided	Health Care Organizations
	▪ Family education and support education ▪ Family support and rehabilitation program (contractual services)	▪ Libbie Young (Prairie North) ▪ SMILE ▪ SHARE (Prince Albert) ▪ Crisis Management (Saskatoon) ▪ Thunder Creek Rehab (Five Hills) ▪ Mobile Crisis Service Inc. (Regina) ▪ Weyburn Group Homes (Sun Country) ▪ S.I.G.N. (Sunrise) ▪ McKerracher Support Services (Cypress) ▪ Schizophrenia Society of Saskatchewan ▪ Crocus Cooperative (Saskatoon) ▪ Portage Vocational (Prairie North)
Inpatient Mental Health Services	The following services are generally provided by inpatient mental health units in general hospitals (not all services are available in all regions): ▪ 24-hour on-call psychiatrist and 24-hour nursing service ▪ Consultation re: involuntary admissions ▪ Specialized treatment service ▪ Adolescent unit ▪ Day treatment provided by inpatient services ▪ Crisis management ▪ Counselling for individuals and families ▪ Outpatient Electroconvulsive Therapy ▪ Nursing consultation to other units ▪ Medical and psychosocial assessments ▪ Behaviour management programs ▪ Clozapine and Modecate, etc. clinics ▪ Health promotion, prevention, and education ▪ Group psycho-educational programs ▪ Family support groups ▪ Case management ▪ Assessment for long-term care placement Saskatchewan Hospital North Battleford is managed by the Prairie North Regional Health Authority but is accessible by the whole province. The hospital provides specialized inpatient and outpatient services as well as a 24-bed forensic unit. There are a total of 156 beds (including the 24-bed forensic unit) divided across three services: short-term psychiatric rehabilitation, transitional, and extended rehabilitation. Services include: ▪ 24-hour interdisciplinary patient services ▪ Specialized treatment services ▪ Outpatient services ▪ Clozapine program ▪ Polydipsia program ▪ Rehabilitation program including vocational, leisure education, life skills, psychosocial, educational, and recreational activities ▪ Family Advisory Council	

Source: 2008/09 Community Program Profile prepared by the Community Care Branch, Saskatchewan Health.

FUNDING LEVELS

According to figures from Saskatchewan Health, total mental health spending in Saskatchewan in 2008/09[256] was **$207.7 million**. This includes approximately:

- $124.027 million for Ministry and RHA delivered services
- $27.249 million for drug plan and extended benefits
- $13.668 million for general practitioner and other physician billing
- $9.470 million for psychiatrist billing
- $33.246 million for days in general wards (non-psychiatric wards) where mental illness is the primary diagnosis

From the total funding envelope, approximately $6.839 million was allocated to Health Care Organizations for delivery of specific services.

This accounts for 5% of the total provincial health budget.

According to a recent analysis by the Institute of Health Economics (Jacobs et al., 2010), the following were the total expenditures on mental health and addictions services[257] in Saskatchewan for 2007/08:

- $60 million for inpatient care[258] ($49.8 million in general hospitals and $10.2 million in psychiatric hospitals)
- $30.6 million for physician services ($8.3 general practitioners – fee for service, $8.6 specialists – fee for service, and $13.7 million for psychiatrist on alternative payment schemes)
- $109.3 million for community and social services ($49.1 million for community mental health, $40.7 million for addictions, and $19.5 million for First Nations mental health and addictions services)

INCOME SUPPORTS

The Department of Social Services oversees the delivery of the Saskatchewan Assistance Plan. Provincial social assistance programs for adults include: the **Saskatchewan Assistance Plan** (SAP) and the Transitional Employment Allowance (TEA). Key legislation governing the programs is the Saskatchewan Assistance Act and its Regulations. Basic assistance through the Saskatchewan Assistance Plan covers the cost of food and clothing and a shelter allowance.

- **Transitional Employment Allowance**: This benefit is for short-term clients of the social assistance program. Recent enhancements to the program include the eligibility of new applicants who will likely become self-sufficient through employment, as well as those who have received social assistance in the past because of a short-term issue or crisis.
- **Saskatchewan Child Benefit (SCB)**: In July 1998, the SCB was implemented and removed children's benefits from the social assistance system in Saskatchewan. Provincial assistance to children was provided through the Canada Child Tax Benefit, the National Child Benefit (NCB) Supplement, and the SCB. This benefit consisted of a non-taxable monthly payment to assist low-income families with children under the age of 18. The Canada Revenue Agency delivered the SCB as an integrated payment with the Canada Child Tax Benefit and the NCB Supplement. In July 2006, the Saskatchewan Child Benefit was fully phased out and all federal increases to the NCB Supplement began flowing through directly to families.

[256] 2008/09 Community Program Profile, Community Care Branch, Ministry of Health, p. 14
[257] Additional analysis was done by the IHE on pharmaceuticals, employee assistance plans and income support programs.
[258] Please note that the 2007/08 inpatient data figures presented in the IHE report are not actuals but are extrapolations based on 2003/04 CIHI data.

- **Saskatchewan Rental Housing Supplement**: In April 2005, the Saskatchewan Rental Housing Supplement was put into place to help low-income tenant families and people with disabilities access quality, affordable housing. The supplement consists of two programs: the **Family Rental Housing Supplement** (e.g., assistance based on number of children, household income, amount of rent paid) and the **Disability Rental Housing Supplement** (e.g., covers additional costs that people with disabilities have for disability-related housing supports). Those qualifying for the Disability Rental Housing Supplement have at least one family member with a disability causing a housing impact, and support in place to address this impact at the time of application.
- Clients with disabilities receiving assistance from the Saskatchewan Assistance Plan are eligible for the following exemptions on **earned income**: $100 plus 25% of the remaining income (maximum of $225) for singles; $200 for single-parent families; and, $200 for two-parent families.
- **Total income** for a single person with a disability in Saskatchewan is $10,477 (includes basic social assistance, other provincial benefits, other provincial tax credits, and GST credit)[259].

The 2010/11 Ministry of Social Services Plan identifies an investment of $1.5 million to continue to **index shelter rates** semi-annually for benefits provided to low-income families and individuals to offset the inflationary pressure of the cost of rental housing.

According to the 2007 Social Assistance Statistical Report (Federal-Provincial Territorial Directors of Income Support, May 2010, pp. 81-87):

- In 2006, there were a reported 45,500 recipients (27,100 cases) of social assistance programs in Saskatchewan
- In 75% of the 27,100 cases, the reason for assistance is health-related (mental and physical health restrictions)
- Approximately 59% of cases had been receiving social assistance for over one year
- Approximately 31% of cases had been receiving social assistance for over five years
- Of the health-related cases, over 35% have been receiving assistance for over five years (approximately 7,200)

Most recently, the first phase of a new program, **Saskatchewan Assured Income for Disability (SAID)**, began rolling out across the province in October 2009. This program was developed through two processes: (1) recommendations from a community-government task team, and (2) a Minister-appointed Program Implementation Advisory Team from the disability community. The intention was to create a program separate from the welfare system that provided for people with significant and enduring disabilities in three ways:

- Basic living expenses (food, shelter, and clothing)
- Disability needs including transportation, special clothing, and special dietary needs as required
- Supplementary Health Benefits

Current benefit levels will be consistent with those available under the SAP – over time, the benefit will be reviewed to ensure it is meeting needs. In addition, SAID requires less reporting, and recipients will not need to reconfirm their disability every year (as is currently required on regular social assistance program). Assured Income Specialists will serve SAID clients in larger urban centres, and will specialize in providing services to people with disabilities.

This first phase focuses on people living in residential care facilities (personal care homes, special care homes, family homes, mental health services approved homes, Community Living Division approved private homes) with an assessed level of care of two or higher – implementation will continue in stages over several years. According to the 2009/10 Ministry of Social Services Annual Report, 3,250 social assistance program clients were invited to apply in this first phase.

[259] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability*, Bulletin Number 2.

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

- In 2009, the Saskatchewan Housing Corporation partnered with the Association of Saskatchewan Realtors (ASR) and contracted with Sigma Analytics to identify methods to **engage the private sector to finance, design, and deliver affordable housing** in 2009. A second phase to identify and build partnerships to develop affordable and rental housing is currently underway.
- The recently released **"Patient First" framework** from the provincial government focuses primarily on medical issues, but the principles dovetail well with recovery-oriented practices.
- The Community Care Branch of the Ministry of Health produces annual reports on Mental Health Services in the province. The depth and breadth of information on the services available, key players involved, a detailed funding breakdown, and the performance of the system is worthy of note. The indicators presented in the annual report are organized in a way that is consistent with the Canadian Institute for Health Information's Health Indicators Framework with the eight dimensions including: acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency, and safety. In addition to providing a detailed overview of the population, services provided, and funding levels, the 2008/09 report contained the following data tables (with source information generally drawn from the Mental Health Information System and Hospital Information System):

Acceptability Indicator 1 - Caseload Size for Mental Health Services, 2008/09

Acceptability Indicator 2 - Overall Mental Health Spending in Saskatchewan 2008/09

Acceptability Indicator 3 - Regional Health Authority Actual Mental Health Expenditures 2008/09

Acceptability Indicator 4 - Nervous System Central Drug Utilization 2008/09

Accessibility Indicator 1A - Wait Times for Rural and Smaller Centres Mental Health Services, 2008/09

Accessibility Indicator 1B - Wait Times for Urban Mental Health Services, 2008/09

Accessibility Indicator 2 - Wait Time for Service at Saskatchewan Hospital North Battleford 2003-04 to 2008/09

Accessibility Indicator 3 - Saskatchewan Hospital North Battleford Admission Statistics by RHA, 2008/09

Accessibility Indicator 4 - Total Mental Health Active and New/Reopened Registrations by RHA, 2008/09

Accessibility Indicator 5 - New and Reopened Registrations by Age and Health Region, 2008/09

Accessibility Indicator 6 - New and Reopened Registrations for all Regions over Time, 2003/04-2008/09

Accessibility Indicator 7 - New and Reopened Registrations by 10,000 Population 2008/09

Accessibility Indicator 8 - New and Reopened Registrations by Region of Residence 2008/09

Accessibility Indicator 9A - Count of Mental Health Related Calls to HealthLine by Presenting Problem and Shift Time, 2008/09

Accessibility Indicator 9B - Count of Mental Health Related Calls by Presenting Problem to HealthLine, 2004/05-to-2008/09

Accessibility Indicator 9C - Percentage of Mental Health* Related Calls to all HealthLine Calls, 2004/05-to-2008/09

Appropriateness Indicator 1 - Length of Stay, Average Daily Census and Occupancy Rates for RHA Mental Health Inpatient Wards 2007/08

Appropriateness Indicator 2 - Mental Health Designated Bed in General Hospitals, 1999/00-2008/09

Appropriateness Indicator 3 - Count and Percent of Clients by Length of Stay (in days) in Mental Health Inpatient Wards by Region, 2007/08

Appropriateness Indicator 4A- Separations and Average Length of Stay by RHA for Psychiatric and Non-Psychiatric Wards (primary diagnosis) 2007-08

Appropriateness Indicator 4B- Separations by RHA for Psychiatric and Non-Psychiatric Wards per 10,000 Population

Appropriateness Indicator 5 - Patient Count and Number of Mental Health Contacts Provided by Fee-for-Service Psychiatrists and General Practitioners 2008-09

Appropriateness Indicator 6 - Psychiatric Separations by Diagnostic Group 2007-08

Appropriateness Indicator 7 - Mental Health Outpatient FTEs by RHA, per 10,000 Population

Appropriateness Indicator 8 - Residential Placements by RHA 2008/09

Appropriateness Indicator 9 - Residential Spaces by 10,000 Population

Appropriateness Indicator 10 - Mental Health Residential Spaces 2004/5-2008/9

Appropriateness Indicator 11 - Pre-vocational and Vocational Program Dollars/10,000 Population 2008/09

Appropriateness Indicator 12 - Client Concern Handling System for Mental Health as Reported by RHAs, 2008/09

Appropriateness Indicator 13a - Emergency Ward Presentations for Mental Health and Addictions Concerns, Regina and Saskatoon, 2007/08-to-2008/09

Appropriateness Indicator 13b - Percentage of Emergency Ward Presentations by Diagnosis out of all Mental Health and Addictions Presentations, Regina and Saskatoon, 2008/09

Effectiveness Indicator 1A - Multiple Mental Health Inpatient Separations by Region, 2007-08

Effectiveness Indicator 1B - Multiple Mental Health Inpatient Separations by Region as a percent of all Separations, 2007-08

Effectiveness Indicator 2 - Separations by Days until Re-admission 2007-08

Effectiveness Indicator 3 - Mental Health Services Separations* by RHA of Residence and Place of Service, 2007-08

The **Saskatchewan Health Quality Council** is an independent agency that measures and reports on quality of care in Saskatchewan, promotes improvement, and engages its partners in building a better health system. Research reports measure overall health care quality in Saskatchewan, with specific areas of focus. While not specific to mental health, specific initiatives of the Council do focus on mental health issues. For example, one of the current activities is an 18-month initiative (the Saskatchewan Chronic Disease Management Collaborative II) which provides strategies for health care providers (including physicians) to apply the best available evidence in treating depression.

- **The City of Saskatoon** has recently established a policy to offer disposable land parcels to affordable housing providers first. There is no open tender process and the land will only be open to the broader marketplace if there is no interest by affordable housing providers.
- **Lighthouse Supported Living Project (Saskatoon)**: This mixed housing project will provide affordable transitional and supportive housing, and will also include commercial office space and market housing (condominiums). The city is contributing a $1.5 million capital grant.
- **Station 20**: A $1.2 million capital grant and five-year tax abatement from the city supports the affordable housing component of this multi-purpose project which also features a branch library and health centre. The land itself was sold by the city to project proponents for $1.

CHALLENGES IN HOUSING AND RELATED SUPPORTS

- **Political will** in making housing a key priority (for both policy and funding) is what's needed to move this forward.
- Innovation is impacted by **current funding and policy constructs**.
- **Economic factors** are impacting planning and priorities – for example, investments are needed to implement the 2008 Task Force on housing affordability.
- There are **significant deficits in housing stock**, and supports to go with this stock. In Saskatoon alone, it's estimated that there is a need for an additional 3,500 to 5,600 affordable, entry level dwellings[260].
- **The vacancy rate in Regina is close to 0%**.

[260] As reported by Allan Wallace (City of Saskatoon) at the 2008 Saskatchewan Housing Forum.

- Competition for units in the private rental market is compounded for people with mental illness due to **discrimination/stigma** by private landlords.
- **Affordability issues** have significantly increased over the last few years coupled with reduced accessibility to rental accommodation and new homeownership.
- As the economy has 'boomed' there's been a high level of conversion of existing housing to **condominiums**.
- Having 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 on the housing continuum (i.e., people may be ready and wanting to move to more independent options, but there is **nowhere for them to go**).
- The focus in recent years has been on closing the gap between rent and income for **families**. It's only been very recently that there's been more attention paid to other groups.
- Needs of **urban, rural, and northern** communities, and **First Nations** on-reserve residents are not being adequately met.
- **Smaller, more rural regions** tend to have very limited or no options for mental health oriented housing (particularly in the areas of support). This forces residents to move to larger communities where they are more isolated.
- In the **more rural communities**, there can be tremendous stigma attached to mental illness so people are reluctant to seek help. Or, they move to more urban centres to access services.
- The residential care options (**Approved Homes**) were first instituted in one form as the deinstitutionalization process began. These present some challenges in providing recovery-oriented approaches.
    - Availability and type varies across the province and this lack of consistency is impacted by not having a long-term provincial strategy for how these homes are best used and services best delivered.
    - This is an even greater issue because there are so few dedicated mental health housing options that provide scattered site apartment models.
- Although the disability income assistance program, SAID, has recently been instituted, there are **no specific additional benefits provided**.
- In general, it would appear that there **aren't close linkages** between housing and housing support workers with clinical mental health services; there are a small number of social housing buildings which have closer connections to health services as the offices are co-located in the buildings.
    - Intervention strategies that address mental health issues before the crisis 'hits' are crucial but not commonly available. These would be very helpful for non-dedicated housing providers. **Coordination of supports** is an ongoing challenge.
    - Integration across community organizations, regional health authorities, and housing providers must be strengthened.
    - Interministerial and interagency coordination must be embedded in any mental health strategy (it's expected that a planning process will begin for a provincial mental health strategy soon).
- Much of the housing funding tends to be 'one-time' and while there may be funding available for housing, **securing funding for supports** is an ongoing challenge.
- It is becoming more and more common for hospitals to discharge to social housing, and the housing supports alone **don't have the expertise** to support the person.
- Current funding construct for mental health services focuses on **people with serious mental illness**. For people without a diagnosis of serious illness, there are some resources within the social services system.

- There are no real options for groups of people who may not have a diagnosed mental illness but may have fetal alcohol syndrome or cognitive issues coupled with mental health issues.
- There are significant **wait lists** for housing across the province. Similarly, there are wait lists for mental health services, particularly in rural areas.

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

- Increasingly, there has been discussion on how to really **engage the private sector** in affordable housing development.
- Province has been **focusing on home ownership initiatives**. While this can create space in other parts of the affordable housing continuum, there is a critical capacity issue and not everyone is interested in/ready for this as an option.
- Increasingly, there is an emphasis on cross-sectoral collaboration between housing and health, and there are regional committees to encourage collaboration and a provincial forum as well.
- There is not a significant focus on housing and supports for people with mental illness although there appears to be more discussion about this population. **The focus is more often on families, seniors, and youth**.
- Most recently, a Saskatchewan Housing Forum was held and identified a "13 Point Plan to Enhance Housing Accessibility." Participants included the Saskatchewan Housing Corporation, government representatives, researchers, and private developers. The plan's recommendations (pp. 14-16) are listed on the next page.

1. Housing needs and associated parameters must be identified and articulated by individual communities or markets. Defining the community need and assigning appropriate parameters is therefore a foundational step that will ideally lead to effective long-term planning for the community.
2. Streamline the regulatory system in Saskatchewan.
3. Identifying the right mix of public policy initiatives together with private sector action is needed to address the housing crisis.
4. Establish a multi-stakeholder working group (or build on an existing group) to explore best housing practices in other jurisdictions.
5. Establish a 'focal point' for resources, references, and ongoing communications to link the various stakeholders within the housing sector (and their programs and services).
6. Advocate for societal and government recognition of housing's importance and its integral role within the Saskatchewan growth initiative.
7. Encourage municipalities to look at modular and Ready to Move (RTM) homes as alternatives to regular home construction. Amendments to zoning bylaws may be required to accommodate this option.
8. Innovative creation of wealth vehicles for infrastructure and affordable housing development is deemed a necessary and overdue initiative (i.e., investment fund with appropriate tax incentives).
9. Enhance the capacity of trade skills training.
10. Create tools and mechanisms to assess credit ratings for immigrants that are willing, ready, and able to access housing.
11. Strategies targeted to enhance our housing market must also address and be inclusive of the issues related to low income individuals as they pertain to housing affordability.
12. Capital gains exemption for reinvestment in the housing sector should be considered as part of a policy discussion.
13. An investment in education is warranted to make young people ready for the purchase or rental market.

YUKON TERRITORY

CONTEXT

ECOLOGICAL CHARACTERISTICS

The total population of the Yukon Territory is approximately 30,370 (Statistics Canada, 2009) with an unemployment rate of 6.3% compared to a rate of 8.1% across Canada (Statistics Canada, 2010). Roughly two thirds of the population live in Whitehorse. Highlights from the 2006 Census Analysis Series include:

- A **population growth rate of 5.9%** since 2001 – slightly above the national average of 5.4%
- Although only 7.5% of the population is aged 65 and over (compared to 13.6% nationally), this represents more than double the proportion of the senior population from the 1986 census – one of the most rapid growth rates in all of Canada.
- Nearly 25% of the population self-identified as **Aboriginal** – a total of about 7,580 people in 2006.
- There are 14 First Nations in the Yukon: White River First Nation; Kluane First Nation; Champagne and Aishihik First Nation; Kwanlin Dun First Nation; Ta'an Kwach'an Council; Carcross/Tagish First Nation; Selkirk First Nation; Little Salmon/Carmacks First Nation; Teslin Tlingit Council; Tr'ondek Hwech'in First Nation; Vuntut Gwichin First Nation; First Nation of Nacho Nyak Dun; the Ross River Kaska Dene Council, and Liard First Nation.
    - While the majority of the population in the two major centres of Whitehorse and Watson Lake are non-Aboriginal, the proportion of Aboriginal to non-Aboriginal people is much larger in the smaller Yukon communities.
- The territories were home to 0.3% of Canada's total population. An even smaller share of **recent immigrants lived in the North (0.1%)**.
- Only about 6,300 **foreign-born individuals** resided in the territories, according to the census. They represented only 0.1% of the total foreign-born population in the country and 6.2% of the population in the North.
- Of the 12,615 households in the Yukon Territory, **63.8% owned the dwelling** they lived in (compared to 68.4% nationally) – this represents an increase of just over 12.5% since 2001, just over the national average of 11.8%. Of owner households, 58.7% held a mortgage.
- Median income increased 15.5% from 2001 to 2006, with median annual shelter costs increasing only 5.9% during the same period of time, the **lowest rate in all of Canada**.
- Residents of the territories reported their homes as being in a greater **need of major repairs** than residents in the provinces. In 2006, 14.9% of the Yukon Territory's households reported that their homes needed major repairs.
- In the Yukon Territory, the proportion of households which reported having less than one room per person was similar to that of the provinces, at 1.5%.
- The Yukon had an above-average proportion of households living in dwellings constructed in the five years before the census at 9.3%.
- The proportion of households in the Yukon **spending 30% or more of their income on shelter in 2006 was well below the national average** of 24.9% at 18.3%.

In its 2009 Social Development Series, the Canadian Council on Social Development notes the following in relation to the Yukon Territory:

- "The culmination of two parallel processes – the devolution of power from the federal government to the Yukon Territory via the 2003 Yukon Act, and the implementation of self-government among 11 of 14 Yukon First Nations, negotiated under the 1993 Umbrella Final Agreement – is expected to spur the development

and implementation of anti-poverty initiatives in the Yukon Territory" (p.1) which will likely impact the development of a more comprehensive housing and support continuum.

- Government tends to focus on service investments – this can mean that there is funding available for a housing advocate, but no actual housing funds available.
- Mining, tourism and government form the main economic engines of the Territory – the reliance on mining and tourism creates a cyclical trend in employment rates (due to the seasonal nature of the work).
- The government (including First Nations governments) is now the major employer.
- The employment rate for those aged 15 and older was 72.8% – one of the highest in the country (p.4).
- The median income for all persons aged 15 and older was $31,352 in 2005, yet it was only $20,690 among the Aboriginal population aged 15+ (p.5).
- All households in the North face high costs of living and affordable housing is a particular challenge: between 2000 and 2006, the **average house price increased by 48.1**%.
- The average two-bedroom apartment in Whitehorse rents for $780 per month - social assistance benefits only cover $492 per month for singles and $807 for families (p.6).
- Rising energy costs have had a significant impact on people's expenses.

In 2001, 87% of Aboriginal adults living in the Yukon reported that at least one family member had attended a **federal residential school or industrial school**. Almost one in four First Nation adults had attended a residential school, and **among those aged 45 to 75, the proportion climbed to more than 50%** (p.14). The following outlines the transgenerational effects of residential schools (Aboriginal Healing Foundation, p. 72):

- Enduring psychological, social and economic effects on survivors
- Models of parenting and child-rearing based on institutional experiences
- Patterns of emotional responsiveness and expression
- Repetition of physical and sexual abuse
- Loss of cultural knowledge, language and tradition
- Undermining individual and collective identity and self-esteem
- Devaluating and essentializing Aboriginal identity
- Individual and collective disempowerment, loss of control and lack of efficacy
- Disruption of family and kinship networks
- Destruction of communities, nations, and peoples
- Damage to relationships with larger society and sense of living in a just society – popular images, racism, stereotypes, government tutelage and bureaucratic control, and judicial and corrections system

"The importance of self-governance in ensuring economic and social security for Yukon First Nations cannot be overstated" (p. 15) – by 2008, 11 of 14 Yukon First Nations were self-governing, and so considered a fourth level of government (a unique situation in Canada). The relationships amongst governments are still being developed, but a number of changes have taken place:

- Some individual First Nations now administer social assistance for their community members – the remainder of social assistance continues to be administered by Indian and Northern Affairs Canada which is primarily based in the Winnipeg area.
- First Nations also have the power now to "draw down" programs to meet specific needs in their communities, including negotiating the transfer of payments for health and social programs with the federal and territorial governments – including housing.

STRUCTURAL ORGANIZATION OF HOUSING AND RELATED SUPPORTS

The Health Services branch of the Department of Health and Social Services is responsible for a variety of health care, disease prevention and treatment services which assist eligible Yukon residents in attaining maximum individual independence within their community. The Department directly administers service delivery – there are no regional health boards. "Mental Health Services" is a non-insured health service provided to eligible Yukon residents by the government. In addition, the Department provides funding support to non-profit agencies in the community to provide services such as shelters, detoxification services, and a transition house for women.

The Yukon Housing Corporation (YHC) manages subsidized housing units throughout the territory, administers the government employee housing stock, in addition to providing funding support for home improvements under the Home Repair Program and the Rental Rehabilitation Program. Access to units is generally through local Community Housing Boards or the Whitehouse Housing Authority. YHC Housing Managers operate out of the local community Housing Offices and are responsible for the day-to-day administration of the local social housing program. Formal authority for YHC is contained in the Housing Corporation Act, providing the authority for the provision, development, financing and maintenance of housing. The Housing Development Act enables YHC to enter into intergovernmental agreements and establishes the Whitehorse Housing Authority. The Corporation also administers the Government Employee Housing Act on behalf of the Yukon Government.

Council of Yukon First Nations (CYFN) – Health and Social Development Department[261]:

- Coordinates and addresses issues and activities pertaining to health and social development within CYFN.
- Facilitates coordination and/or acts as a liaison and/or an advocate on health and social issues nationally, regionally and locally that affect Yukon First Nation's health and well being.
- When appropriate, the department assists/guides Yukon First Nations to develop, implement and evaluate the delivery of health and social programs in their community.
- The Department also identifies needs and workable alternatives for health and social service delivery in conjunction with the First Nations Health and Social Development Commission (representing all of the First Nations), the Grand Chief and the Leadership Board.

The Yukon Anti-Poverty Coalition (YAPC) has a **Housing Task Force** whose 50 members are working to develop a housing action plan for Whitehorse. Most recently, the YAPC created a Mental Health Task Force, which is expected to begin meeting in February 2011, with supported housing as a primary area of focus.

Whitehorse Planning Group on Homelessness: a coalition of women's, church, and social justice groups, together with Yukon government representatives, formed in 2000 to implement the federal initiative on homelessness – they created a "Whitehorse Community Plan" and submitted this for funding under the federal Homelessness Partnering Strategy. Much of the work done by this group relies on volunteers, which creates significant capacity issues.

PROGRESS TO DATE: KEY INITIATIVES

While the Yukon does not have a mental health or housing strategy at this time, the government has been working on a cross-departmental social inclusion and poverty reduction strategy since October 2009. The Department of Health and Social Services created the Social Inclusion and Poverty Reduction Office to guide the development, implementation and on-going management of the government's Social Inclusion and Poverty Reduction Strategy. This office is overseen by an inter-departmental committee made up of seven departments including the Department of Health and Social Services, and the Yukon Housing Corporation. A public education campaign has recently been launched (www.inclusion-is-better.ca) to create a better understanding of social inclusion and

[261] http://www.cyfn.ca/healthsocial?noCache=476:1286564915

exclusion. In December 2010, the Office of Social Inclusion released the Dimensions of Social Inclusion and Exclusion in Yukon, which provides statistical information and analysis on the range of conditions that impact social exclusion and poverty in the Territory. The intention of this, and other pieces of work, is to support the creation of an evidence-based poverty reduction and social inclusion strategy. Data is reported according to two broad categories of social inclusion indicators adopted by the Yukon: personal and community assets, and access to necessities and participation in society.

In November of 2010, the Department of Health and Social Services released the Whitehorse Housing Adequacy Study, providing the findings from surveys with people who are homeless or precariously housed. The intention was to provide both government and non-governmental organizations with statistical information on homelessness and housing challenges, together with the "lived experience" of people living in these situations. The questionnaire was completed by 107 people who were homeless, and 641 other people who were housed (most of whom faced various housing challenges such as hotel rooms or temporary accommodations, or housing that was not affordable and/or acceptable in nature).

RANGE OF HOUSING ACCOMMODATIONS

Table 1. *Overall Range of Housing Options in the Yukon.*

Dedicated Mental Health Housing	n/a
Non-Dedicated Affordable Housing	▪ Social housing ▪ Housing co-operatives (total of two for the Territory) ▪ Rent supplement program
Additional Facilities or Housing Options	▪ Home Care and Community Services (assisted living, supportive housing, community care facilities)[262] ▪ Residential Options for People with Developmental Disabilities (Supports to Home Living, Home Sharing, Staffed Residential Living, Semi-independent Living Support, Supported Apartments, Cluster Living)

DEDICATED HOUSING OPTIONS

Yukon does not have dedicated housing options for people living with mental illness.

NON-DEDICATED AFFORDABLE HOUSING OPTIONS

All of the following programs are administered by the Yukon Housing Corporation unless otherwise noted.

SOCIAL HOUSING

Social housing is the main type of affordable housing available in the Yukon. Social housing units are available for 25% of gross income generally.

- There is a months-long waiting list – just fewer than 90 clients were on the waiting list as of November 30, 2009[263].
- A priority strategy is used based on size of family, whether the applicant is living with a disability, and whether the applicant is leaving an abusive relationship.
- About two thirds of the social housing units are located in **Whitehorse**, mostly in apartment buildings although there are some detached houses, duplexes and row units.

[262] Note that there is not a formal, broad-based program with guidelines – applies to a small number of approved apartments.
[263] Information provided by Yukon Housing Corporation staff and reviewed by Reference Group members

- A couple of communities have four-plexes which are targeted to seniors.
- **Model of support**: Where tenants are tied into existing community support services and are having difficulty, there is an informal agreement for housing staff to contact the support provider. Having sufficient time to make and maintain these connections is a challenge.
- There is one six-plex where Yukon Housing has an agreement in place with a provider who houses their clients with Fetal Alcohol Spectrum Disorders and provides support. This agreement has been in place for about five years, and the provider collects and keeps the rents which facilitates having staff on-site - an identified need for this population group.

There are three main types of social housing (for a **total of 606 units** as of December 2010[264]):

1. Private non-profit housing (Whitehorse):
   - Gateway Housing - a 39-unit seniors' apartment complex;
   - Kaushee's Transition Home - 24-beds and 5 second-stage housing units
   - Grey Mountain Housing – 74 units for First Nation people living on low income
2. Rent supplements (total of 46 for the territory, all located in Whitehorse): Subsidizes rents in eligible private rental dwellings.
3. Public Not-for-Profit Housing – remaining units (includes rent supplements)

HOUSING CO-OPERATIVES

Between 1973 and 1991, the Canada Mortgage and Housing Corporation (CMHC participated actively in the development of co-operatives under three main types of programs described in the National Housing Act (Section 61, Section 95, and the Federal Co-operating Housing Program) – the underlying theme, however, is that all of these co-operatives provide some type of financial support.

- Housing co-ops are member-owned and controlled organizations. There is no outside landlord.
- The monthly housing charges are set by the members to cover the costs of running the co-op. There are some co-op options for people with special needs.
- Typically, 25-75% of households in a co-op pay a reduced monthly charge, based on their income – others pay the full monthly charge set when members approve the co-op's yearly operating budget.
- The federal government ceased funding new development at the end of 1991.

[264] Information provided by Yukon Housing Corporation staff.

Table 1. *Non-Dedicated Affordable Housing in the Yukon.*

Program	Type	Program Description	Capacity
Social Housing	Housing only – some support in private non-profit	Includes three programs: ▪ Private non-profit housing (Whitehorse): - Gateway Housing - a 39-unit seniors' apartment complex; - Kaushee's Transition Home - 24-beds and 5 second-stage housing units - Grey Mountain Housing – 74 units for First Nation people living on low income ▪ Rent supplements (total of 46 for the territory, all located in Whitehorse): Subsidizes rents in eligible private rental dwellings. ▪ Public Not-for-Profit Housing – remaining units (includes rent supplements)	606 units 46 rent supplements
Housing Co-operatives	Housing only	Located in Whitehorse: member-owned and controlled organizations – no outside landlord. Monthly housing charges are set by the members to cover the costs of running the co-op. Typically, 25-75% of households in a co-op pay a reduced monthly charge, based on their income – others pay the full monthly charge set when members approve the co-op's yearly operating budget. Of the two housing co-operatives in the Yukon, responsibility for one was assumed by Yukon Housing about two years ago.	12 units (receives 6 rent supplements included above)

ADDITIONAL INITIATIVES

Affordable Housing Initiative (AHI)/Canada-Yukon Affordable Housing Program Agreement: Based on the housing framework agreed to in **November 2001** by federal, provincial/territorial housing ministers. 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 a grant, a stream of ongoing subsidies or the value of in-kind contributions (e.g., land). Within these terms and 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. In the Yukon, the federal government committed $7.7 million and, as of June 30th, 2010, $5.8 million had been committed and/or announced for a total of 350 units[265]:

Homelessness Partnering Strategy (HPS): launched on April 1, 2007 by the federal government, building on the foundation of its predecessor program, the National Homelessness Initiative. In September 2008, the federal government announced $1.9 billion in housing and homelessness investments for low income Canadians over five years through to March 31, 2014. Specifically on homelessness, the government renewed HPS funding for two years until March 31, 2011 and committed to maintain annual funding for federal housing and homelessness programs until March 31, 2014, a five year commitment. A key focus of the HPS is a housing-first approach and focuses on transitional and supportive housing as important ways to move individuals out of homelessness. Seven organizations received NHI funding in 2002, all located in Whitehorse:

- Salvation Army received $195,564 to renovate a local building to serve as a drop-in/emergency shelter, operating 24-hours per day, seven days per week, and provide beds for up to 10 people per night;

[265] CMHC, National Affordable Housing Initiative Funding Table, http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm

- Options for Independence Society received $38,460 to provide assisted living support services for people with Fetal Alcohol Spectrum Disorder;
- Yukon Women's Transition Home received $11,670 to provide outreach and advocacy services;
- Yukon Family Services Association received $53,634 of an outreach worker for at-risk youth;
- Bringing Youth Toward Equality society received $30,000 to establish a youth peer mentorship network;
- Whitehorse Youth Centre received $31,593 to operate a safe shelter day program; and
- Yukon Aboriginal Women's Council received $53,130 to conduct a feasibility study on the establishment of a non-profit society to coordinate an emergency shelter for homeless people in Whitehorse.

The Yukon Housing Corporation administers the Yukon Government's rural **staff housing program** – aimed at assisting the government in recruitment/retention of staff in rural communities. There are a total of 147 units in 13 communities across the territory.

Residential Renovation

- The **Home Repair Program** provides funding support (low-interest financing of up to $35,000) for home improvements to increase accessibility for people living with disabilities. Subsidies may be available for those with low incomes – an enhanced version of the program is available for higher-interest financing for projects expected to exceed the $35,000 funding limit.
- The **Mobile Home Upgrade Program** offers financing, to a maximum loan of 95% of the projected future value of the home.
- The **Rental Suite Program** offers up to $25,000 in low-interest financing with repayment terms of up to 10 years to upgrade an existing suite.
- The **Rental Rehabilitation Program** offers low-interest loans to landlords (up to $30,000) wishing to repair their homes in a variety of ways, including improving accessibility.
- The **Residential Electricity Management Program** offers low-interest financing to move from an electrical heating system to non-electrical.

Home ownership

- There are many home ownership programs in the Yukon, including: mortgage financing for Yukoners not eligible for bank financing; construction financing for up to two years for Yukoners wanting to build their own homes (owners contribute labour equity or management skills); extended mortgage guarantee for rural residents; home completion financing for rural residents; home purchase assistance for low income clients; Green Mortgage program offers reduced interest rate mortgage financing for homes meeting the YHC's energy-efficient GreenHome Standard.

Northern Housing Trust

- The Yukon government received $50 million in federal funding over three years as part of the $300 mullion Northern Housing Trust established by the Government of Canada in 2006 – the Yukon government has negotiated agreements with First Nations governments on allocation of this funding, with it being determined that First Nations would receive $32.5 million to address priority housing needs. These funds are enabling preservation, and construction of new units, for the first time in many years. More thought is required as to how to provide ongoing operating dollars to maintain the units, and support tenants.

ADDITIONAL FACILITIES OR HOUSING OPTIONS

Part of this mapping exercise is to provide an overview of other types of settings which are not dedicated to serving people with mental health problems and/or mental illness, but where they may be living. Within the Yukon this includes: **shelters, transitional housing and residential care programs**. We summarize some key points related to each of these settings below, together with a table which identifies locations and capacity.

SHELTERS/TRANSITIONAL HOUSING

According to figures from Human Resources and Skills Development Canada (HRSDC), there were **approximately 350 beds** in the northern territories ' emergency and transitional shelters in 2007[266], or 1.3% of known shelter beds across Canada. There are **332 shelter beds per 100,000 people**, a significant divergence from the 82 shelter beds/100,000 people national average. This is **likely an underestimate** because:

- It is based on the number of known shelters – there may be additional shelters not captured in this data set
- It does not represent overflow or seasonal adjustments when utilization exceeds number of regular beds available
- Shelter usage and number of beds has consistently increased over the years, and we can expect that there has been an increase since 2007

Also according to HRSDC, "of the known 1,020 shelters identified across Canada as of March 2007, 723 or **71% were emergency shelters**, providing temporary and short-term accommodation for homeless individuals and/or families. Such shelters typically also offer essential services such as food, clothing and counselling. Transitional shelters offer services beyond basic needs and, while not permanent, generally provide a longer length of stay than emergency housing facilities. Transitional shelters numbered 291 and represented a little more than 28% of the total. There were, in addition, 6 shelters providing both emergency and transitional services, representing less than 1% of the total."

- The Yukon Government provides financial support for a variety of shelter services. It directly provides detoxification services in a 10-bed facility, as well as providing $967,000 in annual funding to the Yukon Women's Transition Home, and $218,000 in annual funding towards the operation of the Salvation Army Shelter. Smaller women's shelters in the communities of Watson Lake and Dawson City also receive funding from the territorial government.
- In January 2008, the Yukon government contributed $227,000 to provide an after-hours outreach program for youth aged 17 to 20. The program is sponsored by the Skookum Jim Friendship Centre, the Blue Feather Youth Centre, the Council for Yukon First Nations, and Yukon Health and Social Services. It runs from 8:30pm to 9:00am daily. There is also an emergency number for youth seeking support or referrals to safe beds that are made available via the local woman's shelter or detox services. Referrals are also made to the daytime family support worker operating out of the Skookum Jim Friendship Centre.

CONTINUING CARE: RESIDENTIAL CARE

The Continuing Care Branch of the Department of Health and Social Services provides residential home care and regional therapy services for people with cognitive or physical impairments. Programs include home care, palliative care, and respite care, in addition to residential care programs. There are three residential care programs in the Yukon: Copper Ridge Place and Macaulay Lodge are located in Whitehorse and McDonald Lodge in Dawson City.

[266] Human Resources and Skills Development Canada, Indicators of Well-being in Canada: Housing – Homeless Shelters and Beds http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=44#M_2

RESIDENTIAL OPTIONS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

While there is a rich array of services and resources for people with cognitive issues, typically, people whose primary issue is mental health-related are generally excluded from housing options – for this reason, we have not included residential options for people with developmental disabilities in this map.

MENTAL HEALTH SUPPORTS

Table 2. *Range of Mental Health Supports in the Yukon.*

Range of Mental Health Supports	
Community Connections	▪ Peer Support ▪ Family support ▪ Rehabilitation therapy
Community Mental Health Services (includes addictions' services)	▪ Assessment, treatment, referral and consultation services via the Mental Health Services Program ▪ Addictions services: crisis line, detoxification services, information and referral service, and prevention services
Inpatient Services	▪ Whitehorse General Hospital for acute inpatient stays
Other	▪ Community development, training, public awareness

The Department of Health and Social Services manages the **Mental Health Services** program, providing assessment, treatment, consultation and referral services to individuals experiencing a range of mental health problems:

- Staff include mental health clinicians, nurses, and mental health support workers.
- Three primary client groups: adults diagnosed with serious and persistent mental illnesses, including clients under the Yukon Review Board; adults who experience other diagnosable mental health issues; and children and youth.
- Community mental health activities include community development, training, public awareness, and policy and program development in areas which have an impact on mental health

Whitehorse General Hospital provides inpatient services to patients admitted for psychiatric reasons. Mental Health Services staff may also participate in the care of these patients.

Several telehealth projects are being used to provide access to all Yukon communities for psychiatric visits, mental health counselling, alcohol and drug counselling, rehabilitation therapy, family visits to health facilities both in and outside of the territory, and health education.

The Department of Health and Social Services also provides a range of alcohol and drug services, including a crisis line, detoxification services, information and referral service, and prevention services

The **Second Opinion Society** provides peer support via a Drop-in and Resource Centre in Whitehorse. Peer support, advocacy, a resource library, recreational and social activities, and workshops are provided to any person in the community wanting to access these supports.

INCOME SUPPORTS

The Department of Health and Social Services administers the territorial **Social Assistance** program. Key legislation includes the Social Assistance Act and its Regulations govern the program. Basic assistance covers basic allowance (e.g., food, clothing, personal and household items) and shelter allowance. Maximum basic assistance rates are also based on a tiered system depending on geographical location.

According to the Social Assistance Statistical Report, 2007 (Federal-Provincial-Territorial Directors of Income Support, August 2009, pp.103-108):

- Recipients of the Social Assistance program are eligible for **earnings exemptions** which consist of: $100 of all income plus 25% of earned income (after the third consecutive month of receiving assistance) for singles; $150 of all income plus 25% of earned income (after the third consecutive month of receiving assistance) for families
- There were a reported 936 recipients (618 cases) of social assistance as of March 31, 2007

About 54% of all cases were identified as employable, with remaining reasons for assistance including mental illness (3% of all cases), unsuitable for employment (5%), developmental disability, over 60 years, children, or physical illness/disability.

Total income for a single receiving social assistance in the Yukon is estimated at $16 981 (includes basic social assistance, other provincial/territorial benefits and GST credit)[267].

PROMISING PRACTICES IN HOUSING AND RELATED SUPPORTS

- Currently in the planning process for an Abbeyfield style-model home that will be a pilot for seniors. Each person will have their own room, but there will be shared living space and a live-in support person who can provide a range of housing support services. Discussion is ongoing with staff from the Ministry of Health to look at how this model might work for people living with mental illness or acquired brain injuries. Another population might be people with co-occurring mental illness and developmental issues.
- As noted, creation of the Social Inclusion and Poverty Reduction is very promising, as is engagement of health and housing key players.

CHALLENGES IN HOUSING AND RELATED SUPPORTS

- A primary issue in social housing is the need for higher intensity supports to prevent the cycle of crisis and, ultimately, eviction.
- There are limited inpatient options, support options, and residential care options.
- Client group can be very vulnerable – making on-site support important from a safety perspective,
- Resources for identification of mental illness are very limited.
- Economic stimulus package has been very important in terms of rehabilitating units.
- New housing development has been at a virtual standstill since 1993 – when CMHC ceased funding capital building directly.
- There will be significant challenges when federal subsidies for social housing end.
- Boom-cycle of the Yukon economy exacerbates the problem of homelessness as market rents far exceed the shelter amounts subsidized by social assistance rates.
- The recent destruction of two hotels and several blocks of rental housing that primarily housed low-income people in order to make way for the construction of high-priced condominiums in the downtown core has also contributed to an increase in the number of marginalized people visible on the streets of downtown Whitehorse.
- Significant concerns about women who are part of the 'hidden homeless' (couch surfing).

[267] National Council of Welfare Reports. *Welfare Incomes 2008: Single Person with a Disability*, Bulletin Number 2

- Generally, the Yukon is seen as having less of a homeless problem than the other territories. However, this analysis does not cover Yukon First Nations communities, and that statistics on homelessness in the Yukon are generally deficient in adequately determining the extent of problem in the territory.
- A 2004 evaluation of the Yukon Housing Corporation's Social Housing Program stated: "If the population remains stable as predicted, there will be no need to increase the total number of housing units." This is neither reflective of current wait lists for housing, nor the experience of staff on the ground.
- Despite the Yukon's booming economy in recent years, 22% of Yukoners reported having financial difficulties securing food (Yukon Health Status Report, 2003).
- 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.
- First Nations housing requires significant rehabilitation – First Nations hold the fiduciary responsibility for housing in their communities and there is a transition process occurring right now.
    - Communities can be quite challenging to plan for in terms of social housing because of their size (i.e., critical mass) – providing supportive housing is even more challenging.

FUTURE DIRECTIONS: TRENDS IN HOUSING AND RELATED SUPPORTS

The government has demonstrated a willingness to invest in housing – they need the data and research to support moving forward.

- The creation of a social inclusion policy, incorporating housing stock and mental health services, is very promising direction for the future.
- Key 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.

APPENDIX EIGHT: SITE VISITS

The following summarizes findings from site visits undertaken across the country. These should be considered in conjunction with the promising practices identified in the provincial and territorial maps.

INNOVATIONS ADDRESSING CHALLENGES RELATED TO HOUSING STOCK AND HOUSING OPTIONS

PHOENIX RESIDENTIAL SOCIETY (REGINA, SASKATCHEWAN)

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

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. This caters to clients needing two levels of support, with 8 at a higher level of support needs and 8 clients who are transitioning into independent living in scattered apartments and receiving reduced level of supports through services offered by the Phoenix Supported Apartment Living Services. All 16 residents also have a case manager from the Health Authority. CMHA and the Abilities Council partner with Phoenix Society in providing employment related supports. In addition there are regular activities related to health and skill development available throughout the week for residents through the Phoenix Oak Skills for Wellness Program

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. There is a case manager and a worker from Phoenix attached to each client. There is regular communication between the case manager and the psychosocial rehabilitation worker.

Integrated Provision of Supports
All groups related to skill and wellness provided at the Phoenix Oak are available to all 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) operating from a cluster apartment model. The services offered for substance use and recovery through this program can also be accessed by residents in other housing programs of Phoenix. So this results in integration, cross-pollination and lack of duplication of services.

Peer Support
There is a Peer Support Specialist Program where former residents are hired to support clients of the Phoenix Residential Society. There is a plan to expand this such that a peer support model exclusive to the housing programs is created.

This is a model that reveals how independent housing options are made available through creative collaboration, to consumers who might have otherwise been forced to live in a group home environment. A continuum of housing options is made available with the opportunity to transition. Affordable, qualitative housing, with adequate supports thereby enables a recovery oriented independent living environment.

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

Over the last decade, developing high supports housing options for people leaving longer hospital stays has been a focus across Ontario. Frontenac Community Mental Health Services, working with the regional specialized hospital (Providence Continuing Care Centre – Mental Health), has developed an innovative, recovery-oriented model to assist people in their transition. This high supports 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 established in 2004 has a total of 18 bedrooms, with shared bathrooms and a common living/kitchen area for tenants. Key elements of the model were developed in partnership with PCCC, based on the needs of people in longer inpatient stays at the hospital site:

- Typically, PCCC identifies the individuals who are ready to transition to community, and then staff from FCMHS and PCCC complete a joint shared care checklist with the tenant.
- The FCMHS team meets monthly with social workers from PCCC to discuss potential new tenants, bridging support for new tenants as they move from PCCC to Lower Union, and other elements of the partnership.
- Part of the transition planning includes day visits and short stays.
- FCMHS owns and operates the Lower Union project and supports the tenants through:
    - on-site residential mental health rehabilitation workers provide day-to-day supports and assistance in building life skills (every tenant is assigned a key worker),
    - on-site Registered Nurse during the weekdays to assist in addressing medication and physical health needs – the Community Care Access Centre is engaged for tenants requiring additional home support services,
    - Community clinical services - all tenants are followed by an assertive community treatment team, or through PCCC's Community 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 inception, the model has evolved to focus on a transitional model of housing (rather than permanent) where people would generally move on to a less intensive model – recognizing that each person is different, with different needs and goals, and flexibility is required in length of stay. Lower Union residents are tenants who sign one year leases – which can be extended as required.

Generally, tenants from the Lower Union project move to other housing provided by FCMHS. This project also provides an option for respite and brief stabilization for tenants of other, lower supports FCMHS housing options.

FCMHS, based on tenant feedback, is now looking at how existing supports could be expanded to include more group options to address vocational, social/recreational, and peer support needs.

Challenges

Consistent with many regions across the country, there are tremendous pressures in the housing system in general which limits housing options for people with mental illness – this creates system flow issues when people are ready to move from Lower Union. Usually, the only option for them exists within the mental health dedicated housing provided by FCMHS, given the significant wait lists for other affordable housing options.

FCMHS is in the process of assessing people's needs at PCCC, in order to better identify what gaps exist to assist them in transitioning to community – consistent with past assessment exercises, many people have significant physical care and physical health needs, an arena in which mental health housing providers generally don't provide as part of their mandate. FCMHS has also noted that this is consistent in terms of emerging needs of clients already in the community, and these physical health needs tend to emerge at a younger age (i.e., aged 50 and over) then would be expected in the general population. As part of this assessment process, FCMHS is identifying what types of supports might be needed to support people who require very high levels of support and supervision, particularly those with histories of violence, fire setting, or sexual behaviours.

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, 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 inter ministerial coordination and commitment led to a fiscal commitment, enabling access to affordable housing. The portable housing benefits are administered through community organisations 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 just for people living with mental illnesses and addictions, but has benefited these groups. Through an innovative business process initiated by CMHA, the property acquisition arm of BC 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 homeownership program and the waiting list. This is part of the Provincial Housing Strategy – Housing Matters 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 put in an amount as 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 paid for it plus the Consumer Price Index; there is a covenant on this property that ensures this practice.

The Rental Model
In addition to this, within the same location, there are 28 apartment rental units just adjacent to the 11 homes that offer subsidized rental units. The rental units are also operated and managed by CMHA. This is exclusively dedicated to people with mental health and addictions. This is a partnership wherein the Interior Health Authority provides onsite clinical support and BC Housing has an operating agreement with CMHA to provide property management. All tenants are encouraged to engage with the other programs and services which CMHA delivers (i.e., clubhouse and peer support). This is a cluster model co-habiting with a mixed model.

The integration of both the 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 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 the NIMBYism found in communities while promoting affordable housing options.

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

The model created by the Portland Hotel Society (PHS) in the down town east core of Vancouver is one which creates a sense of community for highly marginalized populations - the poor, with severe mental illnesses and/or addictions. A number of converted hotels in the area provide single room occupancies for this population. Units in the area differ in space and self-sufficiency 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. The society runs a café below one of the SRO buildings – this provides training and work opportunities for residents of the area. Businesses are encouraged to establish themselves in the area, by providing free space or space at a nominal rent. This encourages community integration and job 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 allows for the disability or welfare cheques to be directly deposited into the account and negates exploitation by the privately run ready cash firms. The society has a harm reduction focus and operates its own 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 seek to access the detoxification centre. PHS reports that of the three detoxification sites funded by the VHA, this is the most successful. Supports for the residents of the SROs are flexible and are provided through multiple sources – health authority staff and housing teams of the Portland Hotel Society.

As this model creates an 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.

Challenges

Due to lack of adequate funding, there is a discrepancy in the quality of SROs available to the population. Some SROs have seen a higher degree of investment than others. So standardization of the SRO housing stock in terms of quality is an issue that needs to be addressed.

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 health and addictions who are on the waiting list of the Burnaby Mental Health and Addictions Centre. Since homelessness is a confounder when it comes to accessing health services, it is ensured that those on the hospital's waiting list are housed until such time that intervention is 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 Coast Mental Health and the Burnaby Centre, through which 22 clients are housed. Once the clients are housed, the staff of Burnaby provides clinical supports, which sometimes negates the need for hospitalization. At other times clients are transferred to the hospital for clinical management of their symptoms once the hospital bed becomes available. In the interim, tenant support staff of Coast Mental Health also work with these clients to help them secure long term housing.

Another floor of the St.Helen's SRO has 5 beds allocated to the clients of the community transition team of the St.Paul's Hospital. Clients are discharged from the hospital into this 3 month transitional housing arrangement wherein they are provided with step down clinical staff support around 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.

CONDOMINIUM PROGRAM – CANADIAN MENTAL HEALTH ASSOCIATION, OTTAWA BRANCH (OTTAWA, ONTARIO)

CMHA Ottawa provides a range of housing to people with serious mental illness through their rent supplements and condominium programs. This innovation story focuses on the Condominium Program. Capital funding from the Ministry of Health allowed CMHA to purchase 22 condominiums in 2005. The City provides rent supplements to bring rents up to market value and the Ministry of Health provides a small annual stipend for maintenance (generally $200 - $300 per unit). Since inception, CMHA has secured additional capital funding to bring the total number of units to 31 – depending on the funding source, some condos are designated for specific groups (e.g., women, people who are homeless).

The tenants' rents from the Condominium Program cover monthly condo fees, and provide for ongoing maintenance. To the greatest extent possible, condos (usually one-bedroom units) were purchased in a variety of neighbourhoods across the City, recognizing the value of having multiple condos co-located where possible to facilitate efficient deployment of support services. Typically, a ratio of one CMHA condo to ten private owner condos was used – which is a similar model CMHA uses in securing apartments from private landlords through the Rent Supplement program. This type of ratio has been successful based on feedback from a service delivery and tenant perspective. Other considerations in buying various condos included:

- Having a range of condos that are considered lower-end through to higher-end depending on amenities and physical characteristics – for example, experience has shown that some people who have had a lengthy history of being homeless often feel more comfortable and integrate more easily in buildings that have fewer amenities, and
- Safety and proximity to transportation, shopping and support services.

Key elements of the Condominium Program

- All tenants sign leases with CMHA Ottawa. CMHA Housing is part of the centralized Housing Registry provided in the City of Ottawa.
- The housing model emphasizes mental health clinical supports and building community connections; CMHA services also include peer support, volunteer matching program, and mentoring opportunities.
- Matching the person's wants with what the housing can provide is key to success.
- Community education, including condo boards, is needed on an ongoing basis – direct participation on the boards or in board meetings is generally not required.
- While each person has a CMHA case manager (and other supports as needed) who provides housing and mental health supports when they move in, people's needs may lessen over time and may not require ongoing case management. CMHA has structured supports in such a way that a person who no longer has a case manager can have rapid access to transitional or ongoing case management supports as needed. Other people may need a high level of support on an ongoing basis.
- In addition to the one- and two-bedroom condos (all of which are occupied by one individual), CMHA Ottawa also purchased a three-bedroom townhouse which is shared by three individuals. The model of support is

slightly different in the townhouse in that a volunteer organization (Ancoura[268]) rents the townhouse from CMHA and provides support to residents through their volunteers. Linkages are made with CMHA Ottawa community mental health supports as needed.

- Some units are physically accessible.
- CMHA usually allocates one month between a tenant moving out and the next person moving in to ensure there's time to do basic maintenance and upgrades.

One of the condo sites in east Ottawa was visited and included a number of units in each of the high-rise condo building, the low-rise condo buildings and one townhouse (having a number of units in the same area enables the case manager to make several visits in a shorter amount of time – "critical mass"). There are no safety issues in neighbourhood, which is within walking distance to grocery shopping, a pharmacy, a primary care clinic, other stores, transportation and some support services such as a food bank.

Lessons Learned

Generally speaking, the system expands housing capacity through two main routes – working with private landlords to rent private housing stock using rent supplements, or securing capital dollars to build new buildings. The Condominium Project presents a third option that combines the benefits of both ownership and rent supplements[269] models, and addresses the challenges that each of these models can have:

- Benefits of ownership:
    - CMHA, as the owner of the condos and the landlord, is often able to provide tenants with more flexibility or options when problems arise than private landlords are comfortable with.
    - The condos are a 'secure' housing option in that they are always available – it can be challenging to rent through private landlords when the vacancy rates are low.
    - Just as with self-contained buildings, the condos can be leveraged (mortgaged) as a source of capital funding to buy new stock.
    - CMHA has greater control over maintaining the condos at a certain level and can provide a higher standard than is often available in the private market rentals (for example, providing air conditioning in all of the condos).
- Benefits of rent supplements:
    - Planning, securing funding, and building new buildings can take a significant amount of time to accomplish. Securing funding that can be used to buy condos that are move-in ready reduces the time from the proposal to the time when people can be provided with housing – in the same way that rent supplements are a more time-efficient option to expanding housing stock.
    - Some people prefer to live in buildings dedicated for people with mental health issues – but others prefer to live in an apartment in a building that is part of the regular housing stock – the rent supplement model enables this "scattered site" approach. Buying a limited number of condos in a

[268] Ancoura (www.ancoura.ca) was formed in 2008 and uses the Montreal l'Abri en Ville (www.labrienville.org) housing and supports model: volunteers interested in long-term supportive housing for people with mental illness secure housing through partnerships, then provide ongoing support. L'Abri en Ville used their experiences and lessons learned to create a guidebook that provides specific advice to communities interested in replicating this model. Advice and support are directly provided to interested communities at their request. The l'Abri model is based on the idea that people interested in creating supportive housing can do so by working together in their community, with the right knowledge and support.

[269] A significant challenge that faces the housing system as a whole is the need to develop a common understanding of how the level of rent supplements' funding should be determined, ensuring they reflect market rents, and the true costs of ongoing repair and maintenance.

variety of buildings facilitates a scattered site approach. CMHA condos are located in high-rise and low-rise buildings.

Reflecting on CMHA's overall complement of housing options:

- Moving into your own home (condo or apartment) facilitates people's recovery process – having stable, affordable housing with supports enables people to focus on their health.
- The person is responsible for their home because they sign the lease directly with the landlord (whether it's CMHA-owned condominiums or a private landlord).
- Positive outcomes on maintaining housing tenure have been demonstrated in all CMHA Ottawa housing programs – for example, there is a lower turnover rate, and a lower eviction rate, compared to tenants in other Ottawa housing.
- The match between the person and the area they move into is crucial – matching the neighbourhood, the supports available, and the lifestyle with what the person wants.

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

INNOVATION IN ADDRESSING BARRIERS IN TRANSITIONING CLIENTS FROM HOSPITALS TO HOUSING

POST-DISCHARGE TRANSITION PROGRAM – HAMILTON HOUSE – CMHA (CALGARY, ALBERTA)

Hamilton House is a partnership between the Canadian Mental Health Association (CMHA) – Calgary Region and Alberta Health Services (AHS) – Calgary Zone. This program is an eight bed transitional housing program which offers an alternate level of support to individuals with a severe and persistent mental illness that puts them at risk for repeated or 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 accepted only 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 their Supportive Living Coordinator to establish an 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 promoting wellness and recovery are conducted on a regular basis.

This unique partnership between AHS and CMHA – Calgary Region 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, resulting in reduced hospitalization for clients. The partnership further facilitates access to a greater range of supports - community resources through CMHA staff, in conjunction with Alberta Health Services supports which are accessed through the AHS nurse.

As this is a new initiative, an extensive evaluation has been completed on the program. Highlights of this evaluation include increase in scores on the Global Assessment of Functioning, the Goal Attainment Scale and the Life Skills Profile – 39, as well as a decrease in symptom severity, as indicated by reduced scores on the Brief

Psychotic Rating Scale. Anecdotal reports from clients indicated that they have experienced a significant reduction in isolation and increased feelings of self-esteem, self worth, safety and security. While no other program exists in Alberta to compare the rate of successful completion to, the finding that over 50% transitioned to some form of supportive living is felt to be high given the high needs and housing history of this client population.

Challenges

Hamilton House has seen an increase in the number of referrals for younger clients who have been newly diagnosed with a psychotic illness. Many of these clients are resistant to having a mental health diagnosis and require intensive education to assist them in realizing the necessity of treatment and the potential for a future even with their new diagnosis. The program also experiences challenges with supporting clients who suffer from substance abuse disorders. Operating from a harm reduction philosophy while assisting clients to transition to other housing programs that are abstinence-based presents a significant challenge in finding appropriate housing within the six month timeframe.

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. TRHPs were funded in both Ottawa and Toronto. New, smaller TRHPs have been implemented in St. Thomas/London, North Bay, and Whitby.

The impetus for the development of transitional housing as far back as the mid-90's included the need for recovery-oriented housing and support options for this population, and the pressure to discharge patients from inpatient beds. The latter was reinforced by directives from the Health Services Restructuring Commission with respect to reducing numbers of inpatient beds in operation.

The Ottawa Program

Three organizations deliver the project through a co-operative partnership: two are community mental health providers (Ottawa Salus and CMHA Ottawa) and one 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[270]: (1) a 4-bedroom transitional home ("Grove"), which is staffed 24/7, and (2) six satellite apartments. Both components include ongoing case management and housing support.

Ottawa Salus leads the service delivery portion of the project with the following staff:

- A program manager, a residential coordinator and on-site rehabilitation workers in the transitional home.
- CMHA Ottawa provides a transitional case manager and rent supplements for the satellite apartments (also funded through the Service Enhancement initiative).
- ROHCG provides a registered nurse, on-call psychiatry and a social worker who follows clients as they transition to Grove.

Typically, the majority of support services are provided by the Ottawa Salus on-site rehabilitation workers to residents at Grove with lesser involvement from the CMHA case manager or ROHCG social worker. Key roles for the on-site rehabilitation workers include: day-to-day support, life skills, wellness promotion, negotiating living independently and living with others. This support arrangement reverses once the person transitions to one of the satellite apartments (i.e., the case manager plays the larger support role, with lesser involvement from the on-site rehabilitation workers). To assist with transition, the program utilizes a teaching apartment that serves as an opportunity to assess participants, as well as a change for participants to prepare them for their move from Grove to their own apartment. Tenants in the satellite apartments can continue to access the on-site rehabilitation

[270] The ROHCG includes two forensic units, located in Brockville (approximately one hour south of Ottawa) and the City of Ottawa

workers at Grove on an ongoing or transitional basis, and may participate in the activities and discussion groups offered at Grove.

The annualized budget for operation of the Grove Street home is just under $700,000. Funding does not cover expenses for the transitional case manager from the CMHA Ottawa, or the staff support from the ROHCG. The cost for the rent supplements is typically $5,000 - $6,000 annually per apartment.

The Toronto Program

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 clients and other CMHA clients with criminal justice sector involvement. Like Ottawa, the TRHP program offers ongoing case management and housing support.

Service delivery is carried out by CMHA Toronto. The program utilized two TRHP workers, who act as transitional case managers for TRHP clients, and a program manager. The staff work alternate shifts between 8 a.m. and 8 p.m. Evening and night supervision (supervision is 24/7) is from other CMHA housing workers and overnight relief workers. TRHP staff provide the following services:

- Education on housing rights
- Coaching on activities of daily living
- Liaise with family members (if involved)
- Provide supports and education about medication, mental health, and recovery
- Utilize assessment tools, workbooks, online resources, etc.
- Regular meetings with individual clients as needed (at least once/week)
- Prepare client for transition to new housing and service providers
- Provide follow-up service with client/housing worker
- Ongoing orientation to community resources

Psychiatric support is provided by clinicians at the Centre for Addiction and Mental Health. CMHA Toronto recently created a peer support position in the program; the peer support worker is a former TRHP client who works with current clients on a one-to-one basis.

Length of Stay

In the Ottawa program, participants stay approximately 9-12 months at Grove, and approximately 6-12 months in one of the satellite apartments. Guaranteed access to housing following the transitional home stay can contribute to reducing anxiety associated with program completion at Grove. Once the participants leave Grove they sign leases directly with private landlords.

In the Toronto program, participants stay approximately 18-22 months at the CMHA-operated apartment building. Case managers assist clients with finding housing in the community once they complete the program.

In both the Toronto and Ottawa programs, there are no limits to participants' length of stay.

Other Features and Lessons Learned

- Flexibility with respect to the changing needs of participants: the range of partners and resources in place allow for a number of strategies to be used to help the person stabilize (e.g., brief hospital stays, apartment moves, or the provision of additional supports as needed).
- Participants need to demonstrate readiness to engage in an intensive rehabilitation program.

- The range of providers in place allows for rapid, preventative measures to be implemented in serving people.
- Achievements must be celebrated – when participants complete the program, a celebration is held and attended by the participant's support team, as well as their family/natural support network.
- Any housing and supports model can be recovery-oriented – the key is empowering and giving the control back to the clients (promoting a sense of normalcy).
- Gradual transitions are built into the program – from hospital to Grove and from Grove to the satellite apartments in Ottawa, and from hospital to apartment to community living building in Toronto.

A formal evaluation of the TRHP has been completed, which evaluated the following outcomes at 6-month intervals: rehospitalizations, reoffences, changes in the disposition orders, level of functioning on a measure of psychiatric disability, alcohol and drug use, self-reported distress, level of social support, level of self-reported recovery, and quality of life.

Anecdotally, all organizations agree that while the program is still relatively new, it has had a major impact on discharge rates and timeliness. Furthermore, a larger number of patients in inpatient units at the regional mental health hospitals would be able to transition to the community more effectively if the capacity of the program were to increase.

INNOVATIONS FOR SUB-POPULATIONS

YOUTH AND YOUNG ADULTS: 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 who are living with a mental illness. The Watson House project is a 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. There is on site staff support from 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. Life skills development is crucial for young clients who have not been in independent living arrangements. There is a group meal cooked once a day by residents who take turns with the cooking. The individual clients are responsible for other meals. Cleaning and other chores are also assigned to clients. 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. This a two year transitional program

The Transition to Supported Independent Living

The clients are supported to meet their housing goals in the two years at Watson House. The majority go into their own housing in market rent units. Coast Mental Health tries to set up a supported independent living arrangement for clients who move out of Watson House. Market rent housing is made available through the Supported Independent Living (SIL) subsidies which help top up the welfare amount to match the rent. Through the SILs staff supports and rent supplements are made available for an additional two years. In two years many of the clients have reached a level of recovery whereby they are ready to move out of the SIL. Some move on to another 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 living arrangement.

This model which facilitates a shift in continuum with a seamless support network helps young adults move towards independence and develops their skills to assist them in maintaining their housing.

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

A unique Montreal model is the "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 that meet the recovery needs of more recent and younger cohorts of youth and young adults experiencing mental health problems.

Paul-Paul residence is a three year old housing and support model that targets specifically transitional needs. Residents are typically youth in care who are about to turn 18 and were leaving the care of youth protection services. A partnership was formed between the Rivière-des-Prairies Hospital and the "Centre Jeunesse de Montréal – Institut Universitaire" and Louis-H. Lafontaine Hospital to collaborate and offer an integrated housing and support model to transitional age 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 an environment of highly individualised psychosocial rehabilitation and recovery services allowing youth to adapt at their pace, to their young adult freedom and independence and meet the challenges of their mental health issues while facilitating their 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, nurse and a part-time sex therapist. The team supports youth's transition to adulthood, development of independence, motivation, social integration and interpersonal skills.

Challenges
This new model has met many challenges in regards to youth leaving a very structured environment to a much more open one (1), different values and approaches from the protection sector versus the values and independence promoted here (2), diagnostic severity differences between child and youth psychiatry and adult psychiatry.

EVA'S PHOENIX: TRANSITIONAL HOUSING FOR HOMELESS AND AT-RISK YOUTH (TORONTO, ONTARIO)

Eva's Phoenix is a transitional housing and training facility that takes an innovative approach to working with homeless and at-risk youth. This Toronto organization is a co-ed facility that houses youth coming from unsafe or unstable housing situations. They provide housing for 50 youth, aged 16 to 24 years, for up to a full year, and since 2002 has also allowed up to 160 youth each year, aged 16 to 29 years, to participate in its employment and pre-apprenticeship programs. Eva's Phoenix officially opened its doors in June 2000, and has continued to be in operation ever since.

The program uses an integrated, holistic approach to provide youth with support in the areas of housing, employment and training, and social support. All youth have an opportunity to receive a variety of supports, such as counselling, mentorship, job placement assistance, housing search support, follow-up support and a range of other services to help youth achieve and maintain self-sufficiency.

The innovative housing structure at Eva's Phoenix includes shared townhouse-style units along an interior "main street" as well as common areas, a kitchen, grocery store and laundry and computer facilities. Each youth has their own bedroom, and is responsible for sharing common living areas with their housemates.

The physical layout provides youth the opportunity to "practice" independent shared living. Each youth is expected to maintain their own environment, including cleaning and cooking chores, as well as cohesive relationships with their housemates. The layout of Eva's Phoenix is integral to the philosophy of the program as it allows for privacy and a degree of independence so that youth may practice what they learn.

The goal of the housing program is to assist youth in developing the skills that they need so they can live autonomously. The housing team at Eva's Phoenix works with youth to educate them in saving money, budgeting, cooking, shopping, searching for housing, and understanding their rights as a tenant to name a few. In addition, through individual counselling, the housing team supports youth as they learn how to resolve conflicts, how to recover from making mistakes, how to set personal short-term and long-term goals, how to manage relationships and much more. Youth living at Eva's Phoenix must actively participate in the community of the shelter, as well as attend life skills programming and workshops. They are also required to be involved in a training or employment program.

The program employed at Eva's Phoenix is a case management approach. This has been one of the crucial factors in the success of the initiative. The basis for a coordinated case-management approach is a commonly understood set of goals. All youth coming into Eva's Phoenix work with staff during the intake process to develop specific, concrete goals in these key areas: housing, sense of community, counselling, and employment. Youth identify the housing and employment goals specific to their own needs, and throughout their stay, receive one-on-one counselling to help them achieve each of their personal goals. Each individual's goals are documented and monitored as a measure to ensure that each youth is successfully and actively involved in all program requirements.

Working with business, labour, and a number of different community partners, Eva's Phoenix provides its residents with the opportunities needed to develop life skills, build careers, live independently, and transition smoothly into the community.

Challenges

Youth often face the tremendous challenge of finding adequate housing beyond Eva's Phoenix. There is so little affordable housing available and so few supports in place for these youth once they do leave. Very little is understood about homeless, at risk or mentally ill youth in this age group. There is a very large gap between children and adults who are homeless or who suffer from mental illness. These youth fall into an "in between" category where they don't fit into either group. There is a distinct lack of service for this group and a lack of expertise. Homeless youth is a virtually invisible issue and large efforts need to be made in order to better understand it and effectively address it.

ABORIGINAL PEOPLES: AT HOME/CHEZ SOI PROJECT (WINNIPEG, MANITOBA)

There is a lack of housing and supports that targets the Aboriginal populations across provinces. In some regions there are housing projects focusing on this population, however, only few are specifically targeted to those with mental health and addictions. The population rarely accesses housing and supports offered through mainstream organizations. Lack of trust of the system finds many in the population preferring to use shelters or to stay under bridges or substandard conditions rather than access services related to housing and supports provided by mainstream organizations.

In Winnipeg, the national demonstration project focuses on inner city Winnipeg which has a disproportionate Aboriginal population. Hence there is a 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 by hosting numerous community meetings and information sessions, 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 that worked with the community come aboard the project. One of the partners of the project, Institute of Urban Studies, University of

Winnipeg had already 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 accessing services through a mainstream organization. Also, the ICM model for this community is a hybrid model with Aboriginal health and wellness practices incorporated into the model.

While this initiative is just underway and results are yet to be seen, this innovative way of 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 a significant step in the right direction.

PEOPLE WITH CONCURRENT DISORDERS: BOLIVAR COURT – FRASERSIDE COMMUNITY SERVICES (SURREY, BRITISH COLUMBIA)

Fraserside is a community organization that provides mental health supported housing programs in Coquitlam and Surrey and an Emergency short stay shelter in Burnaby.

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

It is an extremely low barrier housing approach that is necessary for the residents, due to the previous absence or threat of loss of housing; ongoing instability with housing resulting in constant moving from place to place; the lack of social & 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 for 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 is 4 staff, inclusive of a supervisor available 5 days a week. There is reduced staffing over the weekend between 9a.m. and 6p.m. Apart from this a doctor, a co-occurring disorders (concurrent disorders) therapist and an addictions specialist also provide their services at Bolivar Court. Though every apartment is complete with bathroom and kitchen, there are also common kitchen facilities, communal space and an onsite gym to enhance the sense of community. Informal approaches to support like knocking on the door and helping with medication is also employed if needed.

There is a strong network with other organizations and it is noteworthy that many organizations like Employment Options visit Bolivar court and provide services in-house. The partnership with Fraser Health Authority helps the referral process, easier access to detoxification and access to services such as a certified social service worker and mental health workers. This arrangement has significantly reduced hospitalization.

Challenges

Many of the tenants are active substance users and are street entrenched. This leads to unwarranted situations and incidents of violence and serves to increase the NIMBYism in the community. A strong partnership with the police built over the years has helped respond to this challenge. It has been instrumental in reassuring the community as well as in helping stem the incidence of violence. There is also overnight security made available. There is a high degree of tolerance whereby evictions are prevented and concerted effort is put into working with challenging clients.

ADDRESSING PEOPLE'S MULTIPLE, COMPLEX NEEDS: NAVNET (ST. JOHN'S, NEWFOUNDLAND AND LABRADOR)

NAVNET is an innovative cross system 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. NAVNET co-sponsored Building on "From the Outside In," a Fall 2009 conference where speakers from Australia profiled innovations in service delivery for people with complex needs. Building on these learning's, NAVNET has been engaged in a wide variety of activities aimed at coordinating our response to individuals with complex needs. Some of these activities have included:

- The completion of a comprehensive cost analysis to determine the costs associated with providing services and support to 10-12 clients who use multiple government and community systems.
- Work towards the development of an information sharing protocol in line with existing Privacy Legislation. This will allow NAVNET Member Departments and Agencies to share relevant information to ensure that our services are individualized, coordinated and that duplication does not occur. It is expected that this protocol will include a client consent form as well as a Memorandum of Understanding between NAVNET Members.
- A client identification project which allowed NAVNET to quantify the numbers of individuals in St. John's who meet NAVNET's definition of having "complex needs"
- Exploring ways to facilitate development/increase in housing system capacity that will address gaps and meet the needs of (future) NAVNET clients.
- Enhancing communication through use of specific tools including a webpage (www.navnetnl.ca), newsletters (the "navigator" provides progress updates on the work of NAVNET) and electronic bulletins (shares information and upcoming events between the government and community sectors). Other strategies such as creative networking ideas (workshops, brown bag lunches; lunch and learns) are in progress.
- The NAVNET Project Coordinator has engaged in knowledge transfer and has presented to a wide variety of groups, including the National Health Care Leadership Conference in Winnipeg in June 2010 and at a Roundtable organized by the Mental Health Commission of Canada and the CMHA (National Office) in Ottawa in November 2010.
- NAVNET has submitted a funding submission for a one year demonstration project of a new coordinated service model.

INNOVATIONS ADDRESSING RURAL/REMOTE CHALLENGES

ASSISTING SMALL COMMUNITIES TO PREVENT AND REDUCE HOMELESSNESS AND RELATED IMPACT (NORTHWEST TERRITORIES)

- Small Community Homelessness Fund available to communities outside of Yellowknife, Fort Smith, Inuvik, and Hay River for the development of local projects to address emergency shelter and community homeless issues.
- Steering committee led by Health and Social Services, with representation from Education, Culture and Employment (ECE), Justice and the NWT Housing Corporation, oversees implementation of the SCHF:
    - The Pehdzeh Ki First Nation in Wrigley received funding to renovate a church basement into an overnight shelter, as well as to facilitate a life skills workshop for the homeless.
    - The Deh Gah Got'ie Council in Fort Providence was funded to renovate two bachelor units as emergency housing.
    - The Katlodeeche First Nation in Hay River was assisted in renovating a three-bedroom house into two bachelor units to provide homeless accommodation on the Hay River Reserve.

- The Acho Dene Koe First Nation in Fort Liard received funds to implement their Winter Warm-Up Program. This program includes a weekly hot nutritious meal, a clothing bank and an emergency vouchers program.

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

This is an interesting model where Eden Health Care Services, a 43 year old community based organization run by the Mennonite Faith Community is the primary provider of health care, housing and support services in Winkler, which is a predominantly Mennonite community, and works in close coordination with multiple health authorities, to provide services to many parts of rural/remote Manitoba. This is an example of a well established and accepted community base being 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 in Winkler, 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 counselling 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 really small and remote, there is a tendency to gravitate towards Winkler for services. So there is a higher concentration of people with mental health issues in this community. Eden Health Care services administer the Portable Housing Benefits for the region. In addition 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 continuum 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 for this function. 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. Some of the services are provided by the health authority in collaboration with Eden Health Care Services. It is interesting to note that employees of the health authorities working in this collaboration report to Eden Health Care Services. Employment supports and vocational rehabilitation services are also made available to the tenants as well as the larger community.

Challenges

There is not enough housing stock to meet the needs of the growing population, and waitlists are significant. The greatest need is for those 55 and under, and single. While Eden Health Services strives to maintain the quality of housing, it is a constant struggle to find safe, affordable housing. What does exist has been accomplished through collaborative partnerships with Manitoba Housing, CMHC, area churches, businesses and individuals through donations.

HOUSING AND SUPPORTS PROVIDED THROUGH PARTNERSHIPS: CMHA THUNDER BAY, ALPHA COURT, AND ST. JOSEPH'S CARE GROUP (THUNDER BAY, ONTARIO)

Northern communities can face a myriad of challenges in providing housing and supports to people with mental illness. The City of Thunder Bay provides an opportunity to profile how some of the mental health and housing providers have partnered to address the needs of the permanent residents of the City and the transient population that migrates to the City to access supports. The hallmark of these partnerships is a delinking of housing support from the functions of property management including landlord/tenant agreements, and the models of housing and supports profile the difference between clinical and housing supports. This is in recognition that each organization/sector has an area of expertise that should be maximized, and that if issues with the tenancy arise, it is less complicated when these are dealt with separately from the housing and mental health supports the person is receiving.

- CMHA Thunder Bay provides a range of mental health supports, with very little "bricks and mortar" housing, limited to two buildings (a six-bedroom co-operative and a six-plex apartment building) that were purchased in 1991, as part of the Rent Geared to Income initiative from the provincial Ministry of Housing. CMHA also has 15 of the 67 Phase One rent supplements as part of the Ministry of Health's Homelessness Initiative (Phase one – 67 rent supplements, phase two – 80 rent supplements) and the Service Enhancement Initiative (72 rent supplements for people with criminal justice system involvement).
- Alpha Court, a housing provider, provides property management for CMHA's buildings, works with local landlords to secure units for the CMHA rent supplements, and acts as the landlord in the landlord-tenant lease agreement (i.e., Alpha Court signs a lease with the owner of the building, and then enters a lease agreement with the tenant referred by CMHA). Alpha Court is partners with **BISNO** and **CMHA** with these 67 units. In addition, Alpha-Court provides case management supports to their clients in the Homelessness Initiative Project II and their own two apartment buildings with the focus on wellness and empowerment. Alpha Court provides housing and case management services for three other housing projects (8, 4, 24) funded through the Ministry of Health and Long-Term Care.
- St. Joseph's Care Group is the specialized mental health provider for the region. Included within their Mental Health and Addictions program are two types of supportive housing (high and medium supports for up to 47 tenants) in addition to their administration of the Homes for Special Care program (for up to 41 clients). Clients are able to move between different types of housing depending on their needs – but the reality is that limited capacity through the housing and supports options in the community significantly limits people's ability to move. St. Joseph's partners with three non-profit landlords who own the supportive housing buildings: tenants pay rent directly to the landlords and St.Joseph's works with the landlords to fill vacancies. St. Joseph's provides nursing staff (clinical supports) and Community Support Assistants who provide housing supports.

Mental health and housing providers, including CMHA, Alpha Court and St. Joseph's operate a centralized access point to identify the best housing and support options for potential tenants of the Homelessness Initiative Phase Two rent supplements and supports. Over the course of the last year, there has been a shift to encourage people to transition to the City's affordable housing units within a three-year period (with flexibility built in around timing and the person's needs). This is challenging given capacity in the social housing sector. CMHA has modeled their court support program in a similar way – that is, identifying a goal 'end point' that reflects how supports should shift as people's needs change. Partners also noted that the City has lowered the age for seniors' social housing from 65 years to 55 years – and sometimes 50 years for some individuals – which may provide some assistance around capacity for people transitioning to City housing.

The mental health and addictions system is now engaged in broader system planning around system access and system capacity – housing is a key element in this planning process.

Housing supports can encompass a wide range of supports including assistance with activities of daily living, skill building, finance management, and helping people be connected in their communities. In general, CMHA's Clubhouse Program provides housing supports to tenants in CMHA units (sometimes in combination with Alpha Court). Clubhouses are an internationally recognized model of support that is member-driven (by people living with mental illness) and focuses on community connections such as employment, social/recreational, and peer support opportunities. In addition to these housing supports, most tenants also have CMHA case managers. The exception to this is for tenants living in the Homelessness Initiative Phase Two units, where CMHA case managers integrate housing supports as part of their functions.

Alpha-Court Non Profit Housing Corporation is a housing provider in Thunder Bay, and, in addition to the Homelessness Initiative rent supplements described above, has two buildings totalling 59 units, 37 of which house people with mental illness who receive ongoing support from Alpha-Court case management staff to assist them in maintaining their housing tenure. All clients who are placed in Alpha-Court housing (whether the buildings or the rent supplement units) receive assistance with daily living and advocacy through an Alpha-Court case manager,

who are trained in psychosocial rehabilitation, and whose focus is wellness and empowerment. The level of support the person needs often diminish over time, and annual client and tenant surveys demonstrate a high level of satisfaction. Tenants are engaged in regular building meetings and annual social events. Alpha-Court encourages tenant and client participation at events at the CMHA and the local peer support organization (PACE).

St.Joseph's Care Group housing takes a number of different forms:

- High support housing includes one 5-bedroom home (for people with mental illness and developmental issues – this is funded in partnership by both the Ministry of Health and the Ministry of Community and Social Services), and two 6-bedroom homes. This type of housing is geared for people with a serious mental illness who consistently have difficulty with activities of daily living (including managing their housing, meal preparation, managing finances etc), risk issues, medication management or health issues, and who typically have had frequent long-stays at the hospital. There are rarely readmissions to the hospital.
- Medium Support housing has been designed for people with serious mental illness who frequently have difficulty in the areas identified for high supports housing. They also have had frequent hospital stays, and are receiving from a community treatment team that provides services 24 hours per day. Two apartment complexes provide this type of housing – in one, tenants share apartments (space for up to 18 tenants); in the second, tenants have their own apartments (12 of the 36 units are designated for these tenants).
- Community Support Assistants provide on-site housing supports, assistant tenants with all aspects of daily living activities and skill building. Community treatment teams (which include mental health services such as assertive community treatment) provide mental health clinical supports and work with tenants and the Community Support Assistants.
- Homes for Special Care: This program provides accommodation for persons with a serious mental illness requiring long term care and community based rehabilitation – 6 private home operators (licensed by the Ministry of Health) can accommodate up to 41 clients (2-10 spaces per home). St.Joseph's staff provide treatment and rehabilitation services, and a housing supervisor works with HSC operators around using a recovery-oriented approach.

In addition to the providers outlined above, BISNO (Brain Injury Services of Northern Ontario) provides community services that are a component of the Homelessness Initiative Project Phase 2 and operates in partnership with Alpha Court Non-Profit Housing and the Canadian Mental Health Association – these services are for people living with Acquired Brain Injury and mental illness, and who are homeless or at risk of homelessness. BISNO has actively advocated for their clients' needs over the years which has helped to foster these close working relationships with mental health and housing providers.

Partners emphasized the close working relationships that have been built over the years, made even more important because of the relative isolation of the region – and the reality that many people from around the region come to Thunder Bay to access mental health and housing supports.

Current Challenges/Strategies Required

- St. Joseph's is slated to downsize the current 71 specialized inpatient mental health beds to 38 beds, as per the Health Services Restructuring Commission Directives. This will not be possible with the current housing and support capacity in the system.
- Occupancy levels in acute care tend to run at 105% - the bulk of the people waiting for discharge to the community are waiting for housing.
- While there is a range of housing and supports models available in Thunder Bay, the capacity doesn't exist to meet the needs of the community, or the people transitioning from hospital to community. Other capacity/resource issues exist with respect to:
    - Housing people with substance use issues or concurrent disorders

- Youth and young adults
- Other elements of the housing and supports continuum including social housing, shelters, emergency housing and detox services (important to apply for social housing even if wait lists are long and other options will be pursued – the need must be documented)
- Transitional housing units (of which three exist as part of Alpha-Court) and transitional case management – critical to prevent discharge from hospital or the criminal justice system to shelters
- People who may have tried other services or housing options and, for a variety of reasons, haven't succeeded and may no longer be able to access these services or housing
- People with serious medical and physical care needs - 50% of people presenting with mental health and/or substance use have no family doctor (compared to about 15% in the population overall)

- Ensuring that the high supports housing remains small in size is a challenge
- A full review of the role of Homes for Special Care and how they fit in today's context is needed.
- If tenants become unwell, they are less able to keep up their units and this can create financial difficulties if damages occur. Ongoing relationships with landlords and appropriate housing and mental health supports can help to prevent and/or mitigate costly damages.
- There are disparities in the level of rent subsidy available through different government programs (for example, Ontario Works versus Ontario Disability Supports) – this can create a shortfall for agencies providing housing.
- Limited availability of affordable housing and private landlord concerns on renting to people with mental health issues have created a situation where agencies are left with few options but to use rent supplements to secure units in lower-income, higher-crime areas in the community – increased levels of funding for rent supplements would facilitate renting in safer neighbourhoods.
- Significant time is required to do data input and respond to requests for information to funders – a system to streamline workload would increase efficiencies and direct service time to clients/tenants.
- Most of the services and housing for the region are concentrated in the City – transportation is a major challenge.
- Stigma and "NIMBY"ism can be an issue in housing development. Experience has been that being in the community, involving people with mental illness in building relationships, can be helpful.

MAKING SUPPORTS WORK

Site visits reflected a growing consensus of the sector in embracing a recovery oriented framework of practice which comprised services beyond the traditional basket of mental health services, and in some cases, reflected the active redefinition of the basket of services.

A MODEL ACTUALIZING HOUSING SUPPORTS: 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, including singles, adults and families with children, 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.

The Houselink experience demonstrates that a community is built on the natural hubs created in common spaces. Furthermore, opportunities to participate in recreational activities help strengthen the sense of a 'community of peers' at Houselink. This is further reinforced through various committees comprised of both staff and members. For example, Houselink 101 is a committee designed to provide 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. In 2009-2010, approximately 8,000 meals were served to members. 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.

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 rehabilitation 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 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 of the apartments.

There are two apartment buildings owned by Potential Place – one with 11 apartments and another with 16 apartments. Funding for the first building was largely by donation from a benefactor and federal assistance. Alberta Works provided assistance in painting and renovating the apartments. CMHC funded the renovation of one of the apartment roofs. The second building was acquired through funds from fundraising as well as a combination of provincial and federal funds. Calgary Housing also assists this project by providing rent assistance on a case-by-case basis. Tenants are members of the two local Community Associations and this has helped address any NIMBY issues within the community. Also, partnerships with the police force (Community Liaison Officer) and the PACT (Police and Crisis Team – a partnership between Calgary Policy and Alberta Health Services) team 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. Members talk about being good neighbors to one another. For instance, when one neighbor 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 neighbors upstairs. Many such stories of support abound. Of particular significance was the story related to us by a young man who decided to go off medication, and no amount of convincing from the staff of Potential Place could sway him. However, when he returned after the weekend, he reported his peer neighbors convinced him to continue taking his medication for all their sakes. Looking back, he was very thankful for their insistence and support, as it helped him maintain his recovery.

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 pro-choice and recovery oriented.

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

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 like Nanaimo just three years ago, many people with mental illness and addictions ended up homeless on the street or 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 as well as 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 SRO model where an old hotel (formerly a flea bag hotel and a strip bar) was converted into an SRO and is currently undergoing major renovations. Tenants have to share bathrooms for most part. There is a microwave and hotplate in each apartment. Clients also have access to a frozen meal option provided out of a café operated by CMHA in the same building.

It is 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 connection 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 others are either connected to an Assertive Community Treatment Team or an outreach service.

All three partners, the Vancouver Island Health Authority, the CMHA and the Ministry of Housing and Social Assistance have office space in the apartment building. The café CMHA operates in the building is also enjoyed by the larger community. Service access to the tenants of the building is also facilitated through proximity to services. 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 homeless outreach workers who also operate out of this office space. Vancouver Island Health Authority provides on-site mental health and addiction services. The Assertive Community Treatment team has truly integrated a 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 in 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 within a familiar setting.

Challenges
As there is a significant lack of affordable and social housing in Nanaimo, it is a challenge to replicate the model or to provide supports through a scattered model. Also, the tenants are presently all male. According to the executive director of CMHA, the women who need support have a greater severity of issues like addictions and behavioral problems; most have had their children removed from their care, and the majority are street entrenched. Hence there is a need for greater supports and resources than is currently available. In response to these challenges, B.C. Housing and the City of Nanaimo are building 160 units of new housing. 30-45 apartment units have been awarded to CMHA together with funding for staff, which will be utilized to house women with high level needs and will include a peer-mentorship element to support the tenants.

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/operates 17 buildings, which provide 67 rental units, 24 units managed by SBCS. Overall, SBCS provides housing and related services to approximately 80-90 tenants (including people with complex mental health needs). SBCS operates using a *Housing First* approach. Applicants to housing do not require a diagnosed mental illness to access services. It's important to note, however, that many people who access SBCS services have a range of mental health needs.

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 can not 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 counselling, 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. It is temporary housing and referrals are typically made through health care providers, family counselling agencies, The Department of Human Resources and Employment, family and peers, and self-referral. On-site supports include counselling 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 providing tenants and other clients with assistance regarding education and employment needs and advocacy support with regard to income, is one of several supportive housing locations for low income single individuals. Carew Lodge will be the location of a 'one-stop-shop' housing resource center. This will be the only housing resource center in the province.

MOVING FROM COLLECTIVE CARE TO INDEPENDENT LIVING MODELS: WAKAMOW PLACE (MOOSE JAW, SASKATCHEWAN)

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

Through 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 – or three separate degrees of independence ranging from needing higher levels of service and supports to intermediate to low levels of service and supports. Tenants can revolve through these steps and the services will follow them. The Kinsmen Foundation provided furnishing to all the apartments.

The building in itself has a recreational area, as well as a vocational centre that provides supported employment opportunities to clients. Groups are conducted here on a regular basis on life skills and other issues based on needs. 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, with funds provided through a service agreement with the Health Region as well as the Five Hills Health Region. There is access to the Mental Health Resource Centre. The Health Authority plays a very crucial role in this partnership through a very engaged leadership. There are Health Region staff who work at the venue. 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 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.

INNOVATIONS IN COLLABORATION

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

The housing and supports offered in Brandon is the perfect example of seamless integration between Health, Family Services and Consumer Affairs, 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 is delivered innovatively here. People have to be on EIA (Employment Insurance Assistance) to access PHB. A successful partnership with FS&CA enabled the assistance rate to be raised, by offering a subsidy up to $200 that is portable and 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 with mental health and addictions. The Central Intake Committee for the PHB comprises the Brandon Regional Health Authority, Manitoba Housing, the CMHA and the FS&CA. This enables immediate placement in either social housing or CMHA housing if a fit is seen. This avoids delay in terms of a prolonged application process to the housing provider. There are also instances where there is a 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 Brandon Regional Health Authority.

A range of housing options from 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. It is interesting to note that 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 onsite staff and is cost effective as well as recovery oriented, in that units are more like an apartment rather than a dorm.

Employment support is provided by the EIA department through “job connection workers” and CMHA which hires tenants as cleaners in all of its buildings. In addition the RHA also provides employment support through employment development counselors

The Brandon Regional Health Authority operates acute care beds, group homes, as well as a runs a crisis service centre which enables discharge and transitional care till clients are ready to move into the community. They also avoid eviction prevention by working to stabilize a destabilized client by housing him/her temporarily in the crisis centre. So while avoiding rehospitalization, the necessary supports are provided to the client. A mobile crisis unit outreaching remote areas also operates from this centre.

The Health Authority has cultivated effective partnerships with Manitoba Housing, FS&CA 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 and reach out to them, and support them in their home settings. This avoids dislocation and the maintenance of housing 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.

Challenges

The Maple Leaf factory has created an influx of immigration into the community which is not geared to deal with the demands. This places greater demand on an already inadequate housing stock and is a challenge that needs to be addressed. Also, more wet housing is needed as addictions are a major issue in the community. Also Home Care is essential for people to maintaining their housing, irrespective of their medical or psychiatric condition. Hence there is a strong push towards shared services in this direction.

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 health and addictions in many rural areas. Funding is a constant challenge. In such situations community organizations diversify their services to address unmet needs as well collaborate through effective partnerships for maximum efficiency and reach. The individual services of SHARE and CMHA, as well as their partnership in Prince Albert is one such example.

SHARE converted a 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 pick, 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 anywhere up to $250/month. As homelessness was quite an issue and there was inadequate housing, SHARE expanded its services and now runs a Group Home through the Approved Home Funding. The SHARE vocational program does the maintenance of this building resulting in some cost saving.

CMHA is involved in health promotion and education, and community support services in Prince Albert. They have recently taken on the role of supported housing provider and are nearing completion of an apartment building with 8 independent units – 6 one bedroom and 2 two bedroom units. The tenants will have access to CMHA's drop in centre, the vocational program, 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 health 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 others 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 avail the day programming at CMHA. They use the drop in centre, the vocational programming and the lunch program offered by CMHA. Both organizations jointly advocate for services and supports to the province and the health authorities.

Challenges

The housing stock is very limited in Prince Albert. Lack of adequate rent supplements is a huge problem. As resources are limited, much of a service provider's time is spent on advocating and fund raising. This places an enormous amount of pressure and stress on service delivery. Grants focus on starting new initiatives, not on sustaining them. These challenges are only partially addressed through partnerships. As eloquently stated by one of the players "innovations should not be a rationale for continued under funding".

THE SUPPORTIVE LIVING COMMUNITY PARTNERSHIP (NEWFOUNDLAND & LABRADOR)

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

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

The Supportive Living Community Partnership is tasked with developing programs, assessing need, and responding to the need of communities by supporting the provision of a range of supportive housing/supportive living options. This allows for non-profit, community-based groups to work closely with government while providing funds to operate supportive living. The definition of Supportive housing (within 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-based, broad-based perspective not at the individual level (e.g., those requiring a high level of individual support). The restrictions the program places on funding 'Supportive Housing' are those programs that require a home-support program (e.g., 24-hour a day one-on-one support).

The overall goal of the initiative is funding community groups that will develop a model of services and staff to individuals that do not require a high level of support. The program can fund a range of community services that are individualized for the needs of the community. The focus of funding is on those individuals who are in and out of institutions, health care, and emergency shelters. Furthermore, it is not focused on supporting congregate living but looking more to developing scattered units from 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 is dedicated to non-profit, community-based organizations. Some examples of funding provided by the Supportive Living Community Partnership include, but are not restricted to: Support for the creation of a Housing Resource Centre through Stella Burry Community Services, funds used to sponsor a conference on meeting the needs of individuals with complex needs (held in St. John's in October 2009); to create a full time position to support capacity building within the system and to obtain on site support services offered at transitional housing for youth (at Choices for Youth).

The hope is that through this program more scattered units and out-reach services will be developed (*Housing First*). The amount of funding and funding level by the Supportive Living Community Partnership depends on the target population – a general assessment tool is used by the program to determine funding. This depends on the level of program, services, and staffing. This process was implemented to allow for flexibility in program development and to ensure that funding can meet the needs of the community.

THE CROSS-DEPARTMENTAL COORDINATION INITIATIVES DIVISION (MANITOBA)

This 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 with mental health issues. The office works with regional health authorities and communities to improve policy co-ordination, integrate service provision, improve collaboration and co-ordinate strategies.

The CDCI liaises within provincial government departments, with regional health authorities, with housing authorities and with 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 on-the-ground 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 (e.g., *Housing First*), ensuring people weren't being discharged 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," providing supports to people with mental health issues living in Manitoba social housing units. This was another example of CDCI facilitating coordination across multiple provincial departments including the Department of Family Services & Housing, the Department of Health & 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.

CLÉ EN MAIN PROGRAM (QUEBEC CITY, QUEBEC)

"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 called, "*Clé en main*: le rétablissement par le logement autonome"

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

Clé en main provides a unique, alternative model and approach in response to the housing needs of persons living with a mental illness. One of its critical roles is one of system leadership and catalyst to create and maintain cross-sector operational mechanisms that effectively bridge service provision and delivery from the housing provider sector, the mental health support sector and the participation of the consumer tenant.

Persons living with serious mental health problems are housed through the coordination support of Clé en main. Potential consumer-tenants are provided with access to their own individual apartment from a variety of housing providers in conjunction with community mental health supports delivered from one of a variety of different mental health service agencies.

The key innovation with Clé en main that deserves to be highlighted is its pro-active role in cross-sectoral integration and developing concrete mechanisms to achieve that. Clé en main provides the system leadership and the operational means to bridge the resources from the housing sector together with the resources from the health sector resulting in a tri-partite protocol agreement between client-tenant, housing provider and community support service sector. This model is highly transportable not only across different regions (urban and rural) but also to other marginalized and vulnerable populations in need (e.g., dual diagnosis).

INNOVATIONS IN EVALUATION

EVALUATION FRAMEWORK TO MAINTAIN PROGRAM FIDELITY AND QUALITY (QUEBEC)

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

The evaluation instrument is comprised of 12 assessment grids which 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 establishing organizational improvement goals. Actions plans are written and implemented in the following two years. This ongoing quality assurance process enables the organization to stay attuned with clients’ needs, organizational assets and challenges and environmental realities. The organization has fine tuned and tailored the instrument over the years and continues to increase its efficiency. The instrument and the process benefit the orientation and training of all staff.

SUMMARY OF PROMISING PRACTICES – INDIVIDUAL, PROVINCIAL, AND TERRITORIAL MAPS

ALBERTA

The ten-year **Plan to End Homelessness** represents the first time that any province or territory has committed to ending homelessness, within a specific time frame, and with specific funding investments attached. The Plan has surpassed its first year target (housing 1,779 individuals together with needed supports rather than 1,000). If the plan is carried out in its entirety, the province will have created 8,000 units, housing an estimated 11,000 people by 2019. The expectation is that the plan will pay for itself by about the midway point of the strategy in terms of reduced shelter, health and other costs that will be saved by providing adequate and appropriate housing and support systems. Enablers for success, from the perspective of people who have participated in the MHCC project, have included:

- The current Premier identified this as a priority within his election platform. There are also champions at the ministerial level. This level of leadership has been the main driver in achieving completion and implementation of the strategy.
- The Task Force that created the plan held significant consultation processes across the province to assist in the development of the strategy. This gave a real ‘grass-roots’ sense of the issues involved in addressing the needs of people who are homeless.
- The creation of the Alberta Secretariat is a meaningful way to monitor the implementation of the strategy, to identify where there are issues, and to facilitate making the plan a reality.
- All the ‘players’ – civil servants, politicians, service providers all need to stay committed to the fundamental change in thinking on homelessness – moving from management of issues to solutions.

The City of Calgary, as part of its’ 10 Year Plan to End Homelessness, has identified a priority of developing a system-wide “**Homeless Management Information System**.” The plan itself was developed through a multi-sectoral Calgary Committee to End Homelessness – this Committee chose the Calgary Homeless Foundation to implement the plan. Strategy 4 of the plan identified the need for a locally developed and administered system **to improve data and systems knowledge**. The HMIS will allow the community to[271]:

[271] Information from the 2010/11 Calgary Homeless Foundation Business Plan.

- Collect standard data in 'real-time' that will provide the total number of homeless, length and causes of homelessness, and demographic characteristics and needs,
- Better understand people's experiences being homeless and the services they use,
- Facilitate improved service co-ordination, tracking client outcomes, providing more informed program referrals and reducing the administrative burden,
- Improve research for evidence based decision making
- Help shorten the length of time people are homeless and direct them through the system of care more efficiently and with more understanding

Pathways to Housing: Both Calgary and, more recently, Edmonton have implemented a "Pathways to Housing" model to serve people with chronic homelessness, together with serious mental illness and/or addictions. An evidence-based practice pioneered in New York by Sam Tsemberis, the focus is on rapid rehousing, combined with provision of supports (including assertive community treatment teams) that are based on the principle of client choice.

BRITISH COLUMBIA

- **Portland Hotel Society**: created in 1993 to advocate, develop and implement creative options for people living with mental health issues and/or substance use issues. Various housing options (supportive housing and single room occupancy models) work within a harm reduction framework, Joint funding through BC Housing and Health Authority. In addition to mental health and substance use services, there are a variety of supports available, ranging from home support to nutritional counselling, to arts.
- **Phoenix Centre** – provides a range of services for substance misuse in Kamloops including detox, youth outreach, family services, preventions services.
- **Luma Housing Project in Vancouver**: The Luma Native Housing Society operates over 200 units of Aboriginal social housing in Vancouver. In 2004, they opened a patient lodge that supports Aboriginal patients from across B.C. by providing them with an apartment-type setting to stay in while they are receiving medical treatment in Vancouver. The unique aspect of the lodge is that patients and their families can participate in the complex's common area, programs, social gatherings and become part of the "neighborhood" while they are recovering and receiving treatment.
- **ACE Empowerment Centre and the BC Schizophrenia Society Prince George**: consumer-led initiative, supported by the Schizophrenia Society, which provides member-driven social and recreational events, and peer support.
- **Broadway Youth Centre**: provides housing information, employment, counselling, Aboriginal youth services information, and community connections in Vancouver and Surrey.
- **Coast Mental Health**: provides assistance in housing jobs, community, rehabilitative social and recreational opportunities, food, clothing and basic life skills training in Vancouver.
- **RainCity Housing and Support Society**: serves people within a harm reduction framework, including people with co-occurring mental health and substance use issues who are homeless or who are at high risk of homelessness.
- **Crabtree Housing**: offers safe transitional housing for pregnant and parenting women who are overcoming substance abuse issues. The housing community uses a harm reduction approach and connects residents to YWCA and community resources.
- **CMHA Shuswap/Revekstoke Branch**: supported housing complex designed as a horseshoe – one side is BC housing funded, other side provides home ownership options via CMHC.

- **Homes for Good Society**: formed as a next phase to the Mayor's Action Team on Homelessness: Goal is to end chronic homelessness in the region (Surrey and surrounding) in five years through a *Housing First* approach, and based on two pillars: making use of existing housing inventory where possible, and coordinating availability of existing supports.

MANITOBA

The Manitoba map has highlighted a number of promising practices, including the extensive work and funding investments attached to its poverty reduction and housing strategies. This section provides more information about the Cross Departmental Coordination Initiatives division of the provincial government, as well as the Winnipeg Inner City Research Alliance. Reference should also be made to the site visit summaries.

Partners have noted that the work of the CDCI Division has had a significant impact on the landscape for housing dedicated to people with mental health issues. The **Cross Departmental Coordination Initiatives** division plays a leadership role in working with a variety of stakeholders to address issues of housing and homelessness for Manitobans. The CDCI liaises within provincial government departments, with regional health authorities, with housing authorities and with community-based organizations and research initiatives. Created only three years ago, 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 on-the-ground 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 (e.g. *Housing First*), ensuring people weren't being discharged 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 enhancement of the "**Community Wellness Initiative**," providing supports to people with mental health issues living in Manitoba social housing units. This was another example of CDCI facilitating coordination across multiple provincial departments including the Department of Housing and Community Development, the Department of Family Services & Consumer Affairs, the Department of Health & Healthy Living and Manitoba Housing. 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 Housing and Community Development and generate the funding solution required.

The **Winnipeg Inner-City Research Alliance** brings together researchers, government representatives, health authorities, community-based organizations and others to conduct research projects that are identified as most important by the community. This local research which considers neighbourhood and individual social needs is designed to improve policy and program development impacting Winnipeg's inner city. The partnership approach has fostered research, training and related activities to harness development of Winnipeg's inner city communities. Topics include housing, community development, cross-cultural approaches to education, child and youth issues, health and economic development, while drawing people together to build partnerships, build ideas, and strengthen community capacity. Although the focus is on Winnipeg's inner city, this type of research is relevant to many other Canadian cities as well. Funding sources have included the Social Sciences and Humanities Research Council and the Canada Mortgage and Housing Corporation.

NEW BRUNSWICK

New Brunswick has made significant progress in recent years in setting out clear goals and targets relating to poverty reduction and housing and homelessness as noted in the Key Initiatives section – the mental health

provincial framework is expected shortly. The integrated vision for health, income and housing is reflective of the work of the recently created New Brunswick Health Council. The Council is tasked with developing mechanisms of meaningful community engagement, and the measurement, monitoring a devaluation of:

- Population health
- Health service quality
- Population satisfaction with health services and health service quality
- Sustainability of health services in New Brunswick

The Council, among other achievements, issued a provincial Population Health Snapshot in 2009/10 – which was reflective of the social determinants of health – as well as developing/issuing a Health Systems Performance Report Card. These types of practical tools, combined with the targeted provincial frameworks noted above, may be of great value in identifying the needs of housing and mental health services.

NOVA SCOTIA

Killam Properties is one of Canada's largest residential landlords, and is based in Halifax. Holdings include 118 apartment properties in Atlantic Canada's six major urban centres and has 55 manufactured home communities across Canada. Killam Properties has provided dedicated units at their sites where a housing worker can live and provide supports on an ongoing basis. Benefits to Killam include access to supports for everyone in that particular setting, not just people formally part of a treatment system.

- Killam has contributed 31 units for clients of the Capital District Mental Health Program in Halifax (first piloted in 2007) and a second landlord has since contributed an additional 16 units.
- Killam and the second landlord do make the final decision on tenant selection, but CDMHP do the initial screening and referrals process.
- CDMHP provides tenant support, who also have access to a 24/7 mobile crisis team.
- Subsidies ranging from 5 to 22 per cent of market rents are provided by Killam as a corporate donation (worth $46,000 in 2009).

Supportive Housing for Individuals with Mental Illness - New Dawn: a private landlord in Sydney (Cape Breton) who has 13 apartments where rent is kept at a flat rate, and will not be increased unless the social assistance rate is increased as well. This initiative (Supportive Housing for Individuals with Mental Illness) is a partnership between New Dawn Enterprises, the Cape Breton District Health Authority Mental Health Services Program, the Cape Breton Mental Health Services Charitable Foundation, and the Canadian Mental Health Association.

- Provides a total of 13 apartments in three buildings.
- New Dawn provides property management, while the CBDHA and the CMHA provide tenant support and referral services. Income support is provided by the Department of Community Services.
- The first tenants were members of Crossroads Clubhouse, which also provides employment counselling, food services and counselling in addition to the mental health and health supports provided by CBDHA and CMHA.

Affirmative Industries Association: developed "Building for Independence" in Halifax, a housing and supports model which assists people living with mental illness to earn equity in their apartment which is then available to help the person buy a home, return to school, etc. Tenants pay into Individual Development Accounts (IDAs) and are provided with matching grants (provided by the Department of Community Services on a pilot-project basis).

- A total of 10 supportive housing units (8 one-bedroom, two two-bedroom) for people with mental illness.
- The building site was donated by Halifax Regional Municipality and the project received capital assistance from CMHC, the government of Nova Scotia (through the Affordable Housing Initiative), and through a capital campaign (raised 15% of total capital costs).

- Because there is no mortgage, the rental price is set to the maximum welfare entitlement for people on disability, while AI is still able to generate an operating surplus which can then fund the matching grants to the IDAs.
- Tenants are able to access their built-up equity when they move (maximum tenancy in the building is expected to be five years) or under special circumstances.
- Affirmative Industries was a recipient of the Canadian Institute of Planners National Award for Planning Excellence in Housing for the IDA concept and the community engagement process used during project planning. Affirmative Industries did not set up the IDAs until late 2008, so the evaluation of the effectiveness of a five-year tenancy and savings horizon will take place in 2013–2014.

Coordinated fundraising: Mental Health Foundation of Nova Scotia: the Mental Health Foundation of Nova Scotia is a registered charitable foundation that was established in 1987 to create a higher level of awareness of mental health and support organizations to deliver the highest level of mental health care throughout Nova Scotia.

NUNAVUT

- The Department of Health and Social Services works with **Nunavut Arctic College** by supporting and funding certificate and degree programs that lead to career opportunities in health care and social services. Programs planned for delivery in 2010-2011 include: Human Services (Social Work and Alcohol and Drug Counsellor streams) in Cambridge Bay and the Nunavut Nursing (Baccalaureate) Program
- The Nunavut Housing Corporation contracted with Statistics Canada to conduct a Nunavut Housing Needs Survey (NHNS). Results from the NHNS were released in Fall 2010 and provide reliable data relating to the housing shortage, the type of housing required to meet the demands of a growing population and the resources needed to address the crisis. The final response rate was 79% of all dwellings occupied by usual residents in Nunavut.

NORTHWEST TERRITORIES

Assisting Small Communities to Prevent and Reduce Homelessness and Related Impacts:

- Small Community Homelessness Fund available to communities outside of Yellowknife, Fort Smith, Inuvik and Hay River for the development of local projects to address emergency shelter and community homeless issues.
- Steering committee led by Health and Social Services with representation from Education, Culture and Employment (ECE), Justice and the NWT Housing Corporation, oversees implementation of the SCHF.
    - The Pehdzeh Ki First Nation in Wrigley received funding to renovate a church basement into an overnight shelter, as well as to facilitate a life skills workshop for the homeless
    - The Deh Gah Got'ie Council in Fort Providence was funded to renovate two bachelor units as emergency housing
    - The Katlodeeche First Nation in Hay River was assisted in renovating a three-bedroom house into two bachelor units to provide homeless accommodation on the Hay River Reserve
    - The Acho Dene Koe First Nation in Fort Liard received funds to implement their Winter Warm-Up Program. This program includes a weekly hot nutritious meal, a clothing bank and an emergency vouchers program

NEWFOUNDLAND AND LABRADOR

The Supportive Living Community Partnership
Interdepartmental government initiative was introduced in 2009. The initiative attempts to overcome two major problems that non profit sector was having – 1) having to go to multiple government programs for money and to have to fit their requests within the parameters of all of those programs, which often meant non profit organizations were often compromising on what they really wanted to do, and 2) there a number of good ideas/projects that have capital money but lacked operational funds and thus couldn't get off the ground. The program was developed by provincial government departments (e.g., Department of Justice, Human Resources, Labour and Employment, Newfoundland and Labrador Housing, Department of Education, and Regional Health Authorities). In an effort better support non profit organizations, the departments decided to pool money and put a single request into Cabinet. The request was approved and one of the regional directors has been seconded to implement the initiative. The funds are managed by the one director/department.

The Supportive Living Community Partnership is tasked with developing programs, assessing need, and responding to the need of communities by supporting the provision of a range of supportive housing/supportive living options. This allows for non-profit, community-based groups to work closely with government while providing funds to operate supportive living. The definition of Supportive housing (within 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-based, broad-based perspective not at the individual level (e.g., those requiring a high level of individual support). The restrictions the program places on funding 'Supportive Housing' are those programs that require a home-support program (e.g., 24-hour a day one-on-one support).

The overall goal of the initiative is funding community groups that will develop a model of services and staff to individuals that do not require a high level of support. The program can fund a range of community services that are individualized for the needs of the community. The focus of funding is on those individuals who are in and out of institutions, health care, and emergency shelters. Furthermore, it is not focused on supporting congregate living but looking more to developing scattered units from 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 is dedicated 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
- Funds used to sponsor a conference on meeting the needs of individuals with complex needs (held in St. John's in October 2009)
- Funds to create a full time position to support capacity building within the system
- Funds to obtain on site support services offered at transitional housing for youth (at Choices for Youth)
- Funds to co-fund a Housing Development Worker position in Labrador (monies are to be used for operational costs only)
- Choices for Youth
- Eva's Phoenix – 14 units, onsite, transitional housing; flexible services; educational; employment readiness program (train for the trade)
- Transitional housing for youth
- Funding on site support (ICM model)
- Community Advisory Boards established in 5 communities
- Created community plans

The hope is that through this program more scattered units and out-reach services will be developed (*Housing First*). The amount of funding and funding level by the Supportive Living Community Partnership depends on the target population – a general assessment tool is used by the program to determine funding. This depends on the level of program, services, and staffing. This process was implemented to allow for flexibility in program development and to ensure that funding can meet the needs of the community.

NAVNET

NAVNET is an innovative cross system 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. NAVNET co-sponsored Building on "From the Outside In," a Fall 2009 conference where speakers from Australia profiled innovations in service delivery for people with complex needs. Building on these learning's, NAVNET has been engaged in a wide variety of activities aimed at coordinating our response to individuals with complex needs. Some of these activities have included:

- The completion of a comprehensive cost analysis to determine the costs associated with providing services and support to 10-12 clients who use multiple government and community systems.
- Work towards the development of an information sharing protocol in line with existing Privacy Legislation. This will allow NAVNET Member Departments and Agencies to share relevant information to ensure that our services are individualized, coordinated and that duplication does not occur. It is expected that this protocol will include a client consent form as well as a Memorandum of Understanding between NAVNET Members.
- A client identification project which allowed NAVNET to quantify the numbers of individuals in St. John's who meet NAVNET's definition of having "complex needs."
- Exploring ways to facilitate development/increase in housing system capacity that will address gaps and meet the needs of (future) NAVNET clients.
- Enhancing communication through use of specific tools including a webpage (www.navnetnl.ca), newsletters (the "navigator" provides progress updates on the work of NAVNET) and electronic bulletins (shares information and upcoming events between the government and community sectors). Other strategies such as creative networking ideas (workshops, brown bag lunches; lunch and learns) are in progress.
- The NAVNET Project Coordinator has engaged in knowledge transfer and has presented to a wide variety of groups, including the National Health Care Leadership Conference in Winnipeg in June 2010 and at a Roundtable organized by the Mental Health Commission of Canada and the CMHA (National Office) in Ottawa in November 2010.
- NAVNET has submitted a funding submission for a one year demonstration project of a new coordinated service model.

ONTARIO

- A consumer-led initiative in Toronto, PARC, has developed a partnership with a residential (custodial) care housing provider to implement the creation of 29 new supportive housing units as a mechanism to take existing custodial housing and convert this to be more recovery-oriented in nature. Peer support is a core element of the model, and the model helps to address some of the challenges people experience day-to-day, including food security.
- Supports for Social Housing Program – the City of Ottawa has recently allocated new annualized funding ($1 million) for five support service agencies to provide ongoing services to 100 at-risk clients in social housing.
- A pilot project in London focused on building connections between the hospital and social service systems, in order to decrease the number of people being discharged from hospital to homeless shelters. This integration dramatically diminished discharges to shelters in a two-year period.

- As part of its 2001 Affordable Housing Strategy (which was updated in 2005), the Regional Municipality of Waterloo targeted the creation of 1500 units of affordable housing by 2008. They combined funding from the province and the federal governments for rental housing with its own regional grants and a series of bylaw changes to encourage for profit and not-for-profit groups to build affordable housing. Bylaw changes included: a lower property tax classification for new, multi-residential rental housing which reduce monthly operating costs by $50-$100 per unit; and providing grants for Regional Development Charges for private developers. Units rent at or below market level and target a range of needs (singles, families, and people with disabilities). Since achieving their 2008 goal, their goal by 2013 is to create an additional 500 units. A cost analysis demonstrated that, for every $1 invested by the municipality, an additional $13 of investment was generated from other sources.
- An evaluation of the Provincial Rent Bank Program has demonstrated very promising results to date. Established in 2004, it provides short-term assistance for rent arrears in order to avoid tenant household evictions (generally up to two months). An evaluation was conducted to assess the extent to which housing stability was enhanced, and cost savings were achieved. While there were some limitations due to availability of data, the evaluation highlighted the following (Malatest, 2008):
    - Spending $13 million through the Provincial Rent Bank has lowered emergency shelter costs to the Province by over $7 million.
    - Research suggests that programs such as rent banks can provide additional cost savings to tenants and landlords through reduced evictions: estimates are that evictions cost $2,234 per tenant and between $2,500 and $6,000 for landlords
    - Other potential cost savings can include reduced costs to social assistance, social housing, and to the Landlord and Tenant Board.
    - There is a high level of satisfaction among Service Managers with the Provincial Rent Bank's overall guidelines, and the ability to adapt to local needs and context; funding assistance is generally seen to be sufficient.
    - Almost all Service Managers (88%) thought that the amount of funds being provided to clients was adequate.
    - Some support to consider providing additional months of rent.
    - Some Service Managers noted that they would like to see funding available to provide short-term assistance for those with mortgage arrears.
- Each Municipal Service Manager is mandated to provide coordinated access to available social housing. To this end, there is a provincial body where the chairs of various social housing coordinated access networks meet periodically to share prevailing issues, identify trends, and coordinate training opportunities for staff.
- Mainstay Housing, in Toronto, is the largest dedicated supportive housing in Ontario. They own and manage 41 properties with 867 units providing affordable, low threshold access for 1000 people (singles, couples and families with children). A formal Memorandum of Understanding is in place with 20 support agencies from mental health and social service sectors.
- Houselink, in Toronto, partnered with Toronto Community Housing to identify key strategies in integrating recovery in social housing (findings are profiled in Appendix 1)

PRINCE EDWARD ISLAND

- With the support of the Homelessness Partnering Strategy, a major study is being undertaken to establish the **housing and support needs for youth** in Charlottetown and Summerside (two of the 61 "designated communities" by the HPS across Canada). The study is particularly focused in the 16-18 year age range. The

report is expected in Summer 2010 and may provide learning opportunities for other jurisdictions in the country.

- Most recently, the **PEI Community Advisory Committee on Homelessness** issued the first ever Report Card on Homelessness which identified that the shelter beds were used over 5400 times by about 240 individuals over the course of 2009[272].

QUEBEC

Protocol to monitor and Enable Consumers Self-administration of Medication
The "Direction des services de réadaptation et d'hébergement dans la communauté" of Montreal's Louis-H. Lafontaine Hospital has developed and implemented a standardized tool and approach for the self management of medication in all of their community residences. The six phased process describes the goal and the steps to self-administration of medication by consumers. This user-friendly tool provides guidance for staff to monitor and identify where the consumer has progressed on the continuum of independence and enables a staged acquisition of this independent life skill area. It is a gradual process ensuring consumer's safety and insight in monitoring their own medication.

Supporting Service Providers with System Change
The Psychosocial Rehabilitation and Residential Resource Program of the Douglas Mental Health University Institute have begun to support system transformational changes required by the government to offer more independent long-term housing with support services. The Douglas team is working with their partners from the private and community sectors to integrate and align to the new paradigm in mental health housing. We visited two private service providers who have invested and have acquired space to offer long-term independent housing with support. Firm commitment to the values of emerging models and the vision of the client-centered and empowered approaches are essential to ensuring the success of this transformational change. Leadership and flexibility to educate and support service providers on the benefits of these models are key to making it happen.

Evaluation Framework to Maintain Program Fidelity and Quality
Community organizations are often challenged to integrate evaluation mechanisms and processes that enable them to maintain fidelity to evidence based practices and ensure quality. "Le Mûrier" which manages a large spectrum of housing and support service programs which are delivered to different target populations chose to invest in developing and implementing an evaluation framework in order to continually improve their services. They hired a consultant for the development of the initial evaluation instrument and have continued to tailor it to meet the changing needs.

The evaluation instrument is comprised of 12 assessment grids which 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 establishing organizational improvement goals. Actions plans are written and implemented in the following two years. This ongoing quality assurance process enables the organization to stay attuned with clients' needs, organizational assets and challenges and environmental realities. The organization has fine tuned and tailored the instrument over the years and continues to increase its efficiency. The instrument and the process benefit the orientation and training of all staff.

SASKATCHEWAN

- In 2009, the Saskatchewan Housing Corporation partnered with the Association of Saskatchewan Realtors (ASR) and contracted with Sigma Analytics to identify methods to **engage the private sector to finance, design and deliver affordable housing** in 2009. A second phase of this research is currently underway to identify and build partnerships to develop affordable and rental housing.

[272] Thibodeau, W. *Homelessness 'hidden problem' in Prince Edward Island*. Published in the Guardian, May 4, 2010. http://www.theguardian.pe.ca/inde.g.cfm?sid=338670&sc=98

- The recently released **"Patient First" framework** from the provincial government focuses primarily on medical issues, but the principles dovetail well with recovery-oriented practices.
- The Community Care Branch of the Ministry of Health produces annual reports on Mental Health Services in the province. The depth and breadth of information on the services available, key players involved, a detailed funding breakdown, and the performance of the system is worthy of note. The indicators presented in the annual report are organized in a way that is consistent with the Canadian Institute for Health Information's (CIHI) Health Indicators Framework with the eight dimensions including: acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency and safety. In addition to providing a detailed overview of the population, services provided, and funding levels, the 2008/09 report contained the following data tables (with source information generally drawn from the Mental Health Information System and Hospital Information System):

Acceptability Indicator 1 - Caseload Size for Mental Health Services, 2008/09
Acceptability Indicator 2 - Overall Mental Health Spending in Saskatchewan 2008/09
Acceptability Indicator 3 - Regional Health Authority Actual Mental Health Expenditures 2008/09
Acceptability Indicator 4 - Nervous System Central Drug Utilization 2008/09
Accessibility Indicator 1A - Wait Times for Rural and Smaller Centres Mental Health Services, 2008/09
Accessibility Indicator 1B - Wait Times for Urban Mental Health Services, 2008/09
Accessibility Indicator 2 - Wait Time for Service at Saskatchewan Hospital North Battleford 2003-04 to 2008/09
Accessibility Indicator 3 - Saskatchewan Hospital North Battleford Admission Statistics by RHA, 2008/09
Accessibility Indicator 4 - Total Mental Health Active and New/Reopened Registrations by RHA, 2008/09
Accessibility Indicator 5 - New and Reopened Registrations by Age and Health Region, 2008/09
Accessibility Indicator 6 - New and Reopened Registrations for all Regions over Time, 2003/04-2008/09
Accessibility Indicator 7 - New and Reopened Registrations by 10,000 Population 2008/09
Accessibility Indicator 8 - New and Reopened Registrations by Region of Residence 2008/09
Accessibility Indicator 9A Count of Mental Health Related Calls to HealthLine by Presenting Problem and Shift Time, 2008/09
Accessibility Indicator 9B Count of Mental Health Related Calls by Presenting Problem to HealthLine, 2004/05-to-2008/09
Accessibility Indicator 9C Percentage of Mental Health* Related Calls to all HealthLine Calls, 2004/05-to-2008/09
Appropriateness Indicator 1 - Length of Stay, Average Daily Census and Occupancy Rates for RHA Mental Health Inpatient Wards 2007/08
Appropriateness Indicator 2 - Mental Health Designated Bed in General Hospitals, 1999/00-2008/09
Appropriateness Indicator 3 Count and Percent of Clients by Length of Stay (in days) in Mental Health Inpatient Wards by Region, 2007/08
Appropriateness Indicator 4A- Separations and Average Length of Stay by RHA for Psychiatric and Non-Psychiatric Wards (primary diagnosis) 2007-08
Appropriateness Indicator 4B- Separations by RHA for Psychiatric and Non-Psychiatric Wards per 10,000 Population
Appropriateness Indicator 5 - Patient Count and Number of Mental Health Contacts Provided by Fee-for-Service Psychiatrists and General Practitioners 2008-09
Appropriateness Indicator 6 - Psychiatric Separations by Diagnostic Group 2007-08
Appropriateness Indicator 7 – Mental Health Outpatient FTEs by RHA, per 10,000 Population
Appropriateness Indicator 8 - Residential Placements by RHA 2008/09
Appropriateness Indicator 9 - Residential Spaces by 10,000 Population
Appropriateness Indicator 10 - Mental Health Residential Spaces 2004/5-2008/9
Appropriateness Indicator 11 - Pre-vocational and Vocational Program Dollars/10,000 Population 2008/09
Appropriateness Indicator 12 - Client Concern Handling System for Mental Health as Reported by RHAs, 2008/09
Appropriateness Indicator 13a - Emergency Ward Presentations for Mental Health and Addictions Concerns, Regina and Saskatoon, 2007/08-to-2008/09
Appropriateness Indicator 13b – Percentage of Emergency Ward Presentations by Diagnosis out of all Mental Health and Addictions Presentations, Regina and Saskatoon, 2008/09

Effectiveness Indicator 1A – Multiple Mental Health Inpatient Separations by Region, 2007-08
Effectiveness Indicator 1B – Multiple Mental Health Inpatient Separations by Region as a percent of all Separations, 2007-08
Effectiveness Indicator 2 - Separations by Days until Re-admission 2007-08
Effectiveness Indicator 3 - Mental Health Services Separations* by RHA of Residence and Place of Service, 2007-08

- The **Saskatchewan Health Quality Council** is an independent agency that measures and reports on quality of care in Saskatchewan, promotes improvement, and engages its partners in building a better health system. Research reports measure overall health care quality in Saskatchewan, with specific areas of focus. While not specific to mental health, specific initiatives of the Council do – for example, on of the current activities is an 18-month initiative (the Saskatchewan Chronic Disease Management Collaborative II) providing strategies for health care providers (including physicians) to apply the best available evidence in treating depression.
- **The City of Saskatoon** has recently established a policy to offer disposable land parcels to affordable housing providers first - there is no open tender process and the land will only be open to the broader marketplace if there is no interest by affordable housing providers.
- **Lighthouse Supported Living Project (Saskatoon)**: this mixed housing project will provide affordable transitional and supportive housing, and will also include commercial office space and market housing (condos). The city is contributing a $1.5 million capital grant.
- **Station 20**: a $1.2 million capital grant and five year tax abatement from the city is supporting the affordable housing component of this multi-purpose project which also features a branch library and health centre. The land itself was sold by the city to project proponents for $1.

YUKON

- Currently in the planning process for an Abbeyfield style-model home that will be a pilot for seniors. Each person will have their own room, but there will be shared living space and a live-in support person who can provide a range of housing support services. Discussion is ongoing with staff from the Ministry of Health to look at how this model might work for people living with mental illness or acquired brain injuries. Another population might be people with co-occurring mental illness and developmental issues.
- As noted, creation of the Social Inclusion and Poverty Reduction is very promising, as is engagement of health and housing key players.

GLOSSARY OF TERMS

Assertive Community Treatment (ACT)
A model of case management where a multi-disciplinary team of professionals is responsible for providing services to clients. Caseloads are small, typically a 1:10 ration. Most services are delivered on an outreach basis and there is usually 24-hour coverage (Canadian Mortgage and Housing Corporation, 2006).

Concurrent disorder
Any combination of mental health 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 health disorders and problematic gambling.

Consumer
A person who has experienced significant mental health problems and/or has used the resources of the mental health system.

Co-operative Housing
Non-profit co-operative housing is a form of social housing developed under a number of federal and provincial housing programs. Housing is owned and managed by the people who live there. Tenants elect a board of directors, approve the budget and policies, and share the work involved in running the housing.

Custodial housing
Typically 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. The fixed basket of services seriously limits individualized recovery strategies, for example a client doing his or her own cooking. 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.

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.

Dual diagnosis
Refers to an individual with a mental illness and a co-occurring developmental disability (CMHA website).

Homeless persons
Homeless persons are those who do not have a permanent residence to which they can return whenever they so choose.

Intensive case management
Similar to ACT. This model also provides outreach services, lower caseload ratios and coverage outside of regular working hours. The main difference from ACT is that services are not delivery by a multi-disciplinary team of professionals (Canadian Mortgage and Housing Corporation, 2006).

Market rent housing

Housing is usually owned by private landlords. Tenants pay full rent and need to cook, clean, and care for themselves.

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.

Social housing
Housing with low rent. Households typically pay about 30% of their gross monthly income on rent.

Supported housing
Differs from supportive housing. With supported housing, the support worker provides care and services outside the home. People living in supported housing tend to need much less support and can live more independently than people in supportive housing. Supported housing could be a social housing coalition or any other housing environment that provides staff from a community agency (SHAD)

Supportive housing
Refers to housing where there are support workers in the home who work for the housing provider. The support varies depending on the level of need. There could be no support, on-call support, weekly support, daily support, or 24-hour-a-day support (SHAD)

Target population
A population that an agency is mandated to serve

Transitional housing
Time-limited housing (e.g., two to three years), often with support services and the expectation that residents will move on to independent and permanent housing (Canadian Mortgage and Housing Corporation, 2006).

REFERENCES

Aboriginal Healing Foundation. (2007). *Suicide among Aboriginal people in Canada*. The Aboriginal Healing Foundation Research Series. Retrieved from: http://www.ahf.ca/downloads/suicide.pdf

Affordability and Choice Today. (2009). *Alternative development standards: A guide for practitioners.* Retrieved March 16, 2010, from: http://www.actprogram.com/english/ProjectListing.asp?x=1&cat=23

Alberta Health Services. (2010a). *Alberta Health Services annual report, April 1, 2009 – March 31, 2010.*

Alberta Health Services. (2010b). *Alberta Health Services, 2010/11 operating budget and business plan*.

Alberta Mental Health Board. (2007). *Mental health economic statistics: In your pocket*. Alberta: Institute of Health Economics.

Alberta Secretariat for Action on Homelessness. (2008). *A plan for Alberta: Ending homelessness in ten years.*

Alberta Secretariat for Action on Homelessness. (2010). *2009/10 Report to the Minister - Progress report on the implementation of "A Plan for Alberta: Ending homelessness in ten years"*.

Alzheimer Society of Canada. (2010). *Rising tide: The impact of dementia on Canadian society*. Retrieved from: http://www.alzheimer.ca/english/rising_tide/rising_tide_report.htm

Andersen, M., Tinsley, J., Wilcox, R., Smereck, G., Pfoutz, S., Creech, S., Mood, D., et al. (2005). HIV health care access issues for women living with HIV, mental illness, and substance abuse. *AIDS Patient Care & Standards*, *19*(7), 449-59.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, *16*(4), 11-23.

Anucha, U. (2005a). Conceptualizing homeless exits and returns: The case for a multidimensional response to episodic homelessness. *Critical Social Work*, *6*(1). Retrieved November 10, 2009, from: http://www.uwindsor.ca/criticalsocialwork/ conceptualizing-homeless-exits-and-returns-the-case-for-a-multidimensional-response-to-episodic-home

Anucha, U. (2005b). We are not just rent receipts: Housing, neighourhood, and community re-imagined by formerly homeless people. *Canadian Social Work Review, 22*(2), 188–209.

Ascent Strategy Group (2008, March). *Final summary report: Trends, projections and recommended approaches to delivery of long-term care in the province of Prince Edward Island 2007-2017*. Prepared for the Department of Health and Wellness, Government of PEI.

Atlantic Seniors Health Promotion Network. (2004). *More than shelter - Housing policy kit for seniors in Atlantic Canada*. Retrieved from: http://www.canpension.ca/pages/pdf/engkit.pdf

Auditor General of Alberta. (2008, April). *Report of the Auditor General of Alberta*.

Auditor General of Alberta. (2008, October). *Report of the Auditor General of Alberta*.

Auditor General of British Columbia. (2008, October). H*ome and Community Care Services: Meeting needs and preparing for the future*.

Banyard, V. L., & Williams, L. (2007). Women's voices on recovery: a multi-method study of the complexity of recovery from child sexual abuse. *Child Abuse & Neglect*, *3*, 275-90. doi:10.1016/j.chiabu.2006.02.016.

Barrow, S., & Zimmer, R. (1999). Transitional housing and services: A synthesis. In L. Fosburg & D. Dennis (Eds.) *Practical lessons: The 1998 National Symposium on Homelessness Research* Washington: U.S. Department of Housing and Urban Development, U.S. Department of Health and Human Services.

Beer, A., & Faulkner, D. (2009). *The housing careers of people with a disability and careers of people with a disability.* A report of the Australian Housing and Urban Research Institute.

Begin, P., Casavant, L., Miller Chenier, N., & Dupuis, J. (1999, January). *Homelessness.* Canada – Parliamentary Research Branch (PRB 99-1E). Ottawa: ON: Library of Parliament. Retrieved June 8, 2010, from: http://www2.parl.gc.ca/Content/LOP/ResearchPublications/prb991-e.htm

Benglesdorf, H., & Alden, D. C. (1987). A mobile crisis unit in the psychiatric emergency room. *Hospital and Community Psychiatry, 38,* 662-665.

Birnie, S. (2010). A comprehensive costing analysis of intensive case management for individuals with severe mental illness and a history of homelessness, including cost-effectiveness as compared to standard care. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *70*(9-B), 5807.

Bland R. C., Newman S. C., Dyck R. J., & Orn H. (1990). Prevalence of psychiatric disorders and suicide attempts in a prison population. *Canadian Journal of Psychiatry, 35*, 407-413.

Bond, G. R., Drake, R. E., Mueser, K. T., & Latimer, E. (2001). Assertive Community Treatment for people with severe mental illnesses: Clinical ingredients and impact on patients. *Disease Manage Health Outcomes, 9*(3), 141-159.

Bradford, N. (2005). *Place-based public policy: Towards a new urban and community agenda for Canada*. Research Report F51. Ottawa, ON: Canadian Policy Research Networks.

Braubach, M. (2007). Residential conditions and their impact on residential environment satisfaction and health: Results of the WHO large analysis and review of European housing and health status (LARES) study. *International Journal of Environment and Pollution, 30* (3/4, 2007), 384-403. doi:10.1504/IJEP.2007.014817.

Braun, P., Kochansky, G., Shapiro, R., Greenberg, S., Gudeman, J. E., Johnson, et al. (1984). Overview: deinstitutionalization of psychiatric patients, a critical review of outcome studies. *American Journal of Psychiatry, 138,* 736-749.

Bridge, C., Flatau, P., Whelan, S., Wood, G., & Yates, J. (2007). How does housing assistance affect employment, health and social cohesion? *Australian Housing and Urban Research Institute: Research and Policy Bulletin.* Issue 87.

British Columbia Housing. (2009). *Housing's report on performance* – 2008/09.

British Columbia Housing. (2009, October). *Housing stock overview – Draft*.

British Columbia Housing (n.d.). *What we do*. Retrieved from: http://www.bchousing.org/aboutus/activities

British Columbia Mental Health and Addictions Services: Provincial Health Services Authority. (n.d.). *Riverview Redevelopment Project.* Retrieved February 21, 2010, from: http://www.bcmhas.ca/AboutUs/News/Riverview_Redevelopment/default.htm

British Columbia Ministry of Health and Ministry Responsible for Seniors. (n.d.). *B.C.'s mental health reform: Best practices for crisis response/emergency services*.

Browne, G., & Courtney, M. (2004). Measuring the impact of housing on people with schizophrenia. *Nursing and Health Sciences*, *6*(1), 37-44.

Browne, G., & Courtney, M. (2005a). Exploring the experience of people with schizophrenia who live in boarding houses or private homes: A grounded theory study. *Contemporary Nurse, 18*(3), 233-46. Retrieved from CINAHL database.

Browne, G., & Courtney, M. (2005b). Housing, social support and people with schizophrenia: A grounded theory study. *Issues in Mental Health Nursing, 26,* 311-326.

Bryant, T. (2003). The current state of housing in Canada as a social determinant of health. Retrieved June 8, 2010, from: http://www.irpp.org/po/archive/mar03/bryant.pdf

Bryant, T., Chrisholm, S., & Crowe, C. (2002, November). Housing as a determinant of health. In *Social Determinants of Health Across the Life-Span Conference*. Toronto, Ontario, Canada.

Buhrich, N., & Teesson, M. (1996). Impact of a psychiatric outreach service for homeless person with schizophrenia. *Psychiatric Services, 47,* 644-646.

Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of Intensive Case Management to reduce time in hospital in people with severe mental illness: Systematic review and meta-regression. *British Medical Journal, 335*(7615), 335-336.

Burt, M. R. (1999, August). Demographics and geography: Estimating needs. In Fosburg, L. B., & Dennis, D. L. (eds.), *Practical Lessons: The 1998 National Symposium on Homelessness Research*. Washington, DC: U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services. 1:1–1:24.

Butterill, D., Lin, E., Durbin, J., Lunsky, Y., Urbanoski, K., & Soberman, H. (2009). *From hospital to home: The transitioning of alternate level of care and long-stay mental health clients*. Toronto: Centre for Addiction and Mental Health, Health Systems Research and Consulting Unit.

Calgary Homeless Foundation. (2010, June 26). *Recommendations for the Alberta Health Act consultations*.

Calsyn, R. J., & Winter J. P. (2002). Social support, psychiatric symptoms, and housing: A causal analysis. *Journal of Community Psychology*, *30*(3), 247-259.

Campaign 2000. (2009). *Report card on child and family poverty in Ontario*. Retrieved May 20, 2010, from: http://www.campaign2000.ca/reportCards/provincial/Ontario/ 2009OntarioReportCardEnglish.pdf

Campbell, J. (2003). Emerging new practices in organized peer support. Report for the Substance Abuse and Mental Health Services Administration. Retrieved from http://www.consumerstar.org/pubs/Emerging%20New%20Practices%20in%20Oraganized%20Peer%20Support.pdf

Campbell, J. (2009). Federal multi-site study finds consumer-operated service programs are evidence-based practices. *Missouri Institute of Mental Health*, 1-11.

Canada Department of Justice. (1982). *The Canadian Charter of Rights and Freedom*. Retrieved from: http://laws.justice.gc.ca/en/charter/charter_index.html

Canada Mortgage and Housing Corporation (n.d.). Retrieved from: http://www.cmhc-schl.gc.ca

Canada Mortgage and Housing Corporation. (n.d.). *Housing in Canada online: Definitions of variables*. Retrieved from http://cmhc.beyond2020.com/HiCODefinitions_EN.html#_Core_Housing_Need_Status

Canada Mortgage and Housing Corporation. (2004a). 2001 Census housing series: Issue 3 revised: The adequacy, suitability, and affordability of Canadian housing (Research highlight: Socio-economic Series 04-007). Ottawa: Canada Mortgage and Housing Corporation.

Canada Mortgage and Housing Corporation. (2004b). Housing affordability. *Canadian Housing Observer*. Retrieved from: http://www.cmhc-schl.gc.ca/en/cahoob/hoaf2004 /hoaf_008.crm

Canada Mortgage and Housing Corporation. (2005). *Housing stability validity study*. Retrieved from: http://www.cmhc-schl.gc.ca/odpub/pdf/63802.pdf?fr=1290704282260

Canada Mortgage and Housing Corporation. (2006). *Special studies on 1996 census data:* Canadian households in core housing need and spending at least half their income on shelter - *Research highlight*.

Canada Mortgage and Housing Corporation. (2008). *CHS - Residential Building Activity 2008*. Ottawa. Retrieved from http://publications.gc.ca/site/eng/328933/publication.html

Canada Mortgage and Housing Corporation. (2009a). *Canadian Housing Observer.*

Canada Mortgage and Housing Corporation. (2009b). *National Seniors' Housing Survey.*

Canada Mortgage and Housing Corporation. (2009c). *Seniors' Housing Report – Ontario.*

Canada Mortgage and Housing Corporation. (2010a). *Canadian housing observer: Average rent for two-bedroom apartments, Canada, provinces and metropolitan areas, 1992-2009 (dollars)*. Retrieved from: http://www.cmhc-schl.gc.ca/en/corp/about/cahoob/data/ data_004.cfm

Canada Mortgage and Housing Corporation. (2010b). *National affordable housing initiative funding table* (last updated June 30, 2010). Retrieved July 7, 2010, from: http://www.cmhc.ca/en/inpr/afhoce/fias/fias_016.cfm

Canadian Association for Community Living. (2009). Monitoring the progress toward a vision of full community living for all persons with intellectual disabilities. *Institutionwatch*, *5*(2).

Canadian Centre for Policy Alternatives – Nova Scotia. (2009). *The Nova Scotia child poverty report card*.

Canadian Council on Social Development. (2009a). Poverty reduction policies and programs: The best place on earth?: Contemporary and historical perspectives on poverty reduction policies and programs in British Columbia. In K. Scott (Ed.), *Social Development Series.*

Canadian Council on Social Development. (2009b). Poverty reduction policies and programs: Prince Edward Island. In K. Scott (Ed.), *Social Development Series.*

Canadian Council on Social Development. (2009c). Poverty reduction policies and programs: Yukon. In K. Scott (Ed.), *Social Development Series.*

Canadian Council on Social Development. (2009d). Poverty reduction policies and programs: Restoring hope or treading water?: New Brunswick. In K. Scott (Ed.), *Social Development Series.*

Canadian Council on Social Development. (2009e). Poverty reduction policies and programs: Northwest Territories. In K. Scott (Ed.), *Social Development Series.*

Canadian Council on Social Development. (2009f). Poverty reduction policies and programs*:* Manitoba. In K. Scott (Ed.), *Social Development Series.*

Canadian Council on Social Development. (2009g). Poverty reduction policies and programs: Tracing a path from the past to the future: Newfoundland & Labrador. In K. Scott (Ed.), *Social Development Series.*

Canadian Council on Social Development. (2009h). Poverty reduction polices and programs: Saskatchewan. In K. Scott (Ed.), *Social Development Series.*

Canadian Council on Social Development. (2009i). Poverty reduction polices and programs: Extending the Alberta advantage. In K. Scott (Ed.), *Social Development Series.*

Canadian Mental Health Association. (2004). *Housing, health & mental health.*

Canadian Mental Health Association (2009, September). *The connection between mental and physical health* [Online fact sheet]. Retrieved from http://www.ontario.cmha.ca/fact_sheets.asp?cID=3963

Canadian Mental Health Association Ontario, Centre for Addiction and Mental Health, Addictions Ontario, Ontario Association of Patient Councils, Ontario Federation of Community Mental Health and Addictions Programs, & the Ontario Peer Development Initiative. (2009, July 22). *Joint submission to the Ontario Ministry of Municipal Affairs and Housing long-term affordable housing consultation session.*

Canadian Institute for Health Information. (2007). *Improving the health of Canadians: Mental health and homelessness.* Ottawa, ON: CIHI.

Canadian Institute for Health Information. (2008a). *Health care in Canada 2008.* Ottawa, ON: CIHI.

Canadian Institute for Health Information. (2008b). *Improving the health of Canadians: Mental health, delinquency, and criminal activity.* Ottawa, ON: CIHI.

Canadian Policy Research Networks. (2007a, August). *Fostering better integration and partnerships for housing in Canada: Lessons for creating a stronger policy model of governmental and community collaboration*.

Canadian Policy Research Networks. (2007b, August). *Inclusion and social housing practice in Canadian cities following the path from good intentions to sustainable projects*.

Canadian Policy Research Networks. (2007, September). *City-regions and the provision of affordable rental housing.*

Canadian Policy Research Networks. (2007a , December). *A safer haven: Innovations for improving social housing in Canada.*

Canadian Policy Research Networks. (2007b, December). *Linking social housing and energy efficiency.*

Canadian Social Research Links: Key Provincial and Territorial Government Welfare Links. (n.d.). Retrieved from: http://www.canadiansocialresearch.net/welfare.htm#rates

Canadian Task Force on Social Finance. (2010). *Mobilizing private capital for public good.* Retrieved from: http://socialfinance.ca/uploads/documents/FinalReport_Mobilizing PrivateCapitalforPublicGood_30Nov10.pdf

Canadian Union of Public Employees. (2009, October). *Residential long-term care in Canada: Our vision for better seniors' care*.

CAN-VOICE (Consumer Survivor Community Support Services). (2010, May 20). *Program description.* Retrieved from: http://thehealthline.ca/displayService.aspx?id=279

Carling, P. J. (1990). Major mental illness, housing and supports: The promise of community integration. *American Psychologist*, *45*, 969–975.

Carling, P. J. (1993). Housing and supports for persons with mental illness: Emerging approaches to research and practice. *Hospital and Community Psychiatry*, *44*, 439–455.

Carling, P. J., & Tanzman, B. H. (2006). Consumers' preferences for housing and support. In *Best Practices in Housing,* (Chapter 6, 53-59). NTAC: National Treatment Assistance Centers.

Carver, H. (1948). *Houses for Canadians.* Toronto: University of Toronto Press.

Castelein, S., Bruggeman, R., van Busschbach, J. T., van der Gaag, M., Stant, A. D., Knegtering, H., et al. (2008). The effectiveness of peer support groups in psychosis: A randomized controlled trial. *Acta Psychiatrica Scandinavica, 118*, 64-72.

Commission on Social Determinants of Health (2008). *Closing the gap in a generation through action on the social determinants of health.* Final Report on the Commission on Social Determinants of Health, Geneva, World Health Organization.

Center for Psychiatric Rehabilitation with support from the National Institute on Disability and Rehabilitation Research. Peer Delivered Services Study Group. (n.d.). *Systematic review of peer delivered services literature 1989-2009*. Retrieved from: http://drrk.bu.edu/research-syntheses/psychiatric-disabilities//peer-services

Center for Supportive Housing. (2009). *The seven dimensions of quality for supportive housing: Definitions and indicators.* Corporation for Supportive Housing. Retrieved from: http://documents.csh.org/documents/Quality/SevenDimensionsQualityIndicatorsWEBFINAL.pdf

Centre for Applied Research in Mental Health and Addictions. (2008). *Housing and support for adults with severe addictions and/or mental illness in British Columbia*.

Centre for Addiction and Mental Health. (2002). *Housing discussion paper*. Retrieved June 8, 2010, from: www.camh.net/public_policy/publicpolicy_housing2002.htm

Centre for Addiction and Mental Health. (2003). *Housing stability benchmarking study.* Toronto, ON: Community Research, Planning and Evaluation Team.

Centre for Addiction and Mental Health. (2005). *Housing stability validity study.* Ottawa, ON: Canada Mortgage and Housing Corporation - Community Research, Planning and Evaluation Team.

Centre for Urban & Community Studies. (n.d.). Retrieved from: http://www.urbancentre.utoronto.ca/publications.html#

Champlain District Mental Health Implementation Task Force (2002). *Dual dagnosis service of Brockville Psychiatric Hospital: Recommendations for implementation.* Submitted to the Ontario Minister of Health & Long-Term Care.

Chaix, B., Leyland, A. H., Sabel, C. E., Chauvin, P., Rastam, L., Kristersson, H., et al. (2006). Spatial clustering of mental disorders and associated characteristics of the neighbourhood context in Malmo, Sweden, in 2001. *Journal of Epidemiology & Community Health, 60*(5), 427-35. doi:10.1136/jech.2005.040360.

Chinman, M. J., Weingarten, R., Stayner, D. & Davidson, L. (2001). Chronicity reconsidered: Improving person-environment fit through a consumer-run service. *Community Mental Health Journal*, *37*(3), 215-229.

City of Calgary. (2007,November). *Fast facts #08: Trends in the Calgary housing market.*

City of Calgary, Community and Neighbourhood Services, Social Research Unit. (2007, February). *Background research for the 10-year plan to end homelessness in Calgary.*

City of Calgary, Community and Neighbourhood Services, Social Research Unit. (2008, July). *Biennial count of homeless persons in Calgary: 2008 May 14*.

City of Chicago (2007). *There's no place like a home: Chicago's plan to end homelessness, State of the Plan.* Retrieved from: http://www.cityofchicago.org/ content/dam/city/depts/fss/ supp_info/Policy/homelessStateofPlan2007.pdf.

City of Toronto. (2009, January 19). *Cost savings analysis of the enhanced streets to homes program in Toronto*. Retrieved June 26, 2010, from: http://www.toronto.ca/legdocs/mmis/2009/ex/bgrd/ backgroundfile-18574.pdf

City of Toronto. (2009, October). *2010 per diem rates for the purchase of service shelter system and related matters.* Retrieved May 30, 2010, from: http://www.toronto.ca/legdocs/mmis/ 2009/cd/bgrd/backgroundfile-24920.pdf

Clark Robbins, P., Callahan, L., & Monahan, J. (2009). Perceived coercion to treatment and housing satisfaction in Housing-First and supportive housing programs. *Psychiatric Services, 60*(9), 1251-1253.

Clarke, D. (2010, June). *Health capital investment in Ontario.* Presented to Design & Health Canada 2010.

Chalmers, J. H., Cayen, L., Bradbury, C., & Snowshoe, S. (2005, December). *Stay the course…and together we can secure the foundation that has been built: An interim report on the mental health and addictions services in the NWT*. Submitted to The Department of Health and Social Services, Yellowknife, Northwest Territories.

Coatsworth-Puspoky, R., Forchuk, C., & Ward-Griffin, C. (2006). Peer support relationships: an unexplored interpersonal process in mental health. *Journal of Psychiatric and Mental Health Nursing*, *13*, 490-497.

Cole, M. G., McCusker, J., Ciampi, A., Windholz, S., Latimer, E., & Belzile, E. (2006). The prognosis of major and minor depression in older medical inpatients. *American Journal of Geriatric Psychiatry*, *14*(11), 966–975.

Collin, C. (2006). *Substance abuse issues and public policy in Canada: V. alcohol and related harms* (PRB 06-20E). Ottawa. ON: Political and Social Affairs Division.

Commonwealth of Australia, Department of Health and Ageing. (1999) Measuring remoteness: Accessibility/remoteness index of Australia (ARIA). *Occasional Papers, New Series No. 6*.

Communities and Local Government: London. (2006a). *Delivering affordable housing.* Retrieved from: www.communities.gov.uk/documents/housing/pdf/152897.pdf

Communities and Local Government: London. (2006b). *Planning policy statement: Housing.* Retrieved from: http://www.communities.gov.uk/documents/planningandbuilding/pdf/ planningpolicystatement3.pdf

Community Foundations of Canada. (2008). *Canada's vital signs 2007*. Retrieved from: http://www.vitalsignscanada.ca/nationalvitalsigns2007-e.pdf

Community Living BC. (2005, June). *Business plan.*

Compton, M. T., Weiss, P. S., Phillips, V. L., West, J. C., & Kaslow, N. J. (2006). Determinants of health plan membership among patients in routine U.S. psychiatric practice. *Community Mental Health Journal*, *42*(2). 197-204.

Conference Board of Canada. (2003). *Nunavut economic outlook*. A report prepared for the Government of Nunavut.

Conference Board of Canada. (2010, March). *Building from the ground up: Enhancing affordable housing in Canada.*

Conference Board of Canada (n.d.). Retrieved from: http://www.conferenceboard.ca/HCP

Cooper, H. (2009). *Fixing Ontario's affordable housing crisis*. Presentation at the Social Planning Council Forum, Tuesday May 26, 2009.

Co-operative Housing Federation of Canada (n.d.). Retrieved from: http://www.fhcc.coop/eng/pages2007/about_3.asp

Co-operative Housing Federation of Canada. (2008). *Annual report*.

Corrigan, P. W. (2006). Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric Services*, *57*(10), 1493-1496.

Council of Yukon First Nations - Health and Social Development. (n.d.). Retrieved from: http://www.cyfn.ca/healthsocial?noCache=476:1286564915

Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in support housing. *Housing Policy Debates*, *13*(1), 107-163. Retrieved from: http://repository.upenn.edu/spp_papers/65

daSilva, Y., Fenn, K., McDonald, J., & Steewart, K. (2008). *Review of seniors housing-related programs and services in Atlantic Canada.* Atlantic Seniors Housing Research Alliance.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, *33*(3), 443-450.

Deegan, P. (2006, July 24). *The legacy of peer support*. Retrieved from: http://www.patdeegan.com/blog/archives/000018.php

Deegan, P. E., & Drake, R. E. (2006). Shared decision-making and medication management in the recovery process. *Psychiatric Services, 57*(11), 1636-1639.

Deloitte & Touche. (2010, September). *Review of Nunavut Housing Trust.* Prepared for the Government of Nunavut.

Dennis, C. L. (2002). Peer support within a health care context: A concept analysis. *International Journal of Nursing Studies, 40*, 3, 321-332.

Dennis, M. M., & Fish, S. (1972). *Programs in search of a policy: Low income housing in Canada.*

Department of Health. (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. United Kingdom: Her Majesty's Government. Retrieved from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

de Peuter, J., & Sorensen, M. (2005). *Rural Prince Edward Island – profile: A ten year census analysis 1991 – 2001*. Government of Canada, Rural Secretariat.

Dewa, C. S., Horgan, S., McIntyre, D., Robinson, G., Krupa, T., & Eastabrook, S. (2003). Direct and indirect time inputs and Assertive Community Treatment. *Community Mental Health Journal, 39*(1), 17-32.

Dewa, C. S., Burke, A., Hardaker, D., Caveen, M., & Baynton, M. A. (2006). Mental health training programs for managers: What do managers find valuable? *Canadian Journal of Community Mental Health*, *25*(2), 221-239.

Dieterich, M., Irving, C. B., Park, B., & Marshall, M. (2010). Intensive Case Management for severe mental illness. *Cochrane Database of Systematic Reviews* 2010, Issue 10. Art. No.: CD007906. DOI: 10.1002/14651858.CD007906.pub2

Distasio, J., Dudley, M., & Maunder, M. (2002). *Out of the long dark hallway: Voices from Winnipeg's rooming houses.*

Distasio, J., & Mulligan, S. (2005) *Beyond a front desk: The residential hotel as home*. Winnipeg: Institute of Urban Studies.

Distasio, J., Sylvestre, G., & Mulligan, S. (2005). *Home is where the heart is and right now that is nowhere: An examination of hidden homelessness among Aboriginal peoples in Prairie cities.* Winnipeg: Institute of Urban Studies.

Dixon, L., Hackman, A., & Lehman, A. (1997). Consumers as staff in Assertive Community Treatment programs. *Administration and Policy in Mental Health, 25*(2), 199-208.

Doughty, C., & Tse, S. (2011). Can consumer-led mental health services be equally effective? An integrative review of CLCMH services in high-income countries. *Community Mental Health Journal, 47*(3), 252-266.

Douglas, F., & Gingrich, P. (2009, November). *Child and family poverty: Saskatchewan report.* Regina: Social Policy Research Unit, University of Regina.

Drake, R. E., & Deegan, P. E. (2009). Shared decision making is an ethical imperative. *Psychiatric Services, 60*, 1007.

Drake, R. E., O'Neil, E. L. O., & Wallach, M. A. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. *Journal of Substance Abuse Treatment, 34*(1), 123-138.

Dumont, J., & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook,* Evaluation Center@HSRI and NASMHPD Research Institute, 4-6.

Dunn, J. R. (2000). Housing and health inequalities: Review and prospects for research. *Housing Studies, 15*(3), 341-366.

Dunn, J. R. (2002). *A population health approach to housing: A framework for research.* Ottawa, ON: National Housing Research Committee and Canada Mortgage and Housing Corporation.

Dunn, J. R. (2003, June). *Housing as a socio-economic determinant of health: Assessing research needs. Research Bulletin #15*. Centre for Urban and Community Studies, University of Toronto. Retrieved June 8, 2010, from: www.urbancentre.utoronto.ca/researchbulletin.html

Dunn, J. R., & Kyle, T. (2007, April). *Effects of housing circumstances for people with severe mental illness.* Enabling Grant Final Report to the Wellesley Institute.

Durbin, J., George, L., Koegl, K., & Aitchison-Drakel, C. (2005). *Review of Ontario mental health supportive housing system and potential data sources for system monitoring.*

Durbin, J., Goering, P, Cocharne, J. Macfarlane, D., & Sheldon, T. (2004). Needs-based planning for persons with schizophrenia residing in board-and-care homes. *Schizophrenia Bulletin*, *30*(1), 123-32.

Edmonton Social Planning Council. (2007). *Still standing in a booming economy. Finding solutions for low-income working households.* Edmonton: AB. Retrieved from: http://tamarackcommunity.ca/downloads/vc/ED_Still_BoomEco_1107.pdf

Edmonton Social Planning Council and Public Interest Canada. (2009, November). *We must do better: It's time to make Alberta poverty-free.*

Eggleton, A., & Segal, H. (2009). *In from the margins: A call to action on poverty, housing and homelessness*. Ottawa, ON: Senate of Canada, Standing Senate Committee on Social Affairs, Science and Technology.

Falvo, N. (2003). Gimme shelter! Homelessness and Canada's social housing crisis [pamphlet]. *CSJ Foundation for Research and Education*. Retrieved from: http://intraspec.ca/gimmeShelter.pdf

Fang, R., Kmetic, A., Millar, J., & Drasic, L. (2009). Disparities in chronic disease among Canada's low-income populations. *Preventing Chronic Disease, 6*(4). Retrieved June 8, 2010, from: http://www.cdc.gov/pcd/issues/2009/oct/08_0254.htm

Farrell, S., Aubry, T., Klodawsky, F., & Petty, D. (2000). *Describing the homeless population in Ottawa-Carleton*. Centre for Research on Community Services, Faculty of Social Sciences, University of Ottawa.

Federal-Provincial-Territorial Directors of Income Support. (2009, August*). Social assistance statistical report, 2006.*

Federal-Provincial-Territorial Directors of Income Support. (2010). *Social assistance statistical report, 2007.*

Federal, Provincial, and Territorial Advisory Committee on Population Health. (1999). *Statistical report on the health of Canadians*. Prepared for the Meetings of Ministers of Health. Retrieved from: http://dsp-psd.pwgsc.gc.ca/Collection/Statcan/82-570-X/82-570-XIE1997001.pdf

Federation of Canadian Municipalities. (2004*). Quality of life reporting system: Highlights report 2004.*

Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, et al. (1995). Consumers as peer specialists on Intensive Case-Management teams – Impact on client outcomes. *Psychiatric Services*, *46*(10), 1037-1044.

Fenton, W. S., Mosher, L. R., Herrell, J. M. & Blyler, C. R. (1998). Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness. *American Journal of Psychiatry, 155,* 516-522.

Fischer, W. H., Geller, J. L., & Wirth-Cauchon, J. (1990). Empirically assessing the impact of mobile crisis capacity on state hospital admissions. *Community Mental Health Journal, 26,* 245-253.

Food Banks Canada. (2008). *Hunger count 2008: A comprehensive report on hunger and food bank use in Canada.* Toronto, ON: Food Banks Canada.

Forchuk, C., Martin, M. L., Chan, Y. L., & Jenson, E. (2005). Therapeutic relationships: From psychiatric hospital to community. *Journal of Psychiatric and Mental Health Nursing*, *12*, 556-564.

Forchuk, C., Nelson, G., & Hall, B. (2006). "It's important to be proud of the place you live in": Housing problems and preferences of psychiatric survivors. *Perspectives in Psychiatric Care, 42*(1), 42-52.

Forchuk, C., Ward-Griffin, C., Csiernik, R., & Turner, K. (2006). Surviving the tornado of mental illness: Psychiatric survivors' experiences of getting, losing, and keeping housing. *Psychiatric Services, 57*(4), 558-562. Retrieved from: http://psychservices.psychiatryonline.org/cgi/reprint/57/4/558

Fournier, C. (2010, March 25). *Ontario to sell C$39.7 billion in debt to fund gap (update1)*. Retrieved from: http://www.bloomberg.com/apps/news?pid=newsarchive&sid= aXMgXLp.uQLY

Francis, L. E. (2000). Conflicting bureaucracies, conflicted work: Dilemmas in case management for homeless people with mental illness. *Journal of Sociology and Social Welfare*, *27*(2), 97-112.

Franke, M. F., Appleton, S. C., Bayona, J., Arteaga, F., Palacios, E., Llaro, K., et al. (2008). Risk factors and mortality associated with default from multidrug-resistant tuberculosis treatment. *Clinical Infectious Diseases, 46*(12), 1844-51. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2577177/pdf/nihms-64233.pdf

Gates, L. B. (2000). Workplace accommodation as a social process. *Journal of Occupational Rehabilitation, 10*(1), 85-98.

Geller, J. L., Fischer, W. H., & McDermeit, M. (1995). A national survey of mobile crisis services and their evaluation. *Psychiatric Services, 46,* 893-897.

George, L., Durbin, J., & Koegl, C. J. (2008). System-wide implementation of ACT in Ontario: An ongoing improvement effort. *Journal of Behavioral Health Science and Research, 36*(3), 309-319.

Gerber, G. J., & Prince, P. N. (1999). Measuring client satisfaction with Assertive Community Treatment. *Psychiatric Services*, *50*(4), 546-550.

Gillig, P. M. (1995). The spectrum of mobile outreach and its role in the emergency service. *New Directions for Mental Health Services, 67*, 13-21.

Gilmer, T. P., Stefancic, A., Ettner, S. L., Manning, W. G., & Tsemberis, S. (2010). Effect of full-service partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. *Archives of General Psychiatry*, *67*(6), 645-652.

Gingell, C. R. (1991). *The criminalization of the mentally ill: an examination of the hypothesis.* Doctor of philosophy dissertation. Burnaby, BC: Simon Fraser University.

Gladwell, M. (2006, February 13). Million-dollar Murray: Why problems like homelessness may be easier to solve than to manage. *The New Yorker*, 96–107.

Gnam, W., Sarnocinski-Hart, A., Mustard, C., Rush, B., & Lin, E. (2006). *The economic costs of mental disorders and alcohol, tobacco, and illicit drug abuse in Ontario, 2000: A cost of illness study*. Toronto: Centre for Addiction and Mental Health.

Goering, P., Durbin, J., Foster, R., Boyles, S., Babiak, T., & Lancee, B. (1992). Social networks of residence in supportive housing. *Community Mental Health Journal*, *28*(3), 199-214.

Goering, P., Sylph, J., Foster, R., Boyles, S., & Babiak, T. (1992). Supportive housing: A consumer evaluation study. *The International Journal of Social Psychiatry, 38*(2), 107-119.

Goering, P., Boydell, K., Butterill, D., Cochrane, J., Durbin, J., Rogers, J. & Trainor, J. (1997). *Review of best practices in mental health reform*. Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health.

Goldman, H., Rachuba, L., & Van Tosh, L. (1995). Methods of assessing mental health consumer's preferences for housing and support service. *Psychiatric Services, 46*, 169-172.

Goodwin, R. & Lyons, J. S. (2001). An emergency housing program as an alternative to inpatient treatment for persons with severe mental illness. *Psychiatric Services, 52,* 92-95.

Government of Alberta. (2004, April). *Advancing the mental health agenda: A provincial mental health plan for Alberta.*

Government of Alberta. (2007). *Department of Seniors and Community Supports supportive living framework.*

Government of Alberta. (2010a). *Department of Seniors and Community Supports business plan 2010-13.*

Government of Alberta. (2010b). *Department of Housing and Urban Affairs 2009-2010 annual report.*

Government of Alberta. (2010c). *Department of Seniors and Community Supports 2009/2010 annual report.*

Government of British Columbia. (2006). *Housing matters BC: A housing strategy for British Columbia*. Retrieved from http://www.bchousing.org/programs/Housing_Matters_BC/ strategy

Government of British Columbia (2010, May 25). *News release: $225M in housing investments to create 1,006 new homes.* Released together with the City of Vancouver and Streetohome Foundation.

Government of British Columbia, Ministry of Health (2003). *B.C.'s Mental health reform best practices: Crisis response/emergency services*. Retrieved from http://www.healthservices.gov.bc.ca/mhd/pdf/bp_crisis_response.pdf

Government of British Columbia, Ministry of Health Services. (2009). *2008/09 annual service plan report.*

Government of British Columbia, Ministry of Health Services. (2010, March). *2010/11 – 2012/13 service plan.*

Government of Canada. (n.d.). *Policy research initiative.* Retrieved March 2, 2010, from: http://policyresearch.gc.ca/page.asp?pagenm=pri_bck

Government of Canada. (2005). *Proceedings of the standing senate committee on national finance issue 27 - Sixteenth report of the committee, July 18, 2005.* Retrieved April 5, 2010, from: http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/fina-e/27rp-e.htm?Language=E&Parl=38&Ses=1&comm_id=13

Government of Canada. (2009). *Canada's economic action plan – budget 2009: chapter 3 – Action to stimulate housing construction*. Retrieved May 9, 2009, from: http://www.budget.gc.ca/2009/plan/bpc3c-eng.html

Government of Canada. (2009, June). *Canada's universal periodic review, response to recommendations.* Retrieved July 5, 2009, from: http://www.pch.gc.ca/pgm/pdp-hrp/inter/101-eng.cfm

Government of Canada. (2009, November). *Homelessness partnering strategy 2009 consultations community and Aboriginal roundtable discussions: "what we've heard".* Prepared by Ascentum Inc. Ottawa for Human Resources and Skills Development.

Government of Canada. (2010, May 29). *News release: Minister Aglukkaq shows support for Nunavut's newest boarding home.* Retrieved from: http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2010/2010_85-eng.php

Government of Canada, Canadian Heritage. (n.d.). *Newfoundland and Labrador, Article 6: Right to work.* Retrieved September 8, 2010, from *http*://www2.pch.gc.ca/pgm/pdp-hrp/docs/escr/nf-eng.cfm

Government of Canada, Human Resources and Skills Development Canada. (n.d.) *Indicators of well-being in Canada: Housing – homeless shelters and beds.* Retrieved June 6, 2010, from: http://www4.hrsdc.gc.ca/d.4m.1.3n@-eng.jsp?did=7

Government of Canada, Human Resources and Skills Development Canada. (n.d.). *Housing – housing starts.* Retrieved June 6, 2010, from: http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=42#M_2

Government of Canada, Human Resources and Skills Development, Homelessness Partnering Secretariat. (2007). *Homeless individuals and families information system (HIFIS) initiative*, 2006-07 annual report**.**

Government of Manitoba. (n.d.). *Mental health and spiritual health care.* Retrieved from http://www.gov.mb.ca/health/mh/renewal.html

Government of Manitoba. (n.d.). *The Manitoba shelter benefit for persons receiving employment and income assistance.* Retrieved June 14, 2010, from: http://www.gov.mb.ca/fs/assistance/pubs/shltr_ben_fact.en.pdf

Government of Manitoba. (2009). *All aboard: A poverty reduction strategy for Manitoba*.

Government of Manitoba, Department of Family Services and Housing. (2009a). *2008/09 annual report.*

Government of Manitoba, Department of Family Services and Housing. (2009b, June). *HOMEWorks: A housing strategy and policy framework for Manitoba.*

Government of Manitoba, Department of Family Services and Housing. (2010, Spring). *HOMEWorks – investing in communities: A two year plan.*

Government of Manitoba, Department of Health and Healthy Living. (2009). *Annual statistics 2008-09.*

Government of Manitoba, Department of Health and Healthy Living. (2010). *Annual report 2009/2010.*

Government of Manitoba, Department of Housing and Community Development. (2010). *2009/10 annual report.*

Government of New Brunswick. (2009, November). *Overcoming poverty together: The New Brunswick economic and social inclusion plan.*

Government of New Brunswick (2010, May 3). *News release: Economic and social inclusion corporation vice-chairs and president named.* Retrieved December 8, 2010 from: http://www.gnb.ca/cnb/news/fcs/2010e0659sd.htm

Government of New Brunswick, Department of Health. (n.d.). *Community mental health centres – programs and services*. Retrieved June 27, 2010, from: http://www.gnb.ca/0055/pdf/ cmhcps.pdf

Government of New Brunswick, Department of Health. (2009, December). *2008/2009 Annual report.*

Government of New Brunswick, Department of Social Development. (2009, November). *2008/2009 Annual report.*

Government of Newfoundland, Department of Health and Community Services. (2009). *Annual performance report for 2008/09.*

Government of the Northwest Territories, Health and Social Services (2004). *NWT Disability Framework.* Retrieved from http://www.hlthss.gov.nt.ca/english/publications/pubresult.asp?ID=135

Government of Nova Scotia. (2004). *Standards for mental health services in Nova Scotia.*

Government of Nova Scotia. (2009, April). *Preventing poverty: Promoting prosperity*.

Government of Nova Scotia, Department of Community Services. (n.d.). Retrieved from: http://www.gov.ns.ca/coms/housing

Government of Nova Scotia, Department of Community Services. (2008, June). *Residential review report: Nova Scotia Housing Development Corporation business plan 2010-2011.*

Government of Nova Scotia, Department of Health. (n.d.). Retrieved from: http://www.gov.ns.ca/health

Government of Nova Scotia, Department of Health. (2003). *Standards for mental health services in Nova Scotia*. Retrieved from www.gov.ns.ca/health/downloads/Standards.pdf

Government of Nova Scotia, Department of Health. (2009, December). *Continuing care strategy: Paying for long-term care.*

Government of Nova Scotia, Department of Health, Continuing Care Branch. (2010a, June). *Nursing homes and homes for the aged directory: Accurate bed count as of June 1, 2010.*

Government of Nova Scotia, Department of Health, Continuing Care Branch. (2010b, June). *Residential care facilities for seniors directory: Accurate bed count as of June 1, 2010.*

Government of Nunavut. (n.d.a). *2010-13 business plan.*

Government of Nunavut. (n.d.b). *An introduction to health and social services in Nunavut.*

Government of Nunavut. (n.d.c). *Lease activity report*.

Government of Nunavut. (2004). *Nunavut ten-year Inuit housing action plan, 2004.*

Government of Nunavut. (2010, September 20). *News release: MLAs respond to crisis at Nunavut Housing Corporation.*

Government of Ontario. (2008). *Breaking the cycle: Ontario's poverty reduction strategy.* Retrieved from http://www.children.gov.on.ca/htdocs/English/growingstronger/strategy/ strategy.aspx

Government of Ontario. (2009, March 31). *News release: McGuinty government ends the era of institutionalization*. Retrieved from: http://news.ontario.ca/mcss/en/2009/03/ontario-closes-institutions-for-people-with-a-developmental-disability.html

Government of Ontario. (2010, March). *2010 Ontario budget: backgrounder - Ontario's economic outlook and fiscal plan.*

Government of Ontario, Ministry of Community and Social Services. (2010). *Annual report 2009/1*0. In Appendix A of the MCSS Results-Based Plan Briefing Book 2010-11.

Government of Ontario, Ministry of Finance, Ontario Municipal Partnership Fund (n.d.). Retrieved from: http://www.fin.gov.on.ca/en/budget/ompf/2010/

Government of Ontario, Ministry of Finance. (n.d.). *Ontario Municipal Partnership Fund 2010*. Retrieved August 15, 2010, from: http://www.fin.gov.on.ca/en/budget/ompf/2010

Government of Ontario, Ministry of Health & Long-Term Care. (1999). *Making it happen: Operational framework for the delivery of mental health services and supports.*

Government of Ontario, Ministry of Health and Long-Term Care. (2004). *Making a difference: Ontario's community mental health evaluation initiative.*

Government of Ontario, Ministry of Health and Long-Term Care. (n.d.). *Seniors' care*. Retrieved April 30, 2010, from: http://www.health.gov.on.ca/english/public/program/ltc/ 12_residential_mn.html

Government of Ontario, Ministry of Health and Long-Term Care. (2005a). *Intensive Case Management service standards for mental health services and supports.*

Government of Ontario, Ministry of Health and Long-Term Care. (2005b). *Crisis response service standards for mental health services and support*. Retrieved March 5, 2010, from: http://www.health.gov.on.ca/english/public/pub/ministry_reports/mentalhealth/ cris_resp.pdf

Government of Ontario, Ministry of Health and Long-Term Care. (2007). *Public expenditure analysis.*

Government of Ontario, Ministry of Municipal Affairs and Housing. (n.d.). *Ontario rental market dynamics*. Retrieved August 14, 2010, from: http://www.mah.gov.on.ca/Page1280.aspx

Government of Ontario, Ministry of Municipal Affairs and Housing. (2009). *Affordable housing in Ontario.* Retrieved August 14, 2010, from: http://www.mah.gov.on.ca/Page6454.aspx

Government of Ontario, Select Committee on Mental Health and Addictions. (2010, August). *Navigating the journey to wellness: The comprehensive mental health and addictions action plan for Ontarians,* 2nd Session, 39th Parliament.

Government of Prince Edward Island, Department of Community Services, Seniors and Labour (n.d.). Retrieved from: http://www.gov.pe.ca/sss/index.php3?number=1025803

Government of Prince Edward Island, Department of Community Services, Seniors and Labour. (2010, June 4). *News release*: *Investments made in new and renovated social housing in central and western PEI.*

Government of Prince Edward Island, Department of Health. (2007, December). *A PEI youth substance use and addiction strategy: A framework document.*

Government of Prince Edward Island, Department of Health and Wellness. (n.d.). Retrieved from: http://www.gov.pe.ca/health/index.php3?number=1018432&lang=E

Government of Prince Edward Island, Department of Health and Wellness. (2009, August). *Questions and answers: Youth substance use and addictions strategy.*

Government of Quebec, Ministère de la Santé et des Services sociaux. (2005). *Plan d'action en santé mentale 2005-2010.*

Government of Quebec, Ministère de la Santé et des Services sociaux et la Société d'habitation du Québec. (2007). *Cadre de référence sur le soutien communautaire en logement social: une intervention intersectorielle des réseaux de la santé et des services sociaux et d'habitation.*

Government of Quebec, Société d'Habitation du Québec. (April 2007). *Inventory of provincial and territorial housing programs in Canada.*

Government of Saskatchewan. (2001). *Healthy people, a healthy province: The action plan for Saskatchewan health care.*

Government of Saskatchewan. (2009, May 13). *News release: Province launches new program for people with disabilities.* Retrieved December 1, 2009, from: http://www.gov.sk.ca/ news?newsId=d401f371-6bf1-4ea2-9166-4ff7368b02b2

Government of Saskatchewan, Ministry of Finance. (2010*). 2010-11 Government direction: Balanced, forward-looking, responsible.*

Government of Saskatchewan, Ministry of Health. (n.d.). Retrieved from: http://www.health.gov.sk.ca/health-system

Government of Saskatchewan, Ministry of Health, Community Care Branch. (2010). *2008/09 Community program profile.*

Government of Saskatchewan, Ministry of Housing (n.d.). Retrieved from: http://www.socialservices.gov.sk.ca/housing/

Government of Saskatchewan, Ministry of Social Services. (2010a). *2009/10 annual report*.

Government of Saskatchewan, Ministry of Social Services. (2010b). *2010-11 plan.*

Government of Yukon, Department of Health and Social Services (2010). *Whitehorse Housing Adequacy Study*. Retrieved from: http://www.hss.gov.yk.ca/pdf/Whse_Housing_ Adequacy-FINAL-DEC_03-10.pdf

Government of Yukon, Office of Social Inclusion (2010). *Dimensions of Social Inclusion and Exclusion in Yukon.* Retrieved from: http://www.hss.gov.yk.ca/pdf/SI_REPORT_(Dec._17-10).pdf

Government of the United Kingdom. (2006a). *Delivering affordable housing*. Retrieved from: www.communities.gov.uk/documents/housing/pdf/152897.pdf

Government of the United Kingdom. (2006b). *Planning policy statement 3 – housing (2006).* Retrieved from: www.eukn.org/binaries/greatbritain/bulk/policy/2007/planning-policy-statement-3-housing.pdf

Government of the United States. (2010). *Opening doors: Federal strategic plan to prevent and end homelessness.* Prepared by the United States Interagency Council on Homelessness.

Government of Yukon, Department of Health and Social Services. (n.d.). Retrieved from: http://www.hss.gov.yk.ca/communityhealthprograms.php

Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology, 42*, 1/2, 135-144.

Greenwood, R. M., Schaefer-McDaniel, N. J., Winkel, G., & Tsemberis, S. J. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American Journal of Community Psychology, 36*(3-4), 223-238.

Grigg, M., Judd, F., Ryan, L., & Komiti, A. (2005). Identifying marginal housing for people with a mental illness living in rural and regional areas. *Australian and New Zealand Journal of Psychiatry, 39*, 995-1000.

Gulcur, L., Stefancic, A., Shinn, S., Tsemberis, S., Fischer, S. N. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and Housing First programmes. *Journal of Community & Applied Social Psychology*, 13(2), 171-186.

Gulcur, L., Tsemberis, S., Stefancic, A., & Greenwood, R. M. (2007). Community integration of adults with psychiatric disabilities and histories of homelessness. *Community Mental Health Journal, 43*(3), 211-228.

Guo, S., Biegel, D. E., Johnsen, J. A., & Dyches, H. (2001). Assessing the impact of community-based mobile crisis services on preventing hospitalization. *Psychiatric Services, 52,* 223-228.

Habibis, D., Atkinson, R., Dunbar, T., Goss, D., Easthope, H., & Maginn, P. (2007, July). *A sustaining tenancies approach to managing demanding behaviour in public housing: A good practice guide.* Prepared for the Australian Housing and Urban Research Institute.

Habitat Services. (n.d.). Retrieved from: www.habitatservices.org

Hanson, L., Houde, D., McDowell, M., & Dixon, L. (2007). A population-based needs assessment for mental health services. *Administrating Policy in Mental Health and Mental Health Services Research, 34*, 233-242.

Haertl, K. (2005). Factors influencing success in a Fairweather model mental health program. *Psychiatric Rehabilitation Journal*, *28*(4), 370-377.

Haertl, K. (2007). The Fairweather mental health housing model: A peer supportive environment: Implications for psychiatric rehabilitation. *American Journal of Psychiatric Rehabilitation*, *10*, 149-162.

Hamilton Addiction and Mental Health Network. (2006, December). *Developing a consumer-run housing co-op in Hamilton: A feasibility study, final report*. Hamilton, ON: Author.

Hardiman, E. R. (2004). Networks of caring: A qualitative study of social support in consumer-run mental health agencies. *Qualitative Social Work, 3*(4) 431-448.

Harding, C. M., Brooks, G. W., Asolaga, T. S. J. S., and Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness. American Journal of Psychiatry, 144, 718-726.

Harkness, J., Newman, S. J., & Salkever, D. (2004). The cost-effectiveness of independent housing for the chronically mentally ill: Do housing and neighborhood features matter? *Health Services Research*, *39*(5), 1341–1360.

Hay, D. (2004). *A new social architecture for Canada's 21st century*. Ottawa, ON: Canadian Policy Research Networks.

Hay, D. (2005). *Housing horizontality and social policy*. Canadian Policy Research Networks. Retrieved from: http://cprn.org/documents/12_en.pdf

Health Canada. (2002). *A report on mental illness in Canada*. Ottawa, ON.

High Support Housing Consortium. (2009). *System response to the high support housing crisis within the Toronto-Central Local Health Integration Network*. Report prepared for the Toronto Mental Health and Addiction Supportive Housing Network.

The Homeless Hub, Library. (n.d.). Retrieved from: http://www.homelesshub.ca/Library/

The Homeless Hub (2009). *The backgrounder*. Retrieved from: http://www.homelesshub.ca/%28S%28l2lcdaqzxp5apee2dagzltqc%29%29/Library/Homelessness-Questions-and-Answers-45760.aspx

Houselink. (2008, November). *All the way home: A report on the Toronto Community Housing mental health and homelessness pilot project.* An initiative of Houselink Community Homes and the Toronto Community Housing Corporation. Retrieved from: http://www.torontohousing.ca/webfm_send/5474/1

Housing Assistance Council. (2001a). *Case Studies on Rural Housing and Welfare Reform.* Washington, D.C.

Housing Assistance Council. (2001b). *Housing for persons with disabilities in rural areas*. Retrieved July, 2010, from: http://www.ruralhome.org/index.php?option=com_content& view=article&id=83:housing-for-persons-with-disabilities-in-rural-areas&catid=21: demographics-high-need-areas-and-special-popult&Itemid=34

Housing Network of Ontario. (2009, December 14). *A long term affordable housing strategy for Ontario – discussion paper.*

Housing Network of Ontario. (2010a). *Building the foundation for Ontario's future: 5 tests for success of Ontario's long-term affordable housing strategy*. Retrieved from: http://www.stableandaffordable.com/sites/default/files/HNO%205%20Tests%20for%20Success%20April%2019.pdf

Housing Network of Ontario. (2010b). *Needed: A housing benefit for Ontario fact sheet*. Retrieved from: http://www.stableandaffordable.com/sites/default/files/Housing BenefitHNO.pdf

Housing Opportunities Toronto. (2009). *An affordable housing action plan: 2010-2020*. Toronto, Ontario: City of Toronto. Retrieved from *www.toronto.ca/legdocs/mmis/2009/ah/.../backgroundfile-21130.pdf*

Howlett, K. (2011, March 24). Expect status-quo budget from McGuinty government: Finance minister promises not touch funding for health care and education. *Globe and Mail*.

Huang, D. (2009, February). *The case for affordable housing in Regina*. Prepared for the Canadian Centre for Policy Alternatives.

Hugo, M., Smout, M., & Bannister, J. (2002). A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service. *Australian and New Zealand Journal of Psychiatry, 36,* 504-508.

Hulchanski, J. D. (n.d.). *Homelessness in Canada*. Retrieved September 8, 2009 from, www.raisingtheroof.org

Hulchanski, J. D. (2002). *Housing policy for tomorrow's cities*. Canadian Policy Research Networks. Retrieved from: http://www.urbancenter.utoronto.ca/pdfs/elibrary/ CPRNHousingPolicy.pdf

Hulchanski, J. D. (2003). *What factors shape Canadian housing policy: The intergovernmental role in Canada's housing system.*

Humphrey, J. P. (1984). *Human Rights and the United Nations: A Great Adventure.* New York: Transnational Publishers.

Hunt, P. (2005). Statement to United Nations Commission on Human Rights (2005, 61st session, 29th March). Retrieved December 30, 2009, from: http://www.essex.ac.uk/ human_rights_centre/research/rth/docs/OralstatementtoCHR2005.doc

Hwang, S. (2001). Homelessness and health. *Canadian Medical Association Journal, 164*(2), 229-233. Retrieved from: http://ecmaj.ca/cgi/reprint/164/2/229

Hwang, S., Chiu, S., & Wilkins, E. (2009). *A Survey of domiciliary hostel program tenants in Ontario: Final report.*

Hwang, S., Colantonio, A., Chiu, S., Tolomiczenko, G., & Redelmeier, D. A. (2008). The effect of traumatic brain injury on the health of homeless people. *Canadian Medical Association Journal*, *179*(8), 779-84.

Hwang, S., Orav, E. J., O'Connell, J. J., Lebow, J. M., & Troyen, B. (1997). Causes of death in homeless adults in Boston. *Annals of Internal Medicine, 126*(8), 625-628.

Hwang, S., Wilkins, R., Tjepkema, M., O'Campo, P., & Dunn., J. R. (2009). Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. *British Medical Journal*, *339*, b4036. doi:10.1136

Inclusionary Housing. (n.d.). Glossary of terms. Retrieved from: http://www.inclusionaryhousing .ca/glossary-of-terms/

Jacobs, P., Dewa, C., Lesage, A., Vasiliadis, H-M., Escober, C., Mulvale, G., & Yim, R. (2010). *The cost of mental health and substance abuse services in Canada: A report to the Mental Health Commission of Canada*. Alberta: Institute of Health Economics.

Jacobson, N., & Greenley, D. (2001). What is recovery?: A conceptual model and explication. *Psychiatric Services*, *54*(4), 482-485.

Jenson, J. (2004). *Canada's new social risks: Directions for a new social architecture*. CPRN Social Architecture Papers, Research Report F43. Ottawa, ON: Canadian Policy Research Networks.

Judd, F. K., & Humphreys, J. S. (2001). Mental health issues for rural and remote Australia. *Australian Journal of Rural Health, 9*, 5, 254-258.

Kessler, R. C., Berglund, P., Dernier, O., Jin, R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*, 593-602.

Khandor, E., & Mason, K. (2007). *The Street Health report 2007*. Toronto, ON: Street Health.

Kiesler, C. A. (1982). Mental hospitals and alternative care. Noninstitutionalization as potential public policy for mental patients. *American Psychologist, 37*(4), 349-360.

Kirby, M. J. L., & Keon, W. J. (2006). *Out of the shadows at last: Highlights and recommendations of the final report on mental health, mental illness and addiction.* Ottawa: Senate of Canada, Standing Senate Committee on Social Affairs, Science and Technology.

Kirk, S. A., Koeske, G. F., & Koeske, R. D. (1993). Changes in health and job attitudes of case managers providing intensive services. *Hospital & Community Psychiatry*, *44*(2), 168-173.

Kirsh, B., Gewurtz, R., Bakewell, R., Singer, B., Badsha, M., & Giles, N. (n.d). *Critical characteristics of supported housing: Findings from the literature, residents, and service providers.* Draft copy. Funded by the Wellesley Institute, Toronto.

Klein, A. R., Cnaan, R. A., & Whitecraft, J. (1998). Significance of peer social support with dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*, *8*(5), 529-551.

Koeller, R. (2006). *Background report: Homeless and street-involved youth in Halifax Regional Municipality*. Retrieved from http://www.halifax.ca/qol/documents/Backgrounder-YouthHomelessnessinHRM.pdf

Koegl, C., Durbin, J. & Goering, P. (2004). *Mental health services in Ontario: How well is the province meeting the needs of persons with serious mental illness? Analysis of data collected during the Provincial Psychiatric Hospital and Community Comprehensive Assessment Projects (CAP)*. Toronto, Ontario: Heath Systems Research and Consulting Unit, Centre for Addiction and Mental Health. Retrieved from: http://www.camh.net/hsrcu/v2/publications/reports/consulting/2004/CAPReportFinal.pdf

Kothari, M. (2007). *United Nations expert on adequate housing calls for immediate attention to tackle national housing crisis in Canada.* Retrieved November 6, 2009, from: http://www.unhchr.ch/huricane/huricane.nsf/0/90995D69CE8153C3C1257387004F40B5?opendocument

Kothari, M. (2009). *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.* Mission to Canada (9 to 22 October 2007). Prepared for and submitted to the Human Rights Council, United Nations.

Kuno, E., Rothbard, A. B., & Sands, R. G. (1999). Service components of case management which reduce inpatient care use for persons with serious mental illness. *Community Mental Health Journal*, *35*(2), 153-167.

Lafave, H., de Souza, H. R., & Gerber, G. J. (1996). Assertive Community Treatment of severe mental illness: A Canadian experience. *Psychiatric Services, 47*(7), 757-759.

Laird, G. (2007). *Homelessness in a growth economy: Canada's 21st century paradox.* A Report for the Sheldon Chumir Foundation for Ethics in Leadership.

Lambert, G., Ricci, P., Harris, R., & Deane, F. (1999). Housing needs of consumers of mental health services in rural New South Wales, Australia. *International Journal of Social Psychiatry*, *46*(1), 57–66. doi: 10.1177/002076400004600107.

Lampert, G., Pomeroy, S., & Stegman, M. (2002, March). *Executive summary - The context for private rental housing production in the US.* Prepared for: Research Subcommittee Housing Supply Working Group, Ontario Ministry of Municipal Affairs and Housing.

Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H., et al. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *Journal of the American Medical Association*, *301*(13), 1349-1357.

Lawn, S., Smith, A., & Hunter, K. (2008). Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. *Journal of Mental Health*, *17*(5), 498-508.

Leff, H. S., Chow, C. M., Pepin, R., Conley, J., Allen, I. E., & Seaman, C. A. (2009). Does one size fit all? What we can and can't learn form a meta-analysis of housing models for persons with mental illness. *Psychiatric Services 60*(4), 473-482.

Lesage, A. D., Gélinas, D., Robitaille, D., Dion, E., Frezza, D., & Morissette, R. (2003). Toward benchmarks for tertiary care for adults with severe and persistent mental disorders. *Canadian Journal of Psychiatry*, *48*(7).

Lettner, M. (2008, June). *Health equity now: A working paper on the best first steps for Ontario.* A commissioned grant for the Wellesley Institute.

Levstek, D. A. & Bond, G. R. (1993). Housing cost, quality, and satisfaction among formerly homeless persons with serious illness in two cities. *Innovations and Research, 2,* 1-8.

Lewis, D. A., & A. J. Lurigio. (1994). *The state mental patient and urban life.* Springfield, IL: Charles C. Thomas Publishing.

Lightman, E., Mitchell, A., & Wilson, B. (2008). *Poverty is making us sick: A comprehensive survey of income and health in Canada*. Retrieved from: http://wellesleyinstitute.com/files/povertyismakingussick.pdf

Lilley, S. (1999). *Shifting sands: The changing shape of Atlantic Canada*, prepared for Health Promotion and Programs Branch, Atlantic Regional Office, Health Canada.

Lim, K-L., Jacobs, P., & Dewa, C. (2008). *How much should we spend on mental health?* Alberta: Institute of Health Economics.

Long Term Care in British Columbia. (2009, October). *Taking Care Inc.*

Long Term Care in Nunavut. (2009, October). *Taking Care Inc.*

Lurie, S. (2005). Comparative mental health policy: Are there lessons to be learned? *International Review of Psychiatry, 17(2), 97-101.*

Lurie, S., Kirsh, B., & Hodge, S. (2007). Can ACT lead to more work? The Ontario experience. *Canadian Journal of Community Mental Health, 26*(1), 161-171.

MacDonald, N., Hucker, S. J., & Hébert, P. C. (2010). The crime of mental illness. *Canadian Medical Association Journal*, *182*(13), 1399.

Mackenzie, H., & Shillington, R. (2009). *Canada's quiet bargain: The benefits of public spending*. Toronto: Canadian Centre for Policy Alternatives.

Malatest, R. A. (2008, May). *Provincial rent bank program evaluation report: Executive summary, 2008*. Prepared for: Ontario Ministry of Municipal Affairs and Housing.

Marsh, A., Gordon, D., Pantazis, C., & Heslop, P. (1999). Home sweet home?: The impact of poor housing on health. *Bristol: The Policy Press*.

Marshall, M. (2008). What have we learnt from 40 years of research on Intensive Case Management. *Epidemiologia Psichiatria Sociale-An International Journal for Epidemiology and Psychiatric Sciences*, *17*(2), 106-109.

Marshall, S. L., Crowe, T. P., Oades, L. G., Deane, F. F., & Kavanagh, D. J. (2007). A review of consumer involvement in evaluations of case management: Consistency with a recovery paradigm. *Psychiatric Services*, *58*(3), 396-401.

Martinez, T. B., & Burt, M. R. (2006). Impact of permanent supportive housing on the use of acute care health services by homeless adults. *Psychiatric Services, 57*, 992-999.

Massey, O. T., & Wu, L. (1993). Important characteristics of independent housing for people with mental illness: Perspectives of case managers and consumers. *Psychosocial Rehabilitation Journal, 17*, 81–92.

McAlpine, D. D. & Warner, L. (2002). *Barriers to employment among persons with mental illness: a review of the literature*. Rutgers University, New Brunswick, NJ.

McCrone, P., Killaspy, H., Bebbington, P., Johnson, S., Nolan, F., Pilling, S., et al. (2009). The REACT study: Cost-effectiveness analysis of Assertive Community Treatment in North London. *Psychiatric Services, 60*(7), 908-913.

McKee, M. (2009). *Together into the future: A transformed mental health system for New Brunswick.*

Mead, S., Hilton, D., & Curtis, L. (2001). *Peer support: A theoretical perspective.*

Melchior, M., Moffitt, T. E., Milne, B. J., Poulton, R., & Caspi, A. (2007). Why do children from socioeconomically disadvantages families suffer from poor health when they reach adulthood?: A life course study. *American Journal of Epidemiology, 166*(8), 966-74.

Mellins, C. A., Havens, J. F., McDonnell, C., Lichtenstein, C., Uldall, K., Chesney, M., Santamaria, E. K., & Bell, J. (2009). Adherence to antiretroviral medications and medical care in HIV-infected adults diagnosed with mental and substance use disorders, *AIDS Care, 21*(2), 168-77.

Metraux, S., Marcus, S. C., & Culhane, D. P. (2003). The New York-New York housing initiative and use of public shelters by persons with severe mental illness. *Psychiatric Services*, *54*(1), 67-71.

Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts.*

Millson,P., Challacombe, L., Villeneuve, P.J., Paul, J., Strike, C., Fisher, B., et al. (2006). Determinants of health-related quality of life of opiate users at entry to low-level threshold methadone programs. *European Addiction Research*, *12*(2), 74-82.

Ministry of Children and Youth Services, Government of Ontario. (2006). *A shared responsibility: Ontario's policy framework for child and youth mental health*. Retrieved from: http://www.children.gov.on.ca/htdocs/English/documents/topics/specialneeds/mentalhealth/framework.pdf

Minsky, S., Reisser, G. G., & Duffy, M. (1995). The eye of the beholder: Housing preferences of inpatients and their treatment teams. *Psychiatric Services, 46*, 2, 173–176.

Mizzoni, C., & Kirsh, B. (2006). Employer perspectives on supervising individuals with mental health problems. *Canadian Journal of Community Mental Health, 25*(2), 193-206.

Montgomery, P., Forchuk, C., Duncan, C., Rose, D., Bailey, P., & Veluri, R. (2008). Supported housing programs for persons with serious mental illness in rural northern communities: A mixed method evaluation. *BMC Health Services Research, 8*(1), 156.

Murphy, H. B. M., Pennee, B., & Luchins, D. (1972). Foster homes: The new back wards. *Canadian Mental Health Supplement*, *71*.

Myers, R. P., Shaheen, A. A. M., Hubbard, J. N., & Kaplan, G. G. (2009). Characteristics of patients with cirrhosis who are discharged from the hospital against medical advice. *Clinical Gastroenterology & Hepatology,* 7(7), 786-92.

National Aboriginal Housing Association. (2009). *A time for action: A national plan to address Aboriginal housing*. Retrieved from: http://www.aboriginalhousing.org/ PDF/NAHA_Action_Plan_July_2009_FINAL.pdf

National Council of Welfare. (2007). *Solving poverty: Four cornerstones of a workable national strategy for Canada.* Volume #126, Winter 2007. Retrieved from: http://www.ncw.gc.ca/ l.3bd.2t.1ils@-eng.jsp?lid=30

National Council of Welfare Reports. (2008). *Welfare incomes 2008: Single person with a disability*, Bulletin Number 2.

National Council of Welfare Reports. (2010). *Welfare incomes 2009.* Volume #129. Retrieved from: http://www.ncw.gc.ca/l.3bd.2t.1ilshtml@-eng.jsp?lid=331&fid=20

National Housing and Homelessness Network. (2002). *The one percent solution: What is it? What will it do?*. Retrieved from: http://action.web.ca/home/housing/alerts.shtml?x=25766

National Housing Research Group (2010, November 16). Housing data group meeting, Ottawa. Retrieved from: http://nhrc-cnrl.ca/en/meeting/current/housing-data-wg

National Law Center on Homelessness & Poverty, Housing Program (n.d.). Retrieved from: http://www.nlchp.org/program.cfm?prog=5

National Liberal Caucus Task Force on Housing. (1990). *Finding room: Housing solutions for the future*. Co-Chairs P. Martin, M.P., and J. Fontana, M.P. Retrieved September 8, 2009, from: http://action.web.ca/home/housing/resources.shtml?x=67129&AA_ EX_Session=aaf5ee15fd284cfbe78feb097affa912

Nelson, G., Aubry, T., & Lafrance, A. (2007). A review of the literature on the effectiveness of housing and support, Assertive Community Treatment, and Intensive Case Management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry*, *77*(3), 350-361.

Nelson, G., Hall, G. B., & Forchuk, C. (2003). Current and preferred housing of psychiatric consumer/survivors. *Canadian Journal of Community Mental Health, 22*(1), 5-19.

Nelson, G., Hall, G. B., & Walsh-Bowers, R. (1998). The relationship between housing characteristics, emotional well-being, and the personal empowerment of psychiatric consumer/survivors. *Community Mental Health Journal, 34*, 57-69.

Nelson, G., Sylvestre, J., Aubry, T., George, L., & Trainor, J. (2007). Housing choice and control, housing quality, and control over professional support as contributors to the subjective quality of life and adaptation to community living of people with severe mental illness. *Administration and Policy in Mental Health Services Research*, *34*(2), 89-100.

New Brunswick Housing Corporation. (2010). *Hope is a home: New Brunswick's housing strategy*. Retrieved from http://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/Housing/housingstrategy-e.pdf

Nguyen, T. (2009, May 4). *From hostels to homes*. Presentation to the National Housing Research Committee.

Northwest Territories Housing Corporation. (2008). *Framework for action 2008-2011*. Retrieved from http://nwthc.gov.nt.ca/pdf/English%20Framework%20for%20Action%202008-2011%20-%20June18.pdf

Nunavut Housing Corporation. (2008). *Annual report 2007/2008.*

Nunavut Housing Corporation. (2009). *Business plan 2009/2010.*

O'Brien, A., Inglis, S., Herbert, T., & Reynolds, A. (2002, September). *Linkages between housing and support - what is important from the perspective of people living with a mental illness.* AHURI final report no.25. Australian Housing and Urban Research Institute.

O'Connell, M., Rosenheck, R., Kasprow, W., & Frisman, L. (2006). An examination of fulfilled housing preferences and quality of life among homeless persons with mental illness and/or substance use disorders. *The Journal of Behavioral Health Services & Research, 33*(3), 354-365.

Office of the Auditor General of Ontario. (2008). *2008 annual report*. Retrieved from: www.auditor.on.ca/en/reports_en/en08/ar_en_08.pdf

Office of the Auditor General of Ontario. (2009). *2009 annual report*. Retrieved from: http://www.auditor.on.ca/en/reports_en/en09/2009AR_en_web_entire.pdf

O'Hagan, M., McKee, H., & Priest, R. (2009, June). *Consumer/Survivor Initiatives in Ontario: Building for an equitable future.* Toronto, ON: Ontario Federation of Community Mental Health and Addiction Programs.

Onaga, E. E., McKinney, K. G., & Pfaff, J. (2000). Lodge programs serving family functions for people with psychiatric disabilities. *Family Relations, 49*(2), 207-216.

Ontario Council of Alternative Businesses. (2009, May). *Not for lack of trying: Barriers to employment and the unrealized potential of psychiatric survivors living in boarding homes.* An initiative of the Community Perspective Series of the Wellesley Institute.

Ontario Human Rights Commission. (2009). *Annual report 2008-2009.*

Ontario Social Assistance Review Advisory Panel. (2010, May). *Recommendations for an Ontario income security review*. Submission to the Minister of Community & Social Services, Government of Ontario.

Ontario Non-Profit Housing Association (2010). *Where's home? A study of affordable rental housing within 22 communities in Ontario.* An initiative of the Ontario Non-Profit Housing Association and the Co-operative Housing Federation of Canada – Ontario Region.

Ontario Non-Profit Housing Association, Specific Funding Options. (n.d.). Retrieved from: http://www.onpha.on.ca/AM/Template.cfm?Section=Specific_Funding_Options#hpi

Ontario Non-Profit Housing Association, Supportive Housing Providers. (n.d.). Retrieved from: http://www.onpha.on.ca/AM/Template.cfm?Section=Supportive_Housing1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=4&ContentID=1963

Ontario Non-Profit Housing Association & Co-operative Housing Federation of Canada Ontario Region (2009). *Where's home? 2008*. Retrieved from http://www.onpha.on.ca/ Content/About_nph/wheresHome2008/Wheres_Home_2008_REVISED.pdf

Ontario Retirement Communities Association. (n.d.). Retrieved from: http://www.orcaretirement.com/master.php

Organisation for Economic Co-operation and Development. (2008). *Growing unequal?: Income distribution and poverty in OECD countries.*

Owen, M., & Watters, C. (2005, January). *Housing for assisted living in inner-city Winnipeg: A social analysis of housing options for people with disabilities.*

Parkinson, S., & Nelson, G. (2003). Consumer/survivor stories of empowerment and recovery in the context of supported housing. *International Journal of Psychosocial Rehabilitation, 7*, 103–118.

Parkinson, S., Nelson, G., & Horgan, S. (1999). From housing to homes: A review of the literature on housing approaches for psychiatric consumer/survivors. *Canadian Journal of Community Mental Health, 18*, 145-164.

Parkland Institute, University of Alberta. (2007). *The spoils of the boom: Incomes, profits and poverty in Alberta.* Edmonton: Alberta. Retrieved from: http://parklandinstitute.ca/downloads/reports/Spoilsboomreport.pdf

Patterson, M., Somers, J. M., McIntosh, K., Schiell, A., & Frankish, C. J. (2008, February). *Housing and support for adults with severe addictions and/or mental illness in British Columbia.* Vancouver, BC: Centre for Applied Research in Mental Health and Addictions, Faculty of Health Sciences, Simon Fraser University.

Pauly, B. B. (2008). Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. *International Journal of Drug Policy*, *19*(3), 195-204.

Pearson, C. L., Locke, G., Montgomery, A. E., & Burton, L. (2007, July). *The applicability of Housing First models to homeless persons with serious mental illness*: *Final report.* Prepared for U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

PEI Housing Corporation. (2008). *Annual report for the year ending March 31, 2008.*

PEI Housing Corporation. (2006). *Annual report, 2005/2006.*

PEI Community Advisory Committee on Homelessness. (2010, April). *PEI Report Card on Homelessness.*

Perlman, J., & Parvensky, J. (2006). *Denver Housing First collaborative: Cost benefit analysis and program outcomes report*. Denver: Colorado Coalition for the Homeless.

Philo, C., Parr, H., & Burns, N. (2003). Rural madness: a geographical reading and critique of the rural mental health literature. *Journal of Rural Studies, 19*, 259-281.

Piat, M., Lesage, A., Boyer, R., Dorvil, H., Couture, A., Grenier, G., & Bloom, D. (2008). Housing for persons with serious mental illness: Consumer and service provider preferences. *Psychiatric Services, 59*(9), 1011-1017.

Piat, M., Ricard, N., & Lesage, A. (2006). Evaluating life in foster homes for persons with serious mental illness: Resident and caregiver perspectives. *Journal of Mental Health, 15*(2), 227-242.

Pickett, K. E., & Wilkinson, R. G. (2009). Greater equality and better health. *British Medical Journal*, *339*, b4320.

Pistrang, N., Barker, C., & Humphreys, K. (2008). Mutual help groups for mental health problems: A review of effectiveness studies. *American Journal of Community Psychology*, *42*, 110-121.

Policy Research Initiative. (2005). *Combating the social exclusion of at-risk groups.* Retrieved November 20, 2009, from: http://policyresearch.gc.ca/doclib/DP_PEX_Burstein_ 200511_e.pdf

Pomeroy, S. (2001). *Toward a comprehensive affordable housing strategy for Canada*. Prepared for the Caledon Institute of Social Policy. Retrieved from: http://www.urbancenter.utoronto.ca/pdfs/elibrary/CaledonCompHousing.pdf

Pomeroy, S. (2005, March). *The cost of homelessness: Analysis of alternate responses in four Canadian cities.* Focus Consulting. Prepared for the National Secretariat on Homelessness.

Pomeroy, S., & Berrigan, B. (2007). *Costs of responding to homelessness in Ottawa: Proactive versus reactive responses.* City of Ottawa: Author.

Pomeroy, S., & Evans, L. (2008). *Housing as a mechanism in poverty reduction strategies: A brief review of international experience and implications for Ontario*. Prepared for The Ontario Non Profit Housing Association.

Pomeroy, S., Steele, M., Hoy, J., & Stapleton, J. (2008, November). *A housing benefit for Ontario: One housing solution for a poverty reduction strategy*. Submitted to the Government of Ontario by the Federation of Rental Housing Providers of Ontario, Ontario Non-Profit Housing Association, Greater Toronto Apartments Association, Daily Bread Food Bank, Metcalf Charitable Foundation, and Atkinson Charitable Foundation.

Pomeroy, S., Charles, G., Gaudreault, & Connelly, P. (2006). *Was Chicken Little Right? Case studies on the impact of expiring social housing operating agreements.* Prepared for the Canadian Housing and Renewal Association.

Pong, R. W. (2000). Rural Health Research in Canada: At the Crossroads. *Australian Journal of Rural Health, 8*, 261-265.

Pong, R. W., DesMeules, M., & Lagace, C. (2009). Rural-urban disparities in health: How does Canada fare and how does Canada compare with Australia? *Australian Journal of Rural Health, 17*, 58-64.

Pong, R. W., Pitblado, J. R., & Irvine, A. (2002). A strategy for developing environmental health indicators for rural Canada. *Canadian Journal of Public Health, 93*(5).

Pong, R. W., & Russell, N. (2003). *A Review and synthesis of strategies and policy recommendations on the rural health workforce*. Centre for Rural and Northern Health Research.

Post, P. A. (2002). *Hard to reach: Rural homelessness & health care*. National Health Care for the Homeless Council.

Power, A. (2008). *Income, employment & education: Life skills training*. Retrieved from: http://www.homelesshub.ca/Topics/Life-Skills-Training-226.aspx

Provincial Advisory Committee on Mental Health Housing and Related Support Services. (2008, June 18). *Housing and supports for people with mental illness*. Report prepared for the Department of Health and Healthy Living, Government of Manitoba.

Provincial Forum of Mental Health Implementation Task Forces. (2002). *The time is now: Themes and recommendations for mental health reform in Ontario.*

Public Health Agency of Canada. (1997). *Best practices in mental health reform.* Prepared for The Federal/Provincial/Territorial Advisory Network on Mental Health by the Health Systems Research Unit, Clarke Institute of Psychiatry.

Public Health Agency of Canada. (2002). *The social determinants of health: Housing as a determinant of health*. Retrieved from: http://www.phac-aspc.gc.ca/ph-sp/oi-ar/09_housing-eng.php

Quigley, J. (2008). *Housing policy in the United States.* Prepared for the Institute of Business and Economic Research and the Fisher Center for Real Estate and Urban Economics. Retrieved from: http://www.escholarship.org/uc/item/89p9r7w9

Raine, L., & Marcellin, T. (2009). *What Housing First means for people: Results of Streets to Homes 2007 post-occupancy research*. Toronto, Ontario, Canada: City of Toronto Shelter, Support & Housing Administration. Retrieved from: http://www.toronto.ca/housing/pdf/results07postocc.pdf

Raising the Roof. (2009). *Youth homelessness in Canada: The road to solutions*.

Rajkumar, S., & Hoolahan, B. (2004). Remoteness and issues in mental health care: Experience from rural Australia. *Epidemiologia e Psichiatria Sociale, 13*(2), 78-82.

Raphael, D. (2007). Poverty and policy in Canada: Implications for health and quality of life. Toronto, Ontario: Canadian Scholars Press.

Regional Municipality of Waterloo. (2008). *Affordable housing strategy: Community begins at home*.

Regional Municipality of Waterloo. (2009). *Domiciliary Hostel Standards.*

Rehm, J., Baliunas, D., Brochu, S., Fischer, B., Gnam, W., Patra, J., et al. (2006). *The costs of substance abuse in Canada 2002*.

Research Alliance for Canadian Homelessness, Housing, and Health. (2010). *Housing vulnerability and health: Canada's hidden emergency* (Homeless Hub Report #2).

Resnick, S. G., & Rosenheck, R. A. (2008). Integrating peer-provided services: A quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services*, *59*(11), 1307-1314.

Review of Best Practices in Mental Health Reform. (n.d.). *Crisis response systems / psychiatric emergency services*. Retrieved from: http://www.phac-aspc.gc.ca/mh-sm/pubs/bp_review/pdf/e_revsec1-2.pdf

Reynolds, A., Inglis, S., O'Brien, A. (2002, January). *Effective programme linkages: An examination of current knowledge with a particular emphasis on people with mental illness*. AHURI: Australian Housing and Urban Research Institute.

Rivera, J. J., Sullivan, A. M., & Valenti, S. S. (2007). Adding consumer-providers to intensive case management: Does it improve outcome? *Psychiatric Services*, *58*(6), 802-809.

Robinson E., & Adams, R. (2008). *Housing stress and the mental health and wellbeing of families.* Australian Family Relationships Clearinghouse Briefing Number 12, (AFRC).

Rog, D. J. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal, 27*(4), 334-344.

Rogers, E. S., Danley, K. S., Anthony, W. A., Martin, R., & Walsh, D. (1994). The residential needs and preferences of persons with serious mental illness: A comparison of consumers and family members. *Journal of Mental Health Administration*, *21,* 42–51. doi: 10.1007/BF02521344

Roman, C. G., McBride, E. C., & Osborne, J. W.L . (2006). *Principles and practice in housing for persons with mental illness who have had contact with the justice system.* Prepared for the National GAINS Center. The Urban Institute.

Romanow, R. J. (2002). *Building on values: The future of health care in Canada - final report*. 1-339. Ottawa: Health Canada.

Rosen, D., Tolman, R. M., & Warner, L. A. (2004). Low-income women's use of substance abuse and mental health services. *Journal of Health Care for the Poor & Underserved*, *15*(2), 206-19.

Rosenbaum, A., & Calhoun, J. F. (1977). The use of the telephone hotline in crisis intervention: A review. *Journal of Community Psychology, 5*, 325-339.

Rosenheck, R., Kasprow, W., Frisman, L., & Liu-Mares, W. (2003). Cost-effectiveness of supported housing for homeless persons with mental illness. *Archives of General Psychiatry*, *60*(9), 940-951.

Royal Bank of Canada. (2009, April). *Housing trends and affordability*. Retrieved June 6, 2010, from: http://www.rbc.com/newsroom/pdf/20090416-housing.pdf

Rueda, S., Artazcoz, L., & Navarro, L. (2008). Health inequalities among the elderly in western Europe. *Journal of Epidemiology & Community Health*, *62*(6), 492-498.

Rupert Rooming House Coalition (1998). The human right to adequate housing in Canada: A comment on Canada's compliance with the International Covenant on Economic, Social and Cultural Rights, with a focus on homelessness. Submission to the United Nations Committee of Economic, Social and Cultural Rights. Retrieved August 18, 2010, from: http://www.web.net/rupert/un.htm

Ryan-Nicholls, K. (2004). Health and sustainability of rural communities. Rural and remote health. *Rural and Remote Health Research, Education, Practice, and Policy*, *4*(242). Retrieved from: http://www.rrh.org.au/articles/defaultnew.asp?IssueNo=4x4(242).

Salmon, A., Poole, N., Morrow, M., Greaves, L., Ingram, R., & Pederson, A. (2006). *Improving conditions: Integrating sex and gender into federal mental health and addictions policy*. Vancouver, B.C.: British Columbia Centre of Excellence for Women's Health. Retrieved from http://www.cwhn.ca/PDF/ImprovingConditions.pdf

Salyers, M. P., Hicks, L. J., McGuire, A. B., Baumgarnder, H., Ring, K., & Kim, H. (2009). A pilot to enhance the recovery orientation of Assertive Community Treatment through peer-provided illness management and recovery. *American Journal of Psychiatric Rehabilitation*, *12*, 191-204.

Samele, C., Gilvarry, C., Walsh, E., Manley, C., van Os, J., & Murray, R. (2002). Patients' perceptions of Intensive Case Management. *Psychiatric Services*, *53*(11), 1432-1437.

Saskatchewan Housing Forum. (2008). *Final report.* Provided by Saskatchewan Chamber of Commerce, Association of Saskatchewan Realtors, Saskatchewan Economic Development Association and Canadian Home Builders' Association – Saskatchewan.

Sauer, G. (2005). *Affordable housing in Ottawa, Ontario: A case study of land use policy and transferability.* Prepared for the Affordable Housing Implementation Team, City of Calgary, Community and Neighbourhood Services, Social Research Unit.

Sawyer, D., Gale, J., & Lambert, D. (2006). *Rural and frontier mental and behavioral health care: Barriers, effective policy strategies, best practices.* National Association for Rural Mental Health. Retrieved from: http://www.contracosta.networkofcare.org/library/Rural%20and%20Frontier%20Mental%20Health_Barriers_2006.pdf

Scanlon, K., & Whitehead, C. (November 2004). *International trends in housing tenure and mortgage finance.*

Schaedle, R., & Epstein, I. (2000). Specifying Intensive Case Management: A multiple perspective approach. *Mental Health Services Research*, *2*(2), 95-105.

Schaedle, R., McGrew, J.H., Bond, G.R., & Epstein, I. (2002). A comparison of experts' perspectives on Assertive Community Treatment and Intensive Case Management. *Psychiatric Services*, *53*(2), 207-210.

Schutt, R. K. & Goldfinger, S. M. (2000). The contingent rationality of housing preferences: Homeless mentally ill persons' housing choices before and after housing experiences. *Research in community and mental health, 11,* 131-156.

Schutt, R. K., Weinstein, B., & Penk, W. E. (2005). Housing preferences of homeless veterans with dual diagnoses. *Psychiatric Services, 56*(3), 350-352.

Seilheimer, T., & Doyal, G. (1996). Self-efficacy and consumer satisfaction with housing. *Community Mental Health Journal*, *32*(6), 549–559. doi:10.1007/BF02251065

Shankar, J. (2005). Improving job tenure for people with psychiatric disabilities through ongoing employment support. *Australian eJournal for Advancement of Mental Health (AeJAMH), 4*(1), 1-11.

Shapcott, M. (2009, July 21). *Wellesley Institute backgrounder: Three key housing facts - Ontario has highest housing costs, lowest provincial housing investment, worst municipal downloading.* E-mail communication to the Social Determinants of Health forum.

Shapcott, M. (November 11, 2008). *Public housing investments: generating jobs and other social/economic benefits.* Retrieved from: http://www.wellesleyinstitute.com/blog/public _housing_investments_-_generating_jobs_and_other_social__economic_benefits/

Shapcott, M. (2008). *National housing report card: A report from the Wellesley Institute*.

Shaw, M. (2004). Housing and public health. *Annual Review of Public Health*, *25*, 397-418.

Shomina, Y. (2007). *Housing policy and housing reforms in Russia.* State University-Higher School of Economics Housing in Russia. Retrieved from: http://www.iut.nu/Congress/
Congress2007/PresentationsNational/Shomina_Russia.ppt

Sledge, W. H., Tebes, J., Rakfeldt, J., Davidson, L., Lyons, L., & Druss, B. (1996). Day hospital/crisis respite care versus inpatient care, Part 1: Clinical outcomes. *American Journal of Psychiatry, 153,* 1065-1073.

Sledge, W. H., Tebes, J., Wolff, N., & Helminiak, T. W. (1996). Day hospital/crisis respite care versus inpatient care, Part II: Service utilization and costs. *American Journal of Psychiatry, 153*(8), 1074-1083.

Slem, C. M., & Cotler, S. (1973). Crisis phone services: Evaluation of a hotline program. *American Journal of Community Psychology, 1*, 219-227.

Social Housing Services Corporation. (2008, December). *Ontario social housing primer*.

Social Planning Council of Winnipeg. (2009, November). *2009 Manitoba child & family poverty report card.*

Solomon, P. (2004). Peer support/peer provided services: Underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, *27*(4), 392-401.

Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal, 31*(2), 139-152.

Statistics Canada. (2002). *Canadian community health survey: Mental health and well-being*. (82-617-XIE).

Statistics Canada. (2008). *Changing patterns in Canadian homeownership and shelter costs, 2006 Census.* Retrieved from: http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=97-554-XIE2006001&lang=eng

Statistics Canada. (2008). *Growth in disability rates from 2001 to 2006*. Retrieved from: http://www.statcan.gc.ca/pub/89-628-x/2007002/4125018-eng.htm

Statistics Canada. (2009). *Canada's changing labour force, 2006 Census: The provinces and territories*. Retrieved from http://www12.statcan.ca/census-recensement/2006/as-sa/97-559/p21-eng.cfm

Statistics Canada. (2009). *2006 Census analysis series: Population and dwelling counts.* Retrieved August 20, 2010, from: http://www12.statcan.ca/census-recensement/2006/as-sa/index-eng.cfm

Statistics Canada. (2009). *Population, urban and rural, by province and territory*. Retrieved from http://www40.statcan.ca/l01/cst01/demo62a-eng.htm

Statistics Canada. (2009, December). *Income disparities in health-adjusted life expectancy for Canadian adults, 1991 to 2001.*

Statistics Canada. (2010, September). *Latest release from the Labour Force Survey, Table 4, Labour force characteristics by province*. Retrieved September 15, 2010, from: http://www.statcan.gc.ca/subjects-sujets/labour-travail/lfs-epa/t100910a4-eng.htm

Statistics Canada, Social and Aboriginal Statistics Division. (2008). *Aboriginal children's survey, 2006* (Catalogue no. 89-634-X - No. 001). Retrieved from http://www.statcan.gc.ca/pub/89-634-x/89-634-x2008001-eng.pdf

Stergiopoulos, V., Dewa, C., Durbin, J., Chau, N., & Svoboda, T. (2010). Assessing the mental health service needs of the homeless: A level-of-care approach. *Journal of Health Care for the Poor and Underserved*, *21*(3), 1031-1045.

Strode, A. D., & Roll, J. M. (2007). *Disparities of mental health services between urban and rural communities in Washington State*. Washington Institute for Mental Illness Research and Training, Washington State University Spokane.

Stroul, B. A. (1988). Residential crisis services: A review. *Hospital and Community Psychiatry, 39*, 1095-1099.

Stroul, A. (1993). *Psychiatric crisis response systems: A descriptive study*. Community Support Program Center for Mental Health Service, Substance Abuse, and Mental Health Services Administrations, National Institutes of Mental Health, Rockville, MD.

Substance Abuse and Mental Health Services Administration (2009). *Transforming mental health care in America: The federal action agenda: First steps*. Retrieved from http://www.samhsa.gov/federalactionagenda/NFC_intro.aspx

Substance Abuse and Mental Health Services Administration (2010). *Permanent supportive housing: Evaluating your program.* HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Sullivan, W. P. (1997). A long and winding road: The process of recovery from severe mental illness. In L. Spaniol, C. Gagne, and M. Koehler (Eds.), Psychological and social aspects of psychiatric disability (pp. 14-24). Boston: Center for Psychiatric Rehabilitation.

Susin, S. (2006). *Rent vouchers and the price of low-income housing*. Berkeley Program on Housing and Urban Policy, Working Paper Series No. 1005.

Sylvestre, J., George, L., Aubry, T., Durbin, J., Nelson, G., & Trainor, J. (2007). Strengthening Ontario's system of housing. *Canadian Journal of Community Mental Health*, *26*(10), 79-95.

Sylvestre, J., Nelson, G., Sabloff, A., & Peddle, S. (2007). Housing for people with serious mental illness: A comparison of values and research. *American Journal of Community Psychology, 40*, 125-137.

Sylvestre, J., Ollenberg, M. D., & Trainor, J. (2007). A participatory benchmarking strategy for describing and improving supportive housing. *Psychiatric Rehabilitation Journal, 31*(2), 115-124.

Tabol, C., Drebing, C., & Rosenheck, R. (2010). Studies of "supported" and "supportive" housing: A comprehensive review of model descriptions and measurement. *Evaluation and Program Planning, 33,* 446-456.

Tanzman, B. H. (1993). Researching the preferences for housing and supports: An overview of consumer preference surveys. *Hospital and Community Psychiatry, 44*(5), 450–455.

Toronto Community Housing Corporation & Houselink Community Homes. (2008, November). *All the way home: A recovery journey. A report on the Toronto Community Housing Mental Health and Homelessness pilot project.* Toronto, ON: Author.

Torjman, S. (2009). *A poverty reduction strategy for Nova Scotia*. A report of the Caledon Institute of Social Policy.

Torjman, S., Battle, K., & Mendelson, M. (2009, September). *All aboard Manitoba's poverty train.* Prepared for the Caledon Institute of Social Policy.

Toronto Christian Resource Centre. (2008, February). *Private personal care homes and the 'hardest to house'.* An initiative of the Community Perspective Series of the Wellesley Institute.

Toronto Community Housing Corporation. (n.d.). *Social inclusion: A mental health framework*. Retrieved May 30, 2010, from: http://www.torontohousing.ca/mental_health_ framework#mh_what

Toronto Dominion Bank Financial Group. (2003, June 17). *TD economics special report: Affordable housing in Canada: In search of a new paradigm.*

Tosi, A. & Cremaschi, M. (1999). *Housing policies in Italy.* Università di Roma. Retrieved from: http://www.iut.nu/members/Europe/West/Italy_Housing%20policies.doc

Tota, K. (2005). *Halifax portrait of streets and shelters*. A report of the Halifax Regional Municipality Planning and Development Services.

Tremblay, J. (July 2009). *Keeping the homeless housed: An exploratory study of determinants of homelessness in the Toronto community.* Prepared by Action Consulting.

Tsai, J., Bond, G. R., Salyers, M. P., Godfrey, J. L., & Davis, K. E. (2010). Housing preferences and choices among adults with mental illness and substance use disorders: A qualitative study. *Community Mental Health Journal, 46*(4), 381-388.

Tsemberis, S. J. & Asmussen, S. (1999). From streets to homes: The pathways to housing consumer preference supported housing model. *Alcoholism Treatment Quarterly, 17*(1/2), 113-131.

Tsemberis, S. J., Moran, L., Shinn, M., Asmussen, & Shern, D. L. (2003). Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. *American Journal of Community Psychology, 32*(3/4), 305-317.

Turpin, M., Bartlett, H., Kavanagh, D., & Gallois, C. (2007). Mental health issues and resources in rural and regional communities: An exploration of perceptions of service providers. *Australian Journal of Rural Health, 15*, 131-136.

Tyhurst, J. S., Chalke, F. C. R., Lawson, F. S., McNeil, B. H., Roberts, C. A., Taylor, G. E., et al. (1963). *More for the mind*. Toronto, ON: Canadian Mental Health Association.

United Nations. (1948). *Universal Declaration of Human Rights, Article 25, (1)*. Retrieved December 30, 2009, from: http://www.un.org/en/documents/udhr/index.shtml

United Nations, Educational, Scientific and Cultural Organization. (2006). *The 2nd UN world water development report: Water, a shared responsibility*. Retrieved from: http://unesdoc.unesco.org/images/0014/001454/145405E.pdf

United Nations Human Rights Council. (2009). *Universal Periodic Review, Report of the Working Group: Canada.* Eleventh session, Agenda item 6.

United Nations, Office of the United Nations High Commissioner for Human Rights. (2009). *The right to adequate housing fact sheet No. 21/Rev.1.* Retrieved from http://www.ohchr.org/Documents/Publications/FS21_rev_1_Housing_en.pdf

United Nations, General Assembly. (2011). *States parties to disabilities convention convene three-day session*. Retrieved from: http://www.un.org/News/Press/docs/2011/hr5068.doc.htm

US Department of Housing and Urban Development, Office of Policy Development and Research (2004). *Strategies for Reducing Chronic Street Homelessness*. Retrieved from: http://www.huduser.org/portal/publications/ChronicStrtHomeless.pdf

Vihavainen, R. (2005). *Housing in Russia: Policies and practices*. University of Helsinki, Department of Sociology. Retrieved from: http://blogit.helsinki.fi/respublica/ RP05_Interim_Housing.pdf

Vincent, K., & Morin, P. (2010). *Le logement subventionné : Dans le cadre du programme de supplément au loyer (PSL) dans le secteur privé à but lucratif avec suivi dans la communauté – Source d'inspiration pour créer des modèles innovants.* Province de Québec avec la participation de l'Agence de la santé et des services sociaux de la Capitale-Nationale et la Société d'habitation du Québec.

Wagner, J. D., Menke, E. M., & Ciccone, J. K. (1995). What is known about the health of rural homeless families?. *Public Health Nursing*, *12*, 6, 400–408.

Warner, R., Zahraei, S., Farah, D., Nandlal, J., Jaskulka, I., Peters, V., et al. (2008). *Home for all: What supportive housing agencies can do to be anti-oppressive and culturally competent. A Toolkit*. Supportive Housing and Diversity Group.

Warren, R., & Bell, P. (2000). An exploratory investigation into the housing preferences of consumers of mental health services. *Australian and New Zealand Journal of Mental Health Nursing*, *9*, 195–202. Retrieved from CINAHL database.

Wellesley Institute. (2008, February). *Federal budget 2008: Three housing questions for Finance Minister Flaherty.* Prepared by Michael Shapcott.

Wellesley Institute. (2008, May). *Income inequality, increased housing insecurity, and growing health inequities: An Analysis of Statistics Canada's Income and Housing Census Figures*. Prepared by Michael Shapcott.

Wellesley Institute. (2008, July 30). *Housing, homelessness and Ontario's Poverty Reduction Strategy.y*

Wellesley Institute. (2009, October 13). *Federal government needs to target housing investments to Canadians who need the help.* A submission from the Wellesley Institute to the federal government's housing and homelessness consultation.

Wellesley Institute. (2010, January 15). *It's time to bring Canadians in from the margins.* Presentation Notes on the Wellesley Institute webinar with Senator Art Eggleton.

Wellesley Institute. (2010). *Precarious housing in Canada*. Retrieved from: http://www.wellesleyinstitute.com/news/affordable-housing-news/new-report-precarious-housing-in-canada-2010/

White, H., Whelan, C., Barnes, J. D., & Baskerville, B. (2003). Survey of consumer and non-consumer mental health service providers on Assertive Community Treatment teams in Ontario. *Community Mental Health Journal*, *39*(3), 265-276.

Wilmot, R. (2010). *Best practices in youth housing*. Presentation for Canadian Housing and Renewal Association National Conference, June 4, 2010.

Wilson, M., Joffe, R. T., & Wilkerson, B. (2000). *Unheralded business crisis in Canada: Depression at work*. Report of the Global Business and Economic Roundtable on Addiction and Mental Health. Retrieved from: http://www.mentalhealthroundtable.ca/aug_round_pdfs/Roundtable%20report_Jul20.pdf

Winnipeg Regional Health Authority. (2009). *Personal care homes*. Retrieved May 16, 2010, from: http://www.wrha.mb.ca/ltc/pch/index.php

Wobrock, T., Sittinger, H., Behrendt, B., D'Amelio, R., Falkai, P., & Caspari, D. (2007). Co-morbid substance abuse and neurocognitive function in recent-onset schizophrenia. *European Archives of Psychiatry & Clinical Neuroscience*, *257*(4), 203-10.

Wong, Y. I., Nath, S. B., Solomon, P. (2007). Group and organizational involvement among persons with psychiatric disabilities in supported housing. *Journal of Behavioral Health Services & Research*, 151-167.

Wong, Y. I., & Solomon, P. L. (2002). Community integration of persons with psychiatric disabilities in supportive independent housing: A conceptual model and methodological considerations. *Mental Health Services Research, 4*(2), 13-28.

World Health Organization. (2001). *Mental health: New understanding, new hope.*

World Health Organization. (2004). *Mental health policy, plans and programmes*. Part of the Mental Health Policy and Service Guidance Package.

World Health Organization. (2010). Increasing access to health workers in remote and rural areas through improved retention.

World Health Organization, European Region. (1999). *Health 21: The health for all policy framework for the WHO European Region*. European Health for All Series: No. 6 ISBN 92 8901349 4.

World Health Organization, European Region. (2007). *Local housing and health action plans: A project manual*. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/ 0004/98698/E91004.pdf

Wright, N. M., & Tompkins, C. N. (2006). How can health services effectively meet the health needs of homeless people? *British Journal of General Practice*, *56*(525), 286-93.

Yellowknife Homeless Coalition. (2009). *Yellowknife Homelessness Report Card 2008*. Retrieved from: http://www.yellowknife.ca/Assets/Public+Safety/Homelessness ReportCardSpring2009.pdf

YWCA Calgary (2010, January). *Women and Homelessness in Calgary: Research and position paper*.

Yukon Health Status Report. (2003). *A report of the Department of Health and Social Services, Government of the Yukon.* Retrieved from: www.hss.gov.yk.ca

Yukon Health Care Review. (2008). *A report of the Department of Health and Social Services, Government of the Yukon.*