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HOUSING DISCUSSION PAPER

SPRING 2002

A PAHO/WHO Collaborating Centre

Un Centre collaborateur OPS/OMS

Affiliated with the University of Toronto

Affilié à l'Université de Toronto

Introduction

The purpose of this paper is to highlight critical issues in housing for people with mental illness and to suggest new approaches. The overall importance of housing is well established and is founded on a combination of research, consumer experience, and common sense. Consumers need safe, affordable places to live and the right level of support to make their tenure a success.

This paper will briefly review some of the more recent research findings but in general assumes that the case for good housing as an essential component of community support has been made. In addition, the case for a current crisis in housing can also be taken as made. The crisis has two dimensions: the absolute shortage of affordable units and the lack of a range of models that are reflective of best practice and the diversity of consumer need. In Toronto, the absolute shortage has been documented by the Mayor's Homelessness Action Task Force (1999) and other studies. The report of the Task Force outlines, among other things, the plight of people with mental illness who have no permanent housing. Although focused on Toronto, its overall findings and description of the negative fundamentals of the housing market are considered to be generally applicable across much of the province. The lack of a sufficient range of models is reflected in a number of ways. Mental health clinicians and planners are in agreement that many consumers do not get the type of housing and support they need. Some settings are in short supply, while others do not offer state of the art models of housing and support. Ontario continues, for example, to fund large numbers of custodial beds concentrated in the Homes for Special Care, Habitat, Approved Homes, and Domiciliary Hostel programs. Homes of this type do not provide care that is in line with current best practice evidence and consumer needs.[1]

These problems stand in sharp contrast to the solutions that are now available to us. Research on housing models and consumer preference has yielded a range of approaches that are proven to work. The Report on Best Practices in Mental Health Reform (1997) summarizes this work and calls for a range of flexible models. More recently, programs have been developed that allow even very disabled consumers to be supported in rehabilitation oriented, non-custodial settings. The gap between the current crisis and its solution is, therefore, based on the need for organized and concerted action, not a lack of knowledge of what needs to be done.

The importance of housing is widely recognized as a priority in mental health policy documents. These include the national policy of the Canadian Mental Health Association (A New Framework for Support for People with Serious Mental Illness 1993) and more recent Ontario policy statements (Making it Happen 1999).

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[1] A recent discussion of these programs is contained in the document *Homes for Persons with Special Needs: Consultation Backgrounder* (2000). This document calls for administrative restructuring, but in its conceptualization posits a homogeneous group of consumers who have reached their maximum level of functioning and a program model that remains custodial. The usefulness of the paper is limited by the fact that this characterization is at odds with three things: best practice evidence in housing, clinical evidence regarding the course of serious mental illness, and actual assessments of the consumers involved.

The widespread recognition of housing as a key issue raises the question of who it is for. The focus of this paper is people with mental illness, and here the situation is complex. Significant numbers of people manage some type of mental health problem, but the majority will not want or need specialized housing. They use their own resources to live in the community like any other citizen. In some cases, however, especially where the illness is more serious, the need for a specialized resource comes into play. People who need this extra help are typically, but not always, identified along three dimensions: a diagnosis of a serious mental illness like schizophrenia or bipolar affective disorder; a significant duration of illness; and a marked level of disability. Known in the field as the three Ds, diagnosis, duration, and disability are not defined in an exact way in day to day practice, but form the basis of clinicians' decisions to recommend specialized housing. The absence of exact definitions is important given the broad heterogeneity of the expression of mental illness. Some consumers, for example, have persistent psychotic symptoms such as hearing voices, but are still able to live successfully on their own. In other cases, the symptoms are less severe but more disabling in their impact on daily life. Some consumers may need housing support for a long period of time, possibly for life, while others need temporary help. For some groups, all of the 3 Ds may not be present. A good example is people in the early stages of psychosis, who may not have a significant duration of illness, but for whom timely support can help prevent a worsening of the impact of schizophrenia or bipolar affective disorder.

Moving Forward

Strategies for improving the current housing situation need to be based on three things. First, ***remembering***; developing an understanding of the strengths and weaknesses of past programs and models can bring to light what has worked and what has not. Secondly, ***knowing;*** putting in place the kind of knowledge and information that are needed to shape a responsive and flexible system, and finally, ***doing;*** developing concrete ways of going forward.

Part I
Remembering: A Critical History

Appropriate housing has long been considered essential to the process of deinstitutionalization, and the absence of such housing is rightly seen as one of the central failures of the process. Ontario has two basic housing traditions that continue to shape and influence the field. Recognizing these traditions and understanding their ongoing influence is essential to moving forward.

Tradition I: Custodial Models

The first supportive housing strategy in Ontario was the Approved Homes Program that was launched in the 1930s (Simmons 1990). Approved Homes were based on foster-care and boarding home models and were privately operated. All residents remained registered as inpatients of the hospital which referred them and could be returned immediately if necessary, a situation which was not changed until the 1980s.

The next major development in housing people with mental illness was the Homes for Special Care Program (HSC), developed in the mid-1960s. HSC was intended to support bed closures by offering safe and secure housing, and was developed with three levels:

residential, intermediate, and nursing care. Over the years, the nursing home portion of the program has, in most areas, been gradually eliminated, leaving residential homes and one intermediate home. There are now 1775 HSC beds in Ontario (Ministry of Health 1999). HSC is perhaps best seen as a combination of models; many are large enough to be classed as boarding homes, while others are small and operate as foster-care settings.

Unlike most community mental health programs in Ontario, HSC is regulated by provincial legislation. Over the years, this has made the program particularly resistant to change and innovation. Despite this, the efforts of staff and operators have made the best of a difficult situation and have led to a number of important improvements over the years. The constraints of the program, however, both financial and administrative, have maintained it as an essentially custodial option.

In custodial homes, the operator is required to provide a common basket of services to all residents. From the perspective of the present day, with a greater base of research and emphasis on psychiatric rehabilitation, the important lessons of the custodial sector relate to its broad conceptualization of the basic program model. This conceptualization reflects a dynamic referred to in the literature as ***transinstitutionalization***. Key to this dynamic is the inappropriate application of institutional thinking outside of institutions. In a custodial approach the emphasis is placed on a single set of standards governing such things as meals, supervision, and laundry services. These must typically be provided to all residents in the same way. This makes sense from a custodial perspective; disabled people who are unable to take care of themselves are ensured basic care.

On the other hand, if viewed from a rehabilitation perspective, this approach is very problematic. A consumer living in a custodial setting, for example, may want to work towards independence. In many cases, this involves learning to cook, to do laundry, and to take care of oneself in general. In a custodial setting, this may be impossible. Cooking for oneself, for example, is a violation of the expectations of funders. Another example is provided by a 1996 review of the HSC program. The reviewers found that some of the very best settings in terms of quality were in small family-scale homes, sometimes housing only one or two residents. In most cases, these settings were actually in violation of the provincial standard for 24-hour supervision of the home. Such supervision was not needed and providing it would have made the homes untenable financially. The review of Homes for Special Care also pointed out that the legislative structure of the program discourages rehabilitation and creates substantial obstacles for operators who want to move in this direction.

What, then, can be done about the way in which custodial programs operate and are monitored? The issue is not monitoring itself; all housing programs in receipt of public funds need to be carefully monitored. The issue is how to do this in a way that supports best practice. We will see below that alternative housing programs are monitored in a different way, but the main point here is that the custodial model is only one approach, and in our view, the wrong one.

The essentially institutional model of HSC has had other negative consequences as well. It has made the large size of many homes seem acceptable. The 1996 review indicated that 8 homes have over 30 beds. It has also legitimated crowded conditions and lack of privacy. In some homes, for example, rooms are shared by four people.

In addition to its institutional foundations, HSC established a tradition of under-funding housing programs. Despite a recent large increase, operators receive approximately $40.00 per diem, or about 8% of the costs of an inpatient day at a hospital. This is the case despite the fact that many HSC residents are very disabled by their mental illness and have very high needs.

The institutional nature and the inadequate funding levels of HSC have had a significant impact on other approaches to housing people with mental illness in Ontario. The basic level of HSC funding has acted as a benchmark for newer programs such as domiciliary hostels and Habitat Services (a subsidized boarding home program in Toronto).

In addition to inadequate funding levels, the basic custodial model of HSC has also been replicated in newer programs. Domiciliary hostels and Habitat Services are essentially custodial in nature and mimic the HSC approach in the types of facilities they fund and the services they expect to be provided by operators. It is sobering to realize that these custodial options, despite the contradiction they represent with the Ministry's basic policy position as expressed in Putting People First, account for 4,864 beds in Ontario, or about 44% of the total dedicated beds. Non-custodial, or alternative models account for 6,214 beds[2].

The major problems with the custodial models described above are balanced by one major strength: effective targeting. Despite inadequate funding and other problems with the models, the capacity of these programs to target people with very serious mental illness is consistently good. They focus the resources they have on the most needy as a result of the mandates imposed by funders and the commitment and skill of their operators. This is a significant accomplishment.

Tradition II: Alternative Housing

In the mid-1970s a second approach to housing began to appear in Ontario. Referred to as 'alternative' housing, the name itself expressed the attempt to develop a new approach. When compared to custodial models, alternative programs tend to be smaller and to focus on skills training and community integration (Trainor, Morell-Bellai, Ballantyne, and Boydell 1993). They are typically operated by non-profit agencies within a rehabilitation framework and encourage residents to be involved in decision-making. In most cases, and in contrast to boarding homes, individuals with training in social work or psychiatric rehabilitation make up at least part of the staff.

Alternative housing can be broken into two main categories: supportive and supported. Supportive models were the first to be developed and typically take the form of co-operatives and group homes. The support provided is tied to the facility and the people living there are seen as program clients. More recently, a different approach to alternative housing has emerged. This approach, encouraged by the provincial government, grew out of concerns about the tenancy rights of individuals in all kinds of supportive housing.

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[2] Source: Ministry of Health and Long-Term Care, 2002. The figure for alternative beds breaks down as follows: 238 are federally funded Canada Mortgage and Housing supported units and 5,976 are with the Ministry of Health and Long-Term Care. Of the latter group, 2,376 are in the dedicated supportive housing portfolio, 1,000 are phase I homelessness beds and 2,600 are in phase II of the same program. Over 1,000 of these beds are still being developed as of February 2002.

Some individuals no longer needed or wanted the support services that were provided in their particular housing environment, or wanted services that could follow them when they moved. Called 'supported' housing, the new approach de-links the housing and support functions. Support services are provided from outside the home, often by a different agency than the housing provider, and are portable, in that they can move with the client. The client is a regular tenant in a house or apartment that is ideally obtained on the open market, although many clients are supported within non-profit or cooperative social housing projects.

A number of factors about alternative housing are critical for the development of future programs. The first is the knowledge and experience that has developed in the area of rehabilitation oriented, non-custodial support and program monitoring. Alternative models are enabling in that they attempt to enhance consumer skills and are monitored by funders to support this approach. By using a psychiatric rehabilitation framework and a more flexible approach than the custodial programs, they are successful in supporting consumers without resorting to an overly standardized approach that results in providing each client with an identical basket of services. Experience has shown that the skills and techniques applied in this flexible and non-custodial model can be used successfully with clients who have very high levels of disability.

The approach used by the Ministry of Health and Long-Term Care to monitor the activities and service standards of alternative housing programs is appropriate for non-custodial models in several ways. Agencies are globally funded and encouraged to provide flexible, custom designed support. Rules are not embedded legislatively in an act or regulations and are able to change as new approaches emerge. However, alternative housing programs have not been required to follow clear selection procedures when choosing tenants. In many cases, tenants must meet the eligibility criteria for social housing (e.g. income criteria, immigration status, age) but there has not been a clear articulation of eligibility in terms of the degree of disability or support needs.

Alternative housing programs, then, have left an important legacy. They have pioneered non-custodial models of support and have operated with both linked and de-linked housing and support services. While their operating agreements with the Ministry of Health and Long Term Care have not required them to house and serve the most disabled clients, they have effectively supported consumers with a range of needs, including those with serious mental illness. The absence of clear access criteria for alternative housing is something that needs to be addressed to ensure that the needs of the most seriously mentally ill are centrally addressed in these programs.

It is also important to note that alternative models are better funded than their custodial counterparts. Some models are quite inexpensive, while others, such as high support group homes, have secured funding ranging from $100 to $140 per diem. This is in contrast to the approximately $40 per diem paid to custodial operators.

Summary and Implications for the Development of Housing

This brief look at the development of housing in Ontario can be summed up with a number of points that are relevant to planning for the future. Any new models will be influenced by the traditions of existing programs and, therefore, planners must be aware not only of the

strengths of these traditions but also of their weaknesses, in order to avoid repeating past errors. New strategies will need to:

- Make maximum use of rehabilitation oriented, non-custodial models of support, including programs for consumers with very high needs,
- Ensure that support levels match consumer needs,
- Secure adequate levels of funding,
- be fully integrated with other mental health and community services, and
- Target resources to those most in need.

One point above, adequate funding, is of particular importance. Looked at objectively, it is striking that so few options exist between the very high levels of inpatient spending and the very low levels of funding for housing. The most disabled consumers from psychiatric hospitals, for example, are frequently discharged to HSC or other boarding home models. As we have seen, the funding in these settings is only a small fraction (8%) of the cost of inpatient care. If we compare the clinical condition and support needs of many psychiatric hospital inpatients with the residents of a typical Home for Special Care, this funding disparity is clearly unjustified. A concerted effort will need to be made by planners to break through the underlying perceptions and assumptions that have made this state of affairs seem reasonable.

Part II
Knowing: Getting and Using the Right Information

Best Practices in Housing: The Research Evidence

A foundation of research on housing for people with serious and persistent mental illness has been building since the early 1980s. Although gaps in knowledge still exist, the important elements of successful housing and support programs for people with mental illness are clear. These elements encompass a range of housing and programmatic support features that must be implemented to provide the best opportunities for recovery and success in the community.

The *Review of Best Practices in Mental Health Reform*, produced in 1997 by the Health Systems Research Unit, Clarke Institute of Psychiatry, reviewed research evidence relevant to the reform of mental health systems. Despite some methodological weaknesses in the research to date, numerous studies show that:

- Community residential programs can successfully substitute for long-term inpatient care,
- Supported housing can successfully serve a diverse population of persons with psychiatric disabilities if support networks are in place and monitored,
- Consumer choice is associated with housing satisfaction, residential stability and emotional well-being, and
- Consumers prefer single occupancy units with support available on request.

Best Practices also notes the importance of case management to the success of supported housing approaches. Evidence from numerous studies indicate that consumers with serious mental illness can improve in a number of life areas and live successfully in various types of community housing when supported by assertive community treatment and other case management services.

The *Best Practices* report recommends a shift of resources and emphasis to supported housing options that incorporate the following key elements:

- Use of generic housing dispersed widely in the community,
- Provision of flexible individualized supports which vary in type and intensity,
- Consumer choice,
- Assistance in locating and maintaining housing,
- No restrictions on the length of time a client can remain in the residence, and
- Case management services that are not tied to particular residential settings but are available regardless of whether the client moves or is hospitalized.

This endorsement of supported housing is balanced in *Best Practices* by the recognition that a range of options is needed. People with severe and persistent mental illness vary considerably in their needs and preferences, and no single housing model can be expected to successfully accommodate everyone.

Since *Best Practices*, Parkinson, Nelson and Horgan (1999) and Newman (2001) have summarized evidence of the qualities and features of housing settings that produce positive outcomes for people with serious mental illness. This evidence demonstrates that social support, good housing quality, favorable locations in the community, privacy, a small number of residents, and resident control and choice all contribute to overall satisfaction and emotional well-being. These housing characteristics are typically features of alternative models and are rarely observed in custodial housing programs.

Most custodial housing does not conform to good practice, let alone best practice. Steps have been identified to re-develop these settings so that they can reflect some of the practices associated with alternative housing models (Pulier & Hubbard, 2001). These include:

- *An upgrade of the physical plant*, including issues such as location, access to transportation and community services, improved physical quality and safety, improved accessibility, a reduction in the number of residents, introduction of more common areas, and the introduction of personal storage areas,
- *The introduction of home-like amenities*, including personal decorations and comfortable furniture,
- *In house programming*, including group and personal empowerment, skills development, and
- *Collaboration with a psychosocial rehabilitation centre*, including vocational services and rehabilitation.

The most basic reform, however, remains the transformation of these settings away from the custodial model.

In thinking about various housing strategies, it is essential to note that a subgroup of the most seriously mentally ill has been unable to live in the community in any of the housing models that now exist in Ontario. A survey of long-stay clients in British mental hospitals (Wykes, 1982) describes these individuals as having one or more of the following characteristics:

- active symptoms of schizophrenia or bipolar affective disorder that are unresponsive to medication,

- Fixed delusional beliefs or patterns of behaviour that are unacceptable within conventional housing programs,
- The need for long-term medical or nursing care to deal with security issues and the severity or instability of the clinical condition,
- A tendency towards self-neglect and wandering, and
- Co-occurring physical disabilities, including deafness, blindness, epilepsy, brain damage, physical disability, and developmental delay.

Several jurisdictions that have faced mental hospital bed closures have developed very high support facilities in the community to address the complex needs of these individuals. These programs are for individuals who require very high support if they are to leave inpatient care. In their review of high support facilities, Trainor & Ilves (1999) note that, despite the very high level of client need, many of these programs successfully use psychosocial rehabilitation (PSR) models instead of custodial support. Their success underscores the need for a wider range of program models and support strategies.

Program Evaluation and Monitoring

Program evaluation and program monitoring are critical elements of mental health reform in order to determine whether programs and services have been implemented successfully and to document the effects of change (*Review of Best Practices in Mental Health Reform 1997)*. These activities should occur at the program level as well as at the systems level. At the program level, program evaluation and ongoing monitoring must be built into the development of housing programs. These activities can contribute to a process of continuous learning and program improvement.

There are two main approaches to the evaluation and monitoring of systems: *internal* and *external*. The *internal* approach relies on the capacity within the system to generate and analyze information to achieve quality assurance and manage services in accordance with desired goals. The *external* approach relies on the creation and support of external monitoring and evaluation by stakeholder groups with a vested interest in holding providers and management accountable and/or by investigators with interests and technical expertise in health services research. Both approaches can help to identify effective practices, identify new and emerging needs, and monitor system performance.

New Knowledge

With extensive knowledge of innovative housing models now in place and documented in *Best Practices* and other places, the question arises of what information is still needed? This question has at least two answers: a fine-grained knowledge of the actual housing needs of consumers in different regions of the province and an ongoing exploration with consumers of how housing and support models should change over time. Information in the first area is needed if we are to plan and implement programs <u>now</u> for consumers who need support, and in the second area so that we can develop what will become tomorrow's best practices.

A fine-grained knowledge of the housing needs of consumers in a particular region needs to be based on the routine collection of information. This information becomes the

foundation for planning and resource allocation. The process of collecting information should be broadly conceived to encompass the many dimensions of consumer need and preference. This requires more than simply counting those who need support. Ontario's many diverse communities and cultures are both an important resource and a challenge to housing development. The collection of information should be sensitive to diversity of all types. This information can inform planning and lead to better programs.

A number of other issues are also important to keep in mind when developing an information base. Many consumers, for example, have families and this trend is expected to increase. Putting in place housing units that can accommodate them will be an important part of planning. Another fundamental issue is the state of the generic housing market. The generic market forms a backdrop that will directly influence the need for designated units. If rents are above the amounts paid by the income sources many consumers rely on, the result will be an increased demand.

In Ontario, the current approach is not based on the organized collection of information and its use as the basis for ongoing planning and development. Instead, occasional proposal calls result in spikes of activity followed by inaction. Current information has typically not been available on how many beds of certain types are needed and on what new trends are emerging.

This situation can be compared to the provision of other medical services such as dialysis. By monitoring need and the available treatment capacity on an ongoing basis, the required services are in place. People who need dialysis are not told to wait for the next proposal call in the hope that service may some day be available. This approach reflects a basic attitude about the importance of a service. Although the crisis in housing for people with mental illness does not have the immediate dramatic consequences of a failure in the dialysis system, it is nonetheless an issue of the highest priority. Housing is a fundamental determinant of health and is essential to survival in the community.

The second kind of information required to put in place an excellent housing system is oriented towards the future. Our knowledge of best practices is adequate for action now, but best practices can and should change. This requires ongoing innovation and exploration. The mental health field is rapidly changing with new developments in treatment, community support and self-help. These will inevitably influence housing.

Part III
Doing: Strategies for Action

Enhancing housing resources is a complex task. The most important action items can, however, be grouped under two headings: re-thinking and re-regulating the custodial stock and developing an adequate range of new supportive and supported housing.

1. Re-thinking and transforming custodial stock is essential to moving forward. These units do not meet best practice expectations and do not fully support a rehabilitation agenda.

The common response to criticisms about the absence of a rehabilitation focus in custodial settings is that the clients living in them do not need, or would not benefit from,

such a focus. It should be noted that there is no evidence for this. In fact, our current knowledge of the course of mental illness and the ability of consumers to move forward and recover directly contradict this myth. In addition, a review of Homes for Special Care residents conducted by the Health Systems Research and Consulting Unit at the Centre for Addiction and Mental Health demonstrated that residents form a heterogeneous population with a range of needs. The single level of support offered by the homes is not appropriate for many residents.

The provincial government issued a *'Discussion Backgrounder'* on the four custodial programs in 2000. This paper called for an administrative consolidation of the programs and their regulation under one set of provincial standards. The new approach to regulation was, however, still custodial and the paper described the residents as people who have 'reached their maximum level of functioning'. The *Backgrounder* did not propose a way to modify the custodial programs in line with best practices and the principles of psychiatric rehabilitation. In this critical sense, it did not address the limitations of the custodial programs identified in this paper.

In our view, the points raised by CAMH in response to the *Backgrounder* continue to form the foundation of needed action. It is essential that we:

- Recognize that, in the case of the four programs to be consolidated, Ontario has a tradition of supporting custodial models that violate current best practice,
- Recognize the heterogeneous nature of the clients living in the 4 programs to be consolidated,
- Recognize that there is no basis in fact to assume that the population of the 4 current programs will not benefit from a rehabilitation oriented approach, and
- Secure adequate levels of funding which are structured to provide incentives for operators to move away from custodial models.

2. Developing an adequate range of supportive and supported housing

The range of models that is now established in best practices and more recent research is the foundation for developing new housing programs. For these models to be articulated when and where they are needed will require a change in the current approach to planning and funding housing. As above in Part II, a regular flow of information is needed to fine-tune program development. Instead of occasional proposal calls, a continuous planning model is required, based on a redefinition of the priority given to housing. There are two key aspects of this: regular surveys of housing requirements carried out in each region of the province and a new business and funding model adopted by the Ministry of Health and Long-Term Care.

A new approach to planning and development must be supported by new approaches to funding. Key to this will be new ways of involving the private sector. Examples include apartment subsidy schemes (already introduced by the Ministry) that support the use of private sector units. These programs improve the ability of the system to be expanded if necessary. Although they do not add to the supply of housing in a tight market, they can be put in place quickly and are an essential part of a more responsive system. In addition, the current funding approach must be modified to allow for a wider range of financing schemes to support housing. At the present time, long-term commitments that permit the full involvement of private sector partners are not possible. A commitment to long-term

arrangements including leaseback and turnkey models will increase the flexibility of the system.

Two Action Steps

Ontario is fortunate in having a significant pool of talented people with the skills and energy to successfully confront the housing problems that we now face. These people include consumers, families, professionals, government officials, and private and non-profit housing operators. In addition, Ontario has made significant commitments to funding new housing, research, and evaluation. These factors are the foundation for effective action. There is no doubt that the knowledge and human resources are in place to build an excellent housing system to meet consumer needs.

We believe that it is the responsibility of the Ministry of Health and Long-Term Care, with the full support and involvement of other key stakeholders, to launch a ***housing action strategy*** to harness these resources. Two direct steps can be taken now to move ahead.

1. Transform custodial stock into supportive housing that reflects best practice. It is recommended that the Ministry of Health and Long-Term Care convene a provincial working group of consumers, families, private operators, and professionals to plan the conversion of custodial stock to supportive housing. This will require addressing issues beyond those identified in the *Homes for Persons with Special Needs Discussion Backgrounder*. The working group should be charged with two fundamental tasks.

- Develop a new approach to monitoring and funding that will put in place a model that reflects the principles of best practice and psychiatric rehabilitation.
- Ensure that the interests and talents of private operators are respected and that, subject to operator cooperation, the new model supports the transition of existing homes and offers operators a viable economic model.

2. Create and implement new approaches to planning and funding housing for people with mental illness. If step 1 above is implemented, the need for different strategies for custodial and alterative stock (as reflected, for example, in the Phase I and II Homelessness Initiative and the Homes for Persons with Special Needs strategy) will end. Instead, each region of the province can develop a single coordinated strategy for all the housing resources in its area. Given the different tasks involved in developing a single strategy, it is recommended that the Ministry of Health and Long-Term Care convene two working groups to deal with planning and funding respectively. Consumers, referral source staff, housing researchers, Ministry operational, policy, and regional officials, and operators are essential for the first group. The critical tasks are as follows:

- Develop a strategy that will allow all regions of Ontario to collect, on an ongoing basis, data on housing needs,
- Develop a common method for the analysis of data and its translation into development targets, and
- Develop a method of regularly assessing new ideas and concepts in housing to create tomorrow's best practices.

The second working group, focusing on funding, needs the same membership categories as the first group with the important addition of private sector developers. The critical tasks are as follows:

- Outline a funding and business model that will allow the full participation of both the private and non-profit sectors in the development of new housing, and
- Develop a funding model that will allow for continuous development and adjustment of the mix of housing programs to meet the changing needs of consumers.

Conclusion

People with mental illness need safe and affordable places to live. They also need the right kind of support to live successfully in these settings. To work for consumers and for a health care system that faces high demands and limited resources, a coordinated housing strategy needs to be driven by good information and to utilize models that respect the capacities of consumers and offer only the support that is needed.

Ontario has developed two approaches, or traditions, to providing housing for people with mental illness. Although the development of good housing faces a single set of challenges, and is governed by a single set of best practices, custodial and alternative models are planned, funded, and monitored in different ways. This split reflects historical, policy, and administrative factors, but it does not reflect the needs of consumers.

The ingredients for change are in place. The knowledge of best practices and the talents of consumers, families, government officials, providers, and referral sources can be galvanized to create the needed reform. With its current emphasis on reform, the province is ideally situated to take action. This paper has outlined a series of steps that can shape this action.

The key factor that can start the process is leadership from the Ministry of Health and Long-Term Care. The Ministry alone can create the needed context and coordination. With this in place, it will be the responsibility of all stakeholders to fully support the process and bring it to a successful conclusion.

The Centre for Addiction and Mental Health is committed to working in partnership with the Ministry and all other stakeholders to develop a new vision and to make it a reality. Excellent housing that brings dignity and supports recovery is a goal we can all share.

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