

# Housing and Supports for People with Mental Illness

Provincial Advisory Committee on Mental Health  
Housing and Related Support Services

June 18, 2008

## **Executive Summary**

This position paper was developed by a committee of key community stakeholders brought together by the Department of Health and Healthy Living to advise government on housing for individuals living with mental illness. It is to be used to inform the development of a policy framework on housing and supports for vulnerable individuals who require supports and services to obtain and maintain housing.

The current housing situation for individuals with a mental illness disability in Manitoba has reached a crisis. The committee makes considerations that will move the system further towards providing for this basic human right, however first and foremost a resolve must be made that the current conditions are unacceptable and that vulnerable people throughout Manitoba deserve to live in safe, clean and affordable housing with adequate supports.

Housing is a key determinate of health, a necessary ingredient for recovery as well as a basic human right and yet currently in Manitoba we often fail to provide basic, safe, and affordable housing for vulnerable individuals living with mental illness. Inappropriate housing and inadequate supports can lead to increased homelessness with associated safety risks, increased hospital stays, increased utilization of emergency services and increased burden on family members.

The following principles are essential in underlying all services to individuals with a mental health disability, including housing and support services:

- Choice, self determination
- Consumer centered
- Least restrictive, Integrated, Community based
- Recovery based
- Culturally appropriate
- Gender based
- Quality
- Affordable
- Accountable

The committee reviewed a variety of housing and support models from “transitional” housing, “supportive housing” with supports attached to the program through to “supported” housing with supports attached to the individual. It was determined that a range of housing and supports must be provided to meet the needs of this diverse group. Based on the recovery model and in keeping with psycho-social rehabilitation principles it was identified that the important goal of the model, regardless of its place in the range is the promotion of the most integration and independence as possible. Special consideration needs to be provided to individuals with co-occurring mental health and substance use disorders including the availability of housing alternatives that support a harm reduction model.

Challenges in Manitoba include 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. With respect to supports, challenges include the difficulty of recruitment, lack of competitive remuneration for para-professionals such as proctors and home care workers and lack of consistency across Health

Authorities in the provision of specialized mental health and addictions service. Finally, the committee emphasized the special challenge of stigma as a barrier to efforts to support individuals with mental illness. In conclusion, the committee presents considerations to improve the lives of vulnerable people living with mental illness.

- 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.

**Further, two considerations are made specific to First Nations:**

- 1) 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.
- 2) Development of provincial and federal policies, programs and procedures for Mental Health & Housing in collaboration with First Nations in a comprehensive manner for both on and off-reserve members. This would include:
  - i) Inter-jurisdictional policy & financial barriers, cultural importance and competence;
  - ii) Ensure seamless continuum of mental health and housing systems and support services that are accessible, high-quality and coordinated; and
  - iii) Ensure holistic approach is taken that addresses trauma, poverty, and lack of employment, relocation, residential schools & intergenerational impacts.

## **Introduction**

In the fall of 2007, Manitoba Health and Healthy Living brought together key community stakeholders concerned about housing and support services for people with mental illness. See Appendix I for a list of committee members. It is acknowledged that there are competing views of best models and Manitoba Healthy Living has brought the stakeholders together to identify best practices and to develop a position paper to inform planning. The Terms of Reference for the group indicate that it would complete a review of evidence-based practice and a review of the activities in other jurisdictions and produce a position paper. This position will then be used to inform the development of a policy framework on housing and supports for individuals with a mental health disability who require supports and services to obtain and maintain housing. This paper provides a summary of the types of housing models discussed in the literature, a review of the evaluation of those models and an outline of the committee's direction on providing adequate housing and supports to people living with mental illness in Manitoba.

Access to safe, clean, private and affordable accommodation is considered by many as one of the most important priorities for vulnerable people and a basic human right. Along with income, education and employment, housing is often cited as a key social determinant of health. A wealth of evidence from Canada and other countries supports the notion that the socioeconomic circumstances of individuals and groups are equally or more important to health status than medical care and personal health behaviours, such as smoking and eating patterns. The weight of the evidence suggests that these determinants of health have a direct impact on the health of individuals and populations, are the best predictors of individual and population health, structure lifestyle choices, and interact with each other to produce health (Public Health Agency of Canada [PHAC]).

In 2006, the Senate report on mental health, mental illness and addiction services in Canada was published (Kirby and Keon, 2006). Praised as the most comprehensive study of the mental health and addictions "systems" in the history of the country (Canadian Psychological Association [CPA], 2006), this report identified housing and housing supports as one of the most necessary components for assisting individuals to cope with and recover from their mental health disorders.

It has also been recognized that individuals living with mental illness face significant challenges in finding safe and affordable housing and experience equal challenges maintaining housing without appropriate supports. Lack of housing and inadequate supports can lead to increased homelessness with associated safety risks, increased hospital stays, increased utilization of emergency services and increased burden on family members. Obstacles to obtaining housing include low income, stigma and discrimination, zoning laws, rental market discrimination, house sales discrimination, lack of support services, and co-occurring mental health and substance use disorders. Although Manitoba has many examples of programs that provide excellent housing and support to individuals, it is also well understood that on the whole we need to do more. The committee expressed strongly the urgency of that call to action in the face of what it identified as a serious housing crisis.

## **Service Principles**

The following principles were identified by the group as essential in underlying all services to individuals with a mental health disability, including housing and support services:

- Choice, self determination
- Consumer centered
- Least restrictive, Integrated, Community based
- Recovery based
- Culturally appropriate
- Gender based
- Quality
- Affordable
- Accountable

## **Vision**

In 2002, Manitoba Health's Vision Statement for Mental Health Renewal was published. In consultation with consumers of mental health services, family members and friends of consumers and service providers, Manitoba Health developed the vision statement to reflect the values and beliefs of the mental health system and the direction the system was moving towards.

Manitoba Health Mental Health Renewal Vision Statement:

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. (Manitoba Department of Health, 1992)

It was expected that all new initiatives would be aligned with this vision statement. It was agreed by the group that this vision statement would accurately reflect the vision for mental health housing and support services as well.

## Housing Models

### Housing and Support Options

<b>Crisis/ Transitional Housing</b>	<b>Residential Care</b>	<b>Supportive Housing</b>	<b>Supported Housing</b>
Shelter/hostel accommodation	Licensed residential care facilities	Supported independent living	Housing scattered throughout the community
Short-stay crisis stabilization	Family Care Homes	Group Homes, Congregate Housing	Market, Non-profit or Co-op Housing  Housing First  Low Barrier Housing
e.g. Mainstay program, Winnipeg, Shelter Thompson Manitoba	Various locations across the Province	e.g. Eden East, Carriage Road, Winnipeg, CMHA Thompson	e.g. CMHA
<b>Support tied to the facility</b> <b>Housing likely to be transitional</b> <b>Housing is segregated</b> <b>Tenancy controlled by the service provider</b>			<b>Support tied to the individual</b> <b>Housing is permanent</b> <b>Housing is integrated</b> <b>Tenancy usually controlled by the tenant</b>

Housing models are generally discussed in terms of these main models described in the chart above.

1. Crisis and Transitional Housing
2. Custodial or Residential Care
3. Supportive Housing
4. Supported Housing (including the Housing First model, or principle as well as Low Barrier housing)

#### 1) Crisis and Transitional Housing

As the name implies, crisis or transitional housing provides basic shelter for individuals in emergency or otherwise short-term need. The housing is structured to be transitory, with people staying no more than a matter of days or weeks. Examples in Manitoba include the Salvation Army and Main Street Project in Winnipeg, and the shelter in Thompson, Manitoba. Such programs are meant to shelter individuals from immediate danger and then move them back to their homes in the community.

#### 2) Custodial or Residential Care

Custodial models of care were developed in response to de-institutionalization in the early '60's, when individuals previously living in institutions were discharged to community. Patients were housed in sometimes large, congregate housing operated by private landlords for profit. These settings typically provided meals, laundry and social programming for residents and typically did not provide rehabilitation programs. The basic program model is said to reflect a dynamic referred to in the literature as "trans-institutionalization" (Centre for Addiction and Mental Health

[CAMH], p. 3) which is the inappropriate application of institutional routines outside of institutions.

This model can be understood as necessary from a custodial perspective when disabled, young or elderly people are unable to care for themselves, and the model is specifically efficient in targeting those who are most vulnerable; however, as pointed out in the literature, from a rehabilitation perspective, this approach stands as a barrier to development and recovery.

### 3) Supportive Housing

In response to increasing awareness of consumer needs and individual potential, and with newly trained rehabilitation professionals, the supportive housing model developed next. This model was developed by non-profit agencies to provide rehabilitation services in smaller more home-like settings including halfway houses, group homes and supervised apartments. Supportive housing models provide housing with supports tied to the housing and sometimes are organized along a residential continuum, with the amount of support varying from high to low, depending on consumer need. Individuals could then be moved along the continuum as dictated by their needs, but the program and supports were fixed to the housing.

There is consensus from a rehabilitation perspective that the most effective method of delivery for this model of housing is small number of units, i.e. approximately (but not more than) 40% of the total units.

Although allowing more opportunities for consumers, the central problem identified with this supportive housing model is that because these inflexible supports are tied to the housing, when the client needs change, new supports would not be available, and he or she would have to move. Further, if the client wishes to relocate for another reason, the supports could not follow.

### 4) Supported Housing

“Supported Housing” is independent housing in the community provided to consumers as tenants. It is coupled with “de-linked” and portable community mental health and other support services. Support is provided by an organization separate from the housing organization and if the client moves, the supports move with the client.

Supported housing is a term brought by Paul Carling from the independent living movement for people with physical and developmental disabilities into the field of community mental health. The approach works from a disability rights perspective rather than the medical model. It refers to community based, integrated housing where mental health and financial supports are provided to the individual and not linked to a facility.

Supported housing is generally defined as having the following components:

- integrated housing;
- dispersed in regular neighbourhoods;
- with flexible support services tied to the individual; and
- with a range of housing alternatives to allow consumer choice.

The risk of social isolation has been identified as one shortcoming of this approach. Consumers have identified loneliness as the single most problematic issue in living independently; one that can, in some cases, result in a return to hospital or residential services. It is essential that services in supported housing have a significant focus on reducing social isolation through such options as shared activity groups or communal kitchens (British Columbia Ministry of Health and Ministry Responsible for Seniors, 2002)”

### Housing First

The Housing First approach emerged to meet the special challenges of providing service to disengaged, homeless, and/or co-occurring disorders populations. The approach centres on providing the homeless with housing quickly and then providing services as needed. It emphasizes the provision of permanent housing as a priority, and an essential right, instead of trying to stabilize the individual first, and making them “housing ready” before providing them with the housing.

Traditional continuum of care housing programs for people with a mental illness and/or co-occurring substance use disorder typically require the person to be stable with a clear diagnosis, to be receiving treatment and to agree to abstinence before housing is approved. This can have the unintended effect of preventing the chronic homeless population or individuals with severe and persistent mental illness and/or co-occurring substance use disorder from accessing housing at all. Housing First takes a harm reduction approach, and requires significantly fewer requirements for access.

Housing First was developed in the United States, originally by Pathways to Housing, a non-profit organization in New York, to meet the housing and treatment needs of the chronically homeless severely mentally ill population with co-occurring substance use disorder. As the approach views housing as a fundamental right its proponents advocate that it is often unfairly used as leverage to force individuals with mental health and addictions issues to participate and receive services. There is some evidence to suggest that providing stable housing first results in a higher tenancy retention rate leading to less homelessness, and a more cost-effective way of addressing the needs of these individuals.

The Government of Canada’s Homelessness Partnering Strategy adopts the “Housing First” principle which emphasizes shelter as a pre-condition to full participation in society. The term “Housing First” can have a range of meanings, from very specific programs that deal with individuals with who are chronically homeless, to broad conceptual descriptions of a general approach to social service delivery that emphasizes the importance of housing.

Programs using a Housing First approach have four common elements:

- Permanent housing is the first priority;
- Services provided are focused on sustaining housing;
- Services can be time limited or continual depending on need; and
- Housing is not contingent on compliance with external services
- Participants are subject to regular lease agreements.

Housing First Examples include:

- Pathways to Housing, New York
- Rain City Housing, Vancouver
- Pathways to Housing, Calgary

### Low-barrier housing

Low barrier housing is a type of supportive housing that provides stable housing and support services to individuals who may not yet be engaged in any treatment and does not require sobriety. It supports people to help them achieve greater self-sufficiency and housing stability. This type of housing is provided generally in a dedicated building, and is not alcohol and drug free (Vancouver Coastal Health, 2006, p. 12).

### Literature Review

A review of the literature reveals a consistent theme. The “supported integrated housing” model shows the most promise in achieving recovery goals for consumers and some preliminary evidence suggests good outcomes with the Housing First model.

There is agreement that the supported housing model should be the option of first choice, but that other models should be considered when the client requires more intensive support or supervision for a period of time. It is recognized that mental health service systems may need to have some supportive housing but that such facilities should be considered as “flow-through” options that helps consumers move on to more normalized housing wherever possible.

In the often-cited “Best Practices in Mental Health Reform” (Public Health Agency of Canada [PHAC], 1997, p. 49), a housing checklist is presented. It includes the requirement that:

- there is a variety of housing alternatives available;
- ranging from supervised community residences to supported housing; with emphasis on supported housing”.

In the same document, the Public Health Agency of Canada stated that one of the key goals of Mental Health reform is the “promotion of independence to the fullest extent possible and true community integration” (PHAC, 1997, p. ix). Here too, it is highlighted that safe and affordable housing and community supports is mandatory for successful community integration and that “supported housing” is considered a best practice.

The following summary of research evidence is described:

Quasi-experimental and longitudinal 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 but support networks need to be monitored; and
- consumer choice is associated with housing satisfaction, residential stability and emotional well-being.

Cross-sectional studies show that:

- consumers prefer single occupancy, increased choice, and accessible supports.

Controlled and non-controlled trials have demonstrated that:

- individuals with severe mental illness, including homeless people, can be housed effectively when provided with assertive case management services.

And again, key elements of best practice were identified as:

- a range of different housing alternatives is provided but there is a shift of resources and emphasis on supported housing.

The 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. (p. 49)

The 2006 Senate report on mental health, mental illness and addiction services in Canada identified three dimensions of this problem:

“It would be hard to overestimate the importance of adequate housing for people living with mental illness, in particular those whose illnesses are serious. Three inter-connected dimensions must be addressed:

- more housing units are required;
- more assistance is needed so that people can afford to rent existing accommodation at market rates; and
- more supportive services are needed so that people can live in the community.” (Kirby & Keon, 2006, p. 27)

Specifically, in Recommendation #11, (p. 123), it recommends that “...funds are provided both for the development of new affordable housing units and for rent supplement programs that subsidize people living with mental illness who would otherwise not be able to rent vacant apartments at current market rates”.

Also in 2006, the Winnipeg Region office of the Canadian Mental Health Association hosted a Think Tank on housing to discuss effective public policy measures that are needed to create supported, integrated housing for people with a mental illness living in Winnipeg. These were identified as policies and programs to:

- increase the general supply of rental housing
- increase income support for people with a mental illness and
- increase access to quality community mental health services (Canadian Mental Health Association, 2006, p. 1).

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.

## **Other Provinces' Plans**

A review of other provinces' Mental Health Plans and/or Housing Strategies indicates that of those provinces that have such documents, housing and support services have been built with a focus on the supported housing model. As examples, the supported housing model is specifically mentioned and supported in the housing strategies of the Province of British Columbia, the City of Vancouver, and within Ontario's mental health planning documents. It is also recognized that a range of options need to be made available and that in some cases residential Supportive Housing options may need to be used for some consumers.

In 2003 the Ontario Ministry of Health and Long Term Care funded a research project to examine the province's dedicated housing system for people with serious mental illness and to make recommendations for improving the system (Sylvestre, J., George, L., Aubry, T., Durbin, J., Nelson, G., & Trainor, J. (2007). The project included looking at the research evidence for effective practices as well as cross-provincial consultations with stakeholders about system improvement. The project started with "the underlying belief is that housing is a fundamental right, is necessary for successful community integration and that housing and support services must serve the interests of consumers" (p. 82). Six values were identified that reflect the principles of a reformed mental health system. Three values were characterized as "therapeutic", referring to the relationship between the individual and the neighbourhood:

- choice and control;
- quality; and
- community integration (p. 85)

A second set of three values was characterized as "citizenship" housing values, referring to the opportunity for equal participation, as a citizen, in broader systems:

- access and affordability;
- accountability; and
- housing rights and legal security of tenure (p. 85).

The research reviewed suggested that choice and control, quality and community integration are essential elements of an effective housing model. The report summarized the following recommendations:

- 1) Increase the capacity of supportive housing and community support systems.
  - Recognize housing as a basic human right fundamental to recovery
  - Strengthen existing services
  - Rationalize use of existing resources
- 2) Develop regionally based coordination and planning.
  - Create regional housing and support teams
  - Create regional coordinated access
  - Provide comprehensive planning for housing and supports
- 3) Support the provision of high quality services
  - Set provincial standards
  - Develop collaborative approaches for the development of standards, continuous innovation, and program improvement.

- 4) Identify priorities for system monitoring
  - Monitor service needs, service use, and consumer satisfaction
  - Monitor programs and the system and fund strategic program evaluation
- 5) Ensure affordability
  - Provide housing subsidies and help people with mental illness to escape poverty
- 6) Provide system leadership
  - Strengthen provincial leadership. (p. 82-91)

As its initial step, the report recommended strengthening the system through investments that will support the housing community by identifying, implementing and monitoring good practice in the province (e.g. through the creation of regional housing and support teams). Second, the report recommended creating more supported housing in the form of independent apartments and through the use of additional housing subsidies (p. 92).

### **The Housing**

As discussed, access must be available to a range of housing options, from transitional through to supportive and supported housing models depending on need. Individuals must have adequate funds to pay for housing, and an adequate supply of affordable housing must exist. The supply issue may be addressed through potential incentives for private market and non-profit providers to encourage new investment in affordable housing.

Housing options and financial assistance for individuals with mental health issues must include:

- Rental subsidies, accompanied by services to support low-income individuals who require assistance to find safe, adequate and affordable housing (i.e. portable housing benefit);
- Construction of new affordable housing units with support services and subsidies tied to individuals;
- Increased permanent housing with supports;
- Transitional housing units with support programming; and
- Housing that is successfully integrated into the community, distributed throughout various neighbourhoods and is represented throughout the province in urban, rural and northern areas.

Challenges in Manitoba to providing these housing options include:

- A lack of affordable housing in numerous communities across Manitoba, particularly in the larger urban centres;
- Low vacancy rates for private rental apartments throughout Manitoba, including a 1.5 per cent vacancy rate in Winnipeg, a 0.2 per cent vacancy rate in Brandon and a 2.4 per cent vacancy rate in Thompson. A balanced rental market should have vacancies in the three per cent range.
- Vast geography including rural and remote northern areas that are difficult to access;
- Jurisdictional issues for housing of Aboriginal people both on and off-reserve;
- Municipal barriers posed by restrictive zoning by-laws and uncooperative neighbourhoods;
- Policy implications for public housing to facilitate successful application for tenancy of people with mental health issues.

- Individuals in some cases are losing their tenancy as a result of hospital stays;
- Lack of single, non-elderly units in public housing;
- Many landlords are not aware of financial incentives that exist to rehabilitate the private rental stock (i.e. the Rental Residential Rehabilitation Assistance Program (RRAP));
- Housing that does exist is predominantly situated in the core urban centres that may be unsafe; and
- Stigma. Stigma creates barriers for people with mental illness seeking housing in the private market.

## **The Supports**

For mental health consumers living in any community setting the support available to them is generally considered to be the key ingredient to success, and lack of adequate supports has been identified as a major contributor to housing failure. It should be noted, that this statement is not meant to contradict the legitimacy of a Housing First approach. This approach was developed to meet the special needs of disengaged, homeless, and/or co-occurring disorders populations and works from a harm reduction principle in which treatment compliance with external services is not necessarily a criteria for housing. There is widespread agreement on the importance of providing a range of individualized supports to assist mental health consumers achieve success in tenancy.

The following are basic principles that should underlie supports:

- Flexible;
- Based on client choice;
- Access to a range of services is available;
- A recovery model where the goal is maximizing independence in the most integrated settings possible for each individual; and
- Natural supports and family members are invited to be a part of service planning as appropriate.

Supports are needed for the mental health, financial and housing components. These supports need to be coordinated and all service providers need to be trained to support people with mental health issues. These supports must be available for a range of needs including 24/7 residential with on-site supports through supportive housing to more independent supported housing models and must include:

- The full range of mental health and addictions treatment and support including psychiatry, community and in-patient mental health and addictions treatment, case management, Programs for Assertive Treatment and Crisis Services;
- Case management of varying intensity;
- In-home support for life skills development;
- Employment support;
- Supports through transitions, especially discharge from hospital, or times of other crises e.g. outreach services;
- Outreach to engage with other systems; and
- Support to landlords e.g. mediation, information regarding mental health issues, intervention with clients with behavioural challenges, etc.

Challenges in Manitoba to providing these supports include:

- Providing service across a large geographical area that includes rural and remote areas is challenging. Some areas of the province do not have access to specialized services; transportation is time consuming and expensive for those service providers within northern and rural areas.
- Human Resource challenges. Recruitment is challenging for almost all service providers. Remuneration is a problem for paraprofessionals such as proctors and home care workers. These paraprofessional casual workers are an integral part of the mental health system but can not be attracted with below average wages and inconsistent hours. Further, these workers are not members of an accredited body and do not receive specific job training.
- Inter-jurisdictional challenges are faced within mental health housing as they are in all other components of service provision in Manitoba. Service providers need to work together to ensure services are coordinated and appropriate discharge planning is done between provincial and On-Reserve services.
- Migration. Many cities and towns within Manitoba are changing as young people leave for job opportunities and others retire. Health and social services are faced with fragile infrastructures which makes it difficult to provide service. At the same time, many people are migrating to the larger centres, putting pressure on these areas as they struggle to deliver service to people with special needs;
- Other changes to the population including increased immigrant and refugee populations with their very specific needs as well as an aging population add complexity to service provision;
- Lack of consistency in health services across RHAs. With regionalization comes the advantage of the ability to plan specifically for the special needs of each regional area. At the same time, this creates an uneven landscape with different service across regions and there is not yet a comprehensive and coordinated provincial Mental Health Plan to inform the planning of mental health services.
- Finally but not of less importance, all efforts to support individuals with mental illness are challenged by Stigma.

The committee further identified special considerations relevant to individuals with addictions. It is recognized in Manitoba that individuals with mental illness are at risk of developing a substance use disorder, and that co-occurring mental health and substance use disorders can be considered the expectation rather than the exception. In order for these individuals to be successful in their tenancy, housing and supports need to have a certain amount of flexibility which has not previously the norm. Also, supports need to include timely access to appropriate mental health and addictions treatment.

First it was identified that housing arrangements need to have tolerance of relapse. Relapse is a part of addictions, and individuals need to be supported through the recovery process.

Also, it was identified again that there needs to be a range of housing and housing support services available to allow room for client choice. Some clients will wish to need to stay in the core area close to natural supports. Other clients will want to move out of the core area. Some individuals need to be in housing where there is no use, to support abstinence and others need to be in living situations where use is allowed in a harm reduction model.

Further the practical issues of lack of ID, credit, bank accounts, and basic life skills needed to obtain and maintain housing was flagged.

The difficult issue of individuals losing their housing when entering treatment, and lack of discharge planning at other times of transitions (e.g. out of Justice, out of the child welfare system) was also identified.

Further, the Committee acknowledges the special circumstances of First Nation's communities both on and off-Reserve.

### **First Nation's Key Challenges:**

- Lack of Inter-sectoral, Inter-departmental and Inter-governmental relationships with First Nations for the provision of programs and services on & off-reserve;
- First Nations have a different perspective and view than the rest of Manitoba and Canada of wellness and mental health which are not recognized by main stream society; and
- No provincial services are delivered on-reserve and federal programming is lacking creating gaps in services & inter-jurisdictional ambiguities.

### **Conclusion**

The current and urgent crisis in housing for individuals with mental illness in Manitoba has been highlighted in this paper. It is also acknowledged that some of the current housing models do not match with the identified values and vision of our reformed mental health system. Further, it is acknowledged that providing these services across a culturally and geographically diverse area such as Manitoba is very challenging and layering competing inter-jurisdictional and inter-sectoral responsibilities creates more complexity.

The call has been heard "loud and clear" nonetheless. Current housing models and corresponding funding models are not working to support individuals with mental illness and individuals with co-occurring mental health and substances use disorders in our communities in the best way possible. .

As supported by the literature, the committee felt that a range of housing options and support services was necessary for adequate client choice. Although the term "residential" or "custodial" care was identified as out of date and stigmatizing, it was acknowledged that a small percentage of individuals will need segregated care with 24 hour supports. It was identified that such aggregate living should be with a maximum of 6 people or 40% of the total units in a building to ensure a recovery focus. The important component of the model, regardless of its place in the range is that care is provided from a psycho-social rehabilitation perspective and that the goal of all aspects of the program is movement through the system towards more integrated and independent settings.

The majority of clients can be supported to live independently in every community in Manitoba and this should be our goal. A small percentage, however, will require specialized care so a range of living options must be provided in order to meet these needs.

The committee concludes that a paradigm shift needs to occur. A paradigm shift occurred in the fifties and sixties with the move from institutionalization to community care for the severely mentally ill. That shift has been accepted and people's lives have been improved. Now it is time for the next paradigm shift to occur. We are currently living in a society where individuals with mental illness are living in poverty and substandard housing. This is tacitly accepted in our society. We need to start viewing this living standard as unacceptable and start facilitating improved living conditions for vulnerable populations such as those living with mental illness. This paradigm shift would involve significant changes and significant resource implications.

In broad categories, these changes would involve: 1) adequate funds to individuals to obtain safe housing; 2) adequate choice of affordable housing available in communities; and 3) adequate amount of supports.

Adequate funds to individuals to pay for housing must include funds that allow for rent in the competitive market within a range of safe neighbourhoods. Adequate choice of affordable housing means adequate supply in the full range of housing options described above to ensure client choice. And finally, the key to success for any housing initiative is that an adequate range of supports is available to help individuals find, get and keep housing.

Success for individuals with mental illness living in safe homes also means success for us as a society in moving further toward fulfilling our most basic social need and responsibility: the task of supporting each other. As friends, family members, service providers and government we can embrace a new vision of safe, affordable housing and adequate support for all individuals with mental illness.

## **Considerations**

- 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.

### **Further, two considerations are made specific to First Nations:**

- 1) 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.
- 2) Development of provincial and federal policies, programs and procedures for Mental Health & Housing in collaboration with First Nations in a comprehensive manner for both on and off-reserve members. This would include:
  - iv) Inter-jurisdictional policy & financial barriers, cultural importance and competence;
  - v) Ensure seamless continuum of mental health and housing systems and support services that are accessible, high-quality and coordinated; and
  - vi) Ensure holistic approach is taken that addresses trauma, poverty, and lack of employment, relocation, residential schools & intergenerational impacts.

## **Appendix 1**

## Provincial Advisory Committee Members

### **Manitoba Health and Healthy Living**

Bev Pageau - Mental Health and Addictions Branch (Chair)

### **Family Services and Housing**

Dwayne Rewniak - Manitoba Housing Renewal Corporation (Co-chair)

Caryl Mock – Employment and Income Assistance

### **Cross Department Coordination Initiative**

Joanne Warkentin

Brian Law

### **RHA**

Nancy Sewchuk - Housing Resource Developer NOR-MAN RHA

Deb Taillifer - Mental Health Program Manager South Eastman RHA

Carolyn Strutt – Regional Program Director, Mental Health, Winnipeg RHA

Brent White, Program Manager, Residential and Support services Brandon RHA

### **Mental Health Service Providers**

Dr. Rudy Ambtman - CMHA Winnipeg Branch, Board member/ Nicole Chammartin (alternate).

Kim Canvin – Regional Director, CMHA Interlake

### **Consumer**

Gail Sweetland

### **Family Member**

Ron Dyck, Program Director, Eden East, Steinbach MB

Ed Schreyer

### **Representative with Specific Mental Health Housing Expertise**

Ben Fry, Housing Specialist, WRHA

### **First Nation**

Ardell Cochrane, Assembly of Manitoba Chiefs

### **Addictions Network; Addictions Service Providers**

Jean Doucha, Behavioural Health Foundation

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