A RIGHT TO HOUSING

FOR PEOPLE EXPERIENCING MENTAL HEALTH ISSUES

by

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Abstract

Housing makes a difference to our health. Decent, safe, and affordable housing contributes to our mental and physical well-being, while inadequate housing or even homelessness can do the opposite. Having a pre-existing mental illness or substance use issue often restricts a person's options to access, afford, and maintain the kind of home that would enhance and promote recovery.

On the foundation of reviewed literature, as part of a practicum placement with Northern Health and Mental Health and Addictions, I undertook this quantitative, descriptive study in Prince George, and set forth to develop an understanding of the need and type of housing required for individuals with a serious and persistent mental illness (SPMI). As well, I took a look at the current housing available in Prince George, BC Canada, including speaking with landlords and in some cases, doing some education around mental illness as there was clearly some stigma present.

A survey questionnaire to learn from people with SPMI was prepared and conducted at three separate locations in Prince George. Participation was completely voluntary.

The second part of my practicum project involved developing an Iportal system in which information on current housing availability became assessable to the case managers on the Community Outreach and Assertiveness Team (Coast Team). The Coast team works with individuals who have a serious and persistent mental illness that is chronic in nature.

This is an important part of my practicum as case managers are continuously looking for adequate housing for their clients and by having a system in place such as the *Iportal*, it will substantially reduce the number of hours spent on trying to find housing.

I hope to share the final results and recommendations stemming from my study with those individuals at the decision making levels. In Prince George, that would include upper Managers in Northern Health's Mental Health and Addiction services.

Dedication

To the late Paul Becklake, my practicum site supervisor — "you talked the talk and walked the walk my friend." You were an inspiration to so many people, friends, colleagues, and consumers. Thank you for your words of wisdom, advice, direction, and support. By example, you have shown me that I can achieve anything with hard work and dedication. Thank you for being such a wonderful person.

I would like to thank my parents, Linda and John Ormiston, for their unwavering support and encouragement.

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Preface

As the primary research instrument in the research component of my practicum, I would like to take the opportunity to briefly introduce myself.

I have had no prior experience in doing research in the area of housing and people with serious and persistent mental illness. I do, however, have considerable knowledge and experience in working alongside individuals with mental illness as a case manager in the area of Mental Health and Addictions in the Northern Health Authority.

I tried to approach the issue of housing for people with serious and persistent mental illness objectively. Having worked with this population for eleven years, I do believe, that this group of people are marginalized in most aspects of their lives including their housing needs. Through my practicum and especially the research component, I have tried my best to find out what type of housing is currently available in Prince George, BC and what type of housing is important to those living with a mental illness. My greatest hope is to be able to give a voice to this group of people so their wishes are heard by those who make policy decisions. I believe my own experience and personal history have added to my practicum and my research. Prior to, and during this practicum, I have been a part of a housing committee that addresses housing needs for those people with mental illness. This has afforded me an opportunity to keep abreast of current issues in mental health housing and has complimented my academic learning.

Chapter One

Introduction and Description of Practicum

Finding appropriate housing for people with mental health issues is a subject that has captured the attention of many academics for years. Psychologists have done a tremendous amount of work looking at the positive and negative psychological outcomes associated with different models of housing and support (Baumohl, 1989; Caton, 1983, Goldstein & Lehman, 1983; Kennedy, 1989; Rosenfield, 1992). Planners and geographers have cast a great deal of attention toward the location of housing for people with serious mental health and addiction issues, particularly in urban areas (Dear & Laws, 1986; Taylor, 1989). Canadian social worker Hulchanski (2008) has focused on research around policy options for addressing homelessness in Canada while Plyler, Ricciardi, Sakamoto, & Wood (2008) have focused on research pertaining to homelessness, social supports, and housing.

There is a common thread that joins inquiry across all of these disciplines and diversity of theory guiding research problems in the area of mental health housing. That is, there has been an almost exclusive focus on the objective characteristics of people's housing experiences. Historically, quantitative research has been the methodology of choice (Dear, 1977).

Access to, and retention of appropriate housing is necessary for everyone's well being and is a critical factor in the recovery of people with mental illness (Mental Health Commission, 1999). The direction of service provision for people with mental health problems has been toward deinstitutionalization, with an emphasis on independence and interdependence (Kadmos & Pendergast, 2001). Interventions chosen should be the least

restrictive when possible and promote and encourage the development and maintenance of independence.

Beaulieu, Dorvil, Morin, and Robert (2005) confirm the typology that is currently being used in Canada by Horgan, Nelson, and Parkinson, (1998) which distinguishes among three approaches to housing for people with serious mental health issues. They are referred to as custodial, supportive, and supported and each varies according to three main characteristics: the profit orientation of the support-provider, the nature and terms of support provided, and the degree of resident empowerment. Authors Horgan, Nelson, and Parkinson (1998) describe the types of housing as follows:

Custodial care homes provide room and board, 24-hour supervision, basic assistance with activities of daily living, and medication monitoring. They are typically run for private profit and they are the least empowering for the residents.

Supportive housing focuses on rehabilitation and community integration. They are developed and run by non-profit agencies.

Supported housing involves normal integrated housing with no staff on site. Housing is both affordable and adequate, combined with individualized mental health support services.

A main focus of this practicum was to assess the need for housing and the type of housing required for those individuals with a serious and persistent mental illness as well as to look at what kind of housing is currently available in the community in Prince George, British Columbia. The research conducted as part of this practicum makes a modest attempt at understanding the type of housing needed for people with serious mental health issues and advancing that understanding to the decision-making level.

At the time of my practicum, there were 350 individuals receiving services from the Community Outreach and Assertive Services Team (COAST) at Northern Health. There were only 70 individuals who received some form of supported housing.

The COAST team under Northern Health (NH, one of the five regional health authorities in British Columbia) is a community-based multi-disciplinary team that consists of a psychiatrist, physicians, community nurses, social workers, and a life skills worker. The team also has access to a vocational rehabilitation counsellor and recreational therapists.

The COAST team provides direct clinical services inclusive of assessments, case management, and consultation to families, consumers, and the medical community; education, family support, health promotion and prevention, medication administration, monitoring and support, and we partner with the BC Schizophrenia Society to provide educational groups. The client population served is comprised of individuals over the age of 19 who have a serious and persistent mental illness such as schizophrenia, bipolar disorder, or a delusional disorder.

The practicum took place on a part-time basis over an extended period of time from September 1, 2007 to June 1, 2008. The practicum learning objectives were as follows and were agreed to by Paul Becklake, agency practicum supervisor, Dawn Hemingway, academic supervisor, and Glen Schmidt, practicum supervisory committee member, and the student:

1.   To become familiar with both the private and public sector landlords within Prince George.

2.   To create a data-base of housing listings to be utilized and monitored by the COAST team.

3.   To conduct a housing survey amongst individuals currently receiving services from the COAST team. To assess for the 'need' and 'type' of housing individuals may require based on the outcomes of Objectives 1-2, along with the housing survey findings.

4.   To assist with the creation of new opportunities for supported housing for individuals served by the COAST team.

Chapter Two

Literature Review

The care of people with mental and behavioral disorders has always reflected

prevailing social values related to the social perception of mental illness.

(World Health Organization, 2001, p. 38)

A Glimpse of the History

Historically, individuals who experienced mental illness were either abused or

revered, depending upon the cultural biases. An example of abuse can be illustrated by the

treatment of individuals in Greece. In ancient Greece, people who had a severe mental illness

were thought to be influenced by angry gods and believed to have experienced abuse. Those

people with a mild condition were treated with contempt and humiliation (Prince, 2003).

Conversely, during the middle ages, Moslems believed that the insane person was loved and

chosen by God to tell the truth. They were worshiped as saints (Mora, 1985).

The cyclical pattern of reverie and abuse was not limited to a one time period. During

the 15th and 16th centuries, there was a trend of witch mania where the mentally ill were

persecuted and the cause of mental illness was attributed to possession by the devil

(Friedman & Romm, 1994). Individuals were not recognized as sick people but rather were

accused of having abandoned themselves to shameful and forbidden practices with the devil,

sorcerers, and other demons. During the 18th and 19th centuries, hospitals and asylums

assumed the care for the mentally ill. It was during the 18th century that the moral movement

emerged in France, England, and Italy. This movement's belief was that people could be

cured when exposed to an accepting, healthful, and moral environment. Individuals were

treated firmly but kindly (Mora, 1985). Individuals were closely attended to and cared for by

staff who treated them with respect and deference (Grob, 1973). The treatment often used

was the tranquilizing chair. This device was intended to heal by lowering the individuals'

pulse and relaxing the muscles. It was designed to hold the head, body, arms, and legs

immobile for long periods of time (Bloom, 2006). In the late 19th century, both upper and

lower Canada borrowed from the European experience and designed and developed small

institutions for persons with mental illness based on the moral theory (Grob, 1973).

Appalled at the conditions in jails and mental institutions, an American woman by the

name of Dorothea Dix began a quest to champion the mentally ill. Upon entering the

confines of jails, she discovered prostitutes, alcoholics, criminals, mentally challenged

individuals, and the mentally ill were all housed together in unheated, unfurnished, and foul-

smelling quarters (Viney & Zorich, 1982). Dorothea Dix, also known as the Gentle

Reformer, became a well-known activist who worked untiringly in creating clean, safe, and

curative asylums (Greenstone, 1979). The intention of the asylums was to provide safe

settings for physical, and spiritual care, as well as to shield residents from the harm and

danger common to people with a mental illness (Burgess, 1898). A contrary view identified

fewer humanitarian motivations for asylum development: the segregation of those with

mental illness from a society that did not want the discomfort of eccentric behaviour in its

midst (Foucault, 1961). Families would often submit their elderly relative to an asylum

because they lacked the resources or time to deal with them. Problems arose quickly as

overcrowding occurred because institutions had not established criteria for accepting or

rejecting a patient. The outcome led to a sharp decline in patient care and the revival of old

procedures such as the tranquilizing chair surfaced. Having said that, the establishment of

asylums in Canada brought some relief to the mentally ill who had previously been placed in

jails, almshouses, or who had been left to care for themselves (Sussman, 1998). Once

admitted to the asylums, many individuals spent the rest of their lives in these institutions.

Despite the humane motives that drove much of the professional input for the

institutionalization process, the results for the next century were very mixed. Eventually

institutionalization in Canada became a synonym for an inhumane response to mentally ill

people, often because of a scarcity of resources (Tuke, 1985). There appeared to be no

therapeutic plans in place and often people were left with nothing to do with their days which

led to an exacerbation of symptoms of their illness. People were fed and housed, nothing

more. By the mid-1940s, treatment of the mentally ill took a new turn. Inhumane psychiatric

treatment was forced upon residents. Insulin shock therapy, frontal lobotomy, and

electroconvulsive therapy (ECT) were introduced (WHO, 2003). In modern times, insulin

shock therapy and lobotomies are viewed as barbaric. ECT is still used in the West but is

only used as a last resort for the treatment of mood disorders and administered much more

safely then in the past.

It is worth noting that in Canada during the process of institutionalization, efforts

were made to promote mental health and de-stigmatize mental illness. For example, in 1948,

the federal government established Dominion Mental Health Grants which contributed funds

toward training and services and the establishment of Mental Health Week (WHO, 2003).

Funds from this source also led to the development of public awareness campaigns to

promote the mental health of infants and children. Mental health week was designated in

Canada for the first time in 1951. Similarly, during this period, the Canadian Mental Health

Association (CMHA) fought to change the language used in legislation and in public

discourse, which referred to individuals as "idiots" and "lunatics."

After World War Two, provincially operated psychiatric institutions operated at more than one hundred percent capacity. Understaffing, overcrowding, and ineffective treatments led to the emphasis on custody or housing rather than therapy (WHO, 2003). Contrary to the initial intent of the 'moral' movement, institutional care became restrictive with a reliance on methods involving seclusion, chemical, and physical restraints (Appleton, 1967). All these negative consequences contributed to the eventual process of deinstitutionalization.

Deinstitutionalization

> In my view, deinstitutionalization makes sense for most-not all-but only if the community has the service capacity; if society has been informed in an appropriate public education policy; if safe and affordable housing exists; and if enhanced employment opportunities exist. Can you imagine a time sensitive institutionalized consumer is suddenly discharged to find employment in a stigmatized society where a "not-in-my neighbourhood" housing policy exists? (Michael J. Grass, 2006)

'Deinstitutionalization' is a word that conjures up different images. In the 1970s, its meaning was positive and referred to the discharge of long term psychiatric patients from obsolete custodial mental hospitals that had seemingly outlived their usefulness (Grob, 1995). The presumption from medical professionals and government officials was that these patients could successfully transition into the community with proper supports. Unfortunately, when this process occurred, supports such as case management, housing, financial assistance, and vocational rehabilitation were not in place. Individuals were discharged to halfway houses or shelters and eventually, many of them ended up on the streets with no resources to assist them. Today, deinstitutionalization suggests an image of

homeless former mental health patients who now inhabit the streets of every major urban area (Grob, 1995). The process of deinstitutionalization was a long journey that began in the 1950s. For example there was an effort throughout the United States to remove mentally ill patients from psychiatric facilities and place them in community-based treatment programs (Goldman, 1983). The impetus of this movement came from a convergence of several social forces. First, with the success in treating soldiers in World War Two, psychiatrists became optimistic about their ability to treat mental disorders outside the hospitals. Second, there was a growing feeling that abusive conditions existed in many psychiatric facilities and negative effects from long-term institutionalization were at least as harmful as chronic mental illness itself. As well, many came to believe that the civil rights of the mentally ill were being violated. Third, fiscal conservatives in government were concerned with the enormous expense of caring for patients in large institutions and finally in 1954, the application and use of chlorpromazine (the first effective anti-psychotic medication) made it reasonably possible to manage the care of persons outside of the hospital (Goldman, 1983). During the 1950s, Western countries paid close attention to their mental health system. A gradual shift began away from the provision of custodial care in large, overcrowded hospitals towards short term care in community hospitals, and community housing and support services (Goldman, 1983).

In Canada, the process of deinstitutionalization began in the late 1960s and 1970s. The idea of deinstitutionalization was born out of the perception that the policy was a fiscal and legal necessity and not of logically analyzed mental health considerations (Sealy, 2004). There were two important national reports that helped to shift towards the idea of deinstitutionalization. First, in 1963, the National Scientific Planning Council of the Canadian Mental Health Association (CMHA) released *More for the Mind*, which insisted

that mental illness be dealt with in the same professional, administrative, or organizational

framework as any physical illness. The report recommended that the psychiatric services be

integrated with the rest of the health care system (CMHA, 1963). This report was what really

propelled community-based housing and support services. Secondly, in 1964, the *Royal*

Commission of Health Services, chaired by Emmett Hall, recommended that patients capable

of receiving care in general hospital psychiatric units should be moved there with due speed

(1964, p. 4). The process consisted of three distinctive phases.

The first phase involved a shift from care in psychiatric institutions to care in

psychiatric units within hospitals. It was intended that this shift from psychiatric institutions

to general hospital psychiatric units would have a significant impact, in particular, by

lessening the stigma associated with mental illness and psychiatry as the illnesses and

practitioners who treat them become closely integrated with the rest of medicine

(Wasylenski, 2001). Problems did occur because human and financial resources were not

reallocated to the general hospitals as individuals were discharged from institutions. More

importantly, the closing and downsizing of institutions was achieved without allocating

adequate funding at the community level to provide for psychological support and

rehabilitation. The establishment of new community-based services did not keep pace with

deinstitutionalization. However, many newly discharged patients received inadequate care in

the community though services were stretched beyond capacity. Unfortunately, this is still

the case today. Chronic under funding and allocation of resources has historically been a

problem in the mental health system. Communities were not prepared to make all the

necessary support available to individuals in need. This resulted in a high frequency of

relapse and ultimately increased readmission rates to hospitals; the "revolving door

syndrome." Patients, after readmission to hospitals, were discharged back to inadequate care in the community, only to become ill again, resulting in an increase in homelessness, along with an increase in criminal behaviour and incarceration.

The second phase focused on the need to expand mental health care into community and to provide supports to individuals with mental illness and their families. In this phase, provincial governments began to fund mental health services outside of the hospitals. Services such as education were provided by community-based mental health organizations and agencies. In addition, there was a focus on an extensive array of community support services such as income support, rehabilitation, and housing. During this phase, proponents of community care were pitted against facility-based care and hospitals were seen more as a problem than a solution. Unfortunately, we are still seeing this happen today. Additionally, provincial governments became less involved with professionals and focused on consumers and their families (Wasylenski, 2001). By the end of the 1980s, although mental health services and supports existed in most provinces of Canada, these were not well integrated.

In the third and current phase, the emphasis tends to be on integrating the various mental health services and supports within communities and enhancing their effectiveness (Wasylenski, 2001). This phase is marked by increasing reliance on empirical research or evidence based research and a trend towards adopting the best practices frameworks by policy makers, professionals, consumers, and families.

The rationale for pursuing deinstitutionalization, which combined elements of idealism and pragmatism, reflected justifiable concern for the well being of mentally ill persons, many of whom were living miserable lives inside institutions (Bachrach, 1993). This rationale encompasses several critically important assumptions. First, it was widely, even

passionately, assumed that community-based care would be intrinsically more humane than hospital-based care (Bachrach, 1976). Second, it assumed that community-based care would be more therapeutic than hospital-based care (Bachrach, 1978). Third, it was further assumed that community-based care would be more cost effective than hospital-based care (Bebbington & Thornicroft, 1989). It is unfortunate that plans were carried out based on assumptions and not based on empirical data or research.

However, these assumptions have never been tested empirically, and there has been cause over the years to question their validity (Kovaleski, 1993). We have begun to realize that community care may indeed hold the potential to be more humane and more therapeutic than hospital care; however, this promise cannot be realized unless comprehensive services for the most severely mentally disabled persons are mandated and adequate resources are provided to ensure the implementation of these services (Geller, 2000).

The evolution of community mental health support services has many facets. The underlying theme, however, is the idea that long term hospital care is not the best method with regard to either cost effectiveness or rehabilitation for most people with mental illness. The community mental health movement places a huge emphasis on the empowerment of people with serious mental health issues and on affordable, safe housing and supports with each person's community.

Housing for People with Serious Mental Health Issues

The Universal Declaration of Human Rights states "that everyone has a right to an adequate standard of living, including housing" (UN, 2009, p. 2). Unfortunately, in Canada, housing is not recognized as a right; it is a commodity that is bought and sold in a market

system. This system fails to meet the enormous housing demands of those who are unable to afford the market rates.

Housing stability is an on-going issue for people who are living with low incomes or paying a large proportion of their income on rent. Stable housing is essential to individuals with a mental illness. The alternative is that their mental wellbeing deteriorates. Carling notes (1995, p. 87) that "relapse is a reality in living with a psychiatric disability." In communities where there are strong support services, relapse is not as disruptive to an individual's life as it is in communities where support services are unstable or nonexistent.

The cost of housing is not the only factor in secure tenure for people with serious mental health issues. There are different types of supportive and supported housing for individuals, and a logical connection can be made linking the individual's choice between the types of residencies and stability. For example, if a person is told to live in a residential and supported environment, it can be said that this arrangement is not as stable as compared to someone who has the ability to choose the type of residence he or she may desire. Choice is inextricably linked to stability, and stability in turn, to mental health. People living with a mental illness should have choice and stability in their housing.

There is evidence to support the importance of decent, affordable, and safe housing, associated with proper supports, in improving community integration and quality of life for people with serious and persistent mental illness (CMHA, 2005). If the permanent housing needs of this population are not addressed in both policy and practice, their situation will deteriorate. Having already established the importance of choice and stability, I will examine the types of community-based housing that exist for people with mental illness. The process and outcomes that lead to community integration and improved quality of life will be

discussed in the context of different housing styles. Horgan, Nelson, and Parkinson (1998)

propose three types of housing. They are custodial, supportive, and supported. In Prince

George, we have the following:

Table 1: Current Types of Housing

	Custodial	**Supportive**	**Supported**
Housing	Boarding Home (1)	Iris House Urquhart House	Subsidized Independent Living Place (SILP)
Support Provided	24-hour care	24/12-hour care.	Consumers live on own
	Some recreation provided	Vocational rehabilitation provided	Life skills are provided. Vocational rehabilitation & recreation provided
Empowerment	Staff has control in the house	Staff and consumers work together	Consumers choose services they wish

Custodial Model

The supportive housing strategy in Ontario was an approved homes program

launched in the 1930s (Simmons, 1990). Approved homes were based on foster care and

boarding home models, privately operated. They were not designed to offer mental health

rehabilitation: rather supervised housing. Paid staff was responsible for meal preparation,

medication dispensing, and cleaning.

The inadequacies of custodial housing models are well known. For example, Baker

and Douglas (1990) and Ballantyne et al. (1993) have said that people with serious persistent

mental health issues prefer the freedom of the streets to living in a restrictive custodial

setting. The focus of these for-profit homes is often long term care, not rehabilitation.

Supportive Housing

In the late 1960s, a movement towards community development and services for individuals with mental illness began (Simmons, 1990). CMHA (2010) suggests that the fundamental difference between custodial and supportive housing is that the latter empowers and rehabilitates individuals within the residential environment. Supportive housing presents a continuum of residential facilities, with residents graduating from homes with high supports, such as Iris House in Prince George, to ones with lower supports, such as Urquhart House, as their condition improves. The desired end to this housing system is to see residents graduate to live independently with flexible, individualized supports. Supportive housing is run by non-profit agencies and staff members are usually trained in rehabilitation. In Prince George, staff is comprised of trained life skill workers whose goal is to provide assistance in teaching/assisting individuals with activities of daily living. In Vancouver, this type of housing was adopted by Vancouver City Council on June 6, 2007. The housing was to be scattered throughout the city, located to support the geographic balance (VRHA, 2007).

There is extensive evidence that would suggest that supportive housing provides positive outcomes and is cost effective. In a document by VCHA, (2002), it suggests that the following are positive outcomes of supportive housing:

(1) reduction in emergency room visits by 32 percent and hospital beds by 57 percent;

(2) reduction in symptoms for conditions such as schizophrenia and psychosis;

(3) increased residential stability with people staying in one place longer;

(4) increased consumer satisfaction;

(5) increased independence and empowerment.

The report also suggests that this type of housing is cost effective:

(1) saving of $6000 per person per year from $42,400 for those that are homeless;

(2) savings of $950 per day in hospital bed use.

Having said that, there still exist barriers to community-based mental health housing such as the Not In My Back Yard (NIMBY) Syndrome.

Dear (1992, p. 288) defines NIMBY as "the protectionist attitudes of and oppositional tactics adopted by community groups facing an unwelcome development in their neighbourhood." There appears to be a perceived threat of lowered property values, issues of neighbourhood security, and community character. With the move toward a supported housing model in community mental health, an escape from NIMBY is conceivable.

Supported Housing

In the 1990s, supported housing emerged. This newer model's focus is on person-centred support, self-help, and natural supports with a de-emphasis on professional service (Horgan, Nelson, & Parkinson, 1998). This is the first model which moves away from the medical model of community residential housing. The impetus behind supported housing is that, by empowering people to choose, obtain and maintain the housing and supports they want, they will experience their residence as a home rather than housing (Carling, 1993).

The goal of custodial, supportive, and more recently supported housing has always been deinstitutionalization and integration of individuals with serious and persistent mental health into the rest of the community. All of these models of housing operate today; however, supported housing is emerging in popularity.

It is important to note, that none of these housing models will be effective if there are no supports in place such as financial assistance, qualified staff, and appropriate location of the housing (Simmons, 1990).

Best Practices in Mental Health Housing

The Healing path has Pot Holes Too!
Rupert Ross, 1996, p. 283

In 1997, the Best Practices in Mental Health Reform was published and has since been the standard reference for guidance to mental health agencies and planners. This project, which included officials from Health Canada and the provinces and territories, was funded by the Federal/Provincial/Territorial Advisory Network on Mental Health. The health systems research unit (HSRU) of the Clark Institute of Psychiatry was commissioned to complete the project.

This report indicated that, over the past decade, there has been a shift from residential custodial models of care to supported housing. Research findings summarized from HSRU show that:

(1) supported housing is preferred because it allows for choice;

(2) it can serve a variety of people including the homeless;

(3) assertive case management can successfully support individuals in various housing situations.

The evidence suggests that supported housing should be the first choice of housing option rather than residential care. Residential care should be considered as a "flow through" to prepare for future supported housing (Ross, 1996). In recognizing this, planners and policy makers warn not to embrace supported housing simply because it is the most cost effective

thus re-directing saving away from the mental health system, and in doing so, under funding the support component of the supported housing model. This would be a repeat following deinstitutionalization.

While supported care has been identified as a best practice, there is still a need to develop a continuum of housing that provides a selection of models and levels of support. This allows individuals to find the most suitable housing based on their needs.

There are several challenges to providing housing and support to those individuals with a severe and persistent mental illness. A number of literature reviews and focus groups have explored related issues (Anderson & Burt, 2005). The conclusions to these studies highlight a wide range of challenges which can be summarized in three sections; organizational/community challenges, personal issues and/ or limitations, and systemic challenges.

1) Community and organization challenges include:

- Waitlists that require regular updates from the applicants in order to retain their place on the list;

- The length on the waitlist (often more the one year);

- Rules that ban individuals from using certain services, resulting in homeless people with complex mental health and addictions problems being unable to obtain help;

- Restrictive rules about having pets, overnight guests or substance use.

2) Personal issues and/or limitations include:

- Not having a social support system;

- Lacking income or being unable to keep employment;

- Language and cultural differences;

- Individuals not having access to a phone;

- Aggressive and violent behaviour.

3) Systemic challenges include:

- There are long wait times for subsidized units;

- Homeless individuals have reported facing barriers getting onto waitlists and are disadvantaged when there is no local system for coordinating access to subsidized units;

- Individuals who are homeless require a broad range of services including housing, health and mental health care, substance abuse treatment and social services. The burden of coordination falls on the individual who is often ill- prepared to navigate a fragmented service system.

In BC, the housing market is the highest priced in Canada (Frischmuth, Johnson, & Morrow, 2006). This is important to note because individuals with a mental illness who are receiving disability benefits have limited amounts of money each month and cannot afford to pay the high costs of rent. Rental costs for houses and apartments were especially high in the wake of the 2010 Olympic and Para Olympic Games. Individuals on disability benefits receive $375 per month for shelter. This payment does not come close to meeting the rental costs and forces many people to reside in unsafe housing (Goldner, 2002). Best Practices recommended that individuals with mental illness be entitled to a subsidy similar to the Shelter Aid for Elderly Renters (SAFER) program (Goldner, 2002). The Shelter Aid for Elderly Renters helps make rent affordable for BC seniors with low to moderate incomes.

SAFER provides monthly payments to subsidize rents for those who are age 60 and older.

The program reimburses part of the difference between 30 percent of total income and rent

(Mental Health Reform, 2002).

Housing is fundamental to the health and vibrancy of our communities. An ideal

housing market would provide affordability and choice for individuals in all income groups.

The supported housing model normalises the housing experience of people with

serious and persistent mental health and, as a result, much of the stigma and social

marginalization associated with group homes can be eluded.

Homelessness

We have weapons of mass destruction we have to address here at home.

Poverty is a weapon of mass destruction. Homelessness is a weapon of mass

destruction. Unemployment is a weapon of mass destruction. (Dennis

Kucinich, 2006)

Many people think of the homeless as a relatively homogeneous group largely

composed of older, alcoholic, and vaguely "crazy" men. However, this image does not

correspond to the current composition of the homeless population. The pictures that we now

see are women, children, youth, immigrants, and those with a mental illness. Caring for a

mentally ill person has become one of the greatest challenges to mental health service

providers and to society in general (Bachrach, 1987). Homeless individuals who have

psychiatric disabilities and concurrent substance addictions constitute an extremely

vulnerable population (Wright, 1990). The vulnerability is evident among persons who are

living on the streets, carrying their bundled belongings, sitting in transportation terminals,

and huddled in doorways or other public spaces (Wright, 1990).

Aside from poverty and changing housing markets, illness itself, particularly poor mental health, can precipitate homelessness. In much of the literature on homelessness, the common themes appear to point at deinstitutionalization, unstable housing, inadequate discharge planning and community follow-up, lack of affordable housing, changing economic factors and inadequate mental health services as the catalyst for homelessness.

A study done by the Mental Health Policy Research Group (1997) found that only 3 percent of those interviewed lost their housing because of mental illness. This makes sense that mental illness by itself would not be a direct cause of homelessness. However, mental illness does limit one's ability to work and earn a decent living. In today's rental market, social assistance and housing allowances such as the Subsidized Independent Living Program (SILP) are insufficient for meeting the rising of costs of housing. The plight of people with mental illness is not unlike other disadvantaged groups like single parents. There is simply not enough income, supports, and housing available (Dietrich, 1999). What distinguishes this population from the others is that without adequate mental health supports, the risk of losing their housing increases.

There are varying degrees of homelessness. Therefore, the United Nations has categorized the variances. These two categories are absolute homelessness and relative homelessness. According to the United Nations, "absolute homelessness" is described as the condition of people without physical shelter who sleep outdoors, in vehicles, abandoned buildings, and other places not intended for human habitation. "Relative homelessness" is described as the condition of those individuals who have shelter but do not meet the basic standards for safety and health (United Nations, 2004). "Homeless people" are referred to as those who are sleeping in shelters and those who are "absolutely homeless" (United Nations,

2004).In the Hook magazine, an article entitled *Northern Exposure: Prince George's homeless services pushed to the brink*, states that, in a town of 70,000, a one-day homeless count was conducted by the Prince George Community Partners addressing homelessness. The Partners found 375 homeless people. The same article described the 2007 report d by NDP MLA David Chudtrovsky. He estimated the numbers to be around 1050 including couch surfers and bush campers (The Tyee, 2009).

Shelters are a good starting point for estimating the number of homeless people in Canada (Population Census, 2006). Census data suggests that about 8000 homeless people, that is, five per 10,000, are sleeping in shelters each night (Wright, 1995). Having said that, shelter counts typically underestimate the true number of homeless people. These counts do not account for those sleeping on the streets or in cars.

In Vancouver, as many as six hundred homeless people, or three per ten thousand, are possibly sleeping outside every night (Hwang, 1998). In Toronto, Goldens (1999) concluded that between 30 and 35 percent of homeless people are living with mental illness.

Homelessness remains a persistent phenomenon, but its characteristics have changed considerably over the years. Controversies continue regarding how the homeless should be defined and their numbers counted, but the changing composition of the homeless population is not in doubt. In Prince George, families and individuals are working diligently towards breaking the cycle of homelessness and poverty by getting assistance from the government of Canada. With more than 20 communities across British Columbia joining with the provincial government to recognize *Homelessness Action Week*, it is hoped that more partnerships will be created to find solutions so that individuals will have an opportunity to access safe, secure, and affordable housing. I am unclear as to whether or not this will be a yearly event.

An article written in the Human Resources and Social Development website entitled

The Government of Canada delivers support to help those who are homeless in Prince

George (2009), states that the government is delivering on promises to help those who are

homeless or at risk of becoming homeless by providing funding for transitional housing and

support services such as alcohol and addictions counselling. The article also states that a

Homelessness Partnering Strategy (HPS) was formed to provide $269.6 million over the next

two years to prevent and reduce homelessness in Canada. The government's main objectives

are the Homelessness Partnership Initiative, the Homelessness Accountability Network, and

the Surplus Federal Real Property Homelessness Initiative. So how does this affect Prince

George? The HPS provided $93,015.00 in funding for transitional housing and supports to

the Native Friendship Centre (March 2008). As well, they provided $120,178.00 in funding

for the expansion of services to St. Vincent de Paul Society Drop in Centre. This money

provides daily meals to 300 people, 100 emergency food hampers and assistance with

employment, life skills and social services (January 18, 2008).

A news release from the Ministry of Housing and Social Development stated that the

provincial government and community partners teamed together to provide a 30–unit

apartment building for adults who are homeless and are working at managing their mental

illness and addiction issues. The *Friendship Lodge* is operated by the Prince George Native

Friendship Centre Society in conjunction with community partners such as Northern Health

(September 12, 2008).

The prevalence of mental illness and concurrent disorders among homeless people is

hard to determine precisely, but consistent patterns have emerged from rigorous studies that

have been conducted in Canada and the United States (CMHA, 1998). Contrary to popular

misconceptions, only a small number of homeless people have schizophrenia. The prevalence of schizophrenia is only six percent among Toronto's homeless, while a report conducted by Barbara Schnider and Jeanette Waegermars Schiff (2007) indicates that there is a seven percent prevalence rate of schizophrenia among the homeless population in Calgary. There are more homeless mentally ill men than women; however, women with schizophrenia and who are homeless outnumber men with the same disorder (North, 1993).

Alcohol and drug abuse is considered the most prevalent health condition among today's homeless. Problems with alcohol are six to seven times more prevalent among homeless people than in the general population (Breakey & Fischer, 1991). Introduced in the mid-1980s, crack cocaine was much cheaper than alcohol and other "hard" drugs and offered an intense but short "high." Its low price and easy availability made it a popular drug (Adlaf & Smart, 1991). In a longitudinal study of 1,399 homeless adults in California, it was reported that, while 45.6 percent had no medical or psychiatric illness upon becoming homeless, 9.3 percent of these became excessive users of alcohol; 4.4 percent became users of illegal drugs; and 0.9 percent were hospitalized in a psychiatric facility within 12 months (Winkleby & White, 1992). A 1992 survey of Ottawa street youth notes that drug use was 14 times higher among street youth (Adlaf & Smart, 1991), and that nearly 90 percent of street youth reported either drug or alcohol problems. In Canada, more specifically in Ottawa, among 160 persons using shelters or drop-in services, 36 percent had some form of mental illness. Among those over 65, this soared to 66 percent (Adlaf & Smart, 1991). As a student who works in the area of mental health, it is evident through work with clients or disclosures by individuals themselves that many people who use alcohol or drugs are treating their own

symptoms. Further, the late teen years to early adulthood is a time period when individuals may be affected with the onset of psychosis.

Psychosis is a brain disorder that manifests as a loss of contact with reality. The main symptoms of psychosis include hallucinations, delusions, and/or disorganized thinking. The onset of illness, severity of illness, and propensity for relapse are viewed as the results of an interaction of one or more environmental stressors with an inherent biological vulnerability that has arisen as a result of genetic predisposition, or of pre- and peri-natal factors (Bilsker, Garvin, Goldner, & Parikh, 2000). Addington and Linszen (1998) state that stressors can include drug use and situational life stressors. Drug use frequently appears as a factor associated with the first episode and with relapse.

Homelessness, which is a focus of increasing concern in Canadian cities and on an already overburdened health care system, has important health implications. Individuals may suffer from a wide range of medical problems. Disease severity can be remarkably high because of factors such as extreme poverty, delays in seeking care, non-adherence to therapy, and cognitive impairments (Wood, 1992). Medical problems that are particularly prevalent among homeless adults include seizures, chronic obstructive pulmonary disease, and arthritis (Crowe & Hardill, 1993). Conditions such as hypertension, diabetes, and anaemia are often inadequately controlled and may go undetected for long periods. Skin and foot problems are frequently seen as well. People living on the street are prone to develop skin diseases such as cellulitis, impetigo, venous stasis disease, and body lice (Moy & Sanchez, 1992). Homeless people are at risk of contracting tuberculosis (TB). Conditions favouring outbreaks in shelters include crowding, large transient populations, and inadequate ventilation (Barr, Earth, Nolan, Risser, & Saeed, 1991). Common risk factors for HIV infection in homeless youth in Canada

include prostitution, multiple sex partners, inconsistent use of condoms, and injection drug use (King, Radford, & Warren, 1989).

The homeless have high levels of morbidity and mortality and may experience significant barriers to healthcare. They may also have high levels of health care use (Andrews, Padgett, & Struening, 1995), and most of their care is obtained in Emergency departments of hospitals (Andrews, Padgett, Pittman, & Struening, 1995). Homeless people are admitted up to five times more than the general population to the hospital resulting in higher health care costs (Hartz, Kuhn, Mosso, Salit, & Vu, 1998). Unfortunately, they are sometimes discharged to shelters, even when their ability to cope in such a setting is marginal at best.

Homeless people face many barriers to accessing health care (Stark, 1992). In the US, lack of health insurance is a problem, while in Canada, although there is universal health insurance, many people do not possess proof of coverage as their ID has been lost or stolen (Hwang, Sullivan, Svoboda, & Windrim, 2000). In Toronto, homeless people report having been refused health care because they do not possess health insurance cards (Crowe & Hardill, 1993). In addition, many homeless people (up to 7 percent), do not fill prescriptions as they do not have insurance benefits and they cannot afford to pay directly for medications. This is still a problem faced by many homeless people today.

Homeless people face other barriers to health care that are unrelated to health insurance. For those who are homeless, daily struggles for the essentials of life are in the forefront. Competing priorities may impede adults from accessing health care services, particularly those perceived as discretionary (Anderson, Gallagher, & Gelberg, 1997).

The health care system fails to adequately provide treatment to those with a mental illness who are homeless. Service providers describe enormous difficulties in engaging homeless mentally ill persons who are living on the streets (Cohen & Thompson, 1992). Conflicting agendas between service providers and those experiencing homelessness is most often the problem. Interventions today range from persuasion, such as service providers offering to buy the person a cup of coffee as a way to develop rapport and trust, to a prolonged period of outreach (Keyes, 2002), to involuntary transportation to the psychiatric hospital (Cohen & Marcos, 1986). Some researchers argue that this population rejects services because of distrust and frustration with the still fragmented mental health and addictions services, which lack coordination and are unable to meet their needs (Assmussen, Beatty, & Romano, 1994).

Some survey studies have shown that those who are homeless have different perceptions of their service needs than do service providers (Dattalo, 1990). Homeless individuals believe that their basic needs should be a priority, whereas even today, service providers focus on their mental health needs (Martin, 1990). Consequently, service providers are not servicing this population well.

The Aboriginal population presents some difficulty as well. In addition to facing racism, Aboriginal persons may be unable to discuss their health problems with mental health professionals because of a language barrier; they may lack access to trained Aboriginal staff; and they may find programs culturally inappropriate (City of Calgary, 1996). This population also experiences many of the factors discussed above; however, one must explore the historical and colonial legacy that has destroyed families, communities, and an Aboriginal way of life (SPARC-BC, 2006). Aboriginal peoples are over-represented in low income

groups; for example, 41 percent of registered Indian families are at or below the low income cut-off rate (United Native Nations, 2001). Furthermore, with a younger population than the general population, unemployment is higher. The roots of Aboriginal homelessness also lie in the multi-generational experience of residential schools, and economic and social marginalization from mainstream society (SPARC-BC, 2006).

Despite such findings, mental health programs, especially those involving housing, have not been characterized by consumer-driven service approaches. As a social worker who is currently working with mental health consumers, I believe that stigma is one of many reasons why consumers are not participating in developing programs to serve their needs. Stigma reduces consumers' access to recent resources and opportunities and can lead to isolation and hopelessness. The Mental Health Commission of Canada (2009) discusses at length how discrimination and stigma will prevent someone from accessing services they need and deserve. Discrimination can occur at both the mental health and broader care systems. For example, research has shown us that individuals with a mental illness do not receive the same quality of health care as those without a mental illness (Doebbeling, Malone, & Mitchell, 2009). Stigma and discrimination of all kinds are often anticipated by people with a mental illness, and are among the key barriers that keep many people who could benefit from help from seeking it. This is referred to as self-stigma.

Homelessness for most people generally consists of a short stay in a shelter or transitional house, where such services exist, where they can recover economically and personally (City of Vancouver, 2005). For those who are unable to recover stable shelter, living on the streets is typically only one of the many subsistence patterns, including shelters, hospitals, staying with friends, and rooming houses, that occur over a period of time.

Homelessness places enormous strains on communities across BC. In urban and semi-urban centres, homelessness is highly visible and affects many business areas (Hume, 2006). In major cities such as Vancouver and Victoria, business and tourism report losses; and with the homelessness population expected to triple by 2010, many officials were concerned with this in the wake of the Olympics. It is estimated that businesses such as hotels have lost contracts due to increased homelessness and visible poverty (Hume, 2006).

Having established homelessness is an important concern in mental health, the question remains how best to provide housing. The answer given in the Best Practice guideline suggests "a wide variety of housing option and supports be provided" (HSRU, 1997).

Mental Health and Housing Policy

In September 2004, the premier of British Columbia announced the formation of the *Task Force on Housing and Mental Illness* at the Union of British Columbia Municipalities annual convention. The mandate of the task force is to develop strategies on moving away from shelters and to look at long term housing as a solution (BC Housing, 2004).Under the Canada and BC Affordable Housing agreement, federal and provincial governments matched funding which allowed the task force to provide five hundred and thirty three new housing units.

In October 2006, the province of BC announced *Housing Matters BC*, a housing strategy which provides assistance to those in greatest need for safe, affordable housing. The province allocated 750 new supportive housing units under the provincial *Homelessness Initiative*. The task force also broadened its original mandate to include perspectives of smaller communities and regions trying to cope with the rise in homelessness (BC Housing, 2006).

BC Housing was created in 1967 through an Order-in-Council under the Housing Act to assign in fulfilling the government commitment to develop, manage, and the administration of subsidized housing (BC Housing, 2004). BC Housing works with several partners including non-profit housing provider, the private sector, as well as other levels of government, health authorities, and community agencies, to create more affordable housing.

Several initiatives have been underway to address the glaring gaps within the housing continuum. For example, the administration of the emergency shelter program was transferred from the Ministry of Employment and Income Assistance (MEIA) to BC Housing. The objective was to create an integrative system of housing and support. In addition, administration of federal housing has been redelivered to BC Housing allowing for a smooth transition of various programs and reducing the administration burden on housing providers (BC Housing, 2004).

Canadian Mental Health Association (CMHA) received funding from MEIA to deliver outreach services to individuals with mental illness who are homeless in eight communities throughout BC for the year 2006–2007. Outreach workers engaged individuals to connect to income assistance, housing, primary care, and mental health services and supports.

Based on the Kirby Commission Report (2006), the federal government has agreements with the provinces and territories to share the cost of building new affordable housing as well as to the provinces for rental supplement to low income earners, through the Affordable Housing Initiative. Having said this, the federal government does not have any housing programs to meet the glaring needs of those with a mental illness.

Chapter Two

Practicum Research Plan

Housing ranks as a priority concern of individuals with serious mental illness and professionals that work with them. Locating affordable, decent, safe housing is often difficult, and out of financial reach (US Department of Education, 1998). The same can be said in Canada. Having a pre-existing mental illness or substance abuse problem often restricts people's options to access, afford, and maintain the very kind of help that would help promote recovery (BC Housing, 2005).

The actual proportion of people with severe mental illness who lack affordable and decent housing has not been assessed directly. Yet, one could imagine that this might be a serious problem. In 1994, the US Department of Housing and Urban development (HUD) reported that half of all low income disabled residents, including those with a mental illness, have "worst case" needs for housing assistance. Furthermore, it was reported that most of these people live in inadequate housing (US Department of Housing and Urban Development, 1994; US Department of Education, 1998). In Canada, there have been many attempts to research and measure how many low income families or individuals are without affordable housing. However, the findings have not been conclusive due to the low response rates to the research. Having said that, the TD Bank posted their findings in January, 2007 which indicated that "1.7 million households in Canada, or about one in five, could not find adequate and suitable housing without spending 30% or more of their pre-tax income" (CMHC, 2007). The report went on to further say that there are currently 14,000 households in BC on the provincial wait list for affordable housing. A study was conducted in Toronto, which looked at the total number of patients admitted to a general hospital for treatment but

who were also homeless. Authors Hay, Hopper, Jost, and Welburg (1997) concluded that,

within one year, 330 patients admitted to general hospitals were homeless. This number

represented two percent of the total psychiatric admissions to general hospitals in Toronto.

Deinstitutionalization has led to the need for more community housing but the

residential programs that were developed were essentially replicated institutional programs

(Carling, 1989). Residential programs proved to be ineffective in meeting consumers' needs

as they did not provide any rehabilitation in terms of vocational rehabilitation, recreational

therapy, or support groups. Moreover, living in such programs added to the already rampant

stigma. As a result of these shortfalls, greater emphasis has been placed on conventional

housing, supplemented by appropriate assistance tailored to individual needs (Gordon, King,

Livingston, & Srebrik, 1995). This new concept, called supported housing, moves away from

"placing" clients, grouping clients by disability, staff monopolizing decision making, and use

of transitional settings (Carling, 1989; Letiman & Newman, 1996). Instead, supported

housing focuses on consumers having a self-chosen permanent home. Even if they become

ill, such housing ensures they will have a home to return to that is integrated into the

community, and encourages skills development and empowerment.

Much of the type of housing needed for those with a serious and persistent mental

health problem has been decided by individuals who work in management, government, or as

health professionals. For the purpose of the research component of my practicum, I tried to

discover what people living with a mental illness feel they need in terms of their own

housing. I used the following approach to attain the information.

Methods

Quantitative research is defined as "the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect, "and qualitative research is described as "the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships" (Babbie, 1992, p. 6). Reviewing these definitions of what is meant by quantitative versus qualitative research has helped me focus on the types of methods I have used for my research: Specifically, I have incorporated aspects of each method in order to provide the most useful results.

For the purpose of my research, I did a primarily quantitative, descriptive survey. The study provides information on the demographics of the individuals with mental illness participating in the survey as well as the type of housing they currently have and that they would like to have access to. However, in order for me to capture additional input that might not be captured through close-ended survey questions, I incorporated open-ended questions at the conclusion of each question to allow for additional responses.

The type of study I conducted was descriptive. Descriptive research makes no attempts to change behaviour or conditions. Things are measured as they are. For example, in my survey, one of the questions I ask is: Have you ever been evicted from your home? Yes or No and if Yes, Why? I am attempting to describe if and why a person may have been evicted from their home. The study is a cross-sectional study to which the variables of interest have been evaluated and the relationship between them is determined at one point in time (Hopkins, 2000).

Sample

The participants are adults over the age of 19 and include both male and female

subjects. Participants were sought from among those clients accessing services through the

Community Outreach Assertive Service Team (COAST) in Prince George. Potential

participants were identified by five COAST case managers and all had been diagnosed by a

psychiatrist with an AXIS 1 diagnosis of Bipolar Disorder, Schizophrenia, or Delusional

Disorder. Potential participants were assured that participation was completely voluntary and

that non participation would in no way impact the services they receive. Housing is very

important to those with a mental illness and at the time of my research there seemed to be

very high level of interest among consumers in Prince George about my Project. At least, two

hundred and fifty individuals had access to the survey via their case managers and

approximately one hundred more had access via the Connections Clubhouse (a club house

run by consumers for consumers and their families and friends), and the Activity Centre for

Empowerment (ACE), an activity centre for consumers, families, and health professionals.

As stated previously, there were 350 consumers being served by the COAST team. I

anticipated a good response rate of at least 200 participants for my survey.

Survey Tool

For the purpose of this study, a survey questionnaire, which consists of both closed

(Yes/No) and open-ended questions (Why/Other), accompanied by a letter of explanation,

were available to the sample of potential participants as described above. The letter of

explanation and the survey can be found in Appendix A. The survey entails questions that are

primarily quantitative but with a qualitative component which will allow for more complete

and thorough responses. An example of the type of question being asked on the survey is:

Have you ever been evicted from your housing? Yes / NO If Yes, Why?

Procedure

As described previously, I chose three separate locations from which to conduct the

survey. Prior to commencing the survey, I conducted a pre-test at a consumer and family

meeting. These meetings are held bi-weekly or more often if the need arises. The feedback

from this meeting was used to make any needed adjustments to the survey prior to the actual

launch. The first location to make the survey available was at the Northern Interior Health

Unit on the third floor in the Mental Health office. Consumers who came in for their

appointments with their doctor or case managers were able to participate in the survey. The

second location to conduct the survey was at the Connections Clubhouse. This is a clubhouse

run by mental health consumers for consumers and their families and friends. The third

location was the Activity Centre of Excellence (ACE). As mentioned earlier, the centre is

open to consumers, family members, and health professionals and provides activities such as

playing pool, video night, and computer access. At all of the locations, a case manager or

physician was on site to encourage those individuals about the opportunity to complete a

survey regarding their housing needs. At the same time, all potential participants were

assured that participation was completely voluntary.

Prior to conducting the survey, I advertised at each location at least two weeks in

advance by posters as well as attending a meeting at each location to talk about the survey

and its importance to the consumers.

Once the survey was underway, I was on-site to answer any questions that came up.

Participants were asked to complete the survey on their own. Each was able to take a survey

out of a drop box and use one of the pens provided to answer the questions. I informed

participants that they should read the cover letter prior to starting the survey and that I was

available to answer any questions. Once they read and understood the reason for conducting

this type of research, participants began answering the questions. When they completed the

survey, they were asked to fold the survey in half and place it into the drop box. There was

no remuneration for participating in this research. For individuals who had literacy barriers, I

was available to provide assistance. The survey was available over a one-week period. I spent

two days at each site, which allowed for maximum participation by consumers. At each site,

there was a drop box where consumers could place their completed survey. This drop box

was emptied at the end of each day and the surveys stored in a locked filing cabinet in my

locked office at work.

Ethics

Having first read the cover letter (Appendix A) and completed the informed consent

sheet (Appendix B) as well as having any questions answered, all participants agreed

voluntarily to participate in the research. The cover letter explained that each person could

withdraw from the research survey at any time without having any impact on the services

they receive from Northern Health. Participants who may have required additional

counselling/therapy due to the emotional distress arising from the research were referred to

their clinicians/case managers for additional support. It is important to note that the research

components of this practicum proposal were submitted to both the UNBC and Northern

Health Ethics Boards and received approval.

There was no remuneration given the participant to complete the survey. To ensure

anonymity and confidentiality, the cover letter stated that the participants should not put their

names anywhere on the survey. All information from the survey was transferred to a password-protected electronic data file and hard copies are stored in a locked filing cabinet in the locked office of the researcher and may be kept for up to seven years. On or before the time limit is up, hard copies will be shredded and disposed of, and electronic files deleted according to UNBC REB policies.

Data Analysis

I undertook a primarily quantitative data analysis. Quantitative responses to the survey were entered into a statistical software package called SPSS (Statistical Package for Social Sciences). Data was organized in a spreadsheet format and descriptive statistics calculated. Specifically, responses to the quantitative questions were tallied and frequencies and percentages are provided.

I did not receive any written qualitative feedback from any of the participants and therefore had no data from which to identify qualitative themes. This was unfortunate and unexpected. As a result, I did not collect any information that would allow me a more in depth look at their living situation, or how they thought a change in their living situation might affect them. For example, my research data shows that 48 percent of those identifying as having a mental health disability would choose to live in an apartment but it does not speak to the kind of surroundings or geographical location a person might prefer. Had I obtained some qualitative research feedback, it might have provided some of this information.

Chapter Three

Data Results

Descriptive Statistics

As part of my practicum, research was conducted to identify the population in terms of age, disability, and gender. As well, I wanted to reveal what type of housing was important to individuals with a serious and persistent mental illness.

Table 2: Age Range and Mean Age

N	Minimum	Maximum	Mean	Standard Deviation
88	19	66	40.66	12.940

There are 88 participants, men and women, and the mean is = to 40.66. This means that the average age of the participants was 40.66.

Table 3 (following) presents information on the variables of gender, disability, ever homeless, living and housing arrangements, calculating both frequency and percent. Results for the variable shows that there appears to be approximately 10 percent more men who answered the survey then women — 55.7 percent of the participants were men; 44.3 percent were women. There appears to be a pretty even split between Bipolar Disorder and Schizophrenia. Results for the variable ever homeless shows that approximately one third or 34.1 percent were homeless at some point in their life. Approximately 43 percent of the participants said that they prefer to live on their own while almost half — 48.9 percent — prefer to live in an apartment.

Table 3: Demographics: Gender, Disability, Homelessness, Living Arrangements, and Housing Types

	Frequency	Percent
Gender		
Male	49	55.7
Female	39	44.3
Total	**88**	**100.0**
Disability		
Bipolar	39	44.3
Schizophrenia	40	45.5
Other	9	10.2
Total	**88**	**100.0**
Ever Homeless		
Yes	**30**	**34.1**
Living Arrangements		
Alone	55	62.5
With family	17	19.3
Roommates	13	14.8
Other	3	3.4
Total	**88**	**100.0**
Housing Types		
House	25	28.4
Apartment	43	48.9
Town home	7	8.0
Duplex	3	3.4
Resident House	6	6.8
Other	4	4.45
Total	**88**	**100.0**

Table 4: Housing Preference According to Mental Health Diagnosis

	House	Apartment	Town Home	Duplex	Resident Housing	Other
Bipolar	11	22	2	1	2	1
Schizophrenia	11	18	3	1	4	1
Other	3	3	2	1	0	2

Table 4 shows the types of housing that those with a serious and persistent mental diagnosis would like. However, both people with schizophrenia and bipolar prefer to live independently in an apartment.

Summary of Results

There are 350 individuals who are being served by the COAST team and 200 had an opportunity to participate in my research survey. I was disappointed that only 88 people participated (44 percent of possible participants). However, my supervisory committee has pointed out that is actually a good response rate.

As the Literature Review indicated, people with a Serious and Persistent Mental Illness (SPMI) want to be able to make the decision as to the type of housing and level of support they might need. The results from my data clearly indicate that people with SPMI prefer to live on their own with supports.

Chapter Four

Limitation of Research and Suggestions for Future Research

Limitations

A limitation of my research is the fact that if individuals wanted to participate in my survey, that they had to come to one of the three sites as already described earlier. Transportation is often a problem for this population, so, based on this, I may have missed having some potential participants. As well, the size of the sample was considerably smaller than anticipated. The results of my survey were solely descriptive and not inferential. There were no qualitative responses which, had there been, could have provided a much clearer picture of individuals living with a mental illness and their housing needs or wishes.

Future Research

An interesting direction for future research might include a qualitative analysis which involves interviewing a group of individuals with a mental illness and who are struggling to maintain their housing. By doing so, one would be provided with clear, in depth information on the concerns, daily struggles, and future desires of individuals trying to maintain or have access to appropriate, safe, clean housing.

Another direction for future research might be to compare and contrast the housing needs for those who are mentally ill by interviewing policy and decision makers with those who work with this population on the front line. Historically, decisions are made by those not directly working on the front lines and who may not have worked the front lines for many years. Historically, decisions are made by following examples of other regions and here in Prince George, we follow what is being done in the south in bigger centres. This often does not work in the north or in smaller northern remote communities. What does work is talking

to those individuals who have either direct experience (consumers) or with those who work

every day on the front lines and understand completely the needs and struggles of this

population.

Chapter Five

Investigating Housing in Prince George and Developing iPortal

In addition to the literature review and research, another aspect of my practicum

project was investigating housing availability in Prince George and devising a system in

which information about current housing availability would be more easily accessible. At the

same time as my practicum, Northern Health was coming up with a system that provided

information to all areas in Northern Health and hence, iPortal Project was first drafted

February 27, 2007 and the last revised version was submitted for approval May 11, 2007. I

was able to create an iPortal for housing availability for clients with mental illness.

Purpose of iPortal

Northern Health has an intranet as a web-based service offering one single location to

access news, policies, procedures, forms, and other information and knowledge. This service

is referred to as the Northern Health iPortal.

Audience

In time, all Northern Health corporate services departments and clinical departments

will establish and maintain content in respective iPortal Areas. These are to be sponsored by

senior executives, managers, and department heads of Northern Health, and administered by

individuals within those departments.

iPortal Roles and Responsibilities.

The management and administration of an iPortal intranet Area Is shared between a

number of individuals within Northern Health, each of whom has specific roles and

responsibilities. On my site, the team site sponsor or manager assumes overall responsibility

for the site. This person is my direct manager, Donna Bernard. The site administrator, which

is myself, maintains the site, adds or removes web parts, and provides support to other site

members. The site contributors add content to any documents on the site including members

of my immediate team. In some cases, one individual may have more than one role or

responsibility.

Policies and Principles

To date, there is no Northern Health policy regarding iPortal. There are, however,

guiding principles that promote consistency with content within each site that must be

ensured. To accomplish this, content has been identified and is required for each site.

Mandatory content includes the purpose and objectives of the department, any news

pertaining to the department, and proper contact information. Standard layout is also

mandatory. Each site must be displayed in a consistent way on all respective iPortal areas.

The initial template for iPortal was generated by Northern Health's Information and

Technology Services (ITS).

Laying the Groundwork for iPortal

As part of my practicum, over several months I visited apartment buildings in Prince

George and spoke to landlords — at the same time collecting relevant data on the apartment

to be included in the housing iPortal site. This data included the name of the apartment, the

name of the landlord and phone number, address, apartment description, price of rent, utility

costs, and vacancies. Once all of the data was collected, a colleague and I came up with a

way of displaying this information within the mandatory layout features of iPortal. Each

apartment site and related information was then entered into iPortal to create a housing

database. As well, I included a general guide to housing for individuals with mental illness

who are currently students, and other websites for housing vacancies. I also provided a

general description of what Subsidized Independent Housing (SILP) is, and made a spread

sheet of all the consumers currently on SILP.

Figure 1: Screen Shot of Iportal Face Page

I have included the face page to my iPortal site. Contacts and links are located to the

right of the screen while the site contents are located to the left of the screen. Case managers

on the COAST team can access this site at any time.

As previously described, the iPortal site was created to assist case managers on the

COAST Team so that they have easier access to current housing availability which in turn

saves them time and energy to use to focus on the other needs of the consumers who they serve. Each case manager has been granted access to the iPortal site. They are able to access housing by rental costs, area, or by other descriptions. Feedback from my colleagues has been quite positive. To maintain the site, future students are given the role of updating information and imputing it on to the site.

Chapter Six

Review of Practicum Objectives

1.   To become familiar with both private and public sector landlords within Prince

George.

This was the most time consuming part of my practicum as I physically went to

apartment buildings and met with landlords and introduced myself. During the course of my

conversations with landlords, I found myself providing some education about mental illness

as I found many landlords reluctant to rent to this population of people. In doing so, I feel I

have created a unique relationship between the landlords and myself and it has made it easier

for other case managers to approach landlords with regard to renting to individuals with a

mental illness. This was a very positive and practical outcome of my practicum work.

2.   To create a database of housing listings to utilized and continuously monitored by the

COAST team.

I was given a very unique opportunity to be a part of a new intranet web-based

service offered through NH. As described previously, this web-based service known as

iPortal was to provide information on a topic relevant to each department. I created a service

that provides information on current housing opportunities within Prince George. I provide

information on rent, utilities that are offered, the location, and safety. The site is updated

regularly by either future nursing or social work students.

3.   To conduct a housing survey amongst individuals currently receiving services from

the COAST team. The survey was to learn more about the need and the type of

housing individuals may require based on the outcomes of Objectives 1-2.

A survey was conducted among individuals over the age of 19 and who were currently seeking services on the COAST team. The individuals were diagnosed by a psychiatrist with an AXIS 1 diagnosis of Bipolar Disorder, Schizophrenia, or a Delusional Disorder. Three separate locations were chosen to conduct the survey. The first location was held at the Health Unit where individuals who were coming to see their doctor or case manager had an opportunity to participate. Secondly, Connections Club House provided an opportunity for club house members to participate in the survey. Thirdly, ACE provided the final location for the survey. As described previously, my findings concur with what current literature says: Individuals with SPMI have a desire to live independently rather than in a custodial setting.

4. To assist with the creation of new opportunities for supported housing for individuals being served by the COAST team.

Augmenting my practicum work, I have also had the honour of sitting on a mental health housing committee for the past eight years as part of my job as a case manager. In doing so, I have had the opportunity to witness and participate in providing safe housing to individuals who may be just moving out for the first time on their own or who have been homeless. Along with providing housing opportunities, supports such as a life skills worker have been provided to help maintain individuals in the community. As well, I have had the opportunity to work with CMHA in Prince George to put together housing proposals through BC Housing for current housing bids. This has served to enhance my practicum further.

Conclusion

I have successfully completed my practicum objectives. In review of these objectives, I was surprised and saddened to learn that in today's society, stigma is still rampant and

much more education is still needed if we are to move forward to a place where all people are included in society.

Chapter Seven

Recommendations for Policy and Practice Change

It was expected that the survey, database development, and other related work (as described in the practicum learning objectives) will add to the existing knowledge base regarding housing needs for persons with mental health issues. Further, coupling this knowledge with policy and program development will serve as a catalyst for creating more appropriate housing opportunities for individuals with serious and persistent mental illness.

Why the Current Approach to Housing is Not Working

Current housing and support services have evolved on an *ad hoc* basis, resulting in a substantial lack of accountability and co-ordination. There are glaring contributing factors which point to BC's increased rates of homelessness among persons with serious and persistent mental health and addictions issues. Some of these factors include the following:

1.   There is no provincial housing and support strategy for this population.

It seems that we need a provincial strategy, with definite benchmarks, timelines, and targets that address the housing needs and supports and services of persons with a serious and persistent mental illness.

2.   There is no comprehensive information system.

There is no province-wide information system to help people in need of housing and supports to find appropriate housing. This is needed.

3.   Availability services are a patchwork at best.

Many individuals with mental illness and addictions fall through the cracks due to a lack of coordination and collaboration of services. Most agencies have their own linkages and/or compete with each other. A recent position was created for the entire Northern Health

area. This position is the housing coordinator who will be responsible for providing housing

opportunities to individuals with a serious and persistent mental illness within the NH

catchment area. This is a positive step forward as checks and balances can now be put into

place and coordination and collaboration will be more streamlined.

4. Funding is inadequate.

This is a huge problem as there is no mechanism in place to coordinate and prioritize

different funding sources or ensure resources are put towards the areas where they are needed

the most. There is no centralized system across BC and most discussions are made away

from those who are in the front line.

Recommendations

Advocacy

1. Lobby the Province of BC to implement a rent supplement program that is attached to individuals and not to the properties.

Most residents of supported housing are in market rent housing that is not affordable

to them. In the United States, the Department of Housing and Urban Development (HUD)

operates a rent supplement program called the *Section 8 Existing Housing Program* which

targets low income families/individuals and reduces rent to 30 percent of the household

income (Hendrick, Kaneda, Newman, & Reschovsky, 1994). Because the subsidy is tied to

the individual, they can then apply for subsidy without having to move. This model would

have to discriminate between the levels of needs and acknowledge that the number of people

who may qualify for the subsidy may be greater than funding availability.

2. Continue to target private and public sector landlords and the public with public campaigns to demystify mental illness.

It is unfortunate that some of the public still perceive mental illness to look like the movie *One Flew Over the Cuckoo's Nest* or most recently, the Greyhound Bus incident that took place last summer in Alberta, where it was found that a man with schizophrenia openly attacked and killed a young man on the bus. Education campaigns may help landlords to become less reluctant to rent to individuals with serious and persistent mental illness and addictions and move to a more open communication between landlords and their tenants and those who provide support services.

Solutions at the Local Level

So what happens if higher levels of government do not recognize housing as a priority and a basic human right and do not put money back into affordable housing for those with a serious and persistent mental illness? What can be done at the local level?

Local municipal governments have control over many aspects of planning and development, and they have many ways to increase the supply of new affordable housing stock. They could have non-profit agencies invest in single-room occupancy (SRO) hotels, renovate, and operate these as affordable housing. They have the opportunity to lease the land at a lower rate to these non-profit organizations. This is currently being done in Vancouver. Just recently, the province sold the Astoria Inn in Prince George and put out a bid for local agencies to bid on to provide housing to the homeless. The Native Friendship Centre was the successful agency. As well, the municipal government can provide zoning and regulations which allow for homeowners to build and rent out secondary suites. They can provide cash grants or interest-free loans for affordable housing developers. The municipal government can create an "affordable housing first" policy, where affordable housing

becomes not only the first option but a priority in re-development projects, rather than the last (Ministry of Community, Aboriginal and Women's Services, 2004).

The Federal and Provincial Solutions

In my view, housing should be treated as a fundamental right in Canada, and recognized as a preventative health measure and be prioritized. As well, a comprehensive federal and provincial housing policy and action plan needs to be developed in partnership with Canadian municipalities (Hulchanski, 1991). When the federal government does put money into affordable housing, it needs to be clearly earmarked for affordable housing and not solely for use with programs such as assisted living. Clearly the federal and provincial governments need to reinvest in ongoing sustainable affordable housing.

What else can we do?

"Give priority to rural areas, northern and other under-served regions" (Aubry et al., 2004, p. 202). The Ministry should give priority to rural, northern, and other underserved regions to enable consumers to stay in or return to their home communities. Development in rural land northern areas must address challenges such as transportation, location, and the availability of housing stock.

Strengthen existing services.

Existing supportive housing should be strengthened to meet the needs of current consumers and those who are underserved. This might include an increase in financial support to maintain existing housing. It could also include proper training for housing and community support staff to be able to work effectively with consumers. Finally, increased resources need to be made available to effectively support individuals who choose to live in more independent settings. Currently in Prince George and under NH's current organization

chart, increased resources, such as front line workers like life skill workers and case

managers, don't appear to be a priority. Funding is not made available to create new

positions on the front line.

Dissemination of Research Findings and Practicum Work

In order to assist with implementation of my recommendations, my practicum report

and research findings will be available at the UNBC Library, Northern Health Library, and

through my availability for possible presentations to both service providers and service users.

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Appendix A: Cover Letter

Dear Participants

The quality of housing for everyone, but especially those with a serious and persistent mental illness is of vital importance. This survey, developed by myself, Deborah Turner, as part of my Master of Social Work Practicum Project on housing needs and requirements, asks you to talk about your personal experience in such areas as current living conditions, homelessness, and housing supports.

I am hopeful that your responses will lead to specific recommendations to improve housing for those with a mental illness. I am actively seeking potential participants over the age of 19 including both males and females. Participants must be engaged in services through the COAST team. Five COAST case managers will assist in the identification of potential participants. Identified individuals have been previously diagnosed by a Psychiatrist with either having Bipolar Disorder, Schizophrenia or a Delusional Disorder. The Survey data are **anonymous**. Please do not put your name on the survey. Information given from the survey will be seen by myself, and my Academic Supervisor, Dawn Hemingway. Your written responses to the survey will be transferred to a password protected electronic data file and stored in a locked file cabinet in my office for seven years. At that time, files will be deleted and paper shredded as per UNBC Research Ethics Board policies.

The usefulness of this survey depends on receiving a thoughtful response from everyone. Participating in the survey is voluntary. You have the right to withdraw at any time, or choose not to answer any or all of the questions. If you choose to withdraw from the study, your information will be destroyed and will not be apart of the study. This will not affect the services you receive from the Community Outreach Assertive Services Team (COAST). There is no remuneration for participating in the research. Should you choose to complete the survey, you voluntarily agree to give consent. There are no known risks identified in participating in the survey however; professional counseling is available to all participants if needed. Benefits of participation can be great. For example, my findings will be made available to service providers and policy makers who have the power and opportunity to make needed changes in housing provisions. Once you have completed the survey, please fold the survey in half and drop into the large brown box. A copy of the results of the survey will be made available through each site. Results may also be available through formal publication, and conference presentations.

Should you have any questions or concerns regarding this survey, Please call Dawn Hemingway at 960-5694 or the Office of Research at 960-5820 or email: reb@unbc.ca.

Thank you for your time and participation.

Sincerely,

Deborah Turner, BSW	**Paul Becklake, BSW, MSW**
MSW Practicum Student	**Practicum Supervisor**
Phone: 612-4521	Phone: 960-9931

Dawn Hemingway, BA, MSc, MSW
Academic Supervisor
Phone: 960-5694

Appendix B: Informed Consent

Please read carefully and answer each question.

1. Do you understand you have been asked to participate in a research survey?
   Yes   No
2. Have you read the attached cover letter?
   Yes   No
3. Do you understand that the answers you provide to the research questions will be analyzed?
   Yes   No
4. Do you understand the risks and benefits involved in participating in the survey?
   Yes   No
5. Have you had an opportunity to ask questions?
   Yes   No
6. Do you understand that you are able to refuse to participate or withdraw from the study at any time? This will not affect your current mental health services.
   Yes   No
7. Do you understand what confidentiality means and has this been explained to you?
   Yes   No
8. Do you understand who will have access to the information you provide?
   Yes   No

I fully understand and agree to participate in the Survey.

Participant Name   Date

_____   _____

Researcher Name   Date

_____   _____

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Appendix C: Housing Survey

DEMOGRAPHICS

What is your age?
☐

What is your gender?
☐ Male   ☐ Female

What is your marital status?
☐ Married   ☐ Divorced   ☐ Single   ☐ Common-law

Are you on Disability Pension?
☐ yes   ☐ No

Are you on CPP Pension?
☐ Yes   ☐ No

Are you on Long Term Disability through your work?
☐ Yes   ☐ No

What is your monthly income?
☐ Less than $700.oo ☐ Less than $800.00 ☐ Less than $900.00   ☐ Other _____

What is your level of Education?
☐ Never attended school   ☐ Completed High School
☐ Completed Elementary School   ☐ Other _____

DIAGNOSIS

Do you have a mental health disability?
☐ Yes   ☐ No

If yes, what is your Mental Health Disability?
☐ Bipolar Mood Disorder   ☐ Schizophrenia   ☐ Other _____

CURRENT LIVING CONDITIONS

Do you live:
☐ Alone   ☐ With family   ☐ Roommates   ☐ Other

What is the cost of your rent?
☐ Less than $375.00   ☐ Less than $500.00
☐ Less than $400.00   ☐ Other _____

HOMELESSNESS

Has there ever been a time when you have been homeless?
☐ Yes   ☐ No

If yes, for how long? _____

Have you ever had to access the Emergency Department of the hospital because you had not housing?
☐ Yes   ☐ No

Have you ever had to access Davis Drive because you had no housing?
☐ yes   ☐ No

Have you ever been evicted from your income?
☐ yes   ☐ No

If yes, why? _____

HOUSING SUPPORTS

Have you ever received housing supports such as:
☐ Moss House   ☐ Urquhart
☐ Subsidized Housing   ☐ BC Housing
☐ New Directions   ☐ Other

Have you ever been placed on a waitlist for housing?
☐ yes   ☐ No

For how long? _____

What type of housing is important to you?
☐ Supportive housing (i.e. – Moss House, Urquhart, Iris House)
☐ Subsidized housing (i.e. SILPS, BC Housing, New Directions)
☐ Low – Rental housing with out any supports
☐ Other _____

If given a choice of what type of housing you prefer to live in, what would you choose?
☐ House   ☐ Townhouse   ☐ Resident Housing
☐ Apartment   ☐ Duplex   ☐ Other _____

If you had the choice to live on your own or with others, what would you choose?
☐ On own   ☐ With Others

In choosing the type of housing you would like, what things are important to you? Check all that apply.

☐ Neighborhood ☐ Balcony ☐ Smoking units
☐ Cost of rent ☐ fire place ☐ Non-smoking units
☐ Type of housing ☐ yard ☐ access to transportation
☐ Utilities ☐ Family oriented ☐ Wheel chair accessible
☐ Access to a phone ☐ Elevators ☐ Feeling of community
☐ Pets allowed ☐ Washer & Dryer
☐ Other_____

COMMENTS

_____
_____
_____
_____
_____
_____

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