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CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

BC's Mental Health Journal Visions

Housing

health identity community support opportunity access

"Prairie Sunrise" by Jocelyn Caldwell (painting)

BC's Mental Health Journal

Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA, the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family members, service providers, and community. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

The Canadian Mental Health Association invites readers' comments and concerns regarding articles and opinions expressed in this journal. Please e-mail us at **office@cmha-bc.org** or send your letter with your contact information to:

Visions Editor
CMHA BC Division
1200 - 1111 Melville Street
Vancouver, BC
V6E 3V6

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In this edition of *Visions*, we look at housing for people with mental illness. To paraphrase a comment by a previous contributor to the journal: "it's amazing how when a person has decent housing, the problems with the illness go away." Within these pages, then, we'll try to understand what makes this comment so credible and then consider how to achieve the vision underlying it: a person in control of his or her illness, living in decent, stable, affordable housing.

Towards this end, we tried to keep several practical questions in mind when we planned the issue and asked for submissions. First of all, "Why housing?", or in other words, what is it that's so important about housing when considered along with the other elements of support? Just what is the relationship between good (or bad) housing, a person's mental health, and a person's ability to manage their illness?

The next question in mind was "what does good housing look like?" Here, we were thinking about things from the standpoint of research that seeks to define what constitutes "best practices" in providing the full range of housing programs.

More importantly, we wanted to ask this same question from an experiential angle, seeking to understand what makes a housing situation good or bad from the perspective of the person who lives there. Keeping with this perspective, we also wanted to look at some housing support options that were designed and run by consumers and families themselves.

Once we have an idea of what good housing looks like, how then can we create more good housing opportunities and help people gain access to these? From the perspective of a community that's trying to improve its housing, and from the vantage point of the professional who works within a housing program, how can we move towards best practices? Here, we wished to look at some regional initiatives, provide a snapshot of existing programs across the province, and provide some information designed to help people gain access to housing in their area.

Finally, we wanted to examine the issues surrounding people whose needs often go overlooked, or may require more specialized forms of support. This includes young people, single mothers, seniors, people from diverse ethnocultural backgrounds, people with co-existing substance abuse problems, and people in the forensic mental health system.

Our failure to deliver adequate housing to the more specialized populations, in particular, has left people with mental illness living on the street or significantly under-housed. So we wanted to consider the problem of homelessness, in concert with some attempts to deal with it, in the final section of the journal.

When considered in the context of homelessness and some of the estimates of its prevalence among people with mental illness, finding answers to the practical questions related to envisioning, creating, and accessing good housing obviously becomes more urgent. Hopefully, this edition of *Visions* will contribute to some of the solutions.

Eric Macnaughton

- Special thanks to Jocelyn Caldwell whose painting "Prairie Sunrise" was selected for our cover. Jocelyn has been a mental health consumer since 1991 and aspires to be a professional watercolour artist. She paints at Vancouver Community Mental Health Services' Art Studios.

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Why Housing?

A Framework for Housing and Mental Health

James R. Dunn

Jim Dunn is an Assistant Professor of Geography and an Associate of the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia. He earned his Ph.D. from Simon Fraser University in 1999, where his research focused on relationships between socio-economic status, housing, and health in Vancouver neighbourhoods. His current research interests include housing and health issues for mental health consumers and factors that explain the link between urban inequality and population health.

As most readers will be aware, housing is a particularly important issue for people with mental illness. I have been interested in the influence of housing on health for several years now and I continue to find it fascinating to hear about people's experiences with housing. People love to talk about housing, it seems to me, because it strikes so closely to their day-to-day experience. But because it is so close to their day-to-day experience, it's difficult for them to explain exactly why it is that housing makes a difference to their health.

I'd like to propose a simple framework for thinking about the connection between housing and mental health. It is based on my research in housing and health, and it suggests that there are three important aspects of housing that can affect health: the material, meaningful, and locational aspects of housing.

Material

When I use the expression '*material* aspects of housing,' I mean it in two ways. First, at a very simple level, housing is meant to provide us a reasonably controlled environment with respect to light, temperature, ventilation, and sanitation, as well as a place to store possessions, to sleep, to prepare food, and to satisfy basic bodily needs. These come as no surprise, but we may take them for granted, so we don't appreciate the stress that can be caused for people living in housing of poor physical quality.

But that said, there is a much more hidden issue related to the material aspects of housing and this concerns the inequalities in income and wealth that can be generated by housing markets. The big factor here is whether one rents or owns their home. First, there are inequalities in who can own a home as it usually requires a substantial down payment that many people cannot afford. It's estimated that less than 25% of households who currently rent could afford a basic starter home.

There are further inequalities associated with the difference between owning and renting, though. Another inequality stems from the ability for owners to earn capital gains on their homes. This simply refers to the profit they could realize on the sale of their home (the difference between the price they paid and the price they could sell it for). The thing that is so important about capital gains though, is that the first $500,000 in capital gains that you earn on your house in your lifetime is tax-free. This can create a substantial wealth advantage for owners and give them much more control over their life and daily living conditions than renters, over and above the control they get from owning (they can't be evicted, for example). This notion of control is important if a person's home is going to be meaningful for them, and this is the second aspect of housing in the framework.

Meaningfulness

People's homes are important sites for the investment of emotional and social *meanings*. What do I mean by this? Well, first, people paint, decorate, hang pictures and paintings, and furnish their homes in a way that reflects their identity. So most people have photos and paintings and decorations in their homes that express something about who they are. These things tend to make us comfortable because they also reinforce our identity, and remind us who we are. They remind us who loves us, what things we've done and accomplished, what things we like. Our homes are an important source of self-expression. If a person's housing is unstable, however, and they cannot be sure that they will be living there for long — or don't wish to live there for long — they will be less likely to 'invest' in it by creating an emotional connection to their home. This is the case for many low-income people and also some mental health consumers. In short, people need to have an opportunity to nurture an emotional connection to their homes; this can be difficult to do for people who live in marginal, unstable, or unsuitable housing.

But homes also have important social meanings. They communicate something to the world outside about who we are. In other words, they can be an expression of status, and by the same logic, they can also be an expression of stigma. This is immediately and powerfully visible if you read advertisements for new housing developments. The ads are trying to appeal to people's sense of status by showing how unique and trendy the homes themselves are, as well as the neighbourhoods they're located in. At the same time, we know how some neighbourhoods and some kinds of housing can be stigmatized — just think about the expression 'on the wrong side of the tracks', 'tenement housing' or 'skid road.' I may be saying it in overly simplistic terms, but I think it's fundamentally true that people need to feel good about

themselves for good mental health and to feel good about themselves they need to live in a dwelling that they feel good about and that isn't stigmatizing.

Another important note on the meaningfulness of home is the role our homes play in allowing us to make and maintain social relationships with friends and family. Social support is a crucial part of both mental and physical health and well-being for everybody. Some studies have shown that social isolation is as strong a risk factor for ill health as *smoking*. A home with an adequate amount of privacy, adequate space and furnishings, that is clean and in good repair, and is situated in a safe neighbourhood is essential to being able to establish and maintain strong social relationships. We need to have a home that we can be proud of in order to invite guests over. And the symbolic value of inviting someone to your home should not be underestimated. To invite somebody to your home is an important gesture of intimacy and if one's home does not allow it, then it will restrict them in a fundamental area of well-being.

The final point about the meanings surrounding housing gets back to the idea of control. In our culture, a person's home is the only space in their life over which our society permits them to have exclusive control. In other words, there are no other spaces in a person's life that they can expect to have complete control over. This is considered to be important for health because we all need a place of refuge, where we can be alone with our thoughts, or can be alone with our loved ones so as to develop our emotional relationships. This principle of home as refuge is even embedded in the law. The police, for example, cannot enter your home without just cause; likewise, if you rent an apartment, your tenancy agreement likely says that your landlord cannot enter your home without your permission plus a certain amount of advance notice. Some people in very low-income housing, including some mental health consumers, do not enjoy this right that most people expect and take for granted. Again, the stress and lack of dignity that comes from not having a secure place of refuge, a place to make into a meaningful home, can be detrimental to mental health and well-being.

Location

The third and final component of the framework on housing and health concerns the *locational* aspects of housing. What I mean by this is that a person's home is the base for their daily routines and activities. It roots them to a particular point in the landscape. This may give them more or less access to a range of important amenities and services like shopping, job opportunities, friends and family, social services, health services, etc. Relatively easy access to all of these things is important to health and well-being, especially for people with mental illness.

But at the same time, a person's home may root them to a point in the landscape that exposes them to things that are unhealthy such as pollution, crime, vandalism, violence, discrimination, exclusion, social isolation, and a lack of services. In this way, people can easily become 'prisoners of space,' especially if they are poor and cannot afford to move and live elsewhere. Again, the lack of control here is important too, especially so if you are living in an unhealthy home or neighbourhood.

I hope that you find this framework useful for thinking about the connections between housing and health while you are reading the articles in this issue of *Visions*. The articles in this issue are a very important contribution to our understanding of housing and mental health as they are written by people who are deeply committed, knowledgeable, and experienced in the area of housing programs for people with mental illness. The articles contain numerous lessons for me on this issue, and will be a valuable resource for future research in the area of housing and mental health. I believe that meeting the housing needs of mental health consumers is crucial to their well-being.

Appropriate, affordable, flexible, and stable housing can help people with mental illness to maintain treatments, establish and maintain relationships with friends and family, seek refuge, create a meaningful home environment, access work opportunities, access services and amenities, belong to a community, and have a purposeful daily life. I believe that everybody is entitled to such things in their lives and I think housing is a cornerstone in ensuring that all people do. To that end, I look forward to the future partnership of the Canadian Mental Health Association, other consumer and family groups, and the regional health authorities in conducting research that shows how housing programs can be designed to optimize the health and well-being of British Columbians. ■

What "Best Practices" Means For Mental Health Housing

Linda Thomas

Recently, the Ministry of Health released a series of documents addressing 'best practices' in a number of areas of mental health including housing. Written by small working groups of individuals with expertise and experience in various aspects of mental health, the reports were intended to guide the implementation of the Mental Health Plan and to help improve mental health services.

So what exactly is a 'best practice'? Basically, a best practice describes a service or approach that has been proven through research to have more positive outcomes than other services or approaches. While research evidence is clearly an important part of designing services, the Best Practices in Mental Health Housing report, rather than relying solely on research also acknowledges the importance of consumer, family, and service provider expectations in designing and delivering services. The goal was to blend research and expectations to produce a report that would be evidence-based and at the same time very practical, understandable, and easily implemented.

The report documents research confirming the critical link between mental health and housing. A lack of safe, secure, affordable, and appropriate housing is shown to have negative effects on both physical and mental health, resulting in increased need for and use of emergency, treatment, and support services. Research also points out that adequate, appropriate housing is often the essential ingredient needed to help people with mental illness move forward toward recovery. Having housing helps people better manage their illness, reduces the need for treatment and support services, increases stability, and generally improves quality of life.

The report identifies three distinct types of housing: supported, residential, and emergency/crisis stabilization (see Table 1 on the following page). While a range that includes all three types of housing is needed to allow consumers to select the alternative that best suits their needs, the report places its strongest emphasis on supported housing. Supported housing is affordable, secure, independent housing in the community that provides a person with access to flexible support services as requested. This style of housing seems to best reflect consumer expectations for control and independence and is seen as the preferred first option.

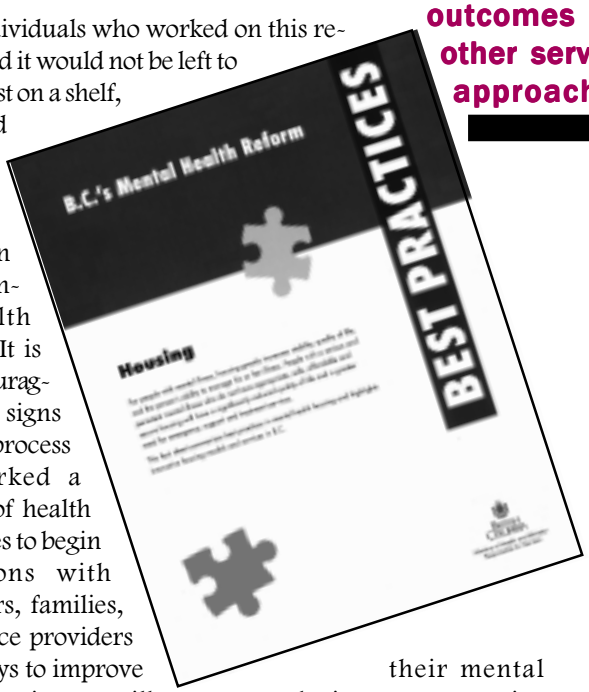
In the past, individuals often had to start in residential housing and move through increasingly independent housing options to reach supported housing. It is now recognized that making these many changes is extremely disruptive to people's lives and that, if given an option, many consumers would select supported housing as the preferred starting point. The most significant barrier to being able to offer consumers a true choice of housing options is the lack of available supported housing. At present, people who could successfully live in supported housing are required to accept residential services because it is the only option available, resulting in significant personal costs for the individual and financial costs for the mental health system.

Consumer involvement, choice, self-determination, and the need to de-emphasize illness and instill hope are some of the key values and principles from psychosocial rehabilitation and the recovery model which are reflected in the attributes, goals, and standards the report identifies for each of the housing options. These goals and standards, along with practical strategies for implementation, are provided to assist in the implementation process and to ensure that whatever form of housing is provided, it meets basic standards for accessibility, consumer involvement, individualized service, recovery focus, and accountability.

There are always barriers in any system making implementation of new ideas difficult. The report provides specific recommendations both for health authorities and for the Ministry of Health that must be addressed if we are to be able to meet the challenge of having a mental health housing system that truly reflects 'best practices.' These recommendations include the need to develop improved services to individuals with highly specialized and unique needs who are at greatest risk of being homeless and the need to create a system that supports cross-regional access to housing.

> "a 'best practice' describes a service or approach that has been proven through research to have more positive outcomes than other services or approaches."

Those individuals who worked on this report hoped it would not be left to gather dust on a shelf, but would act as a catalyst for discussion about mental health housing. It is very encouraging to see signs that the process has sparked a number of health authorities to begin discussions with consumers, families, and service providers about ways to improve their mental health housing. It will now be important to maintain this momentum and to continue to emphasize the links between housing and health. ■



Linda Thomas is the Director of Housing for the Vancouver Richmond Health Board and was co-chair of the Best Practices in Mental Health Housing Working Group.

The table below (one table extended across two pages) is adapted from the *Report on Housing* prepared by the Best Practices Working Group. It defines the three types of housing identified in the previous article, provides examples of each, lists their key attributes, and outlines recommended strategies for implementing and improving each option.

	Housing
	Supported
Definition	accommodation, with a range of support, for an individual able to live independently; services are available on an as-needed basis instead of being offered in a "one size fits all" manner for all people in a given setting (i.e., are "delinked" from the accommodation); the individual may live alone or in a group setting
Examples	- supported "apartments" - unlicensed group homes - supported hotels
Key Attributes	support on an "as needed basis" is identified by residents and provided by health authorities or a contracted non-profit society on an outreach basis, or for supported hotels and some block apartments on an on-site basis. Support can include food/meals, personal care, home/money management, social network building, medication/crisis support, etc. supported "apartments" are suites in a block, in "satellite" fashion scattered throughout various buildings, in a mobile home leased by a non-profit agency, or in self-contained smaller suites in a designated building where communal space and meals are available on site (known as "congregate housing"). Supported apartments are rent subsidized through the Supported Independent Living (SIL) Program and are governed by the Residential Tenancy Act. group homes are "rent subsidized or rent shared." Access is determined by availability and by an assessment of a person's ability "to live safely with supports" a strict definition of supported housing emphasizes choice, support which is truly "delinked" from housing, non-segregated living situations, and the valuing of everyday community roles such as tenant and neighbour. By these definitions, not all of the examples listed above would be considered supported housing.
Barriers/ Recommendations	affordability and access problems could be lessened by: - increasing the supply of subsidized units under the SIL program - a clearer process for determining eligibility for existing SIL subsidies - allowing portability of subsidies across health regions (i.e., if a person moves) - increasing the shelter payment component of disability benefits - offering market housing shelter subsidies similar to the SAFER program (Shelter Aid for Elderly Renters, a rent subsidy program for low-income seniors) - increasing access to generic social housing for people with mental illness there are accessibility problems in some regions for people not presently connected to community supports or who require more support. This could be addressed by: - a policy shift to truly delink housing and support - increased options for flexible, individualized support - pre-planning and negotiation between consumers and providers regarding plans to provide support as needed in the future - exploration of effective strategies for medication compliance or illness self-management potential isolation or loneliness in independent living requires strategies for building social support (e.g. through peer support, common areas, etc.) Ministry of Health funding rules should allow capital funding and long-term bridge (transition) loans to health authorities for non-residential housing options, in addition to residential facilities

TABLE 1: Three Different Housing Options, Their Features, and Recommendations for Implementation

(Underlined words are also included in the glossary at the bottom of the page).

Type	
Residential	**Emergency**
accommodation in a group setting with built-in support options for people presently unable to live independently and/or who are in the process of acquiring the skills and confidence necessary for independent living	accommodation and support provided on a short-term basis for people who do not require hospitalization but who require intensive stabilization, or short-term accommodation for people who have no other housing
- licensed, fully-staffed, twenty-four hour residential facility or "community residence" - partially-staffed (less than twenty-four hour support) unlicensed community residence - unlicensed family care homes	- licensed or unlicensed step-down home - short-stay, licensed crisis residence with twenty-four hour staffing, short-term treatment, and crisis stabilization - licensed or unlicensed shelter/hostel with twenty-four hour staffing
all options can be for either the short- or long-term on-site support includes assistance with personal care, home/money management, socialization, medication administration, etc. "exit" criteria: consumer attains personal goals or wishes to leave, or if the program cannot meet an increase in a person's medical or psychiatric needs even with added support when care is taken to determine that an individual is there by choice, that environments are kept small and homelike, are in non-segregated or non-isolated areas, and offer private bedrooms, "rehabilitation or strength-building focused" residential settings can offer a valuable transitional opportunity to more independent living residents receive $83 monthly comfort allowance	crisis residence offers safety, stabilization, and a return to longer-term housing linked with crisis outreach and offers treatment support and coordination with community resources provides alternative to hospitalization or hospital "step-down" function hostel/shelter offers an alternative to homelessness shelter may provide support to individuals with a range of needs other than mental health concerns stays for crisis residence or shelter normally in range of 7-14 days
with more flexible and individualized support options many individuals would not require residential facilities residential housing not desired by people who desire more control over their income than allowed by comfort allowance (direct payment of BC Benefits and increased comfort allowances is recommended) legislation change needed to change licensing regulations so that two-person bedrooms are disallowed persons in high-need denied accommodation because of safety risk; there need to be more inclusive and flexible support options to prevent homelessness there needs to be increased commitment to ensure existing residential options offer support in line with "best practices" in psychosocial rehabilitation	NIMBY barriers require community education strategy and good partnerships with municipalities emergency shelters reflect the lack of appropriate supported housing, especially for high-need people there needs to be a development of services in shelters for special-needs populations and for people with mental illness and substance use issues ("dual diagnosis")

Glossary

- **step-down housing:** short-term housing for individuals making the transition from hospital to independent housing
- **family care homes:** operated by a family for up to two individuals
- **NIMBY:** Not In My Back Yard (a negative attitude towards the integration of social housing in residential neighbourhoods)
- **licensed:** regulated according to the Community Care Facility Act which sets standards related to facility design, staffing levels, etc.
- **comfort allowance:** monthly payments for "spending money"

Provincial Programs for Supported and Subsidized Housing

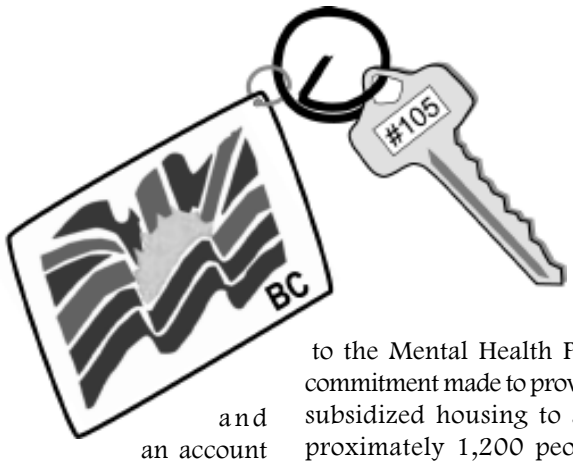
In this article, we describe two of the main provincial programs for supported and subsidized housing for people with mental illness. We also provide contact information for people interested in finding more details about program availability. Later on, in the "Regional and Community Perspectives" section (p. 19), we describe some specific local program options.

Supported Independent Living Program (SILP)

The Ministry of Health introduced the Supported (or Semi-) Independent Living Program in 1993 to provide supported, subsidized housing. Mental Health staff select residents to live in private market units; non-profit organizations provide the support services. The program provides both housing subsidies and outreach assistance. BC Housing administers the financial aspects of the program. A local mental health service agency is then contracted to provide "community living support workers" for people in the program.

People who collect BC Benefits income support pay the maximum shelter allowance, minus a rebate for their phone and utilities. The rebate varies depending on location and is based on the average cost for phone service, electricity, or gas for a one-bedroom unit in an area. Residents who do not receive BC Benefits pay 30 per cent of their income for rent.

BC Housing calculates the rent subsidy for each client to make up the difference between the rent they pay and the cost of the unit. A cheque



and an account summary is issued each month to the delivery agency which issues the subsidy cheque to their client or directly to the landlord.

As of March 1999, BC Housing provides 1,110 individuals with SILP rent supplements. This number is expected to increase to 2,600 in the next three to four years. For information about accessing housing under the SIL Program, contact your local mental health centre or supported housing agency.

BC Housing Health Services Program

The BC Housing Health Services Program began in the early 1990's as a partnership between BC Housing and the Ministry of Health. Since then, over 600 people with mental illness have received housing through this option. In 1997, the program received national recognition as a Best Practice Model in Mental Health Reform in Canada. In 1998, it hired six more health service consultants throughout the province, and expanded its operations to the non-profit housing sector. This was in response to the Mental Health Plan commitment made to provide subsidized housing to approximately 1,200 people with mental illness.

Applications to the program can be made through the local mental health centre, participating non-profit housing agencies, or directly through the local BC Housing office. The primary objective of the program is to increase access to subsidized housing units. As well, the program supports people with mental illness presently living in BC Housing or non-profit housing.

The program is designed for people who are able to self-manage their illness, who are presently able to live independently with some support, and who are actively engaged in daily activities. Tenants must agree to maintain some ongoing contact with the local mental health team. BC Housing Health Services Program staff also provide consultation to tenants "to ensure that adequate support services are provided to facilitate tenants in maintaining their housing. The need for staff involvement may vary from a few hours to a number of weeks."

Another function of the program is to provide education and support to landlords and housing staff. A workshop entitled "Demystifying Mental Illness" is offered to landlords and support is available for housing caretakers who need advice or referrals in order to support tenants who may have a mental health concern or emergency. Consultants also provide housing project development advice.

When a vacancy comes up, the eligible applicant will meet with the local Health Services program person to ensure that the opening is a good fit. For example, a vacancy occurring in the West End of Vancouver may not be ideal for a person living in Surrey, since it would take the person away from his or her support network.

BC Housing Health Services Program Locations and Contact Numbers:

Central Office:
(604) 433-1711
Lower Mainland, West Region:
(604) 609-7024
Lower Mainland, East Region:
(604) 525-3033
Coastal Region – Northern Island: (250) 703-2134
Interior South Region:
1-800-834-7149
Interior North Region:
1-800-667-1235

Other Options for Subsidized Housing

Co-op Housing – see page 13.

BC Housing – low-income applicants can apply at any BC Housing office. Applicants can have their name put on a registry that alerts them to vacancies in non-profit, public, and co-op housing as they

come up. Check the blue pages, or BC Housing's web site at www.bchousing.org for a list of BC Housing locations or an application form. Because of limited vacancies, applicants are strongly advised to apply directly to individual non-profit societies and cooperatives, at the same time as applying to BC Housing.

"The Link" – A resource directory covering all affordable housing developments for families, seniors, and adults with disabilities across the province. Includes general information about applying for affordable housing and resource groups that are knowledgeable about local housing issues. The Link is available on the Web at: www.bchousing.org/applicants/The_Link_Intro.html. It's also available through some non-profit and co-op housing organizations, as well as local libraries. ■

Independent Housing that Works for People with Mental Illness:

The Supported Living Program (SLP)

Barry Niles

Barry Niles is the Executive Director of the Mental Patients' Association.

Since 1971, the Mental Patients' Association (MPA) has provided housing to people with mental illness in the City of Vancouver. Traditionally, the housing was either a group home or licensed care facility, both options resulting in a number of individuals living communally in a house. Of course, apartments were available through our agency or other service providers, but they were built in buildings exclusively for people with mental illness and all residents were thought of as clients rather than tenants. These types of housing options were often not a conscious choice people made, but instead were places they found themselves in for a number of other reasons: as a result of their illness, because of a need for supervision, or because poverty precluded them from affordable independent living.

In 1992, the introduction of the Supported Living Program (SLP) enabled people with mental illness to live in market rent apartments. By adding a rental subsidy to the shelter portion of their income assistance cheque and by providing staffing costs for a supportive outreach worker, a number of individuals obtained an immediate improvement in their quality of life. As a housing provider, the MPA always felt that this type of supported housing was beneficial, but it wasn't until we undertook a survey in September 1998 that we realized how great the impact was.

For the purposes of the survey, we looked at the utilization of acute-care beds and Venture (short-stay crisis stabilization) stays for program participants prior to and after entry into the program, comparing equal intervals before and after entry. The average duration of stay of surveyed clients in the program has been four years. Data was collected from mental health teams and private psychiatrists of which 40 surveys out of 88 were returned. The time period covered was September 1992 to September 1998. Table 2 outlines the results.

To measure the value for dollars spent on the individuals surveyed and the economic benefit of the SLP program, we calculated the cost savings resulting from the decrease in hospital and crisis stabilization unit stays, using the following cost estimates: average cost of an acute-care bed per day $380.00 (this may be conservative), average cost of a Venture bed per day $200 (this is a conservative figure and doesn't include administration costs). See Table 3 on the next page for a calculation of the economic benefits of SLP.

The survey represents less than half of SLP participants at the MPA. If a survey was conducted that covered all the agencies in Vancouver that provide similar programs — totaling 246 individuals — the economic benefit would have been $3,948,300 assuming that the same reductions in acute-care resources were achieved during the same period of time.

There is of course a financial cost attached to the SLP. We have calculated that the cost of a SLP bed per day is $21.12. This is based on our global budget from the Vancouver Richmond Health Board and includes all program costs and 1/17th of a FTE (full time equivalent) wage and benefit cost (client to staff ratios are approximately 1 to 17). This would seem a small price to pay when one considers the alternative.

It is clear that there is a need for acute-care beds in hospital. However, if the dollars spent were in the area of programs such as the SLP, the end result could well be a reduction of the

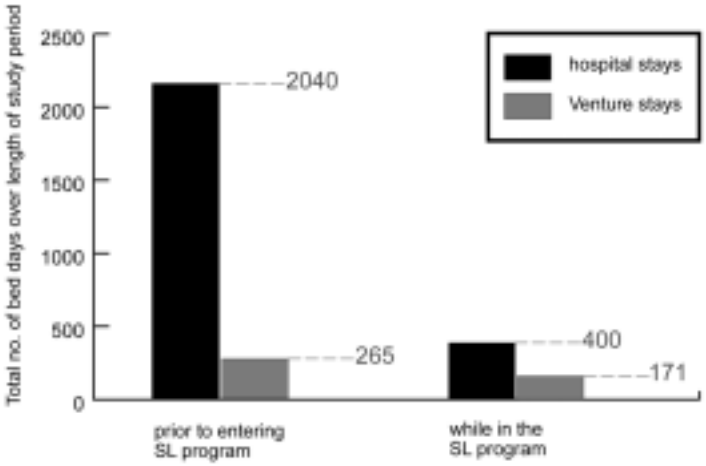


TABLE 2: Effect of the SL program on the number of days spent in acute-care or crisis stabilization beds

numbers of such beds. Done properly, this reduction could be done in concert with the move to de-intitutionalize individuals and provide less costly community care.

This program provides significant benefits to the individual in some of the following ways:

- reduction of stigma by normalizing the living environment
- empowerment of the individual by providing independence
- socioeconomic improvement in the quality of life
- reduction of hospitalizations
- support, proactive intervention, validation.

In today's climate of acute-care bed scarcity and the nursing crisis, we have to provide solutions for the utilization of psychiatric emergency beds. I guess the question we all have to ask ourselves is the following one: "Is it responsible to reduce the rate of relapse to high-cost acute-care beds or should we continue to allow an over-utilization of these beds and provide only crisis management for people with mental illness in the community?"

TABLE 3: Economic Benefits of SLP

Economic benefit of reduced acute-care bed day costs since inception of SLP

2040 bed days @ $380.00 per day
– 400 bed days @ $380.00 per day

$623,200.00

Economic benefit of reduced Venture bed days since inception of SLP

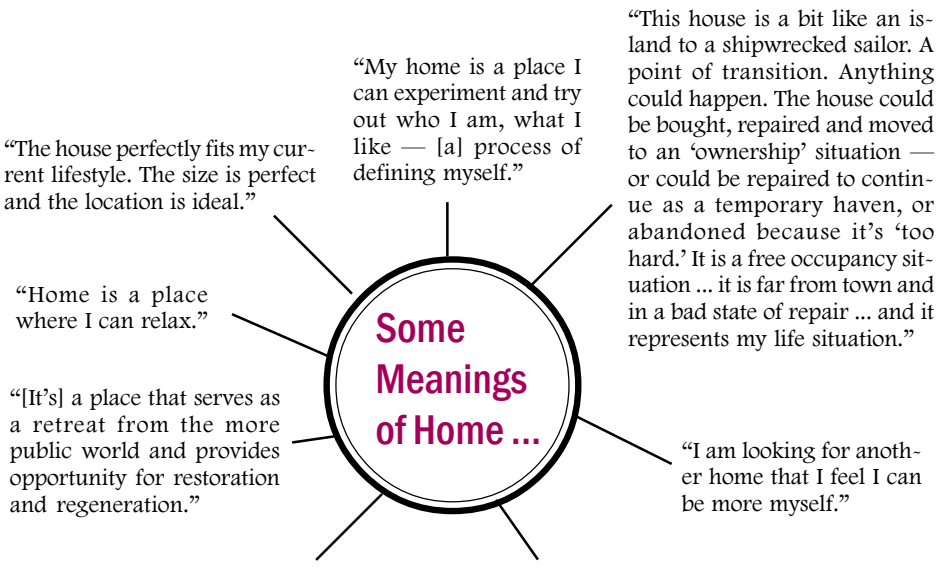
265 bed days @ $200.00 per day
– 171 bed days @ $200.00 per day

$18,800.00

Total Benefit = $642,000.00

What is the Meaning of Home?

"Best practices" must be grounded in an understanding of what makes a given housing option "a home" for an individual. The following passages and quotes from real people are excerpted with permission from an article by Mark Groves, Ph.D. in the June 1998 (Vol. 8, No. 1) edition of *Seniors' Housing Update* (SHUP). SHUP is put out by Simon Fraser University's Gerontology Research Centre. The full article is available online at www.harbour.sfu.ca/gero/shup/jun98.html#groves



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A Room of My Own

Brian Strong

For a lot of people who live with a mental illness, a home is nothing more than a hotel room or a room in a house. I have the luxury of living in a small cabin and have no one on the other side of a paper-thin wall. Living in this small town, I have to be worried more about wild animals than people on the street — not the same for those living in the Downtown Eastside in Vancouver, a place where I used to live.

The one big contributor to improved mental health is a decent, safe living arrangement. Independent living is something that a lot of my fellow consumers strive for. Having a nice place to live then enables a person to have an improved standard of living.

The thing that goes along with a decent standard of living is good clothing and a nice kitchen full of food. I also think that it is really important to have a place to carry out proper hygiene.

Income and shelter are directly interrelated. How much a person makes and then has to spend on rent also affects the food and clothing areas. Only having $175 for food and clothing for a month was fine in the early seventies and eighties. Yet…

Some of us are lucky to have a disability pension or to have a job, and I wonder sometimes how fortunate I really am having a combination of both. The stable home allows me to then have a job. What employer would hire someone who has dirty clothes and is undernourished and not able to work physically?

A safe environment may allow for the purchase of a TV, a stereo, or a computer — things that give us a sense of comfort, which helps improve the quality of life.

Brian lives in Naramata, BC.

In my personal experience, most people are not aware of the difference between having it all and having little or nothing. Only when a person has been without everything that is taken for granted in a stable environment can a person appreciate what life is all about.

Have you ever had to use the bathroom while shopping downtown? As a customer, the store or restaurant will gladly let you use their facilities. A person living on the street has no way of using a washroom. What about if you want to get a simple thing like a glass of water? Try doing that when you share a kitchen and washroom with fifteen or twenty people.

Another really good benefit of having a nice home is that it is a place to recover from an unbalanced period by being able to take the medication needed for recovery. ■

Home is Where the Mirror is:

When a single-family home has more than a single family member with mental illness

Janice

My house is a really lived-in place. My room is cluttered with too many shoes and knick-knacks and dog hairs on my throw-rug — just the way I like it. The cutesy peach wallpaper doesn't thrill me anymore, but then again I've had this room for over a decade, and it didn't look that bad when I was nine. (How did I know back then wallpaper paste could stick so well?)

See, I love this house, but that doesn't mean I always love coming home.

Now, I'm sure that applies for most people, but I think I'm an interesting case. I'm young and live in a multi-person, multi-generational household. For most people who don't live alone or who live alone now in a place that used to be filled with others, home is more than what you can turn the house or a room with four walls into. "Home" has just as much to do with all the visible people and invisible relationships that also occupy that space. As I struggle each day to recover from a mental illness, "home" for me is a cream and brown place in suburbia; it's also where I happen to live with two other mental health consumers: my mother and my grandmother. I am a survivor of panic attacks and currently battle depression. My mom is depressed, anxious, and close to burnout much too often. My grandma is depressed and often suicidal and also lives with dementia. All our depressive conditions are expressed so differently. But, oh, how alike we are.

When I had to go through intake interviews with a psychiatrist a couple of years ago, the doctor heard my family history and said it's quite common to see depression run in families. I've since discovered that my maternal line has a long history of mental illness, and I may just be yet another expression of that genetic tendency. The fact remains though, that I'm not just a mental health consumer living with roommates who may or may not be consumers as well. My "roommates" often mirror my symptoms when I least need them to. I love them, but frankly, I didn't choose them. They're family.

When I look at them sometimes, I feel like I might just be looking at myself thirty or sixty years down the road — forecasts of my mental health destiny. I feel like I'm looking in an emotional

Since this article was written, Janice has moved out to her own place in the Lower Mainland.

mirror and it can really scare me. I wonder if depression, anxiety, or dementia genes have already been programmed and are running around my blood with the code for my future.

Right now, my depression comes in waves about a month or two apart. When I'm about "due" for another dark period, I can sense it in my bones. I sense becoming more irritable and emotionally sensitive to things I wouldn't have cared about the week before. Of course, I try not to let the calendar dictate my internal balance and instead fight as hard as I can. But, unfortunately, my waves aren't synchronized with my mom's or grandma's.

Last month, I went through a morning of gulping back a depressive lump in my throat and steadying my resolve for the day ahead. "You are not going to crumble today," I'd keep reassuring myself. But my mom had had a hard weekend and told me over breakfast that she was on the verge of tears. I gave her a hug and we both wept. I couldn't help it.

drawing by Bill Pope, Vancouver-based consumer

I'm sure if it weren't her, it would have been something else, like my granny telling me how much she prays for death. See, I had a few days in the mid-90s when suicidal thoughts had flown across my mind, so those suicidal words would have likewise pierced a bubble from the past and flooded me with feelings — a strange combination of "déjà-vu," resentment, anger, empathy, and pain. And if it weren't either of them, it probably would have been a sad song on the radio.

Still, I get so angry at both of them. I want to yell "Why did you give me this?" or "I'm getting better! But every time I get close to recovery, I end up coming home to a depressing environment. Can't you see we're not good for each other? Home is not a healthy place to be." I want to yell this and more … but I don't because at the same time, I know my mom and grandma understand what I'm going through in a way no one else can.

Hugs and support from fellow sufferers and survivors are so meaningful. Now that I've understood this value, I'm in a better position to believe that I'm a unique person shaping her own future and not hostage to DNA. And now that I've finished school and found work, I know I can move out on my own this year and be okay.

In the end, for me, "housing" is about shelter and security; "home" is all about people and relationships. ■

Satellite Housing

Linda Carpenter

Linda lives in Vancouver.

I sort of fell into satellite housing. I had been living at Coast Foundation's Frances Court building by Vancouver's Commercial Drive for about a year. Then I met my future husband Rui Coelho. Rui had his name on the wait list for satellite housing. At that time, 1990, the wait list was two or so years. It is now four. Rui had been waiting two years.

I was pretty happy to be living at Frances Court. I finally had my own apartment. That had been my dream since being released from hospital several years before. The environment was friendly and supportive — friends down the hall, coffee get-togethers once a week, dinners on special occasions, and a supportive, compassionate manager. I also liked the neighbourhood. Then I met Rui.

Suddenly, things changed. I pretty much moved in with him, and we realized that as nice as the suites were, they simply weren't big enough for both of us to share. So, when Rui's name came up on the satellite waiting list, we decided to move into the program.

Rui had his reasons for wanting this type of housing. He wanted more independence, and less company in his suite. I used to tease him that his apartment was a lot like a coffee shop, but it was true. People were constantly dropping by and Rui was getting sick of it. He wanted his peace, he said. I didn't know much about Satellite Housing. I figured I'd go where Rui went.

I remember the first time I saw what was to be our future home. It was in the West End, a one bedroom chosen by Coast. It was on the ground floor with a huge balcony that faced the street. I walked in the front door and a wave of fear washed over me. This was it. Goodbye to the sheltered existence of Frances Court, and hello to uncertainty. From now on I would be independent in a way I hadn't experienced since before my illness when I had shared an apartment with a friend.

I have learned a lot over the years and realized the advantages ▶

Co-ops as a Housing Alternative

Barbara Bawlf

As a person with a mental illness who has had to live on a fixed income in the past, I appreciate the need for affordable housing. It is difficult to find accommodation, especially in an urban setting when your budget for shelter is $325 per month (the amount currently available on welfare). A small, cramped room in a hotel or shared accommodation may be your only option in a city like Vancouver.

Co-operative housing can be a solution for people with disabilities provided they can pay the 'share purchase' of $1,000 necessary to get in. If this is possible, co-ops can prove a worthwhile alternative to renting. For your monthly housing costs, you either pay 27% of your gross income or the maximum housing charge (Regular Occupancy charge), whichever is less. For those whose income doesn't reach a certain level, subsidies may be available.

Currently, if the income of a co-op resident drops, and they cannot meet their monthly housing charges, it is possible for them to obtain a subsidy which can allow them to pay as little as 25-30% of their regular cost. The structure makes it ideal for people with mental illness given the unpredictable nature of such conditions which sometimes result in periods of unemployment. There are also various sources of assistance for individuals unable to pay the $1,000 share purchase price up front:co-op sponsored Disability Trust loans, low-interest loans from CCEC Credit Union (a financial institution composed of co-ops, community groups and their members), and an upcoming share purchase assistance program sponsored by the provinical government.

Co-operative housing was initiated thirty years ago under Trudeau's Liberal government. The idea was to supply needed affordable housing to accommodate seniors, families, and people with disabilities. The co-ops were built with federal money, with a small portion of provincial money going into a land-purchase system. Twenty years ago, the "56.1s" were built with strictly federal funding. The co-op in which I live is called a 56.1, after the number of the operating agreement under which it was founded. There are other co-ops with different initials or numbers, but they are federally and provincially funded.

There are many reasons why co-ops are good alternatives for people with mental illness. They are affordable, with housing costs for a one bedroom less than $600 a month (at least in my co-op). Also, the monthly charges are based on your income, which means that as your income changes, so do the charges, resulting in an affordable living situation. Another benefit of co-op living is that there is often a strong sense of community creating a support network for people with disabilities and instilling a feeling of belonging. For a person with a mental illness, loneliness and isolation are often two major problems. Having the option of socializing with others provides some comfort for the individual. There are usually many social activities and volunteer tasks available in the co-op, hence an opportunity for meeting people. A feature of the co-op not shared by many other facilities is that one is allowed to own a pet, a condition which has been seen to enhance the quality of life for most of us, and especially for people with disabilities. Pets are good companions, and their pres-

Barbara works at CMHA BC Division in the area of consumer issues and peer support. She also administers the Lorne Fraser Educational Fund.

of satellite housing like the freedom and delight of knowing that absolutely no one knows that you are a mental patient. I can come and go in this building free of worry. If I choose to stay home all day and sleep, the manager isn't going to wonder if I'm depressed or something.

Our rent is subsidized here. We still have to watch our funds, and yes, most of our money is gone before payday, but there is a lot to do in the West End that is free, so one doesn't have to be rich to live here. We can go for long walks in Stanley Park or go window shopping on Robson Street.

The subsidy used to be paid by Coast to the landlord. The way it worked was that Coast paid our rent, and then there was a monthly meeting at Coast where we paid our share of the rent to them. Recently, however, they have been sending us the subsidy directly. Consequently, we pay the landlord ourselves, so they have no reason to feel we are any different from any of the other tenants.

We still have contacts at Coast. Our coordinator meets us in a local café when we want to, just for a chat. When we run into problems, all it takes is a phone call to her and she is extremely helpful and kind.

This is my tenth year in satellite housing. I have come to appreciate a great deal the satisfaction it has brought. I am no longer seen as a mental patient by neighbours who know too much about me. Instead, I am simply a neighbour. I look no different, I act no different, and even though my lifestyle may not be a nine-to-five working lifestyle, no one knows. I have come to appreciate my life more. It is full, I am independent and even though I still live on the poverty line, I feel rich.

I am no longer surrounded by other mental patients all waiting for cheque day so we can all run out and go grocery shopping. Environment does make a difference. I truly feel that being in a more normal environment like satellite housing, as opposed to [other] supported housing has made me more comfortable with my situation. The waiting list is long, and it can be intimidating at first. But it is worth it. ■

So why is it called "satellite" housing?

Traditional housing programs for consumers are often apartment suites in the same building or block. The term "satellite housing," then, differentiates it from the more traditional approach because suites for consumers are scattered in "satellite" fashion in various buildings.

ence has been found to lower blood pressure in humans.

The co-op I live in is called Kinross Creek. It is located in Champlain Heights in southeast Vancouver near the Burnaby border. I am surrounded by woods and there are walking trails behind me. The atmosphere is so incredibly quiet you could swear you were in the country. I have a 700 square-foot apartment with a patio facing the trees. I also have a wonderful cat called Mozart and I can attest to his therapeutic properties. My involvement in the co-op is about right for the amount of free time I have. I write editorials for the newsletter, clean the laundry room once a month and try to attend as many general meetings as I can.

Safe, affordable housing is important for all of us, but particularly for those with a mental illness, many of whom are on a fixed income and require a stable living environment. A co-op provides all these necessary requirements, and for me has proved a wonderful place to call home.

In order to get into co-op housing, you should first acquire a list of co-ops that are currently taking members. The list can be obtained from the BC Co-op Housing Federation Information Line at (604) 879-5112. It describes availability, housing charges, and the number of available subsidies. The most difficult units to get into are usually those that are two bedrooms and up.

After you have received an application form from the co-op(s) of your choice, you complete the form, return it, and await a call for an interview. I was interviewed by the co-op's Membership Committee approximately five months after applying . The questions I was asked mainly had to do with my reasons for wanting to live in the co-op and what I thought might be a negative aspect of community living. After my first interview, I did not get a place in the co-op because I was second on the waiting list, but two months later I was accepted. It's difficult to assess how long the actual process is from application to acceptance, but for me it took approximately 8 months. The waiting period is dependent on a number of factors including movement both in and out of the co-op.

Call the BC Co-op Housing Federation Information Line for further information regarding co-op housing. You can also visit their web site at www.vcn.bc.ca/chfbc ■

Life in a Group Home

Chuck West

Chuck lives in Cranbook, BC.

The following passages are excerpted from a story sent to *Visions* by Chuck West of Cedar Ridge Manor in Cranbrook. He writes: "I am a mental health consumer and have lived in a group home for 13 years. I think [it] would be helpful for other consumers, families, the public, and professionals to hear my story so they can understand that mental illness is very difficult. Enclosed is an article I wrote about my life with mental illness and how the group home has helped me…"

"I was living in hell when I grew up. I was a mixed-up kid at the time. I was kicked out of my mom and dad's home. It was about 21 years ago that I left my home town when I got sick and I was put in the hospital for two weeks.

The first eight years on my own were tough. I was out living in an apartment, I got my first job, and then I got into the booze and drugs. It was lonely (I still haven't had a date with a girl) and people seem to forget you're in town — sometimes even your family and old friends — because they think the way the media portrays people with mental illness is true. But we are no different from anyone else. I hate being left out of things.

I've been living in the group home for thirteen years. I don't mind it at all. It has excellent values to help you with your problems and it has very good help if you use it and willingly help yourself…but I wish they would raise the comfort allowance because the cost of living goes up. I've had volunteer jobs the thirteen years I've lived in the group home. I meet so many interesting people who live here… [but] I wish people would phone me and have coffee with me and go fishing or hiking or horseback riding, so they could see we are no different than them…" ■

Independent Living vs. Interdependence:

A Particular Tension for Families from Diverse Ethnocultural Backgrounds

Promoting independent living is a major thrust in housing programs for people with mental illness — and rightly so. For too long, people have lived dependent lives in institutions or in institution-like boarding homes. In our push to promote independence, however, we tend to overlook the interdependence between the person with mental illness and his or her family and support network. Education aimed at helping members of the support network to be supportive becomes crucial.

This is true when the family has been thrust into the caregiver role for a person living at home and is especially relevant for people who come from cultures where stronger family bonds are valued and promoted. The following passage, excerpted from The Australian Transcultural Psychiatry Newsletter *Synergy*, describes some of the issues from the perspective of a woman of Greek heritage whose son has schizophrenia and lives at home:

The trauma for us started as we saw our sports-loving, witty son and brother turn into a walking zombie, screaming and yelling, then laughing out of control. I rang and spoke to the nurse at the clinic for help because the symptoms were getting worse. I was told that he presented reasonably well on his visits and that I must remember he has schizophrenia.

We transferred to the private system. "Yes, your son has paranoid schizophrenia," I was informed. "If he takes his medication, his symptoms will improve."

Well, his symptoms didn't improve, so I kept ringing the psychiatrist for him to listen to what I was noticing. "She is an over-protective Greek mother," wrote the psychiatrist to my referring GP.

That conclusion was decided after I tried to tell him of my observations of new and strange behaviours even on large doses of medication. "He presents in control at his appointments," I was told. "I think he should live away from home," I was advised. "Being independent will help him." My anxiety level rose to such a level that it created great tension in the family.

When I told my husband the advice given by the psychiatrist, he made a very poignant statement. "Kali, our boy is very ill. He wouldn't be screaming and punching holes in the walls if he was well. We must help him get through this. Why should we ask him to leave his home? If he had a diagnosis of cancer and the pain was so bad wouldn't he scream out of frustration? Would we tell him to leave? We would nurse him and nurture him and work with the doctors."

The issue of independent living is a serious one and causes a great deal of conflict, especially within various ethnic groups whose family loyalties are very tight. Many times mental health professionals don't understand these family traditions.

Nowadays, the relative with mental illness is discharged from hospital after very short stays and is placed in the care of their families, often having not recovered well enough from the psychosis. It is imperative that the worker understands the family dynamics and arrange for support and education for the carer, who must be heard and understood. To be interdependent is what should be fostered and nurtured.

Service providers need to see their work as a process of collaboration with consumers and carers in which everyone works together in partnership to develop the most effective strategies for dealing with the illness. By listening carefully to both consumer and carer, certain problems that arise within their relationship can be addressed in different ways using different techniques.

There is, for example "The 14 Principles of Coping" course available through the Schizophrenia Fellowship, which is taught by relatives who have gone through the experience and have gone through a teacher training program [in British Columbia, the similar Family to Family program is available through the BC Schizophrenia Society].

"To be interdependent is what should be fostered and nurtured. Service providers need to see their work as a process of collaboration with consumers and carers."

Looking back to the beginning of my son's illness, I'm convinced our anxiety levels reached such a point that they worsened my boy's illness. I now understand that "anxiety is contagious." The term "Expressed Emotion" is not just a term used in psychology. I have experienced it dealing with many mothers that I have worked with. When there is collaboration between all parties, these experiences can be shared and solutions found.

Excerpted from *Synergy*, the newsletter of the Australian Transcultural Mental Health Network. Vol 1, No. 3, Christmas 1999.

Consumer-Run Housing Options

Jasmeet Bhullar

Jasmeet is a psychology undergraduate at Simon Fraser University and is working at CMHA BC Division on a number of education projects including Open Mind Media Watch.

The following consumer-run agencies provide brief crisis intervention in a "home-like" setting, long-term housing, or assistance in finding a house.

The Gerstein Centre

The Gerstein Centre is funded by the Ontario Ministry of Health, Community Health Branch and offers non-medical, community-based crisis services to consumers in the city of Toronto. The target group is people 16 years of age and over who are experiencing an acute crisis and severe or persistent mental health problems. The goal is to provide people with the support they need to remain in the community and avoid hospitalization when possible. Both self-referrals and second party referrals are accepted.

The Gerstein Centre offers three services: (1) crisis workers, available 24 hours, provide telephone crisis intervention by helping callers find effective ways of dealing with their problems and finding appropriate referrals; (2) a mobile crisis team is available to meet people in the community. The meeting place is arranged at a suitable location such as the caller's home, a coffee shop, or another convenient location; and (3) the residential crisis intervention centre provides a safe, supportive environment to help the person get through his or her crisis. Ten beds are available and the average length of stay is three days. For more information, go to the web site www.gersteincentre.org or call (416) 929-0149.

Seneca House

Seneca House is a non-profit organization primarily funded by the Winnipeg Community and Long Term Care Authority, Province of Manitoba. The word "Seneca" refers to a "healing root," reflecting Seneca House's healing qualities. Short-term crisis support is provided for people 18 years of age or older with mental health problems. Peer counselors help people deal with their crisis, provide resources, and help clients with problem-solving and goal-setting. Assistance is provided to individuals to become "empowered in their own recovery process" and to prevent hospitalization. Seneca House is open 24 hours a day, seven days a week.

Five rooms plus food and laundry facilities are available. An initial screening is done by staff over the phone. Clients are asked to provide a reference and the check-in process is completed upon arrival at Seneca House. Individuals may either self-refer or may be referred by someone else. All individuals must meet the eligibility criteria. The length of stay is seven days at a time, after which the person can access the service again after a minimum of seven days. Seneca House also has a Help Line and a Mobile Crisis Unit. To contact Seneca House, call (204) 231-0217.

Unity Housing

Unity Housing is a housing society funded by the Vancouver Richmond Health Board and administered by the Portland Hotel Society. It provides affordable housing to individuals living in a substandard, unsafe, or unhealthy environment. This service has five houses for twenty-five people with mental illness and is open to anyone who has experienced the mental health system. Some of the consumers include people who are not connected with care teams, people who are resistant to medication, and people who are hard to house. Since Unity Housing has only one external staff person and there are no staff available in the houses, individuals must be able to take care of their basic needs. Unity Housing offers peer support and helps individuals liaise with other mental health organizations.

The intake procedure involves an initial screening by the Housing Manager, followed by a meeting with the members of the house. In an attempt to build community, individuals live together, take care of each other, and participate in group facilitation.

In addition, two outreach workers ensure that the staff is aware of people's mental health. Workers also organize community-building events such as a trip to Silver City, a video night at one of the houses, inner tubing at Mount Seymour, and skating at Britannia ice rink.

According to statistics for the year 1999, 40% of members have lived in Unity for more than two years, 60% have lived in Unity for more than one year, and 20% have lived in Unity for less than one year. Contact Unity Housing at (604) 801-5334.

Lower Mainland Community Housing

"Let's Help – Mental Health Housing" is a free housing service provided to mental health consumers by mental health consumers. Services provided by this organization include searching for a house in the Lower Mainland (excluding Vancouver and North Vancouver), information on market rental housing, referrals to other agencies, landlord-tenant counseling, and welfare advocacy. Lower Mainland Community Housing can be reached at (604) 525-5376.

Kelowna Mental Health Registry Proposal

The Kelowna Mental Health Registry has proposed the "development and maintenance of clean, affordable accommodation, education about mental illness with landlords, and provision of safe and supportive transportation for prospec-

tive tenants to view accommodation possibilities in the Kelowna area." This task is to be undertaken by three consumers who will operate the Housing Registry. The resource will be available to anyone with a mental illness as well as family members or friends looking for accommodation on behalf of someone with mental illness. It will provide support and problem-solving for landlords who have tenants with mental illness and tenants who are looking for housing. This program will also (1) provide a stable environment for people with mental illness, (2) educate the community in order to create awareness and reduce the stigma associated with mental illness, and (3) reduce the pressure on formal mental health and community services in Kelowna, since having adequate housing will improve mental stability. ■

Giving Residents a Voice:

The All Consumers Housing Council

Sheila Gamblen

Why not have a group in place that can help people with mental illness living in mental health residential facilities network with each other? This was the thought of several residential consumers in 1997 interested in forming such a group of peers. The All Consumers Housing Council currently consists of a Project Manager and eight members who currently live at a residence or have lived in one for at least a year.

THE RESIDENT

The Newsletter of the All Consumers Housing Council

join us!

Monthly meetings are held on the second Monday of every month (except July and August) at the MHRS Board, 1970 West 4th Avenue, Vancouver, from 7:00 to 8:30 pm. Any resident is welcome and encouraged to attend. Council vacancies are posted at the residences where all residents are eligible to apply. For more information about the Council, contact Sheila at (604) 734-5265.

Now entering its fourth year of operation, the Council still works toward its mission statement: "to provide consumer liaison to all mental health residential care facilities and group homes in Vancouver and Richmond in order to enhance the living conditions of the residents." Funding through the Consumer Initiative Fund at Vancouver Community Mental Health Services allows it to continue pursuing this mandate.

Some Council Projects

- **Residential Bill of Rights.** The Council has been working on the Bill since last summer. There has been consultation with all stakeholders — including all-important residence service providers — and it is anticipated the Bill of Rights will be ready to post at all residences by the end of April.
- **Buddy Program.** The Council runs a peer orientation program where most residences have a resident that acts as a buddy to newcomers. They introduce the person to the household, to services in the area, and accompany the person to their first medical and dental program.
- **Newsletter.** The Council started publication of a newsletter, *The Resident*, in the fall of 1999. It is published four times a year and distributed to all residences in the area covered by Greater Vancouver Mental Health Residential Services (MHRS). The mandate of the newsletter is to inform the residents about what the Council is doing, to publish articles written by residents, and to provide light-hearted fare.
- **Contests.** There are three contests held yearly at Christmas: writing, poetry, and drawing. The winning entries are published in the newsletter. In addition, prize money is awarded to the 1st, 2nd, and 3rd place entries in all three categories.
- **Outreach.** In the coming year, the Council hopes to institute an Outreach Program where Council members will go to the residents in their homes to provide information about the Council and what it's doing. Encouragement will be given for residents to provide feedback as to what other activities they would like the Council to undertake. The Council has also been considering extending its outreach to other consumers in different residential situations.
- **Web site.** The Council will be preparing a web site this year to provide general information about the Council. The site will contain the mission statement, member responsibilities, history, present Council activities, Buddy Program news, and contact information. ■

Sheila is Program Manager for the All Consumers Housing Council. She is also Rehabilitation Assistant with the Vancouver Community Mental Health Services' Art Studios.

Housing Issues Brought Forward to the Provincial Mental Health Advocate:

"The Numbers Don't Add Up!"

Nancy Hall, Ph.D.

Nancy Hall is the Mental Health Advocate of BC.

In the old institutional mental health system, care, housing, and sustenance were brought together. In the new community mental health system, the providers have uncoupled care, housing, and sustenance and left it for the person with a mental illness to put things back together. Unfortunately, the process of finding housing is a frustrating experience for the consumer. The purpose of this article is to articulate some of the issues raised by consumers and advocates who called the Mental Health Advocate's Office for assistance in housing issues.

First and foremost, there is an issue of supply. Using common prevalence figures, there are an estimated 60,000 people living with serious and persistent mental illness in BC. Figures from the Ministry of Health note that combining all available housing options from group homes to SIL units, there are approximately 5,000 spaces. Riverview, the Forensic Psychiatric Institute, and provincial jails "house" another estimated 1,300 people with mental illness. The rest are left to fend for themselves or stay with their families. Consumers complained about the long waiting lists for housing, especially those living in Vancouver where the wait list is over 2,700 people. Some contacts to the Office reported very inappropriate, make-do arrangements such as a mother who called to complain because her 21 year-old daughter with schizophrenia was housed in a care facility with Alzheimer's patients.

The Mental Health Plan targets 2,600 housing spaces as well as 244 residential spaces for the "hard to house." Since March 1998, 318 units of supportive housing and 170 units for the hard to house have been added. People often assume that government has failed to resource this issue but experience with the first wave of housing funding associated with the Mental Health Plan suggests that many units are vacant and the programs are not being run at capacity.

Secondly, there is the issue of access to affordable housing. The BC Benefits shelter allowance of $325 does not allow the person with a mental illness to participate in market housing. For example, the average rent of a bachelor suite in Vancouver is $585 per month. Some who contacted the Advocate reported that they felt forced to live in substandard housing because of the social assistance levels. That Mental Health now subsidizes some consumers' rents with "SIL" (Supported Independent Living) subsidies means that there are actually two tiers of care established, with the "SIL" haves and have-nots. A system with greater equity would see the Ministry of Social Development and Economic Security raise the shelter allowance for everyone on Disability Level II to reflect market rates and enable the person with a mental health disability to find market housing. Some advocates argue against this, suggesting that slumlords would raise the rent of existing low-income housing and the money would not go to the person. Others suggest that raising the shelter rate would allow mentally ill people to move outside of the downtown low-income ghettos and participate in community life.

Access to housing has become even more complicated in the regional health care system. One consumer called who, having moved across the street, was in another health region and thus ineligible for his SIL subsidy. The whole issue of portability of basic benefits such as housing subsidies should be examined, as portability is a basic condition of Medicare which appears not to be possible in the regionalized system.

Innovative Housing directions:

- **Richter House in Kelowna:** A transitional housing program for those leaving the hospital. Established by John Campbell, the Kelowna advocate working with CMHA and the Mental Health Program. For more information, contact Jennifer Marte, CMHA Kelowna, at (250) 861-3644.
- **MPA Housing for Single Mothers:** Contact Barry Niles, (604) 738-2811, for more information.
- **Youth Hostel:** Capital Health Region is setting up a boarding home near the hospital that will act as an Early Intervention Treatment Centre for youth who are newly diagnosed. For more information, see the article by Dennis Suwala later in this issue. ■

The Best Practices in Mental Health Housing Report:

Its Impact in Vancouver

Arleen Paré

The recent provincial *Best Practices for Mental Health Housing Report* is an excellent document and well worth the read. It was written primarily to help BC communities to develop the best mental health housing possible. It offers guidelines and recommendations for planning, developing, and operating improved mental health housing.

In Vancouver, we have decided to use the Best Practices Report as a template to help us improve our mental health housing. It will also help us to develop a mental health housing system for the future. The report's recommendations are sensible, and where possible, are supported by research, field experience, and/or consumer preference.

The report stresses that:

- the Supported Housing option should be emphasized
- communities should offer a *range* of mental health housing
- consumers and families must be involved in *all* aspects of housing
- housing for populations with special needs should be addressed
- access to housing should be improved
- the principles of psychosocial rehabilitation and recovery must guide housing services delivery.

It was useful to note that a number of recommendations are already in place in Vancouver:

- a wide range of mental health housing options currently exist, including a variety of residential care homes, supported block apartment buildings, group homes, a Supported Independent Living Program (SILP) and SuperSIL (with more intensive staff support), and a Step-Down home. In the next few months, an enhanced supported block apartment building (with meal services) and a dual diagnosis residential home will open (for more information, contact Barry Niles at the Mental Patients Association at (604) 738-2811)
- some housing for those with special needs is provided, including a home for the older and frailer population, and women escaping abusive situations (for more information, contact Janet Smith at the Kettle Friendship Society at (604) 251-2854)
- both residential and supported housing wait lists are centralized and well maintained
- residential system staff have completed full performance reviews of all residential community homes
- staff and consumers are currently developing an outcome measures tool for evaluation of the supported housing system
- supported, residential, and emergency housing programs all report utilization statistics which are reviewed and published in an Annual Housing Report
- residential system staff have supported the development of an All Consumers Housing Council.

Despite the progress made so far, there is still plenty of room for improvement.

Having adopted the report as a guide, we hired a team of housing consultants to help us find more ways to

Arleen is the Acting Director of Mental Health Housing for Vancouver Community Mental Health Services and was a member of the Best Practices in Mental Health Housing Working Group.

Consumer and Family Perspectives: Related Resources

- *Community Housing Project*: a survey of the housing situations of consumers living in the downtown core of Vancouver, done by the Mental Health Action Research and Advocacy Association of Greater Vancouver. For more information phone (604) 689-7938, toll-free 1-877-689- 9991, or see their web site at http://home.istar.ca/~mha_adv/
- *Now That You Ask: A Model for Consumer/Survivor-Driven Evaluation of a Community Mental Health Agency*: produced by Community Resource Consultants of Toronto, this tool outlines an approach for evaluation of a housing service, based on qualities of service which clients perceive as valuable. Parts II and III contain instrument, protocol, and review of evaluation process. Order at www.crct.org/education.htm
- *"Apartment Dwellers Skill Kit":* a weekly course offered in a small-group setting using self-paced curricula; offered as part of the Skills Training Exploration Program (STEP) run by THEO BC (formerly Arbutus Vocational Society). For more information, phone or e-mail Carrie Gadsby at (604) 872-0770, cgadsby@theobc.org, or visit their web site at www.theobc.org
- *The Independent Living Guide* (2nd Edition, 1995, Community Resource Consultants; 96 pages): Information for people living on their own. Topics include cooking, nutrition, budgeting, cleaning, and tips on how to make your place a home. Ordering information at www.crct.org/publ1.htm
- *Family to Family Program:* a 12-week course for family caregivers. For more information, contact the provincial office of the BC Schizophrenia Society (BCSS) at (604) 270-7841, or see the phone book for the nearest local BCSS branch.
- *British Columbia Schizophrenia Society Respite Services:* support for families who are caregivers for a person with mental illness who lives at home. For more information, contact Program Coordinator Brenda Blanchard at (604) 608-0477.

implement its recommendations. Jim Woodward, Debbie Kraus, and Margaret Eberle have agreed to work with the mental health housing community — consumers, family members, housing staff, and service and care providers — to help us identify gaps between the Best Practices Report and the way housing is delivered in Vancouver. They will conduct interviews, focus groups, and consultative forums which will help them prepare an implementation plan for Vancouver. We expect to be considering new housing models and new ways of delivering services for the future. It is exciting work and we look forward to the discussions that will result and the improvements that will develop.

If *you* have suggestions for mental health housing improvements, please fax them to me at (604) 874-7661. If you have any questions about the projects mentioned in this article, please call me at (604) 874-7626. ■

Related Resource

Vancouver/Richmond Health Board. (2000). *Strategic Plan for Housing Services: A Discussion Document.* This document is intended to stimulate dialogue about future directions in housing in the Vancouver/Richmond health region. For more information, contact linda_thomas@vrhb.bc.ca

Moving Towards Best Practices in the Capital Health Region

Dennis Suwala

Dennis is Manager of Facilities and Tertiary Care for the Capital Health Region and was co-chair of the Best Practices in Mental Health Housing Working Group..

The Mental Health Housing Team in the Capital Health Region (CHR) has been initiating changes in the Region's housing program in order to better meet the needs of people with mental illness and to implement the goals as identified in the best practices literature.

Over the past two years, four surveys have taken place in order to provide direction to the program. The surveys included an initial tally of the present and preferred housing needs of 1,060 people with mental illness. A second survey, done by a consumer group, surveyed people about their satisfaction in bridging [transitional] or independent living situations, and about improvements that could be made. A third study was carried out after training sessions by a peer group of consumers, family members, and clinicians from Duncan who surveyed all 12 residential facilities in Victoria. The fourth study also surveyed people in residential facilities, identifying reasons why people were in a residential setting and looking at whether there were individuals who could instead be living in supported independent living.

Supported Independent Living

From the first survey, it was apparent that the major need was for supported independent living. There is a constant wait list of over 180 people for supported independent living programs. At the same time, great efforts have been made to increase the numbers of these resources and to move people from other inappropriate housing. The housing stock keeps increasing thanks to the generous support of many agencies. For example, one low-cost housing program uses a rent subsidy from BC Housing, an agreement with a private landlord for the use of apartments, support from the clinical teams, and property management from a non-profit society, using funds from the Capital Health Region.

The partnership program with BC Housing has been most valuable in identifying resources so that agreements are in place with several private landlords for access to apartments and apartment blocks.

Residential Housing

From the residential housing survey, it appeared that one main reason why people remained in residential settings related to symptoms of the illness or to behavioural and safety issues. Follow-up from the survey results will continue in order to make certain that care and rehabilitation plans clearly state the issues that need attention, as well as to ascertain if these issues can be addressed in supported housing rather than in residential settings.

Another main reason for living in a residential setting related to disincentives in the programs themselves. The most consistent example is where people who are ready to move into more independent living situations are discouraged from doing so by their caregivers. The caregivers find the present situation to be beneficial since their workload is less than if new people were admitted into the facility.

One improvement is that the residential facilities have been divided into three categories according to the intensity of the care and rehabilitation programs needed by individuals. This allows for the development of specialized programs and the development of a culture of care and rehabilitation geared to the specific needs of the residents.

Another ongoing reform is the implementation of psychosocial rehabilitation. There is more and more evidence that housing workers are implementing this approach; for instance, over the past year, 77 people have been able to move out of residential settings into other accommodations. The enrollment in the bridging program within the facilities has gone from 19 to 41 people. (This program offers transitional housing and support to people in preparation for their moves to more independent living.) More moves are anticipated in the following months as people benefit from these resources.

Best Practices in Housing:

Simon Fraser Health Region's Response

Diane Miller

Diane is the Manager of the New Westminster Mental Health Centre.

The Simon Fraser Health Region (SHFR) currently has a total of 590 units of housing for people with serious mental illness. This includes 10 short-stay crisis residential beds, 238 licensed residential beds in 16 facilities, 7 family care beds, 228 SIL units, and 107 supported living units (not classified as SIL).

The Region endorses the Best Practices Housing Report and its mission, beliefs, values, and goals. This report strengthens the direction outlined in the SFHR Strategic Plan, which is to focus on supported housing consistent with consumer preference, to develop new housing options, and to implement significant quality improvements in the existing residential program.

Focusing on Supported Housing Options

Over the past 3 years, SHFR has focused on increasing the range of supported housing options:

- since 1998, 66 additional SIL units have been added, representing a 40% increase
- 2 group homes with a total of 9 beds have opened in the last two years
- CMHA staff at St. John's House in Maple Ridge and Barnabus House in New Westminster provide daily support to a group of residents in congregate living
- the MPA Cottages at Riverview (transitional housing) recently expanded by 6 cottages (18 beds) for a total of 8 cottages with 23 beds. Staff support in the MPA Cottages is available 12 hours a day, 7 days a week
- Maple Ridge – Pitt Meadows Community Services Society has developed a life skills program in an apartment unit to teach individuals the skills necessary for independent living, prior to moving into supported housing.

New Developments in Housing

The Region will continue to increase the housing choices for consumers in the future:

- a partnership between BC Housing and Pioneer Community Living Association is developing an apartment block on the Community Residential Short Stay Emergency Treatment (CRESST)/Pioneer property with an additional 23 supported living units scheduled for occupancy in January 2001
- Maple Ridge Mental Health Centre and Mental Patients' Association are developing a 13-bed transitional housing facility to expand the range of supported housing options in that community, with an anticipated opening of April 2000
- in addition, the Region is working with BC Housing, Lookout Society, and city planners to develop a shelter for homeless individuals in New Westminster. As an interim measure, the Region assists in funding a program to provide shelter ▶

In June, a new 6-bed, active rehabilitation residential facility will open for people experiencing their first break of a mental illness. This facility is intended for people who presently are not able to live independently or to return home. Every attempt will be made not to institutionalize people in a residential setting, and towards this end, individuals who choose this option will be able to learn about their illness and to stay connected with their community. The length of stay is estimated at 8–12 months.

Providing Choices and Options for Support

Providing sufficient choices and options for care, rehabilitation, and crisis situations continues to be a major challenge. The Housing Team has tried to meet these needs through regular care and rehabilitation programs, and also by accessing additional care and crisis funds. Three contracted agencies are currently accessing funds in order to provide flexible, short-term emergency housing. The agencies work with the BC Benefits program to ensure as few people as possible end up losing their accommodations or, alternatively, are assisted in finding short-term accommodations. The ultimate hope is that people will remain stable or regain stability in their own housing so that fewer people need to be hospitalized or end up homeless on the street.

A final improvement has been the creation of a Facility Care and Housing Access and Information Package in order to assist people in understanding and accessing housing.

There is such a long way to go in housing, but the team members remain motivated by their own dedication and by the their desire to meet the housing needs of people with mental illness, as identified by consumers themselves, family members, and by mental health clinicians.

For more information about this article, contact Dennis Suwala at (250) 952-4322 or Dennis_Suwala@caphealth.org. ■

▶▶ Wendy, a resident, and Janet, CMHA-contracted supervisor, in front of Barnabus Transition House in New Westminster.

and food vouchers in a hotel for six people who are without lodgings.

Quality Improvements in Residential Services

The Region's Community Residential Program is a significant component in an integrated system of care for people with mental health problems. Access to appropriate, affordable housing along with the necessary supports for treatment, rehabilitation, and supervision are instrumental in helping individuals reach and maintain an optimal level of functioning.

The SFHR's long-range Residential Services Strategic Plan is providing direction to the SFHR Mental Health Services (MHS) in developing and reshaping residential services to meet the needs and expectations of our residents. The Strategic Plan will also guide the process of making significant quality improvements to existing residential services that are consistent with best practices in the field.

The SFHR MHS has recently completed a review of the residential program based on best practices recommendations. The primary outcome of the review has been the development of a draft set of new operational standards and a facility review process. Each standard will eventually include *outcome indicators* and evidence required for compliance. These have been presented at a formal meeting of facility owners, managers, consumers, family members, and licensing and mental health staff for feedback. The next steps in implementation of the new standards and facility review process include developing indicators for compliance, test piloting the process, incorporating feedback into a final draft, and beginning formal facility reviews by the Fall of 2000.

For more information, contact Diane Miller at (604) 660-8622 or e-mail her at Diane_Miller@sfhr.hnet.bc.ca ■

Glossary term:
"outcome indicator"—a marker associated with quality or program success that can be measured. An example might be "the percentage of people within residential facilities that have a private bedroom."

CMHA Simon Fraser Branch Housing and Community Support Evaluation:

Key Findings and Follow-Up

Catharine Hume

Community agencies are striving to improve existing housing programs in order to respond to the preferences of people with mental illness. The following article describes CMHA Simon Fraser's evaluation of its housing programs and the steps it has taken to address the recommendations arising from the evaluation report.

Catharine works at CMHA BC Division. She was the facilitator of the Housing and Community Support Evaluation project.

Background

In 1997, CMHA BC Division was contracted by the Simon Fraser Branch to conduct an evaluation of their housing and support services. Services to be evaluated included Bluebird House (a five-bed short to medium-term home), 16 semi-independent living (SIL) units, 15 scattered BC Housing units managed by the agency, and 35 community living support contracts.

A total of 34 peer interviews were conducted with consumers about these services — including some consumers who were not receiving housing support.

Housing Satisfaction

We found that the majority of people (62%) who received a housing subsidy were satisfied with their housing, while only a minority of people (35%) without a housing subsidy were satisfied with their housing.

While more people with housing subsidies were satisfied then those people without, the level of housing satisfaction among people who received subsidies was lower than anticipated. Concerns included:

- being on the first floor and being concerned about safety and security
- not having an adequate say in their housing selection
- poor building maintenance
- poor relations with neighbours
- poor location.

Many peer interviews were conducted in people's homes. Interviewers noted that there was often minimal apartment comfort in terms of furniture and accessories both for people in subsidized and unsubsidized housing.

Criteria for Receiving Housing Subsidies

People were asked to describe a fair way to decide who should receive housing subsidies. Overall, respondents felt that housing subsidies should be available to a wider range of people than those coming out of residential programs. One interviewee, in particular, spoke about how the subsidized housing system felt more like a lottery than a fair process and, for that reason, had decided not to put her name on a waiting list despite her dissatisfaction with her current housing.

Bluebird House

Most people had positive feelings about their experiences with Bluebird House and appreciated the freedom and flexibility that Bluebird offered. Almost all respondents, however, had significant concerns about the general lack of staff support and supervision.

A number of people identified that the additional stress this placed on them resulted in the feeling that they had to "take on" other tenants' issues or problems. People described the need for staffing that allowed real relationship-building to happen both between residents and staff, and among residents themselves.

Semi (Supported) Independent Living Program

The findings for the SIL program were different than expected in that both overall program satisfaction and housing satisfaction were lower than anticipated. CMHA staff and consumers expressed concerns with the required monthly support visits. While some people found these visits essential, others felt that they were intrusive and unnecessary when they were well.

BC Housing – Scattered Apartments

The people interviewed were very satisfied with their housing and the program overall. People involved in the BC Housing program identified a significant program impact in terms of their personal sense of security.

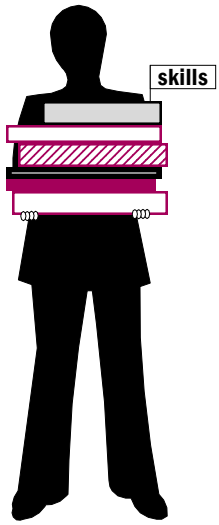
Recommendations and Branch Follow-Up

The following passage lists key report recommendations and describes steps being taken to implement them.

- ☑ Set up a follow-up committee made up of the Executive Director, people who have received services, and at least one staff person and one member of the Board of Directors to develop plans for addressing priority areas. [A housing steering committee was established and continues to meet on a regular basis. The first priority for change identified was Bluebird House and work has focused on strengthening this program.]
- ☑ Review the evaluation results and develop a clear statement of purpose for Bluebird House.
- ☑ Review the evaluation results and develop a clear job description for the Bluebird House staff person that includes an emphasis on relationship-building and facilitating

What Makes a Good Housing Support Worker?

Catharine Hume



(Based on an interview with Louise Groves, CMHA Simon Fraser Branch's Housing Coordinator)

As we continue to move towards semi-independent and independent housing options for people, housing support workers will become an increasingly larger part of the mental health workforce. While there are no doubt many different kinds of people who are effective housing support workers, we wanted to hear from a local Housing Coordinator about the things she looks for in selecting new workers.

Key skills and knowledge for a housing support worker, from Louise's perspective, include:

- flexibility regarding scheduling and in overall approach to working with people
- being an independent worker who requires minimal supervision as most of the work is done outside of the office in people's homes or other community settings
- having an understanding of the principles underlying CMHA's *Framework for Support* including the importance of (a) seeing people as people rather than as clients and (b) supporting people to direct their own care
- having knowledge about a variety of mental illnesses and key symptoms
- being a team player with an ability to learn from and support colleagues
- being quick on one's feet and able to adapt to unplanned events or situations
- having the ability to take over in a crisis and support the person to make choices — often limited ones — about next steps
- ability to be direct and clear about your role and your ongoing relationship with individuals
- having an awareness of the range of options for involvement in the community
- being resourceful in terms of supporting people to access this range of options
- recognizing the importance of establishing trust with the other person.

It is interesting to note that many of these same skills are recognized in "The Community Support Skills Standards Project" as key competency areas and skills for human service workers in direct service positions. This project, based in the United States, is part of the Human Services Research Institute (HSRI). It states that:

"the field of human services is rapidly changing with the challenge of providing more individualized, community-based services with fewer resources and growing numbers of people who need support. As a result, programs and staff knowledge and skills must change to reflect the demands of the new environment. Human service workers must know how to work with service participants and families to weave together a vast array of community resources, specialized assistance, and natural supports to promote well-being, empowerment, and community membership."

For more information on this project, you can visit their website at www.hsri.org/skill/csss.html ■

"CMHA Simon Fraser Housing Evaluation" – (cont'd)

intra-house communication. [A number of changes have taken place at Bluebird since the evaluation. The house was painted and re-organized to signify a new start. Clear house rules were established including weekly meetings and regular talks scheduled on areas of interest. People are encouraged to become involved in community activities and are required to connect to the mental health centre once they have been accepted into Bluebird. A goal of increasing staff hours to 10 hours a week has also been established.]

- ☑ Develop clear and consistent processes for deciding who can access Bluebird House and BC Housing subsidies.
- ☑ The second priority for change identified by the housing steering committee is clarifying the criteria for receiving scattered BC Housing units and work is beginning in this area.

Benefits of the Evaluation

Housing Coordinator Louise Groves identified the following benefits of being involved in a program evaluation that uses a participatory approach:

- ☐ provides opportunities to pull out a few key findings for follow-up
- ☐ helps the organization move beyond anecdote and assumptions
- ☐ provides a way to demonstrate accountability
- ☐ is experienced as empowering by consumers who are involved in the process and in follow-up. ■

Reference

Hume, Catharine. *1997-1998 Housing and Community Support Evaluation: Final report.* Canadian Mental Health Association, New Westminster [Simon Fraser] Branch. This report is available from CMHA BC Division.

Collaborating to Develop Affordable Housing and Support:

Nanaimo's Bob Currie Place Project

Mary Magrega

The following article describes the process of developing a housing proposal in Nanaimo. The focus will be on how a number of community partners came together and created this proposal. As a case study, it provides valuable lessons to people and agencies seeking to create new housing in their own communities in that it describes the range of players that need to be brought to the table and the conditions necessary to maintain a collaborative partnership throughout the course of the housing proposal development process.

Description of the Bob Currie Place Project

The goal of the Bob Currie Place Project is to provide 36 affordable apartments for people with chronic psychiatric disabilities. In addition, it will house, at cost, the programs of the Canadian Mental Health Association and the Nanaimo Mental Health Outreach Nurses. It will also bring together the administrative offices of the Columbian Centre Society, Advantage Management Services, and, we hope, a few other societies that serve the needs of the people who will live in the housing component of the facility.

Partners and Expertise Brought to the Project

The project is the dream of what we call the Nanaimo Mental Health Collaboration Group. Each of the partners on the Group brings a particular expertise to the project. In alphabetical order, the partners are the:

- BC Schizophrenia Society which brings knowledge of people's housing needs;
- Canadian Mental Health Association which brings knowledge of needs, programming expertise, and funding;
- Central Vancouver Island Health Region (CVIHR) which offers knowledge and funding;
- Columbian Centre Society offering experience in housing people with mental illness and funding and fundraising expertise;
- Friends of Schizophrenics Housing Society, formed by the Schizophrenia Society to enable fundraising and property ownership
- Nanaimo Mental Health Services Benefits Society, also known as Advantage Management Services, which brings property management expertise to the table.

This group makes up the steering committee. Other members of the Collaboration Group involved as advisors or community partners include:

- Nanaimo Mental Health Unit, a future tenant
- The City of Nanaimo, represented by Social Planner Alison Millward
- Nanaimo Credit Union, community partner
- Nanaimo Regional General Hospital.

Two individuals who are not, strictly speaking, partners but who are key participants in the process are our project consultant, John Jessup, and our architect, Jerry Ellins. Jerry was familiar to the group as the architect for the Columbian Centre Society's KC House (Supported Independent Living) and both have, I believe, contributed far more time and ingenuity to the project to date than has been covered by any fees.

Mary is on the Board of Directors of the Columbian Centre Society in Nanaimo.

Defining the Need

The people who will live in the residential component of Bob Currie Place are, at the moment, having a lot of trouble finding a decent place to live. A housing needs assessment conducted last year by the City of Nanaimo identified 90 existing medium to long-term and indefinite-stay units or beds, with a waiting list of 63, as of February 1999.

The proposed housing will provide 36 new units for independent living with support close at hand as well as opportunities for a sense of community in a stable setting. As an old bureaucrat and fundraiser, I would like to have more quantifiable information about the need. But perhaps it has been summed up best by Jim Draper of CMHA who reported at a meeting of the steering committee last month that he is already getting requests to be put on the waiting list for apartments.

> **"It has been a pleasure to work with people having such a commitment and willingness to find solutions."**

History of the Project

I first talked with Bob Currie, the former Executive Director of the Columbian Centre Society, about the project back in 1997 or 1998. At this time, the need for housing was recognized, and there was considerable — if somewhat theoretical — interest in collaboration among the agencies serving the housing and support needs of people with chronic psychiatric disabilities. Though it took some time to really get off the ground, the project got its start due to the vision of Bob, of Jim Draper from CMHA Mid-Island Branch, and of Jim Spinelli at the Nanaimo Affordable Housing Society. The availability of 500,000 dollars in seed funding — which came to be administered by the Columbian Housing Society

through the Central Vancouver Island Health Region — was the other main factor which got things started.

In the fall of 1998, a group consisting of the Collaboration members already listed, plus the Nanaimo Affordable Housing Society, met to discuss collaboration not only for housing, but also on sharing resources and presenting a united front on funding, advocacy, and other political issues.

In March 1999, a formal planning session was held, which gave the group focus and new vigour. This session was convened on behalf of the Columbian Centre Society by Carol Matthews and conducted by planning consultant Gavin Perryman. Originally, the intent was to focus only on housing, but the availability of the former Nanaimo Credit Union building inspired the idea of bringing support services and shared administrative space together under the same roof.

And then, in August 1999, the group began to develop the funding proposal. At this point, we were lucky enough to engage consultant John Jessup to guide us through the process of preparing the application. Nanaimo architect Jerry Ellins also agreed to get involved in our search for a workable location. Thus, the steering committee was formed.

We looked at a lot of properties over the next month or two. Our criteria were location (preferably close to downtown) and, of course, affordability. Gradually, we came to realize that the Nanaimo Credit Union property could not only meet our housing needs, but also the space needs of CMHA and the Nanaimo Mental Health Outreach Nurses.

We entered into a contract to purchase the Nanaimo Credit Union property and thank the Credit Union for its generous terms and enthusiastic support of the project. The net capital cost of the project at present is estimated at $1.2 million.

Making the partnership work: Keys to success and lessons learned

It has been a pleasure to work with people having such a commitment and willingness to find solutions to problems as they arise. A number of things related to the partners combined with the availability of seed money came together to give this project a life of its own: a commitment to an overall improvement of life in Nanaimo, awareness on a daily basis of the need, and an opportunity to make a contribution of money or expertise (or in two or three instances, a tangible benefit to the organization.)

One of the keys to our progress so far has been to find a really good consultant. Without someone familiar with the housing scene, the cost factors, the regulations surrounding such a project, the steps to be taken, and the order in which to take them, we would never have been able to act so effectively. Our consultant is John Jessup; we owe him a great debt of gratitude for his ability and energy.

Another key was beginning with a clear vision of the result we wished to achieve. We didn't formalize our collaboration beyond a letter from each organization stating a willingness to collaborate. It may have been a mistake not to formalize things up front, but so many things seemed to depend on so many other things that we didn't. We assumed that structural issues would resolve themselves as the project progressed.

Lesson #1 on collaborating (as opposed to co-operating, or merging, or any other form of joint action) is that there must be something in it for each party. In some cases, the "something" must be more than a sense of ability to make a useful, even if non-fiscal, contribution.

Lesson #2 from the process has been to develop a tolerance for ambiguity. The biggest problem is the necessity of dealing with unresolved questions. In turn, the biggest of these is the determination of actual operating costs. CMHA and Nanaimo Mental Health are both committed to becoming tenants, provided that the cost is within their reach. Here, the ability to tolerate ambiguity has been essential.

A summary of all the lessons learned from the Bob Currie Place Project, then, might be:

- keep in mind who and what you are working for (this goes without saying, but it is easy to get caught up in the process and lose sight of it)
- have a clear — and clearly-recognized — goal
- maintain flexibility
- get the right people involved
- define the terms of your relationship up front and make sure all partners receive some benefit, tangible or intangible
- be ready to take advantage of funding programs as they come available (see the Resource List at the end of this section for information about available sources)
- don't expect things to happen as quickly as you think they should
- tolerate ambiguity — it seems like everything always depends on something else
- have a good business plan.

Keeping the Partnership Going

Our partnership has been successful in getting this far. We're not there yet, but once the doors do open, the partnership will continue. Columbian Centre Society will make sure the roof doesn't leak, that the heat and hot water are reliable, and most important, that residents have an opportunity to form a community and have a say in how the place is run. Our major tenants, the Nanaimo Mental Health Outreach Nurses Team and CMHA will provide support and opportunities for rehabilitation and recovery.

For more information, contact Mary Macgrega at (250) 245-0845 (phone and fax) or mkmagrega@seaside.net ■

The next issue of Visions is on mood disorders. Watch for it in October ...

Overcoming 'NIMBY' in Nelson:

A Lesson in Perseverance and Resourcefulness

Sarah Hamid

Sarah is the Communications Coordinator at CMHA BC Division and Visions' Production Editor. She is also a consumer.

Nelson, a beautiful city in the heart of the West Kootenays, has also been at the heart of some recent controversy over an exciting new housing project.

Two years ago, the Nelson and District Housing Society identified an urgent need in the area for adequate housing for mental health consumers. "A lot of people with mental illness are doubly discriminated against," says Joan Reichardt, secretary for the Housing Society and one of its original members. "First they have to compete with the market prices when they're often not on the same playing field financially as other renters. Then they have to deal with attitudes of landlords who say 'not in my basement.' As a result, consumers often end up paying more for inappropriate housing because it's all they're able to get."

The Housing Society has a well-established commitment to helping consumers. Robson Street House for people with mental illness was a project that was undertaken more than twenty years ago. The Housing Society thought of adding success to success by expanding the Robson complex. However, when community members — many of whom were never aware that people with mental illness lived there — were informed of the plans, there was an outcry that still stuns Reichardt to this day. "It was a real shocker to me. Neighbours had been living next to these consumers for twenty years and had no problems with them. More than that, they were *comfortable* with them. I just couldn't believe the response," she says. In its exasperation and disillusionment, the Housing Society decided it might benefit from looking at other options and other locations. "The consumers have got enough problems to deal with. We weren't going to put them in a place where they're going to be treated like pariahs [or outcasts]," says Reichardt.

▲ Robson Street House

So the search was on in 1998 for another site and a bid was finally put on a long-established motel close to the lake.

The Nelson Housing Society may have started the wheels rolling on this plan, but it has taken many committed partners to see it to completion. For instance: BC Housing has contributed Canada Mortgage and Housing Corporation (CMHC)-insured mortgage financing to the tune of $840,000, plus substantial ongoing operating assistance to make the suites affordable for the tenants; a CMHC RRAP (Residential Rehabilitation Assistance Program) grant is adding up to $360,000 in federal money; the Real Estate Foundation of BC kicked in a generous $150,000 grant; an individual donated $59,000 to the Canadian Mental Health Association with a request that it be used on a local initiative; the Kootenay and Boundary Health Services Society's Mental Health Division donated $50,000; the Vancouver Foundation contributed $40,000; the Daybreak Rotary Club is providing new electric ranges for all the units; and the local credit union has offered preferential rates on the mortgage. It's a project worth at least 1.6 million dollars.

▲ The Lakeside Motel Project

The NIMBY plot thickens....

Since the Housing Society and its partners had to submit applications to City Council to rezone and renovate the property, the community soon got wind of the project and a small, yet passionate, opposition put up a resistance. This time the Society would not be moved as it had been initially when a NIMBY (Not In My Back Yard) phenomenon occurred similar to what had happened with the Robson Street House proposal.

Concerned citizens sent a flurry of letters to the editor of the Nelson Daily News. Some expressed concern about decreased property values (even though studies across North America have demonstrated that the presence of social housing in a neighbourhood does not reduce house prices). Others — including a retired police officer — hit a more emotional chord in their editorials, warning that the new housing development project would be "a hazard to kids in the adjacent park" — an opinion based in fear, myth, and ignorance.

Says Reichardt: "When the motel was operating, it was one of the least expensive in town and has seen its share of characters in the fifty years it's been around. Imagine the irony, then, when one of the neighbours says to me after the housing project was born, 'But Joan, we won't know who's in there!' I replied 'We never did know who was in there!' Another acquaintance has said to me 'We don't need any more low-cost housing because low-cost housing just attracts poor people.' And this was from someone from a visible minority who may have needed just these kinds of supports after immigrating to Canada."

Russell Rodgers, Coordinator of the Friendship Outreach Clubhouse, is one of the partners in the project and did a lot to keep the initiative on solid footing. He invited the Mayor and City Council for dinner at the clubhouse one evening to discuss the matter. "It was a great success," says Rodgers. "Some of them

were surprised to see people at the clubhouse that they knew from other contexts. By the time the Mayor and Council left, they were in full support of this project."

After a meeting with the public liaison officer of the Police Board, another dinner was planned at the clubhouse with the Chief of Police. This was followed by a presentation to the Police Board by a group of consumers. "The presentation must have been engaging because the Board really wanted to hear more from the consumers."

With the City and the Police on side, the NIMBY controversy began to die down. "Consumers are slowly moving in as the units are being renovated. And I've kept looking in the local editorial pages and haven't seen anything for quite a long time," says Rodgers.

The existing motel suites are now being renovated, with plans to add an additional eight units to the structure. This "eight-plex" is dedicated for mental health consumers, plus four other units in the rest of the motel. Though the remaining sixteen units are not dedicated for consumers, as Reichardt says, "we're not about to exclude mental health clients either."

There were also ideas of adding an emergency housing component. As Rodgers explains, this would house a mix of people in need of short-term shelter including victims of domestic violence needing transition housing and temporary shelter for those who have been evicted. However, Reichardt notes that this component is still awaiting funding and the necessary intensive staffing commitments. Without these resources, the unit may threaten the security of the long-term residents who remain the first priority.

For more information, visit the Nelson and District Housing Society's web site at www.kics.bc.ca/~ndhs/index.html and follow the links related to the Lakeside Motel Project. ■

NIMBY Resources

- *Towards More Inclusive Neighbourhoods ("The NIMBY Toolkit"):* on the web site of the Housing Policy Branch of the Ministry of Social Development and Economic Security. Includes an extensive bibliography and resource list of relevant publications and videos (e.g., studies of the effect of social housing on property values, articles on understanding and overcoming the NIMBY syndrome, etc.). Also includes material related to building partnerships with local government, design details, gaining and keeping community acceptance, and "resources for sponsors": (for example, public relations tips and tools such as sample media releases, advice on choosing a developer, and a checklist of steps to be considered in the municipal approval process) See: www.sdes.gov.bc.ca/housing/NEIGHBOUR/index.htm, or call (250) 953-3586 for more information.
- *A Management Strategy for the NIMBY Syndrome:* case studies of successful NIMBY strategies produced for the Federation of Canadian Municipalities, Affordability, and Choice Today (ACT) program. See www.fcm.ca/PDFs/!untitle.dfo/pb0143/!kingse.pdf
- *Dealing with NIMBY:* case studies and guidelines produced by the Rural and Small Town Research Programme at Mount Allison University (NB). See www.gov.ns.ca/homa/muns/plan/plandev/pd18/nimbyvue.htm

Brief

The following listing, by no means exhaustive, attempts to gather mental health housing programs and related services from around BC. For a more complete listing of mental health and housing resources in your community, see the "Red Book" (in the Lower Mainland) or its web site at www2.vpl.vancouver.bc.ca; outside the Lower Mainland, consult your local community services directory (for contact numbers see the "Community Directories" link at www.vcn.bc.ca/isv). Your local mental health centre or BC Housing office will also have information about housing programs and subsidies.

Canadian Mental Health Association

Province-wide

Many, if not, most of CMHA's 22 branches run housing programs. For instance, CMHA Richmond offers subsidized housing and ongoing support to satellite apartments for consumers. CMHA Kelowna and CMHA East Kootenay have residential units for the homeless-at-risk on the horizon, and, in addition, CMHA East Kootenay is developing an affordable rental housing project in Golden. CMHA Vernon is a dedicated housing provider and CMHA Simon Fraser, CMHA Victoria, CMHA 100 Mile House, and CMHA Prince George also run supported housing initiatives. Contact your local CMHA for more information on local programs and the "sister societies" often formed to handle housing services. Contact information is available from the on-line CMHA directory at www.cmha-bc.org

Victoria Cool Aid Society

Victoria **(250) 383-1977**

With 58 units, Swift House and The Pandora Project, two nationally renowned housing projects, help break the cycle of eviction and promote independent living for those who are hard to house and/or managing a mental illness.

Capital Mental Health Association

Victoria **(250) 389-1211**

A sister society of CMHA's Victoria Branch, Capital Mental Health has a satellite housing program (a limited number of bachelor and one-bedroom units in apartment buildings throughout Victoria), a supported housing program (37 units in two apartment buildings), and a supported independent living program. See www.pacificcoast.net/~cmha/housesrv.html for more details.

Upper Island/Central Coast Community Health Services Society, Mental Health Services

Courtenay **(250) 334-1229**

Provides community support, information about and referrals to semi-independent living, subsidized housing, and supported housing for people with chronic or persistent psychiatric illnesses or disabilities such as schizophrenia or manic depression.

Reports from around the Province

Sarah Hamid

Cowichan Valley Independent Living Resource Centre Society

Duncan **(250) 746-3930**

Provides information and referral, peer support, and independent living and empowerment skills development. Available to individuals with any kind of disability.

Kamloops Active Support Against Poverty Society

Kamloops **(250) 554-0166**

A non-profit society established to provide advocacy to individuals on a volunteer basis regarding welfare and tenancy issues. Promotes education and awareness on poverty and social justice issues. Lobbies all levels of government and housing providers for affordable, special needs, and accessible housing.

Okanagan Similkameen Housing Society

Penticton **(250) 770-2284**

A non-profit charitable organization whose mandate is to provide and maintain residences and low cost rental housing projects for people with a mental illness. The Society is in the process of building a 23-unit apartment building, currently operates 8 subsidized apartment units, owns and maintains 2 group homes, and runs a Semi-Independent Living Program.

Nanaimo and District Home Support Association

Nanaimo

- Program for Adults in Community-living and Education
  (250) 754-3351
  Professional mental health therapists and mental health home support workers offer support to adults with serious mental illness. Active assessment and support services, together with life skills, household, and money management education for clients allows them to live independently and minimize hospitalization.
- Mobile Outreach to Seniors Team (M.O.S.T.)
  (250) 755-1322
  M.O.S.T. provides mental health outreach to people over 65 and/or their caregivers who are living in Ladysmith, Nanaimo, Parksville and surrounding areas. M.O.S.T. is "mobile" because it travels to seniors' places of residence, offering them support while maintaining seniors' independent living in the community. The team works closely with family doctors and other health professionals in the community, providing assessment, treatment, consultation, and education on mental health issues of the elderly.

Venture

Vancouver **(604) 879-8222**

Offers short-term residential care for people with mental illness in crisis, offering inpatient observation, psychiatric assessment, supportive counselling, treatment, and stabilization.

18th Street Community Care Society

North Vancouver
(604) 241-9009

An affiliate of Mennonite Central Committee Social Housing Society, 18th Street manages a Supported Independent Living (SIL) Program. Clients registered with the North Shore Mental Health Centre can be referred to receive supportive visits and subsidized housing in apartments on the North Shore.

Coast Foundation Society, Housing Division

Vancouver **(604) 872-3502**

Provides general forms of low-cost, supportive housing for people with a mental illness. Housing includes a staffed block apartment, satellite suites, a transitional housing program, and a supported independent living program. Referrals or applications for all apartments are available through the agencies' Housing Division.

Kettle Housing Service

Vancouver **(604) 251-0999**

Operates 62 semi-independent living units and a 19-unit apartment building which provide subsidy and community living support for persons with a mental health disability.

Progressive Housing Society

Burnaby **(604) 433-9522**

Provides supported housing in Burnaby for adults with psychiatric disabilities. The Supported Independent Living Program places clients in their own apartments and provides ongoing support services. Applicants for the apartment program must be registered with, and referred by, Burnaby Psychiatric Services.

STEP-up/STEP-down program

Vernon **(250) 542-4890**

STEP stands for Short Term Evaluation and Planning. The six-bed facility provides short-term residential service to people who require stabilization and intervention for psychiatric distress. Goal-setting exercises help consumers get back on track with their lives. The program also houses a psychiatric day program and serves as a base for the after-hours mental health crisis response team.

Mennonite Central Committee Supportive Care Services

Abbotsford **1-800-622-5455 or (604) 850-6608**

Provides housing and vocational opportunities for people who have experienced mental illnesses.

photo courtesy of The Daily Townsman (April 26/00, p. 3)

Janice Bradshaw, Executive Director of CMHA's East Kootenay Branch, and Dick Visser, Housing and Mental Health Programs Director, outside the Abbott Gardens Housing project which opened May 1, 2000.

CRESST – Community Residential Emergency Short Stay Treatment

New Westminster	(604) 521-1205
Surrey	(604) 587-4220
Abbotsford	(604) 870-7583

Ten- to twelve-bed community emergency psychiatric residential facilities which serve clients who are experiencing a mental health crisis. As pre-admission facilities, CRESSTs seek to prevent unnecessary hospitalizations and maintain each client's autonomy while providing a safe, supportive, and supervised residential setting. Clients stay at the facility voluntarily.

QUESST – Quesnel Unit Emergency Short Stay Treatment

Quesnel	(250) 992-0608

A five-bed crisis stabilization unit located in the G.R. Baker Hospital and co-managed and co-funded by the Cariboo Community Health Services Society and Quesnel Community Health Council. QUESST also manages a crisis line and provides a day program and a drop-in support group for consumers and families waiting for out-patient counselling. ■

Community and Regional Perspectives: Related Resources

Housing Proposal Development

- *BC Housing – Research Information:* for a wide variety of proposal research and development resources, see www.bchousing.org/about/research.htm or contact your local BC Housing office. Also contact the planning department of your regional or municipal government.
- *"Building Partnerships with Local Government"* (part of the "NIMBY Toolkit"): provides advice to housing sponsors regarding how to work with local government during the proposal development and approval process. See www.sdes.gov.bc.ca/housing/NEIGHBOUR/index.htm, or call (250) 953-3586 for more information.
- *Planning, Building and Running Supported Housing for People with a Mental Illness: A manual for non-profit societies:* a comprehensive resource binder produced by the Coast Foundation. For ordering information, call (604) 872-3502. Also available from the CMHA BC Division library.
- The Catherine Sanford Housing Society: provides support for development of residential housing options in Vancouver/Richmond by building and providing ongoing property management services. BC Housing provides a similar service for other health regions. For more information, contact Bonnie Rice at (604) 732-5105.
- *The Land Centre:* an internet clearinghouse providing instant access to information about real estate and land use. Contains an excellent collection of affordable and supported housing web page links from the proposal-planning and consumer perspective. See www.landcentre.ca or call (604) 688-1150.
- *The Canadian Housing Information Centre:* a service of the Canada Mortage and Housing Corporation that provides an extensive collection of housing research information. See www.cmhc-schl.gc.ca/cmhc.html

Housing Project Funding Sources

- *Homes BC:* announced in June 1999, the program will fund 2,400 affordable housing units over the following two years. For information about eligibility, deadlines, and guidelines for preparing an application, see www.bchousing.org/programs/homes.html or call the BC Housing Coordinator of Program Implementation at (604) 433-1711 or 1-800-257-7751.
- *Real Estate Foundation of BC:* provides grants for non-profit and charitable activities related to the real estate and land use fields. Grants can be any size, but in most cases will not be the sole source of project funding. The Foundation is one of only two of its kind in Canada. For more information about the grant application process see www.landcentre.ubc.ca/foundation, call (604) 688-6800, or e-mail ref@istar.ca
- *The Acre Fund:* In the US, the "mortgage backed security market" provides a huge funding pool for non-profit housing developers and community development corporations. In Canada, the "Acre Fund" has started which provides start up loans and long-term project financing to non-profit societies, co-housing organizations, and special needs groups seeking to build affordable housing. The affiliated Access Building Association is a not-for-profit society that, in affiliation with ARC, helps create social and co-operative housing communities, from the research and fundraising to the building stages. For more information about the Acre Fund, Access, and ARC, see www.access.bc.net
- *The Community Housing and Land Trust Foundation (CHLTF):* helps social and co-operative housing groups in BC transfer their land into land trusts as well as acquire land through donations and endowments. For details, see www.vcn.bc.ca/chfbc/land.htm
- *BC Funders Council:* an association of non-governmental organizations and foundations operating in BC and having the common interest of supporting co-operative and community economic development activities in the province. The Council can help you access a broad range of funding and services to

Because of low income and other barriers, people with mental illness have had little opportunity to consider or attain home ownership. This article and the ones following describe activities undertaken in various communities to help people with mental and other disabilities purchase and maintain a home.

Building Strong Foundations for Home Ownership:

Habitat for Humanity BC

You want to purchase your own home but you're a low-income earner who can't afford the down payments and mortgages in the conventional housing market. So why not get a group together and build a house yourself? That's exactly what Habitat for Humanity has been doing for the past twenty-five years.

Habitat for Humanity (HFH) is a non-profit organization dedicated to eliminating poverty by housing one family at a time. Through volunteer labour and donation of money and materials, HFH builds and repairs simple, decent, affordable homes for homeowner "partner" families in need. And "in need" can easily apply to people with mental illness as *The Times Colonist* article on the next page describes. Habitat houses are then sold to partner families at no profit and financed with affordable, no-interest loans which in turn, return to a revolving HFH fund used to build yet more homes.

The organization lives by its motto "A Hand Up, Not a Hand-Out." As such, in addition to a down payment and mortgage payments, each homeowner invests hundreds of hours of their own labour — "sweat equity" — into the building of their house and the houses of others.

For more information, consult your local community services directory or visit www.habitat.ca

There is also the Home Ownership Made Easier (HOME) project, a variation on the "sweat equity" model carried out by the New Beginnings Housing Co-operative in Prince Albert Saskatchewan. For more information, see www.cmhc-schl.bc.ca/rd-dr/en/ah-la/potm.html or call the New Beginnings Housing Co-operative at (306) 763-4221 or "Homegrown Solutions Maison," Canadian Housing and Renewal Association. They can be reached at (613) 594-3007 or hgrown@web.net ■

Habitat Facts

- There are seven HFH affiliates in BC: HFH Boundary in Grand Forks, HFH Greater Vancouver, HFH Kelowna, HFH Nanaimo, HFH West Kootenay in Nelson, and HFH Upper Fraser Valley in Mission.
- HFH affiliates in BC have built over a dozen homes since 1996.
- HFH Canada has over 48 affiliates; there are 1,500 around the globe.
- Habitat for Humanity International has built more than 75,000 homes in 64 countries.
- One of the most notable volunteers and advocates for the organization is former US president Jimmy Carter.
- Currently, a three-bedroom Habitat house in Canada costs the homeowner between $50,000 and $80,000. In developing nations, a Habitat house costs $500 to $3,000, depending on design, materials, and location.
- Habitat does not accept government funds for the construction of new houses or the repair of existing ones. It will, however, accept government funds in the purchase of land and other administrative expenses.
- All Habitat affiliates are asked to give 10% of their unrestricted cash contributions to fund house building in developing nations. In Canada, affiliates give to Habitat for Humanity Jamaica.

promote economic and social development in your community. For more information or to see their funding directory, go to www.ccabc.bc.ca/ccweb/bcfc/html

- *Community Solutions:* a new program which provides funding to community-based, non-profit organizations, co-operatives, and First Nations organizations to develop and implement locally designed and driven projects "that stabilize or create housing, training and employment" or have other social, economic, and environmental benefits. Provides needs assessment grants of up to $20,000, seed funding of up to $25,000 for new project development, and grants of up to $50,000 for longer-term project development and implementation. For application and guideline information, see the website of the Ministry of Community Development, Co-operatives, and Volunteers at www.cdcv.gov.bc.ca or call 1-877-777-1533.

- *Municipal Governments:* some municipal governments fund affordable and supported housing. For example, the City of Vancouver funds projects through a levy that is placed on new market housing developments. Contact the social planning department in your local government to enquire about municipal funding sources. Municipal governments may also promote projects through regulation, zoning, and other inducements. For a description of planning "tools" that are available, see the summary article in *Network: the affordable housing newsletter* at www.tenants.bc.ca/newsletters/january/tools.html

- *Properties for Housing:* a $10 million program will make certain surplus federal properties available "on an exceptional basis" over the next four years. The program will subsidize the purchase price of the land to make up the difference between the land's market value and the price local housing sponsors can afford. Federal ministers will consider requests from provinces, territories, and municipalities on a case-by-case basis. For more information, see the Canada Mortgage and Housing Corporation (CMHC) web site at www.cmhc-schl.gc.ca/cmhc.html

- *Proposal Development Fund (PDF):* a loan program run by the CMHC to encourage the development of social housing project proposals. For details, see the CMHC web site.

- *Canadian Centre for Philanthropy:* For information about how to order a one-time customized foundation search or to subscribe on a yearly basis to an on-line foundation directory, see www.ccp.ca/publications/description/fdnsearch.htm

Habitat's volunteer builders give woman her home back

Gerard Young

Reprinted with permission from The Times Colonist *(July 9, 1995; A1 & A2)*

Mary was close to losing her home until volunteers stepped in with an offer to help rebuild her life.

The 57-year-old woman, who doesn't want her name disclosed, needed psychiatric care after she became mentally ill three years ago. She has been living in a group home but is ready now to move back to her own house. The problem was that her 85-year-old house at 1158 Mason St. was in serious need of major repair due to its age and years of abuse by renters.

And Mary had no way of coming up with the $25,000 needed to refurbish the place.

To make matters worse, the public trustee responsible for her affairs gave her until June 30 to move home or her house would be sold to pay for her continued care, said Bill McElroy, president of the group that rescued her.

The Victoria branch of Habitat for Humanity convinced the trustee to give the woman another month, then started work on the house, he said. Crews of about 20 volunteers, including Camosun College plumbing students, have been updating and repairing the house the past few Saturdays, he said. And they expect to complete the renovations by the end of the month. "When we heard about this, we were sure this was a good project for us," McElroy said.

Mary, who has been stressed out by the ordeal, doesn't want to talk publicly about her situation, but she and her son are involved in her home's restoration, he said. And depending on what she can afford from her disability income, she will make small payments toward the cost of the materials, he said.

The Victoria Habitat for Humanity group will get a helping hand Monday at 2 p.m. when former governor general Ed Schreyer arrives in town with the organization's national president to lend a hand on Mary's home. Schreyer is an active volunteer and will visit 10 other projects involving constructing or renovating houses across Canada this month. Donations of time, materials, and cash fund the projects.

The non-profit Christian organization was founded in 1976 in Americus, Georgia, and is now active in 40 countries. Former US president Jimmy Carter is an active member of the organization. It was formed in Canada 10 years ago and has 26 branch offices. It is open to all religious denominations. The philosophy of the organization is to work with people who need decent, affordable housing without giving them a straight hand-out. Homeowners invest 500 hours of labour, called sweat equity, in their houses. That serves as their down payment on no-interest mortgages. More than 125 houses have been built in Canada since the organization was founded. But this was the first one renovated or built in Victoria. McElroy said the price of land in Greater Victoria makes construction prohibitive. ■

photo courtesy of The Times Colonist Newspaper

▲ The Victoria Habitat for Humanity group (1995)

Editorial Note: HFH Victoria would like to stress that a Habitat home may not be appropriate for chronically-ill mental health consumers since the contribution of "sweat equity" is an important part of the contract and would seem to require some stabilization of the illness.

Manufactured Housing as an Option for Home Ownership

Jasmeet Bhullar

Ultimately, people need access to safe, secure, stable, private, and affordable housing to maintain their mental health. Ownership may be the only way to truly protect people's belongings and tenancy from being at risk while they are in hospital. Newer manufactured homes may be cheaper to purchase than a house; therefore, mental health consumers may want to include manufactured homes as one option, in a range of options, when considering home ownership as a possibility.

Manufactured housing refers to structures such as mobile homes, modular homes, and trailers. A study cited by a CMHA BC Division survey on manufactured housing reported that 91,005 people in BC, or 2.5% of the population, lived in moveable dwellings in 1996. In addition to providing privacy, stability, and security, manufactured housing can be an affordable, good-quality housing option. In some cases, it may be comparable, if not preferable, to a private independent home. The CMHA study talked to thirty mental health consumers from

Vancouver Island and identified a number of advantages and potential disadvantages that should be kept in mind when considering manufactured housing as an option:

ADVANTAGES

- Privacy, independence, and the option of having pets, a yard, and a garden make manufactured homes a preferred residential option. Many parks allow tenants to keep pets, though the types of pets are usually restricted to small animals such as cats, dogs, birds, and fish. For people interested in having a yard and garden, a manufactured home may be preferred over an apartment.

- Home ownership may provide a sense of pride and stability to the resident. Security of belongings is very important to people while in hospital.

  "My aunt likes living in a mobile home. She has been there fifteen years in a very small park in a country-like setting out of town. She says that it's much less work than a house and the neighbours help her out by watching the place when she's gone."

  "I lost my pets five times when I was living in an apartment and went into hospital. There was no one to take care of them so they were taken to the SPCA. Now with owning my own mobile home, I don't have to worry about having pets."

- Manufactured homes, especially the older ones, can be relatively affordable. The purchase cost of this type of housing ranges from under $20,000 for an older home to over $100,000 for a new home. In addition to the purchase, there are monthly pad rental fees. In the Lower Mainland, pad rentals range between $400/month to $600/month. On Vancouver Island, the average pad rental is $350/month. In other areas of BC, rentals range from slightly more than $100/month to over $500/month. Rent supplement assistance, such as SIL payments, may be available to aid in rent payments. Since the CMHA study showed that the average income of consumers surveyed was $700/month, this option may be more realistic for individuals living outside the Lower Mainland.

  "My friend plans to purchase a new mobile home because it is cheaper than buying a house."

- The quality of newer manufactured housing is as good as conventional housing since the newer houses must be built according to building code standards.

DISADVANTAGES

- Some homes, especially the older ones, may be unsatisfactory from a housing quality point of view. The older homes may tend to be too cold in winter, too warm in summer, too noisy, and/or a fire hazard.

  "The furnace turning on and off in a mobile home is really hard for a person with schizophrenia to deal with during the paranoia stage…noises can really get to you because they are quite loud."

- Many parks are located in isolated areas without easy access to public transportation and other social networks.

- Residents are responsible for inside and outside maintenance and repairs which can be problematic for low- or fixed-income households. Lack of maintenance can result in eviction, a particular problem if a mental health consumer is hospitalized for long periods of time. Paying someone for maintenance can add to the expenses of the home.

  "When my wife and I retired, we moved into a mobile home park. On the day we moved in, the park landlord asked me to water the grass on the property because it was getting a little yellow. Three days later, I still hadn't done this because we were still trying to get the inside set-up. On the third day, the landlord said that if I didn't water the grass he would serve me with an eviction notice, so I quickly watered. He gave us a very hard time over this."

- Eviction from a park may pose problems for the resident of the home. Except in sub-lease situations, the home must be moved to another location. This can be problematic with older homes which parks may refuse to accept. Even if a home is not too old to be accepted in another park, moving a manufactured home can be expensive and stressful.

- It has been estimated that half the manufactured home parks are restricted to seniors, especially in areas such as the Lower Mainland and the Okanagan.

The full report, "Manufactured Housing as a Residential Option for People with Mental Illness" by Danae Slater, is available from the CMHA BC Division office. Please call (604) 688-3234 or 1-800-555-8222 to order a copy.

For more information on manufactured housing, see www.cmhi.ca, the web site of the Canadian Manufactured Housing Institute, the national body representing the manufactured housing industry. ■

Using Trusts to Enable Home Ownership for People with Disabilities

Jack Collins

Jack Collins is the Past President of the Planned Lifetime Advocacy Network (PLAN).

A trust refers to an estate reserved in a will for a beneficiary. A trust may be appealing for someone with a relative with a mental disability for two main reasons: (1) the relative may need assistance in managing their financial affairs and (2) a trust can prevent one from losing disability benefits. A trust can also promote home ownership and the maintenance and renovation of a principal residence. The following article explains the nature of trusts so that family members of a person with a disability can consider their use as a way of improving the housing situation and the quality of life of a relative.

A person receiving income benefits from Disability Benefits Level II is permitted to have a maximum of $3000 in cash assets, unless the assets are held in a trust for the person's benefit. If it is a "discretionary trust" — that is, a trust set up by someone else, for example, by a parent through a will — there is no maximum on the amount allowed in the trust. If the trust is "non-discretionary" — that is, it is set up by the person him or herself, for example, from money they have received from Disability Benefits — there is a maximum of $100,000 in assets allowed if he or she is to continue to receive benefits. In either case, the beneficiary can spend money from the trust without affecting benefits as long as it is spent on items listed in the regulations (i.e., "exempt assets"). The principal two items on which money can be spent are up to $5484 a year on "activities which promote independence" and the maintenance/renovation of the principal residence, the home in which the person lives. These can significantly improve the quality of life for the person on benefits.

Since a principal residence is an exempt asset and does not affect benefits, the trust monies may be used to purchase a home for the person with the disability. Care must be taken when setting up the trust to ensure that the trustee is given the power to do this. Careful consideration should be given to the title the home is registered in which may be in the trust in the person's name, jointly as tenant in common, etc. What is appropriate will depend on the strengths and needs of the person and the wishes of all involved. It is important to note that the rules for trusts are different in different provinces and the mentioned regulations only apply to people in BC.

Planned Lifetime Advocacy Network (PLAN) is a family controlled, non-profit society which lobbied the government to bring in these benefits. PLAN assists families and persons with disabilities to deal with these issues and to plan for the future. Our experienced family consultants meet with the individuals involved and assist them to develop goals that meet the needs and wishes of the person with a disability and their family. We do not receive government funding and we charge a modest fee for our services for those who can afford it. Readers can contact PLAN at (604) 439-9566. ■

Promoting Home Ownership:

More Ideas for Consideration

Jasmeet Bhullar

Limited incomes, institutional barriers, and stigma can make it difficult for someone with a mental disability to purchase a house. Here are some strategies that have enabled people with disabilities to achieve home ownership in other jurisdictions and which could be considered by policy makers in BC:

The HomeChoice Mortgage Program

The HomeChoice program, a US Federal government initiative, has set aside $50 million in mortgage financing for people with disabilities on low or moderate income. Lenders and coalitions throughout 16 states and the District of Columbia have provided loans through the program. HomeChoice is more flexible than other mortgage providers, offering the option of low down-payment, accepting non-traditional credit histories, and providing financial assistance and counselling through non-profit organizations. Together with the efforts of the National Home of Your Own Alliance, people with disabilities, advocacy groups, and other state and local initiatives, the program has resulted in more people with disabilities becoming homeowners. For more information on HomeChoice, contact 1-800-7-FANNIE.

The Massachusets Home of Your Own (HOYO) Program

This program is coordinated by the Citizen's Housing and Planning Association (CHAPA). Through research, education, and advocacy this statewide non-profit association in Massachusetts focuses on increasing affordable housing for lower income households. Some of the services for people with disabilities provided by the Massachusetts Home of Your Own Alliance include access to flexible mortgages, down-payment

and closing cost assistance, supports from independent living centres and other state disability agencies, and pre-purchase and post-purchase home ownership counseling.

The Wisconsin Supported Housing Network

This network is a "co-operative effort to promote home ownership by people with disabilities and their families." Three important services are provided by this network: first, access to financial resources including down payment assistance and assistance with loan closing costs; second, access to housing counseling including home ownership concerns and any special issues for people with disabilities; and third, a local support organization.

More information on the HomeChoice Mortgage, the Massachusetts Home Of Your Own program, and the Wisconsin Supported Housing Network can be obtained from the web site *Opening Doors,* a housing publication of the US disability community at http://www.c-c-d.org/od-dec98.htm

Supported Independent Living (SIL) Payments

Through SILP (the Supported Independent Living Program), rent subsidies for people with mental illness are available, along with support services. The rent subsidies are provided by the Ministry of Health and are given to BC Housing which administers all rent supplement payments. Each region has its own maximum rent supplement. Currently SIL payments cannot be used for mortgage payment. Yet, some housing advocates have proposed that the money for rent subsidies could go towards paying for one's mortgage and thus help a person with a mental illness in purchasing a house. A benefit of being able to use SIL payments for home ownership is that when the mortgage is paid off, the rent subsidy could then be used for someone else.

Promoting Home Ownership: Related Resources

- *Information for First Time Home Buyers:* describes the basic requirements for buying a home in BC for the first time. See www.oklawyers.com/bas2400.htm
- *The Newcomer's Guide to Canadian Housing:* home ownership and rental advice for newcomers to Canada, designed to "help you find a comfortable place in a friendly neighbourhood." See www.cmhc-schl.gc.ca/cmhc.htm or contact your local immigrant services society to enquire about translated versions of the guide.
- *National Affordable Housing Network:* a US-based site for a non-profit organization that strives to "produce solutions to high housing costs for those with limited resources." See www.nahn.com
- *Manchester Neighborhood Housing Services, Inc.:* based in New Hampshire, this neighbourhood group promotes home ownership by acquiring and renovating substandard dwellings, helping residents access capital to carry out home improvements, and providing other support. For more information, see www.mnhs.net/mission.htm. Also contact Dr. Paul Gorman at the New Hampshire Department of Health and Human Services at (603) 271-5007 for information about a co-operative business that builds and renovates homes for mental health consumers, itself run by people with mental illness.

Innovative Affordable Home Ownership Design Options and Models:

- *"Flex Housing":* housing which is adaptable for the needs of people with physical disabilities and seniors — http://indie.ca/crcd/affordab.html
- *"ProHousing":* a philosophy of adapting affordable home designs which are appropriate to different jurisdictions using options like "accessory dwelling units, the garage home, the shared house, and the owner-built house." See http://serv.net/~rkonzak/prohousing
- *"Infill Housing":* designed to change as the owners' needs for space change or grow over time; an option, for example, for low-income couples planning to raise a family. See www.fcm.ca/PDFs/!untitle.dfo/!pb0177-.44/act44e.pdf
- *"Equity Housing":* a form of co-op housing which enables home ownership — see www.cmhc-schl.gc.ca/cmhc and enter "equity housing" into the search option; also see www.landcentre.ca for information about how to order the report *Housing Issues and Options for People with Mental Disabilities: a feasibility study of equity housing*, prepared by K. Stierhoff for the Social Planning and Research Council of BC; or contact your local BC Housing office and enquire about the "New Options for Home Ownership" program
- *"Co-Housing":* an affordable housing option with some similarities to co-op housing, but with more of a communal philosophy. Check out http://vtn1.victoria.tc.ca/community/housing/cohousing/menu.html

This article is the first in a series which will look at the special needs of people and groups that are often overlooked when housing programs are planned for and developed: people who are either at risk of (or currently are) homeless, youth, women, seniors, longer term residents of institutions, those with concurrent mental illness and substance use problems, and people from diverse ethnocultural backgrounds.

Under the Viaduct ... 10 years later:

An interview with Ralph Buckley

Nearly 10 years ago, Sheila Baxter wrote a damning exposé entitled *Under the Viaduct: Homeless in Beautiful BC*, a report based on interviews with homeless people themselves and with those working in the field. As part of the book, Ralph Buckley, Director of the Strathcona Mental Health Team in Vancouver, was asked about homelessness among people with mental illness. *Visions* talked with him ten years later to reflect on what he said then, and on how, if at all, the situation has changed in the year 2000.

In the early '90s, Buckley had conducted a survey to determine the number of homeless people with mental illness in the Downtown Eastside. He concluded that problems existed, but the magnitude was nowhere near the scale in other metropolitan areas on the West Coast of North America. He felt, though, that things were on the verge of getting significantly worse. Speaking in the present, he believes that due to the efforts of the community, we are still holding the line.

Ten years ago, Ralph's observation was that "… from the survey we have done, maybe 15 to 20 per cent of [the shelterless population] would be mentally ill…but what I'm saying is that though most of these people are not in the streets, a lot are in hotels. They could be in better accommodation than what they're in.We're in a situation where we appear overall to be sort of holding the line, but that delicate balance could change with more hotels closing down."

Visions: How do you see the situation today?

RB: "Back then, I had been to Portland, San Francisco, and Los Angeles and I remember going to one place, the L.A. Mental Health Centre, and being struck by the number of people sitting on the sidewalks in large groups. The shelterlessness was rampant. In Vancouver, we may have had a problem, but the proportion was nowhere close. Back then, our caseload was 500 or 600 and now it's hovering around 1000, so the caseload has gone up lots."

"In terms of shelterlessness, there's a bit more, but it's difficult to know [how much]. There's a lot of people with mental illness in Lookout and in Triage (short-term shelters). There's a lot of movement that goes on, but we still don't see a lot on the streets. Since then, there's the Living Room, there's the Jim Green complex (new housing programs). There's more [homelessness], but I'm not sure how much more. The problem is that we don't have the statistics to say. Vancouver is still doing a better job than Toronto, but that's nothing to be smug about."

***Visions:* You pointed to the threat of the stock of hotel rooms as a potential problem. What have you seen there?**

RB: "It is going down, but you're also seeing [things like] the new Portland Hotel going up. Despite what some people are saying [about a housing crisis], there has still been an effort by the community to respond — although it's better to be proactive than reactive."

***Visions:* What do see as the relationship between the downsizing of Riverview Hospital and the housing situation in the Downtown Eastside?**

RB: "There is a relationship, but that has been more of a problem for acute care, in that there's a wait list for Riverview and they can't handle it. So they choose the best of the worst to discharge. Some work and some don't. The Downtown Eastside does become a dumping ground, but it also becomes a dumping ground for new immigrants and for students. People with mental illness are just one marginalized group out of the whole population that ends up here."

"I'd prefer to be mentally ill in Downtown Vancouver than in any other city in North America. I said that ten years ago, and I'd still stand by that today."

***Visions:* What are your thoughts about how to respond to the housing needs that exist?**

RB: "People with serious mental illness are like everyone else. They want a place with a bathroom and some privacy. Our central office (in the Vancouver Richmond Health Board) is switching over from a focus on residential care or boarding homes towards more independent living — which makes more sense. I'm not a big fan of boarding homes. With people getting $80 a month for comfort allowance [in a boarding home] and so many people smoking, that doesn't work out." ■


There are 100,000 to 250,000 homeless people in Canada, and 2 to 3 million in the U.S. One hundred million people in the world have no shelter of any kind.

Sheila Baxter went to the streets of Vancouver to talk to people who have been, and who are, homeless. Their stories show the reality of life in Skid Road hotels, under bridges, and on the streets more vividly than any government statistics could.

Baxter also spoke to frontline social workers, housing activists, and politicians to uncover the causes of homelessness. She concludes with cautious optimism, and a selection of innovative and realistic solutions from homeless people, squatters, and activists across the country.

References

Baxter, S. (1991). *Under the Viaduct: Homeless in Beautiful BC.* New Star Books: Vancouver.

Buckley, R. *Report of the Vancouver Downtown Eastside/South Mental Health Needs Assessment Survey: October '91 – April '92.* To order a copy, call (604) 253-4401.

Housing is a Human Right:

Responding to Homelessness in Canada

Libby Davies, MP

Housing is a human right. Every woman, child and man in Canada has a right to live in decent, affordable, secure, and safe housing. Indeed, in the *Declaration of Human Rights,* Article 25 (1) spells this out: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care."

Even so, the National Housing Coalition has estimated that 200,000 Canadians are either homeless or living in substandard housing. Furthermore, the Federation of Canadian Municipalities has estimated that across Canada 834,000 tenant households are paying 50% or more of their pre-tax household income on their housing. That's a total of more than 2.25 million women, men and children who are one rent cheque away from being homeless. Unfortunately, these shocking numbers don't even begin to describe the real hardship endured by many Canadian families and single people.

How, in a country as wealthy as Canada, can we have allowed a housing crisis of this magnitude to happen? This is the question from an increasing number of Canadians who are ashamed by the federal government's record on housing.

It is also a question being posed by the international community. The UN *Covenant on Economic, Social and Cultural Rights* is a covenant that Canada ratified in 1976. It clearly articulates the right to housing, declaring "the right of everyone to an adequate standard of living …, including adequate food, clothing and housing, and to the continuous improvement of living conditions."

However, in 1998, a United Nations Committee examining Canada's compliance with the Covenant expressed grave concern that a country as wealthy as ours had allowed the problem of homelessness and inadequate housing to grow to such proportions. In its report, the UN committee stated: "Given the evidence of homelessness and inadequate living conditions, the Committee is surprised that expenditures on social housing are as low as 1.3 per cent of government expenditures."

The UN Committee's condemnation pointed out what has become obvious to a growing number of Canadians. We have a housing crisis as a result of two devastating public policies: the elimination of a national housing program in 1993, coupled with an unprecedented assault on social programs that has eliminated $7 billion from health, education and social programs. Growing poverty and inequality are the result, as more and more Canadians fall through the social safety net.

Last year, I travelled to nine different communities across Canada to see for myself the extent of the housing crisis. I was shocked. In large urban communities like Toronto and Vancouver, the housing crisis is tragically visible with shelters overflowing and homeless people left to fend for themselves. But smaller communities, too, are experiencing severe problems.

There are many myths about homelessness. For example, it's common to read in the media and even government reports that people are homeless *because* they have a mental illness and refuse to go to shelters and appropriate services. The reality is that homeless people are a diverse group that includes young people, seniors, families, people with disabilities, and people facing mental illness who are certainly at greater risk. But, let it be clear that homelessness is primarily due to a lack of housing. It's that straightforward.

Libby Davies is the (federal) Member of Parliament for the Vancouver-East riding. She is the NDP Spokesperson for Social Policy and Housing.

"How, in a country as wealthy as Canada, can we have allowed a housing crisis of this magnitude to happen?"

A 1998 study from New York demonstrates this very well. In the *American Journal of Public Health* (Vol. 88, No. 11), New York University researchers who followed poor and homeless New Yorkers for five years reported that the main cause of family homelessness is the scarcity of affordable housing. Furthermore, the study refuted the assumption that behavioural disorders are the root cause of homelessness.

One of the authors of the report, Professor Marybeth Shinn, had this to say: "We found that subsidized housing succeeds in curing homelessness among families, regardless of behavioural disorders or other conditions. Whatever their problems — substance abuse, mental illness, physical illness or a history of incarceration — nearly all of the families in our study became stably housed when they received subsidized housing."

It is critical to address the serious problems of inadequate services and social and community supports for people with mental illness, but we must not let the federal government get away with the argument that somehow homelessness is a "social" problem rooted in individual problems and behaviour. The abandonment of a national housing supply program is the real culprit and that's what we have to address and set right.

Last year, I introduced a motion in Parliament calling on the federal government to adopt a national housing strategy and a housing supply program that recognizes housing as a human right and meets the goal of providing an additional 1% of federal budgetary spending to meet basic housing needs in Canada.

Unfortunately, although that motion received the support of housing advocates across the country, it failed to spur the federal Liberals to take concrete action to address the crisis. The Liberal solution is to institutionalize shelters, and that is no solution at all. What they should be doing is admitting that the federal decision to retreat from social housing was not only shortsighted, it was shameful. Canadians know what needs to be done. We need the government to commit to a national housing strategy, a strategy that calls for the following: a federal investment of an additional 1% of overall spending on housing, or $2 billion annually; and an approach that is national in scope and in vision. That means no more patchwork solutions. And, we need a return to the supply of social, not-for-profit, and co-op housing.

The time has come to turn the disgrace of being the only industrialized country without a housing strategy into a rallying point for those of us who care about social justice and want to live in a country governed by compassion, not contempt, for those struggling to make ends meet.

You can contact Ms. Davies at (604) 775-5800 or via e-mail at daviesl@parl.gc.ca

Homelessness and Housing: Related Resources

- *The Supporting Community Partnership Initiative:* the Government of Canada's strategy to address homelessness. Greater Vancouver, and possibly other communities in BC, along with several other communities across Canada, will receive funding to develop and implement a homelessness plan. For more information, see www.cmhc-schl.gc.ca/ah-al/en/rrap/back3.html or contact Kimiko Karpoff of the Regional Steering Committee on Homelessness, the Lower Mainland group formed to respond to the federal initiative, at (604) 525-3682 or kkarpoff@direct.ca
- *Towards a National Housing Strategy:* the response to the federal homelessness initiative developed by the National Housing Policy Options Team of the Federation of Canadian Municipalities which calls for a comprehensive national affordable housing strategy. See www.fcm.ca and follow the links to their news release and policy paper on housing.
- *The BC Perspective on Homelessness:* for the full text of this paper written by Jim O'Dea of BC Housing, see www.bchousing.org/programs/finalhomelessnessconf.PDF
- *Kelowna Homelessness Survey:* this new project — funded by the Community Solutions program of the Ministry of Community Development, Co-operatives and Volunteers — will hire and train homeless people to research homelessness in the Kelowna area. For more information, contact J.J. Clermont-Ferrand of the Okanagan Tenants' Advocacy Society at (250) 717-8725 or otass@home.com
- *National Resource Center on Homelessness and Mental Illness:* this US centre maintains an extensive bibliographic database on homelessness in rural areas. Go to www.prainc.com/nrc/bibliographies/rural.htm
- *Knowledge Exchange Network – Homelessness:* a US site listing housing alternatives and resources and model programs regarding treatment and supports for homeless people with mental illness making the transition from homelessness. For more information, see www.mentalhealth.org/cmhs/Homelessness/index.htm
- *Pathways to Homelessness*: a Toronto-based research project which examined the link between mental illness and homelessness. For more information, see www.camh.net/CLARKEPages/research/pathways_to_homelessness.html
- *The Housing and Homelessness Network of BC:* for information about joining the network, call the Tenants Rights Action Coalition at (604) 255-3099 or see their web site at www.tenants.bc.ca
- *"Homelessness and Disability":* the March/April 2000 issue of *Transition*, the newsletter of the BC Coalition of People with Disabilities. For ordering information, call (604) 875-0188 or e-mail trans@bccpd.bc.ca
- *No Place Like Home:* a special report on housing and homelessness by BC journalist Frances Bula based on her 1998 Atkinson Fellowship research. For ordering information, call (416) 368-5152 or see www.atkinsonfdn.on.ca
- *The Facts on Homelessness: The changing face of homelessness:* a fact sheet produced by BC Housing as part of its "Affordable Housing Opens Doors" initiative. Includes several fact sheets and a six-part video series. For more information, contact BC Housing at 1-800-257-7756 or go to www.bchousing.org
- *Homelessness, Housing, and Mental Health Problems (1992):* part of the CMHA National's "Focus" series. To order this four-page document or the longer "discussion paper" on the same topic, call (416) 484-7750 or go to www.cmha.ca
- *Yes In My Backyard: NIMBYs of the past are successes of the present:* an article from Seattle's Real Change weekly newspaper devoted to homelessness, presenting the story of three successful non-profit housing developments where there was initially strong neighbourhood opposition to housing people who were homeless or considered "hard to house." See www.realchangenews.org/articles/fea_novNIMBY_Gone.html
- *A Fine Line:* A video looking at six clients with mental illness at the Hostel Outreach Program run by the Community Resource Consultants of Toronto. They talk about how they became homeless and eventually regained stability. Ordering information at www.crct.org/education.htm
- *Best Practices Addressing Homelessness (1999):* A report by the Canada Mortage and Housing Corporation. Describes examples of strategies for people with mental illness including congregate living arrangements. See www.cmhc-schl.bc.ca, call 1-800-668-2642, or e-mail chic@cmhc-schl.gc.ca

Semi-Independent Living for Youth with a Mental Illness

John Fox

John is the Director of Opportunity Development at Riverview Hospital.

When we remember back to our first attempts at independent living, it probably brings smiles where once there was confusion and anxiety.

We probably shared the rent for a basement suite with a friend, lived in a house with numerous (sometimes ever-changing) roommates, went away to University or College and lived in residence, or moved into the basement of a parent or relative's house and called it "our place." These were times of freedom, excitement, exploration, and independence. We were finally able to look after ourselves and do what we wanted. Life was not complicated.

That is not the case for youth that have developed or are in the process of developing a mental illness. There are seldom friends to share an apartment or house with. Post-secondary education may not be an option. The opportunity to live in a relative's basement is often not offered.

The cost of market housing combined with low-paying or no employment, insufficient support for the illness, and severe isolation causes constant pressure. Combine this with the service delivery move at age 19 from a family-oriented service (Ministry of Children and Families) to an adult system (Ministry of Health) with little or no transitional support, and you have a picture of a situation that will usually fail. This failure may result in higher hospitalization, increased substance misuse, ongoing crisis, and greater rates of criminality and suicide.

The Semi- (or Supported]) Independent Living Program for adults with serious mental illness, which provides rent subsidies and intensive community support, has proven to be very successful. To date, no such service has been available for youth, although a similar level of success could be expected.

The Ministry of Health, Adult Mental Health Division and the Ministry of Children and Families recently announced a pilot program that will provide semi-independent living services to youth in the Vancouver/Richmond and Simon Fraser Health and Ministry of Children and Families regions. Up to 10 units of service (rent subsidy and intensive support) will be provided in each region to youth under the age of 19 who have a mental illness and are able to live independently with support.

The semi-independent living units will be attached to existing adult services which will be adapted to support youth. When a young person turns 19 and their service responsibility moves from the Ministry of Children and Families to the Health Authority, there will be no change or disruption in support and service. Their living arrangements and support will remain fixed.

It is anticipated that this intensive support provided in a continuous manner — by bridging youth and adult services — will benefit youth that suffer from a serious mental illness. These two pilot projects will be fully evaluated in order to understand and address shortcomings and build upon successes.

As semi (or supported) independent living is only one part of a continuum of residential supports, ranging from fully independent living to higher-needs residential support, there is a need to review and develop these other areas for the benefit of young people with a mental illness. ■

Stable Housing and Women's Health

Excerpted from the web site of the BC Women's Centre of Excellence for Women's Health. For more information, see www.bccewh.bc.ca/effects.htm

Many women living in Vancouver's Downtown Eastside neighbourhood face multiple forms of oppression such as poverty, violence, cultural marginalization, and lack of sufficient health care. Bridge Housing Society in collaboration with women of the Downtown Eastside designed a housing project to address the needs of women who are currently homeless or who are living in unsafe conditions in local hotels. These women are more likely to be exposed to life-threatening conditions including physical violence and infection with HIV or other diseases.

Women who will be living in Bridge's new building will collaborate with community workers at the Downtown Eastside Women's Centre and with university researchers to examine how safe, well-designed housing affects women's daily lives and their physical, emotional, and mental health over time. This study will provide a useful model for future community development projects that involve the participation of neighbourhood residents, university researchers, and community organizations. The study will contribute to social policies that impact marginalized women, particularly as they relate to the design, development, and management of affordable housing. ■

Related Resource

No Room of Her Own: a literature review on women and homelessness. Includes regional field reports on women's homelessness in Canada. To access this report, go to www.cmhc-schl.gc.ca/research/reports/index.html or call 1-800-668-2642.

Adapting the Home to Meet the Needs of Persons with Dementia and the Needs of Their Family Caregivers

Nancy Gnaedinger

Nancy conducted this national study with funding from the External Research Program of Canada Mortgage and Housing Corporation. Nancy is an independent consultant in gerontology who is affiliated with the Gerontology Research Centre at Simon Fraser University. She lives in Victoria BC.

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Approximately 80 per cent of people with dementia live at home with their caregiver, usually a spouse. This practice will likely continue in Canada for both economic and humane reasons — that is, we cannot afford to accommodate the increasing numbers of elderly persons with dementia in institutions and we know that the familiar, domestic environment is the most appropriate for supporting people with Alzheimer's Disease (AD) and related dementias.

With increasing numbers of family caregivers looking after relatives with dementia at home, it is useful to know how people adapt their homes to accommodate the characteristic behaviours of persons with dementia and the needs of primary caregivers.

The Study

National, primary research was conducted to investigate this topic. Research methods included a literature search, telephone interviews, a national survey questionnaire sent to 1000 members of the national Alzheimer Society, and 25 face-to-face interviews with former and current caregivers, in their own homes across Canada.

About three quarters of the sample were current or former full-time caregivers, about two-thirds were female and over half were age 65 or over. Most of the caregivers interviewed were spouses.

Although the caregivers interviewed varied in age, income, educational level, and ability to cope, they did have several characteristics in common. They appeared to be highly organized individuals. Their devotion to the family member they were, or had been, caring for was profound. The stress and exhaustion they experienced was palpable, even in those people whose relatives had been placed in a special facility or had died years before. And they clearly needed to tell the world about their years of anxiety and grief.

Symptoms and Behaviours Typical of Persons with Alzheimer's Disease

Because general information on dementias is likely well known to the reader, only the typical behaviours of persons with Alzheimer's Disease and related dementias that specifically relate to adaptations in the home are outlined here.

It must be pointed out that not all persons with Alzheimer's Disease and related dementias have the same symptoms or exhibit the same behaviours. They vary by individual and with the stage of the disease. However, there are some changes associated with the disease and behavioural characteristics generally recognized as "typical" that are particularly relevant to adapting the living environment.

The relevant *cognitive* changes are loss of memory (especially recent memory), marred visual perception (especially depth perception), and disorientation.

Typical *behavioural* characteristics are agitated, persistent behaviour that may appear to be purposeless (such as wandering and rummaging), changes in sleep patterns (typically getting up in the night), quickness to anger (often directed at the primary caregiver), and a demonstrated fear of darkness and of being alone.

The main *physical* change that seems to be associated with AD is the tendency to stumble (related perhaps to the loss in depth perception). Many persons with AD, however, remain very fit into advanced stages of the disease.

Summary of Research Findings: Adaptations to the Home

Research questions were clustered into four specific areas of concern: (1) safety and security in all parts of the home and immediate surround, (2) wandering/pacing and orientation, (3) agitation, and (4) caregivers' needs.

Surveillance

The most outstanding theme was the reported need for constant surveillance or supervision of the person with Alzheimer's Disease as a basic precaution before and after all else.

Although this is not a practical, physical adaptation to the home — the topic of research — it was mentioned so frequently as a primary safety and security precaution, it must be reported. A number of respondents reported that neighbours are part of an extended surveillance system.

Safety/Security

In addition to this vigilance, a number of basic safety and security precautions are taken in many Alzheimer households such as:

- installing extra locks on exit doors, for example, adding a lock requiring two or more steps, which will usually thwart a person in the later stages of AD, or adding a simple hook and eye lock well above the normal line of vision; or simply using a dead bolt that locks from the inside and pocketing the key
- removing the lock from the bathroom door (several of those who had not done so explained that they were married couples who had never locked the bathroom door during all their married life)
- removing dangerous objects or substances, for example, pills, cleaning solvents, sharp knives,

power tools, scissors, lighters and matches, even the car keys — anything the person with dementia can no longer use safely in the judgement of the caregiver

- regulating appliances with the potential to cause burns or fire, for example, by removing the fuses or knobs or turning off the circuit breaker for the stove; lowering the hot water temperature to prevent scalding; and placing furniture in front of hot radiators
- adding a number of assistive devices in bathrooms such as grab bars, bath seats, long hoses for bathing a seated person, and non-slip mats
- removing stoppers from all sinks to avoid accidental overflows
- installing rubber treads on inside and outside stairs to improve traction
- adding a safety railing on inside and outside stairs and along a verandah.

A few respondents mentioned safety/security measures that they had tried and found unsuccessful. These included a locked gate without a padlock, which could be opened too easily; and placing heavy pieces of furniture in front of exit doors which caused the person with dementia to become angry.

Orientation

Caregivers also reported making a number of practical changes to enhance the orientation of the person with dementia such as:

- adding night lights near or in the bathroom or keeping the lights in the house on all day and night
- removing or consciously closing or marking doors to reduce confusion and decision-making about where to go, and posting signs, symbols or notes (the latter with apparently limited effectiveness).

Also regarding orientation, it was pointed out that too many modifications might increase *dis*orientation. The number and degree of adaptations in the home varied with the individuals involved and the stage of the disease.

One gentleman redecorated his wife's bedroom to try to relieve her depression, but she refused to enter it — she said it was not "her room."

Pacing

The physical environment was adapted to accommodate pacing by having the furniture pushed back against walls and by having coffee tables, other small tables, and any lamp cords and so on removed to clear a path.

Agitation

The most common physical changes to prevent or reduce agitation were keeping curtains closed (to eliminate reflections which are typically not recognized by a person in the later stages of AD and can be very frightening for them) and removing or covering mirrors for the same reason.

Other strategies to prevent or reduce agitation seemed to be in terms of lifestyle rather than in terms of physical strategies — for example, avoiding violent or overstimulating television programs.

Caregivers' Needs

The only needs that caregivers expressed that related to the physical, practical aspects of their dwellings were these:

- First, the need for "a room of one's own" — a place to lock oneself away and rest or read or cry with frustration and exhaustion. This could be a locked bedroom, basement den, or refurbished attic space. One caregiver had fixed up a refuge near the laundry room in the basement. Almost half of the study sample agreed that this was very important.
- The need for assistance with what might be considered fairly straightforward tasks such as the installation of a grab bar or a lock.

▼ photo courtesy of Chatelaine magazine (Nov. 1996, page 42)

▲ Helen (above) lives in her daughter's Vancouver home. She also lives with dementia and has seen many adaptations to her living environment since her arrival. For Helen's story, contact Visions' editor at CMHA BC Division and ask for a copy of the Chatelaine article "My Mother's Keeper."

Other needs expressed by caregivers were the need for help in carrying out their difficult tasks, for reliable support from *and confidence in* home support workers, the medical profession, neighbours, family members and other Alzheimer caregivers. It is noteworthy that these needs were expressed over and over again, despite the fact that research questions, on both the written survey questionnaire and in personal interviews, belaboured the theme of "practical, physical modifications" to the dwelling.

Concluding Comments

Although adapting the home can help, in a small way, to relieve the burdensome task of caring for a family member with AD or related dementia, family caregivers still have an overwhelming task.

They need and deserve all the emotional and instrumental help that society can possibly afford to provide.

Alzheimer Societies across Canada provide emotional support to caregivers through groups and counsellors. Instrumental help, however, is harder to find. For example, purchasing and installing special locks or alarm systems and assistive devices is daunting for many older caregivers who may not have the free time, energy, or skills to do these tasks. There is a need for practical programs to assist caregivers in instrumental ways. ■

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Resource

Copies of the research report *Housing Alzheimer's Disease at Home* and an instructive booklet based on research findings (*At Home with Alzheimer's Disease: Useful Adaptations to the Home Environment*) are available free of charge from Canada Mortgage and Housing Corporation's Housing Information Centre. Call 1-800-668-2642 or e-mail chic@cmhc-schl.gc.ca

Adapting Municipal Housing for Tenants with Dementia

Nancy Gnaedinger and Myra Schiff

The physical and operational design of municipal housing for seniors was based on the assumption that if and when senior tenants needed supervision and care, they would move to special long-term care facilities. A shortage of long-term beds means that this assumption no longer holds true. Municipal housing providers are now challenged by numerous factors related to increasing numbers of tenants with dementia.

Nancy Gnaedinger and Myra Schiff, PhD, of Toronto ON, were funded by the External Research Program of Canada Mortgage and Housing Corporation to conduct this national study. Gnaedinger and Schiff are both independent consultants in gerontology. Dr. Schiff is affiliated with the University of Toronto.

A national study on this topic has recently been completed which investigates the extent to which municipal housing providers are aware of and concerned about tenants with dementia and their expectations about this situation in the future; the steps they are currently taking to address the situation and how they see themselves responding in the future; and barriers to making changes to the physical environment or to policies and procedures, and how to overcome these barriers. Research methods included a literature search, a mailed questionnaire to municipal housing providers in every province and territory, and four case studies. The literature search revealed an absence of published material on this topic.

The 250 completed responses to the survey indicated that:

- Housing providers who are both aware of and concerned about the presence of tenants with dementia in their buildings are clearly making efforts to support those tenants and other tenants, on an ad hoc basis. The providers who are *not* aware of tenants with dementia in their buildings appear to be doing little to prepare for such a situation in the future.
- Housing providers' efforts to accommodate tenants with dementia include working co-operatively and collaboratively with health and social service agencies and with families, providing education on dementias to both staff and other tenants, increasing the monitoring of special tenants by their own housing staff, and making minor physical modifications to buildings. Virtually no providers, however, have developed policies for how to handle the current situation or future increases in the number of tenants with dementia.
- Barriers to making changes that would accommodate increasing numbers of tenants with dementia are identified as cost, lack of staff (in both housing and health/social service agencies), lack of skill in managing persons with dementia, resistance to and fear of turning seniors' housing into long-term care facilities, and the inappropriate design of buildings. Working co-operatively with other agencies is the main strategy for overcoming these barriers.

Case studies were carried out in Alberta, Ontario, Québec, and Nova Scotia. In each case, it was shown that:

- Housing providers are making concerted efforts to maximize the quality of life of their tenants with dementia, while ensuring the safety and security of their other tenants.
- The housing organizations in four communities have developed programs which help tenants with dementia to remain in their homes.
- These programs were typically developed to assist and support frail residents, however. They were not designed solely for tenants with dementia. Housing providers do not appear to categorize tenants with dementia as separate from other frail elderly tenants who need assistance and supervision.

In summary, municipal housing providers who have tenants with dementia are working, in an ad hoc manner, with tenants' families, community-based health and social service providers, and their own housing staff to create secure living environments that allow tenants with dementia and other elderly, frail residents to continue living in their own familiar environments as long as they are not a threat to the safety and quality of life of other tenants. Virtually none of these housing providers has developed any formal policies for dealing with current and future tenants with dementia. A few, however, are being proactive in developing programs which will allow cognitively-impaired tenants, as well as other frail elderly people, to continue to age in place.

Lack of staff to provide supervision, lack of skill in supporting persons with dementia, and inappropriately designed housing are all obstacles that can be overcome with funding for personnel, for education programs, and for minor physical adaptations to buildings. Some other challenges revealed in case studies, particularly the lack of collaboration at the provincial level between health and housing ministries, can be met if key government decision-makers recognize two things: first, there are going to be more tenants with dementia living in social housing in years to come with few other places for them to go; and, second, the relationship between seniors' health and their housing should be reflected in a relationship between health and housing policy. ■

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Related Programs and Resources

Adapting Municipal Housing for Tenants with Dementia: available from Canada Mortgage and Housing Corporation's Information Centre.

Revitalizing Sunset Towers: a project to revitalize a 500-unit seniors housing development in the West End of Vancouver. Improvements include added space for physical and mental health care services for tenants on-site. For more information, see www.bchousing.org and follow the links to the "News Releases" section.

Best Practices in Seniors Mental Health: this initiative includes an examination of seniors' mental health housing needs. For more information, contact Dr. Martha Donnelly, c/o Dr. Elliot Goldner, Head of the Mental Health Evaluation and Community Consultation Unit (MHECCU) at the University of British Columbia at (604) 822-7727.

Housing, Mental Illness, and Substance Misuse

John Russell

Housing is an essential factor in the stability and recovery of individuals who have a mental illness. This is even more true for individuals who have both a mental illness and a problem with substance misuse.

Unfortunately, substance misuse is one of the factors that contribute to people losing their housing as well as their access to other recovery services. Once housing is lost, the only alternative left is either a shelter or a single-room occupancy hotel. In Vancouver, this means the downtown core, where drug and alcohol use are rampant. In an environment where drugs are readily available, it is even less likely that the person will be able to get control over either their illness or their substance misuse.

This scenario is all the more serious given the facts that:

- for people who have schizophrenia, almost half are likely to have a substance use problem
- for people who have a diagnosis of depression or bipolar disorder, the likelihood of concurrent substance misuse goes up to 60%
- conversely, for people who have a substance misuse problem, a high proportion will also have a mental illness, especially depression.

In other words, the co-existence of mental illness and substance misuse is the norm, not the exception. Living with both of these disorders exposes the person to greater risks, of which homelessness is just one. Others include a greater risk of contracting serious communicable disease associated with drug misuse, greater risk of suicide, greater risk of committing violent acts, and a greater risk of being incarcerated for a criminal offence.

What is the role of housing in the solution?

Clearly mental health housing programs must recognize that the co-occurrence of mental illness and substance misuse is common. While individuals with drug problems can be disruptive and pose some risk to other program participants, eviction only exposes the individual to much greater risks. Housing programs need to have the capacity to provide a more effective response to someone who is missing drugs and alcohol. They also need to be less restrictive in accepting individuals who have had substance problems in the past or are even actively involved in substance misuse.

Current research indicates that the most effective intervention for mental illness and a co-occurring substance misuse problem is an assertive community treatment model. In the model, staff have the expertise to provide treatment for both mental illness and substance misuse in a comprehensive, integrated program. One of the keys to these programs is to overcome initial resistance to treatment by being very client-centred and starting with the needs that the client identifies. One of those needs is likely to be safe and stable housing, preferably not in an area where drugs are easily accessed. Another key is to be able to work with the inevitable and recurrent relapses that individuals will experience as they gradually gain control over both their substance misuse and their mental illness.

There are apparently contradictory findings on the role of specialized residential treatment programs for people who have co-occurring disorders. In a review of the literature, Drake et al. found very poor outcomes associated with residential treatment programs modeled on the intensive residential treatment programs that are common in the alcohol and drug dependence field. These programs had very high non-compliance rates associated with clients dropping out or being evicted from the program. The conclusion is that the expectations of these programs simply do not work for people who have a mental illness.

On the other hand, many people in the field believe that a supervised residential facility is needed for those individuals who are unable to make a start on recovery while living independently in the community. Such facilities provide structure and support rather than intensive treatment. Successful treatment seems to involve only one to two short group sessions a week, frequent repetition of program content and, most importantly, a supportive and creative approach to relapse.

In summary, current policies with respect to substance misuse in many housing and residential programs are an ineffective response to substance misuse. The common response of eviction only compounds the problem and exposes the person to much greater risks. Safe, supportive housing is part of the solution, within the context of a carefully paced program of recovery that accepts and works with inevitable relapse. Such a program can be provided by an assertive community treatment team with supported independent living units or, for some, a more structured residential setting.

In time, relapses will become less frequent and of shorter duration and for many people two years in such a program can lead to effective control of both substance misuse and the symptoms of mental illness. ■

John was the Director of Greater Vancouver Mental Health Services. He now works as a consultant and is the Chair of the BC Mental Health Monitoring Coalition.

Reference

Drake, Robert E., C. Mercer-McFadden, K.T. Mueser, G.J. McHugo, G.R. Bond (1999). "Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders." *Schizophrenia Bulletin*, Vol. 24(4), pp. 589-608.

Related Resource

Dual Diagnosis Residential Home: this program is scheduled to open soon in Vancouver. For more information, contact Barry Niles at the Mental Patients' Association at (604) 738-2811.

The Access Project

Mary Macinnes

Mary is Acting Coordinator of Resource Planning and Implementation for the Adult Mental Health Division, Ministry of Health.

Editorial Note: Lack of appropriate — often specialized — housing is a significant reason why many people remain in institutional settings, often for long periods. At the same time, the occupation of these hospital beds prevents access to acute-care services from those in the community who need it. The following article describes a project that addresses this problem.

The Access Project is one of a number of initiatives of the Mental Health Plan intended to improve care for people with serious mental illness. This is not a downsizing project. No funding or bed capacity was removed from Riverview Hospital (RVH) or the Forensic Psychiatric Institute (FPI). The ultimate goal of this initiative is to increase timely access for higher need patients requiring inpatient care to RVH and FPI. This improved access would relieve some of the pressures facing acute psychiatric units, emergency departments, and the justice system. The intermediate goal was to speed up community placement of people who no longer require inpatient care at RVH and FPI.

In March, 1999, there were 159 patients in RVH and more than 30 patients in FPI who were identified as "ready for discharge" and whose discharges were delayed because current community resources were unable to provide sufficient or appropriate levels of care. To facilitate these discharges, the Ministry of Health Mental Health Plan targeted new funds to the health authorities and forensic clinics to support the community placements. The Access Project helped to identify the community needs of selected people, and using existing community resources, as well as new funding, facilitate their community placement within a four month time frame.

There was no direct funding for housing in this project. Health regions were to use existing resources to accommodate the people who were discharged from the two hospitals. What did happen, however, was that health authorities used the funding to move clients who were in existing residential facilities into semi-independent living units, and then placed the people from the Access project into those vacancies. They used part of the funding to provide resources for the former RVH or FPI residents as well as to provide added support for those individuals who were moved to SIL units.

The project was implemented in three phases. Phases I and II targeted discharges from RVH and Phase III targeted FPI. Because the majority of people from RVH identified the Lower Mainland as their preferred location upon discharge, the Lower Mainland health authorities were approached first. Phase I commenced April 1/99 with 33 RVH residents discharged to the community July 31/99. Phase II, which included all the remaining health authorities, placed 16 former RVH residents in the community. In Phase III, the Provincial Forensic Clinics placed 26 FPI residents into the community.

In spite of the project being initiated during the summer months, the Access Project proceeded due to the hard work of the staff at RVH, FPI, health authorities and forensic clinics. The project is currently being evaluated, and so far, of the 75 people who were placed in the community, four returned to RVH and two returned to FPI. These individuals all returned within one month of their placement. These people were replaced with others who were awaiting discharge. Those individuals who were placed into the community will be followed-up by RVH and FPI tracking programs to see how well they do in the community.

In January 2000, the Ministry of Health announced funding for the expansion of the initiative for an additional 20 RVH and 10 FPI residents with higher needs awaiting community placement. These new phases were implemented on February 15, 2000. To date, five Riverview Hospital residents and seven Forensic Psychiatric Institute residents have been placed in the community. ■

Making Room

Liz Evans

One of the founders of the Portland Hotel Society, Liz won the Registered Nurses Association of BC's 1999 Health Advocacy Award.

Based in the heart of the Downtown Eastside, the Portland Hotel Society works in one of Canada's poorest neighbourhoods. The work of the Society began in 1991. Jim Green, the Organizer of the Downtown Eastside Residents Association (DERA) at the time, took on a management agreement to run the rooms at the Portland Hotel. This imaginative step was taken to save the precious hotel stock under the threat of development.

Out of this initiative, the Portland Hotel Society was formed. The Portland Hotel itself houses seventy people — seventy out of the some 7,000 people who live in substandard hotel rooms. The Society houses those who have found it impossible to find stable housing. Of those currently living at the Portland Hotel:

- 76% have had over 5 addresses in the year prior to moving into the hotel
- 52% have a diagnosed mental illness
- 50% are HIV positive or have AIDS, with an additional 40% who are living at high risk for HIV
- 88% have a drug or alcohol dependency; this could include anything from rice wine or aftershave to cocaine or heroin
- 73% are injection drug users.

Life for those housed by the Society is compounded by numerous challenges including an income well below the poverty line, chronic illnesses including Hepatitis A, B, and C, T.B., chronic and repeated cellulitis infections (infections of the connective tissue, usually beneath the skin of the face or legs), endocarditis (infection of the lining of the heart and valves), and pneumonias. Many have experienced repeated childhood trauma including sexual, physical, and emotional abuse. Most have come from backgrounds of drug and alcohol addiction.

Meanwhile, the housing situation in the Downtown Eastside is worsening. Cheap land is being speculated and developed, the AIDS crisis has reached critical proportions among injection drug users, and there continues to be a loss of cheap hotel accommodation as a result of new developments. Now, over 60% of hotel rooms are being rented for more than the $325 welfare rate.

Those housed in the hotels of the Downtown Eastside are often viewed as undeserving of decent housing, respect, and support. The Society attempts to challenge those who would demonize and dehumanize, or simply ignore, those forced to survive in such a brutal environment. The Society has worked to provide housing, services, and advocacy specifically to a group of people who have not been well received in other housing settings.

This recognition means that the Society is committed to working with people throughout both their good and their bad times. What the Society hopes to provide is a form of "asylum" for people who have been socially alienated and without stable housing. This means seeing that people are not being malicious when they mess up, but rather, focusing on the good in each person.

In many other housing settings, this population is forced to conform to unrealistic and often unattainable expectations. By default, this means exclusionary policies. By adopting the notion of a "therapeutic family," the Portland attempts to create a community where people have real relationships, in the face of real struggles.

The staff complement is the Society's single most important resource. They have worked to build a strong team-based ethic and the right tolerance-level and outlook to cope realistically with the community.

Through an extensive staff education program, the Society has tried to move away from being a more traditional policy-based organization, towards a culture that supports staff to attain the skills necessary to innovate and exercise independent judgement. This program emphasizes to the staff that as individuals, we each bring our own attitudes, values, struggles, and pain to our work. Rather than ignoring this, the program tries to focus on creating self-awareness and a supportive environment. This enables residents to be treated with the respect and dignity they deserve.

The Society has attempted to get access to services for people. These services are those that have not easily been accessed but rather bound by institutional tradition or moralistic judgements. Services have had a hard time meeting the needs of people in this situation.

The Society has developed a program that includes providing in-house services for residents to access how and when they like, including:

- a clinic team including a physician, a nurse, and a hospice co-ordinator
- an unlimited 24-hour needle exchange
- food programs in partnership with A Lovin' Spoonful and the Central City Mission Foundation
- a methadone program
- an in-house events program including acupuncture, massage, professional counselling, nutritional assessments, an art group, hair dressing, a writing group, and visits to local events.

Portland Hotel

The original Portland Hotel is an old and inadequate building. However, a new 86-unit, purpose-built project to replace the existing hotel is being completed and residents will move in this summer. This building was designed by the renowned Canadian architect Arthur Erickson.

Many organizations are involved in providing funding for the new building being developed by the Portland Hotel Society. The City of Vancouver provided the land at a discounted cost, the provincial government provided funding through the Ministries of Attorney General, Health, and Social Development and Economic Security, including BC Housing. Vancouver Community Mental Health Services, the Real Estate Foundation, the Vancouver Foundation, the Central City Mission Foundation, and the federal government also provided funding.

The Society now manages four hotels: the Sunrise, Washington, Regal, and Portland and currently attempts to extend its resources across these four hotels. The goal is to ensure those living in single-room occupancy hotels can find a supportive and stable community.

However, there remains a huge need to ensure that a group of people who are now, more than ever, at risk of homelessness, find room among us.

For more information on the Society, contact Liz Evans at (604) 683-0073, ext. 351 or liz@portlandhotel.com A case study of the project can also be found in *Excerpts from Local Responses to Homelessness: a planning guide for BC communities* at www.sdes.gov.bc.ca/PROGRAMS/housing.htm ■

Housing Policy Discriminates

Rachel Rosen

Rachel works at End Legislated Poverty. She is also the editor of FLAWline (FLAW stands for Front-Line Advocate Workers).

Like many people who have been in Canada for a longer time, low-income immigrants and refugees also have a hard time getting affordable housing. In fact, it is often harder because of discrimination, lack of familiarity with Canadian laws, and because Canadian laws make it impossible for some immigrants and refugees to qualify for subsidized housing.

"The difficulties immigrants and refugees face in terms of finding housing are part of the general crisis in affordable housing in BC," says May Farrales of the Kalayaan Resource and Training Centre. According to 1996 census data, one out of four renters spends on average more than 50% of their income on rent.

Many immigrants and refugees are forced to leave their countries because of poverty and political instability. Once they reach Canada, the poverty continues. According to a study commissioned by the Working Group on Poverty, of the immigrants and refugees surveyed for the report, 51% of those who arrived in Canada between 1991-1996 live in poverty. "Increasingly, people are being asked to do more with less," says Sadia Ramirez from Tenants Rights Action Coalition.

Excerpted from The Long Haul *(March 2000 issue) with permission of End Legislated Poverty. The article is also available online at http://www.povnet.web.net/housdis.html*

Catalina Hernandez from the Inland Refugee Society estimates that 60-65% of refugees who come to Canada come as single individuals. Once they reach Canada they are very often alone and isolated. Many refugees need to find roommates or share rentals. Hernandez suggests: "Many times these shared rentals do not work out and many refugees find themselves forced to move — often within their first year in Canada."

The process to get permanent resident status in Canada can take refugees up to 18 months. During this period, a person is not allowed to work. "As the welfare rates for shelter are not anywhere near the market rental costs, many people are forced to live in substandard housing or to take money out of their food budgets in order to find housing," states Hernandez. "The government must raise the shelter portion of welfare for everyone." At the Inland Refugee Society, many people tell stories of being harassed and discriminated against by their landlords. According to Hernandez, "There is a lot of discrimination against Latinos particularly due to the portrayal of Latin Americans as drug dealers in the media. Landlords have refused to rent to or have evicted Latinos because of this."

For many refugees, if they do face harassment from a landlord, making a complaint through the Residential Tenancy Act [RTA] is extremely difficult. "Many refugees have come from a situation where they have no rights," says Hernandez. "As well, refugees have so much to do with immigration officials that dealing with another government ministry is too much."

When immigrants and refugees do make a complaint, they face barriers in arguing their case. "There is a lack of knowledge of the rental culture here in BC and if they do not speak English, then that is basically tough luck for them in arbitration," says Ramirez. She describes the situation of one immigrant family who was found negligent because they didn't give notice they were moving. They had left because the landlord didn't provide heat or hot water, and they didn't know the law says they needed to give notice. Ramirez adds, "The Residential Tenancy Act is just not enough. In one case, a family won against their landlord in arbitration. But they never saw a penny of the settlement money, and they were served with an eviction notice the next day!" Currently, the only way to enforce payment of settlement fees won through the RTA is in small claims court, an expensive and timely process. Ramirez believes the RTA needs "teeth to prosecute landlords with heavy fines if they disregard their responsibilities or take advantage of people."

Ramirez encourages people to find out about their rights and responsibilities as tenants. She tells people to always bring a witness to dealings with a landlord, make a checklist of damages before moving in and giving a damage deposit, and to always get a receipt immediately after paying rent to a landlord.

While there is a general lack of affordable housing, Farrales believes that the eligibility policies of BC Housing directly discriminate against immigrants and particularly women who have worked in Canada under the Live-in Caregiver Program [LCP]. In order to be eligible for housing through BC Housing, you must have been a resident of BC for at least one year. For women working under the LCP, this one year waiting period does not begin until after the 2-3 year live-in requirement. "Because of their extreme isolation for two to three years upon entering Canada, these women face a particular dilemma in accessing adequate and affordable housing. As contract workers, they are not eligible to access subsidized housing provided by the provincial government," states a study on housing prepared by the Kalayaan Resource and Training Centre.

The need for affordable housing is acute for low-income people. It is clear that all levels of government should build affordable housing instead of reducing taxes for the rich. Farrales adds, "Canada must stop the privatization of housing and meet people's basic need for shelter." ■

Related Resource

PovNet: for advocates, people on welfare, and community groups and individuals involved in anti-poverty work. PovNet provides up-to-date information about welfare and housing laws and resources in BC. Visit PovNet's Housing Section at www.povnet.web.net/housing.html or contact them by phone at (604) 876-8638 or by e-mail at povnet@web.net

Housing for Special-Needs Populations: Related Resources

- *Native Health Society – Metropole Hotel Project:* the society is leasing one floor of the newly-renovated hotel in Vancouver's Downtown Eastside and will offer supported independent living services for people with mental illness. For more information, contact Lou Desmarais at (604) 254-9949, or for more information about housing needs of aboriginal people, see *Healing Ways: Aboriginal health and service review* (1999). To order, call (604) 709-6484.
- *Housing Needs of Ethnocultural Communities (1996):* prepared by MOSAIC for BC Housing. For more information, contact BC Housing at 1-800-257-7756 or MOSAIC at (604) 718-2777.
- *Family Housing Project:* currently being developed by the Coast Foundation in the Collingwood area of Vancouver. For more information, contact Heather Edgar at (604) 872-3502.
- *Single Mothers Housing Project*: for more information, contact Barry Niles at the Mental Patients' Association at (604) 738-2811.
- *Seniors' Housing Update (SHUP):* a journal published twice a year by Simon Fraser University's Gerontology Research Centre (at Harbour Centre). For an index of articles written over the last four years, visit http://www.harbour.sfu.ca/gero/shup/index.html
- *Housing for people with higher, specialized needs:* "Seven Oaks" in Victoria was chosen as a case study for the national report Best Practices in Mental Health Reform: Situational Analysis (1997). For more information, contact Dennis Suwala at the Capital Health Region at (250) 952-4322, or for ordering information for the national Best Practices report, see www.camh.net/CLARKEPages/research. For information about an innovative housing model — based on the concepts of "mindfulness" and "therapeutic community" — for people with higher needs who have been institutionalized for longer periods, contact Lisa Trank at The Naropa Institute in Boulder, Colorado at (303) 546-3567 or see www.naropa.edu. For information about a similar model based in Massachussets, "The Windhorse Therapeutic Community," see http://users.javanet.com/~windhors/Pages/program.html

Housing for people at risk of homelessness

For more information contact:

- Karen O'Shannacery at the Lookout Emergency Aid Society (emergency shelter) in Vancouver at (604) 255-0430 (The Lookout is featured in the provincial Housing Best Practices Fact sheet)
- John Van Luven of the St. James Community Service Society at (604) 606-0303 for information about the Cordova House renovation project to provide housing for people over the age of 45 who are "hard to house" and at risk of being homeless
- Bonnie Rice of the Katherine Sanford Housing Society at (604) 732-5105 about their new "homeless at risk" project on Lakewood Drive in East Vancouver.

Resource List

Below (and on the back) is a general list of resources related to supported housing. For a more exhaustive list, read the article endnotes and be sure to check out the resource sidebars on pages 10, 19, 28, 30, 31, 35, 38, and 47.

Background and General Information

***Supportive Housing in Supportive Communities: The Report on the Supportive Housing Review* (1999):** the report by the Province of British Columbia containing recommendations based on a year-long review to identify barriers to supportive housing and to clarify government's role in encouraging its development. To download the report, go to www.hlth.gov.bc.ca/cpa/publications/housing/index.html

BC Non-Profit Housing Association (BCNPHA): the organization representing the interests of the non-profit housing sector to government and the public. Carries out advocacy, networking/information sharing activities, regional workshops, and produces the bi-monthly newsletter *InfoLink*. See www.vcn.bc.ca/bcnpha

- BCNPHA Annual Conference: November 16, 2000, at the Coast Plaza Stanley Park Hotel, Vancouver. For more information, see www.bcnpha.bc.ca

Lower Mainland Network for Affordable Housing: for information about the group's activities, call Heather Edgar of Coast at (604) 872-3502 or Sean McEwen, the Lower Mainland Housing Advocate at (604) 733-8948.

Center for Psychiatric Rehabilitation's Catalogue of Publications on Housing and Residential Rehabilitation: see www.bu.edu/sarpsych/CATALOG/reprints/housing.html

The Center for Community Change – Resource List: includes much information on supported housing. To order, call (802) 658-0000 or e-mail ccc@courage.trinityvt.edu

HomeSight: The Comprehensive Guide to Housing Resources on the Web: a collection of thousands of rated links dealing with housing-related information. See www.homesight.org

over ▶

Resource List

The Landcentre: a comprehensive local website dealing with a wide variety of housing issues. See www.landcentre.ca

Consumer-Oriented Information

Tenant Survival Guide: produced by the Tenants' Rights Action Coalition (TRAC). Offers information on protecting yourself, finding a home, making your agreement, repairs and services, locks and privacy, rent increases, evictions, moving out, and arbitration. See www.tenants.bc.ca/tsg1/index.html or call (604) 255-3099 to order the fact sheet series (in one of several languages).

Residential Tenant Self-Advocacy Guide: produced by the Nelson Advocacy Centre. For more information, call (250) 352-5777.

Non-Market Housing in Vancouver: a web-site inventory of all non-market housing — "housing owned by government, a non-profit, or co-operative society" — in Vancouver. Organized by neighbourhood and includes contact information. See www.city.vancouver.bc.ca/commsvcs/housing/sochouse/page1.htm

Greater Vancouver Housing Corporation: manages rental accommodation for low-income families and people with disabilities. Applications can be obtained from 4330 Kingsway, Burnaby, V5H 4G8, Tel: (604) 432-6300.

Lower Mainland Housing Advocate: call Sean McEwen at (604) 733-8948.

South Fraser Valley Housing Advocate: call Kimiko Karpoff at (604) 525-3682 or email kkarpoff@direct.ca

Tools for Housing Project Sponsors and Community Groups

***"Supporting people, not structures: Changes in the provision of housing support"* (1996):** an article by Jennifer Pyke and Joanne Lowe which describes and evaluates a process of organizational change, transforming a residential-type housing program into more independent supported housing. In *Psychiatric Rehabilitation Journal*, 19(3): pp. 5-12.

Canadian Centre for Public-Private Partnerships in Housing: The Centre is an experienced team within Canada Mortgage and Housing Corporation which links housing proponents to potential project partners who can help with proposal development, fundraising, financing, construction, and project management. For a free one-on-one consultation with a partnership expert, call or e-mail the regional representative for BC/Yukon at (604) 666-4660 or shall@cmhc-schl.gc.ca. There are fees for custom requests. The Centre also provides local housing market analysis, keeps an online housing database, and produces a quarterly newsletter that highlights housing partnership best practices. See www.cmhc-schl.gc.ca/ah-al/en/ccpppph/index.html

Tips & Tools: a newsletter for BC Housing staff and non-profit societies. Covers topics such as conflict resolution, resident involvement, and effective communication. Available on-line at www.bchousing.org/applicants/tips.html

BC Housing's Non-Profit Guide Series: includes guides on financial responsibilities, corporate responsibilities, housing programs, maintenance guide, resident relations guide, tenant handbook, and tools for HOMES BC operators. Order on-line at www.bchousing.org/media/publications.asp?Section:3

Community Housing Initiative (CHI): a BC Housing program that increases the capacity of local communities to identify and take action on housing problems. CHI supports nine regional housing centres throughout the province to promote community development, public education, advocacy, research initiatives, and training activities related to housing. For more information, see www.bchousing.org/programs/initiatives/html

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

Canadian Mental Health Association,
BC Division
1200 - 1111 Melville St.
Vancouver, BC
V6E 3V6