PLANNING SUPPORTED HOUSING FOR PEOPLE WITH SERIOUS MENTAL HEALTH ISSUES

by

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**A thesis
presented to the University of Waterloo
in fulfilment of the
thesis requirement for the degree of
Master of Arts
in
Planning**

Waterloo, Ontario, Canada, 2000

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ABSTRACT

Housing for people with serious mental health issues is a subject that has captured the attention of academics for many years. Psychologists have done a tremendous amount of work looking at the positive and negative psychological outcomes associated with different models of housing and support. Planners and geographers have cast a great deal of attention toward the location of housing for people with serious mental health issues, particularly in urban areas.

On a foundation of reviewed literature, this qualitative study set forth to develop an understanding of the housing environment of supported housing residents in a District of Ontario comprising the Regional Municipality of Waterloo and the counties of Wellington and Dufferin. Supported housing involves normal integrated housing that is both adequate and affordable, paired with flexible and individualised mental health support services. One-to-one interviews were conducted with 31 participants (singles or couples) in the cities and small towns located in the study area. The interviews were semi-structured and investigated four dimensions that have featured prominently in academic literature. These dimensions are physical housing environment, social housing environment, housing affordability and choice, and housing history. Discussion around the physical and social housing environments occurred at two scales: the neighbourhood scale and the individual place of residence. In the second stage of this research, a focus group discussion was held with 11 professionals from the community. This group included housing and mental health service providers and municipal planners. During this meeting, the perspectives of professionals on a variety of issues surrounding supported housing were sought.

The gravest concerns of supported housing residents were around affordability and the social environment, including loneliness and a desire for more understanding communities. Housing providers, planners, and mental health advocates confirmed that constructing new housing is a grim prospect and that without large-scale reinvestment by the federal or provincial governments in housing, only small gains will be made. These small gains are occurring mostly through initiatives taken by private non-profit housing providers. There is a ray of hope in developing working relationships and partnerships between agencies but no matter how well the non-profit community works together, without government involvement or private sector building, the housing gap will not close.

The final results and recommendations stemming from the study are being shared with a number of local advisory and decision-making groups.

ACKNOWLEDGEMENTS

I sincerely thank everyone who committed time to share experiences with me. The support I received from participants was tremendous.

I am especially grateful to Professor Mark Seasons for being an excellent research advisor and committing to my program from day one. The constructive advice and positive atmosphere that you create for your students was appreciated. I sincerely thank Professor Laura Johnson for supporting my research as a committee person and providing me with helpful feedback on my work. It was a real pleasure working with both of you.

Many thanks to Shelley Adams, Wendy Czarny, and Don Roth for introducing me to the mental health community and making me feel welcome.

I appreciated the ongoing help and advice offered by the Working Group on Housing and Homelessness in Guelph and the Mental Health Housing Sub-Committee in Waterloo Region.

A sincere thank you to Professor Geoff Nelson for helping to steer me in the right direction when I was just beginning to consider supported housing as a research focus.

I owe an enormous debt of gratitude to Susie Bell, Harriett Lenard, and everyone else at the District Health Council office. The work would never have gone so smoothly without your assistance.

I am grateful to Professor Trudi Bunting and Sybil Frenette for joining my examining committee as readers. Many thanks to Edie Cardwell for helping me navigate without incident through the university system.

With the rising cost of tuition, books, housing, and just about everything else that a student needs to live, I really appreciate the financial assistance I have received from the following:

Ministry of Training, Colleges, and Universities – Ontario Graduate Scholarship program
Waterloo Region – Wellington-Dufferin District Health Council – research costs
Dr. Mark Seasons – student employment funded through a UW-SSHRC research grant
University of Waterloo – entrance scholarship and teaching assistantships
Canadian Institute of Planners – student scholarship program
Ontario Professional Planners Institute – student scholarship program

The value of a good undergraduate education becomes very clear in graduate school. Thank you to the faculty at the University of Lethbridge who worked hard to prepare me for the challenges of graduate studies. Finally, thank you to all of my classmates for the fun times. And to Brian Cheguis, Sherri Hanley, and Daniela Kiguel, thank you for everything.

PREFACE

Patton (1990) has identified the credibility of the researcher as one of the most important issues that need to be addressed in establishing the credibility of a qualitative study.

> Because the researcher is the instrument in qualitative inquiry, a qualitative report must include information about the researcher. What experience, training, and perspective does the researcher bring to the field? What personal connections does the researcher have to the people, program, or topic studied (472)?

As the primary research instrument for this study, I would like to briefly introduce myself.

I have had no prior experience doing research in the area of housing for people with serious mental health issues. My parents own and operate a group home for people with mental health issues and my mother has schizophrenia. My mother is also a past Executive Director of the Schizophrenia Society of Alberta and is perhaps the most well known advocate for people with the illness in Alberta. I do have a considerable amount of insight into the particularities of schizophrenia and some knowledge of other mental health issues.

I do not approach the issue of housing for people with serious mental health issues objectively. I believe that this group of people is cruelly marginalised in most outward aspects of their lives, housing included. Having said this, however, I do believe that the supported housing model is a promising one and I have been eager to learn the positive aspects of this model from the participants in this study. In this study I have tried my best to hear the positive as well as the negative and endeavoured to highlight both with fairness. I believe that my own experience and personal history have added a great deal to this research. Over the course of this research project I have also been a member of two committees/working groups that address housing for people with serious mental health issues. This experience has kept me abreast of current issues in mental health and housing and has greatly complemented my academic learning.

Supported housing comprises two parts: housing and support. In this study, I have concentrated exclusively on the housing part. This has essentially been a housing study addressing the needs of a marginalised group in the housing market. I have had some training in qualitative research methods but this is in fact the first qualitative study that I have done.

DEDICATION

To my mother. Thank you for all your support and for leading such an exemplary life.

TABLE OF CONTENTS

Chapter One
Introduction 1

Part I – Review of Literature

Chapter Two
Housing Location and Conflict 7
2.1 Introduction 7
2.2 Location – the Object 8
2.3 Encountering the NIMBY Syndrome 14
2.4 Zoning and the Arms of Government 17
2.5 Case Example – Walker Way Inc. 20
2.6 Location – the Subject 24
2.7 Conclusion 27

Chapter Three
Housing and Health: The Evolution of Housing for People with Serious Mental Health Issues 29
3.1 Introduction 29
3.2 Housing and Health 29
3.3 Housing the Mentally Ill (pre-1930) 33
3.4 Housing the Mentally Ill (1930s-1960s) 34
3.5 Housing People with Serious Mental Health Issues (1960s to present) 35
3.6 Community-Based Housing for People with Serious Mental Health Issues 36
3.7 The Physical/Architectural Dimension of Mental Health Housing 41
3.8 The Social Dimension of Mental Health Housing 44
3.9 Discussion without the Typology 47
3.10 Best Practices in Housing and Community Support 48
3.11 Homelessness and Mental Illness 51
3.12 Conclusion 53

Chapter Four
Mental Health and Housing Policy 55
4.1 Introduction 55
4.2 Mental Health Reform in Ontario 56
4.3 Housing in Ontario 61
4.4 Conclusion 64

Part II – Supported Housing for People with Serious Mental Health Issues in Waterloo Region and Wellington-Dufferin

Chapter Five

District Profile of Housing and Support 67
5.1 Introduction 67
5.2 Housing for People with Serious Mental Health Issues 67
5.3 Conclusion 80

Chapter Six

Methodology 82
6.1 Introduction 82
6.2 Methodology 82
6.3 Research Stages 83
6.4 Conclusion 91

Chapter Seven

The Experience of Residents in Supported Housing 92
7.1 Introduction 92
7.2 Place of Residence: Structural and Design Issues 92
7.3 Place of Residence: Social Issues 99
7.4 Neighbourhood: Physical Characteristics 106
7.5 Neighbourhood: Social Characteristics 109
7.6 Housing Affordability and Choice 114
7.7 Housing History 117
7.8 Summary and Discussion of Findings 119

Chapter Eight

Creating and Improving Supported Housing 126
8.1 Introduction 126
8.2 Forecast of the Social Housing Situation for 2003 126
8.3 Increasing Supported Housing 129
8.4 Programs for Community and Resident Participation 132
8.5 When Mental Health Problems Arise 134
8.6 Summary and Discussion of Findings 135

Part III – Conclusion and Recommendations

Chapter Nine

Conclusion and Recommendations 139
9.1 Conclusion 139
9.2 Recommendations 141
9.3 Future Research 148

Appendix A – Letter of Permission from DHC 150

Appendix B – Selection Criteria for One-to-One Interview Participants 151

Appendix C – Letter of Information and Consent Form for One-to-One Interviews 152

Appendix D – Notes on the Development of the One-to-One Interview Schedule 154

Appendix E – One-to-One Interview Schedule 155

Appendix F – List of Focus Group Participants and Observers 163

Appendix G – Letter of Information and Consent Form for Focus Group Participants 164

Appendix H – Moderator's Guide – Focus Group 166

Bibliography 167

LIST OF TABLES

3.1 Defining Characteristics of the Three Approaches to Housing 38

4.1 Changing Paradigms in Community Mental Health 59

5.3 Estimate of Adult Population with Serious Mental Illness in Waterloo Region 70

5.4 Estimate of Adult Population with Serious Mental Illness in Wellington-Dufferin 70

5.5 Benchmarks for Housing and Support Services – Waterloo Region 71

5.6 Benchmarks for Housing and Support Services – Wellington-Dufferin 72

5.7 Supportive/Supported Housing in Waterloo Region 78

5.8 Supportive/Supported Housing in Wellington-Dufferin 79

7.1 The Importance of Having Community Services and Supports Within Walking Distance 108

7.2 Proportion of Monthly Income Spent on Rent (ranked categorically according to frequency) 115

LIST OF FIGURES

5.1 District Map – Study Area 68

CHAPTER ONE
INTRODUCTION

Housing for people with serious mental health issues[1] is a subject that has captured the attention of academics for many years, particularly since the de-institutionalisation movement began in the late 1950s and early 1960s. Psychologists have done a tremendous amount of work looking at the positive and negative psychological outcomes associated with different models of housing and support (*e.g.*, Lehman 1983; Goldstein and Caton 1983; Kennedy 1989; Segal, Silverman, and Baumohl 1989; Rosenfield 1992). Geographers have cast a great deal of attention toward the location of housing for people with serious mental health issues, particularly across urban space (*e.g.*, Dear 1977; Beamish 1981; Joseph and Hall 1985; Kearns 1987). Planners have also devoted a considerable amount of energy to spatial issues concerning housing for this group of people, their focus being primarily on land use and the zoning ordinance in cities (*e.g.*, Dear and Laws 1986; Taylor 1989). Planners have also taken a careful look at the relative costs of different models of community-based housing and support (*e.g.*, O'Brien 1991).

A common thread joins inquiry across these disciplines and the diversity of theory girding research problems in the area of mental health housing. That is, there has been an almost exclusive focus on the objective characteristics of people's housing experiences. For the most part, the methodology of choice for investigating these characteristics has been quantitative. When qualitative techniques have been used, it has only been to 'flesh out' the quantitative results and 'attach a face' to research results. While this disparity has long been recognised (*e.g.*, Dear 1977; Taylor, Elliott, and Kearns 1989; Nelson *et al.* 1994; Boydell *et al.* 1996), researchers have been reluctant to embark upon research programs focussing on the subjective experiences of residents.

Few would question that planning is a political process occurring outside of pure rationality. Indeed, planning theorists have written for decades of the importance of dialogue between planners and citizens (*e.g.*, Friedmann 1979). In 1973, Friedmann introduced us to his theory of Transactive Planning. He asserted that if the communication gap between planner and client were to be closed, "a continuing series of personal and primarily verbal transactions between them" (177) would be needed and that through this, processed knowledge and personal knowledge would both be fused with action.

[1] There are three dimensions used to identify people with serious mental health issues: disability, anticipated duration and/or current duration, and diagnoses. Disability refers to a person's compromised ability to carry out normal life functions. Duration refers to the acute and ongoing nature of the problems, and the most predominant diagnoses are schizophrenia, mood disorders, organic brain disorders, and paranoid or other psychoses. Severe personality disorder, dual disorder and dual diagnosis are also included (Ministry of Health 1999b).

This idea of mutual learning marked an important shift in planning theory. This concept has evolved since the 1970s and has resurfaced most recently in the context of planning in a multicultural society (*e.g.*, Ball and Caldwell 1998). Planning theorists are calling upon the profession to include the 'voices from the borderlands' - the voices of those in the multicultural city who have been marginalised, oppressed, or dominated (Sandercock 1998). The common element underlying much of the theory that has been written about planning practice, from the early 1970s to today, is that dialogue must occur throughout the planning process. At the same time, planning practitioners are calling upon planning researchers to conduct research that is more sensitive to the actual practice of planning (*e.g.*, Witty 1999). There is a concern that the transferability of planning research from the academy to the front lines is suspect. Dialogue must also be fostered between planning practitioners and academics.

Critiques of planning practice have occurred in the context of the modern/post-modern debate. Post-modern planners have placed great value in the argument that increased understanding and knowledge can only reveal differences and not set direction for rational action (Beauregard 1991). Globalisation and the rise of civil society are also forces that presently challenge traditional planning practice and drive planning theorists to explore new centres of meaning for the profession. Friedmann and Douglass (1998: 2) note that:

> Citizens have remained committed to expanding their rights even in the face of faltering economies and severely weakened structures of government. Alongside a corporate economy seeking global hegemony, struggles for collective empowerment committed to this social project will usher in the next millenium .... It is a struggle for increased access to the material bases of social power – for housing, work, health and education, a life-sustaining environment, financial resources – in sum, for the basic conditions of livelihood and human flourishing.

The struggle to rebalance power relations between the world elite and people provides a new centre of meaning for some planners and the work that they do. A revival of older concepts, such as 'radical' planning with the disempowered, that were previously marginalised in practice (although not in theory), are again relevant to those wishing to pursue the ideals of social justice (Friedmann and Douglass 1998). Bringing the concepts of voice, difference, and human flourishing before the state and corporations and challenging them to respond in collaborative processes can be the burden of any planner who would choose to pursue social justice.

This contemporary thrust of planning theory coincides with shifting research paradigms in the social and natural sciences. Qualitative research has achieved a firm hold in social science. The value of this methodology or paradigm is not as often questioned anymore as it is neglected. It has developed more fully as an alternative ontological stance rather than being simply a means for adding a touch of life to statistical research. In qualitative research, the ways in which people experience the world constitutes reality. Applied to the goal of positive social change, the degree to which real

change can occur will depend upon people's ability to empathise with the lived experiences of others. Richardson writes (1990: 127):

> Social interaction depends on actors making sense of others' actions and motivations from the point of view of the others, from their biographical perspective. Social cooperation relies upon this human capability, a capability grounded in narrative.

Even in the domain of the natural sciences a 'post-normal' approach has emerged that democratises science (Funtowicz and Ravetz 1993). The aim of post-normal science is not to replace applied or core science. It simply addresses a weakness of traditional science; namely, its inability to deal with uncertain problems expeditiously. By expanding peer communities and engaging diverse local perspectives in dialogue, scientists can avoid disasters resulting from the "prolonged stifling of criticism" (*ibid.*: 754) within the academic community. AIDS research, research in the field of complementary medicine, and climate change research are three examples of areas where post-normal science has become acceptable.

Contemporary trends in the social and natural sciences toward empathic inquiry and the democratisation of research are in harmony with the persistent trend in planning theory toward mutual learning and the acceptance of difference. Research in the area of housing for people with serious mental health issues has not kept pace. This point was raised by Burek in 1996 and it is still relevant today. Research still occurs where the only consideration appears to be the accumulation of abstract data and not a desire to understand the lived experiences of people with serious mental health issues. If planning researchers accept that the ultimate goal of their practice is to improve the living situations of marginalised people, then an approach to human research is necessary where empathic understanding is pursued. And given the political nature of planning, planning researchers must commit to asserting their new knowledge and understanding at the decision-making level. The research undertaken for this thesis makes a modest attempt at understanding the housing experience of people with serious mental health issues and advancing that understanding to the decision-making level.

A typology has been developed by Parkinson, Nelson, and Horgan (1998) that distinguishes among three approaches to housing for people with serious mental health issues (Chapter Three and Table 3.1 elaborate on this typology). They are referred to as custodial, supportive, and supported, and each varies according to three main characteristics: the profit orientation of the support-provider, the nature and terms of support provided, and the degree of resident empowerment.

Custodial care homes are typically run for private profit and they are the least empowering of residents. Typically, services offered in custodial care homes are not oriented toward rehabilitation. Supportive housing developments are run by non-profit agencies and place a strong emphasis on

rehabilitation, with the hope that the condition of residents will improve and that they will be able to move out into the community. Supported housing involves normal integrated housing that is both adequate and affordable, paired with flexible and individualised mental health support services. In supported housing, the landlord and mental health service provider are different agents. Supported housing is presently the most popular model of housing and support and appeals to the majority of people with serious mental health issues. However, there is agreement within the mental health community that this model does not suit the needs of all people and that some supportive living arrangements are still a necessary part of a community's range of mental health housing choices. As stated in the best practices literature for mental health reform, "a range of different housing alternatives needs to be provided, but there should be a shift in resources and emphasis to supported housing (HSRU 1997c: 6)."

There has been a great deal of research done on custodial and supportive housing arrangements. As discussed earlier, this research has been conducted from different disciplinary perspectives. Supported housing, the newest and most widely accepted model of housing and support, has not received as much attention in the research literature, particularly from a qualitative perspective. This thesis looks at the housing experience of residents of supported housing in the Regional Municipality of Waterloo and the counties of Wellington and Dufferin, Ontario. The goals of this research were to represent the perspectives of supported housing residents on their housing environment, and combine this knowledge with that of housing and mental health service providers and municipal planners to derive workable recommendations for improvement. A final goal was to transmit this combination of knowledge to professionals, decision-makers, or other interested individuals in the community who are in a position to use it.

On a foundation of reviewed literature, this qualitative study set forth to develop an understanding of the housing environment of supported housing residents in the study area. One-to-one interviews were conducted with 31 participants (singles or couples) within the cities and small towns in the study area. The interviews were semi-structured and investigated four dimensions that have featured prominently in academic literature. These dimensions are physical housing environment, social housing environment, housing affordability and choice, and housing history. Discussion around the physical and social housing environments occurred at two scales: the neighbourhood scale and the individual place of residence. In the second stage of this research, a focus group discussion was held with 11 professionals from the community. This group included housing and mental health service providers and municipal planners. The perspectives of professionals on a variety of issues surrounding supported housing were sought at this meeting. The

final results and recommendations stemming from the study are being shared with a number of local advisory and decision-making groups.

This thesis is organised into three parts. Part One looks at published literature in the field of housing and mental health, including issues of location, the evolution of different housing and support models and their characteristics. This part ends with a discussion of present policy around housing and mental health locally, across Ontario and to a lesser extent, Canada.

Part Two looks at supported housing for people with serious mental health issues in Waterloo Region and the counties of Wellington and Dufferin. This part relays the results of the primary research conducted for this thesis. The presentation of results is preceded by a profile of housing and support needs in the study area and by a discussion of research methodology.

Part Three presents the conclusions and recommendations of this work and discusses areas for further research.

PART I

REVIEW OF LITERATURE

CHAPTER TWO
HOUSING LOCATION AND CONFLICT

2.1 Introduction

Where people locate in space has a profound impact on their opportunities for activity and experience. The spatial dimensions of housing for people with serious mental health issues have been investigated thoroughly over the past twenty years, by planners and by geographers. In this chapter, issues surrounding the location and siting of housing for people with serious mental health issues will be reviewed. As noted earlier, the focus in this thesis is on supported housing and not on supportive group homes or custodial board-and-care homes, for example. This being said, the discussion in this chapter will focus greatly on congregate living arrangements like supportive group homes and custodial board-and-care homes. There are two reasons for this. First, the majority of published literature addressing location issues pertaining to housing and mental health has looked at siting group homes. Until the late-1980s and early-1990s, congregate living arrangements were most favoured by mental health professionals and those who advocated on behalf of people with serious mental health issues. As a result, these living arrangements were the most prominent. The second reason is that a thorough discussion of the issues surrounding group home siting is important because it sheds a lot of light on the stigma and social marginalisation that "shadows" (Kearns 1987) people with mental illness.

The supported housing model 'normalises' the housing experience of people with serious mental health issues and as a result, much of the stigma and social marginalisation that is associated with group homes is eluded. Studies addressing residential location issues around supported housing have begun to emerge. Some of these will be discussed. What is interesting, though, is that planners and geographers seem to have turned away from studying location issues that pertain to supported housing. The attention received by group homes has not carried over to this newer model of housing and support. Research undertaken in this thesis will begin to address this.

Links between health and place are established in the academic literature (*e.g.*, Kearns 1993; Doyle, Burnside and Scott 1996). As Kearns (*ibid.*) points out, however, few have explicitly developed the relationship between personal health and sense of place. Humanist writers such as Relph (as discussed in Cloke, Philo and Sadler 1991) have emphasised the agency of individuals in constructing place. Structuralist writers have discussed how social and political structures operate to constrain individual opportunities and in effect, shape the local experiences of individuals. Structuration theorists (*e.g.*, Giddens as discussed in Cloke, Philo and Sadler 1991) have highlighted

the middle ground; namely, that individuals construct place within social and political structures beyond their control. One's health, as it relates to place, will depend on individual experiences within the local environment and the degree to which societal structures mesh with individual proclivities. This relationship between health and place will be important later on in the chapter when research is reviewed that takes a subjective approach to characterising the neighbourhood environment of supported housing residents. The link between health and home, perhaps the most important place, will be explored in the next chapter.

Most research that has been done on the location characteristics of housing for people with serious mental health issues has taken an objective approach to space. It has not explicitly considered the experiences of individual people. Attempts to convey how people experience place in their lives is a complement to objective studies. As Entrikin (1991 as cited in Kearns 1993: 141) notes, an optimal understanding of location "lies somewhere between the subjectivity of experience of place and the knowledge of place as object." Research reviewed in the first parts of this chapter focuses primarily on objective location characteristics. Works by Boydell *et al.* (1996) and Taylor, Elliott, and Kearns (1989) that are reviewed later in the chapter are more subjective. The primary research conducted for this thesis is, for the most part, subjective.

In the next section, the location of group homes will be discussed with attention to the external effects of 'facility' siting, community responses to group homes and board-and-care homes, and the clustering of services and housing in the inner city. The second section focuses on the Not-in-my-Back-Yard (NIMBY) syndrome and its interplay with the siting of group homes. Following this, zoning issues will be explored along with policy implementation issues dealt with by different arms of government. A case example of a failed group home siting process will be presented in the fourth section of this chapter to illustrate some of the concepts discussed in earlier sections. In the fifth section an examination of housing location issues specific to supported housing will occur. The research reviewed in this section takes a subjective approach to investigating the desirability of housing location, focusing on the experiences of residents. Most of the research reviewed in this chapter looks at housing location in large cities. Most of the published literature in this field looks only at large cities. In the conclusion to this chapter, a case will be made for casting our attention toward small and mid-size cities and towns, the focus of this thesis.

2.2 Location – the Object

The concentration of people with serious mental health issues in the inner city was noticeable even in the 1930s (Faris and Dunham 1939). Following the start of the de-institutionalisation movement in the 1950s and '60s, the majority of discharged ex-patients congregated in "cheap single-

room-occupancy hotels and rooming houses, found largely in the decaying portions of inner cities" (Reich 1973 as cited in Dear 1977: 588). Here they shared space with prostitutes, discharged prisoners, and substance abusers (Ley 1983). Reich (1973 as cited in Dear 1977) notes that the mentally ill were easy prey for the others with whom they shared living space because they are the weakest. They were victimised, terrorised and abused physically. If not victimised by their living companions, they could also be subject to general abuse or neglect from boarding house landlords and staff. Capponi (1992) writes about her experience as an ex-psychiatric patient in one of the infamous Parkdale boarding houses in Toronto called Channan Court. Her story tells of staff who abuse and show disrespect for residents, and a landlord who fails to provide basic amenities such as porch lights, shower curtains, and proper furnishing, while charging room-and-board rates equal to about 95 percent of one's monthly social assistance cheque. At this point, the intention is not to go into descriptive detail of the unsatisfactory living conditions of discharged patients. The intent here is simply to paint a picture of the housing norm for ex-patients following de-institutionalisation. As Dear (1977) notes, discharged patients resembled other minority or immigrant groups who congregate to cheap, transient neighbourhoods, typically in the inner city, where they can begin to establish themselves.

This congregation of ex-psychiatric patients to the inner core of large cities brought with it a congregation of demands for mental health support services. One of the promises of the de-institutionalisation movement was a prior building of community integration capacity in the form of community support and housing services for people discharged. This commitment was neglected. Ex-patients first flocked to the cheap housing, then as community support services did begin to proliferate, they too set-up shop in the inner core, where the clients were. Wolch and Dear (Wolch 1980; Dear and Wolch 1987) write of the interdependency between the location of households using mental health services and the facilities from where support services were dispatched. This mutual attraction of service clients and providers in the inner city affects the urban housing market. "It is likely," states Wolch (*ibid.*: 332), "that housing prices are influenced by service saturation." Beamish (1981) refers to this phenomenon as the transformation toward a 'public city', where publicly funded services and the homes of people who use them are concentrated.

While this phenomenon was first noticeable in the United States, it also affected the urban landscape in Canadian inner cities. Another contributing factor to this 'ghettoisation' was the degree of community resistance to mental health facilities in more stable residential areas (Dear 1977). For landlords wishing to open a board-and-care home in a stable residential area or non-profit agencies seeking to build a supportive group home, often the "conflict costs" (Wolch 1980: 332) can be prohibitive. In other words, community opposition can make the establishment of homes for people with serious mental health issues unfeasible in areas outside the inner core. Dear (1977) asks the

important question of whether the 'inner city asylum' is indeed a negative thing. Perhaps this inner core congregation is a desirable form of segregation for people with serious mental health issues. Urban planning has long promoted the idea of social integration as a guiding principle. In a discussion of pluralistic planning and multiculturalism, Qadeer (1997: 483) proposes that:

> present public attitude toward ethnic concentrations reflects the notion that residential or business concentrations arising from individual choices freely exercised without prejudice to others should be sustained, whereas socially or racially homogeneous neighbourhoods formed through discriminatory practices and explicit or implicit exclusionary policies should be recognised as prejudicial to the public interest.

Dear (1977) states that more research is needed which considers the viewpoints of people with serious mental health issues on the positive and negative aspects of this community service nodality or public city. He also states that the characteristics of both communities that accept and reject mental health facilities need to be better understood. The focus will now shift to a review of research on community responses to mental health facility siting.

A picture has been painted of an urban inner core where people with serious mental health issues and their support service providers congregate because of cheap real estate or limited options elsewhere. The concern has been raised, however, that this concentration of 'noxious' facilities can create a field of externalities so great as to steer inner cities into a cycle of decline (Dear, Taylor and Hall 1980). In light of this, the concept of 'spatial equity' arose and is investigated by Joseph and Hall (1985) in their study of the spatial concentration of group homes in Toronto. They introduce the idea of placement policies as a relief measure for certain areas of the inner cities that bear a disproportionate social and economic burden resulting from the concentration of mental health housing and services.

The spatially inequitable siting of group homes is a media topic pervasive even today (CBC Radio 1999a). As planners and policy-makers, it is important to ask the questions: Inequitable for whom? and the question too often passed over: So what?

The concept of spatial inequity can be advanced on two fronts. First, it can be argued that people with serious mental health issues benefit from moving into less centralised residential areas. On the second front, it can be argued that central city communities do not deserve to bear the disproportionate social and economic costs of facility concentration. An illustration of this is presented by Joseph and Hall (1985: 146): "This fact is borne out by even a cursory examination of the population:facility ratios. Note that the cities of Toronto and North York, similar in population size, have overall ratios of 3, 274 and 17, 485 people per facility respectively."

This statistic alone is insufficient reason for a dispersion of facilities from the centre of the metropolitan area. It is certainly a necessary component of analysis. However, without the

perspectives of people with serious mental health issues to weigh against this objective characterisation of inequity, it is incomplete. Research that explores the experiences of people with serious mental health issues in different areas of the city is uncommon. It is important to understand the external effects of mental health facilities. With a better understanding of the real and perceived effects that facility siting has on a neighbourhood, one is in a better position to make decisions that are equitable to all parties.

Community opposition to the siting of community-based mental health facilities is often couched in a belief that the 'character' of the host community will suffer. The concerns most often raised by would-be host communities generally encompass some of the following: a negative effect on property values, higher traffic volumes, and general issues of residential satisfaction (Dear, Taylor and Hall 1980). However, the most important concerns are centred upon the characteristics of the group home residents themselves (Hall and Taylor 1983). The perceived unpredictability and dangerousness of residents' behaviour is the cause of much community apprehension. As expressed by Hall and Taylor (*ibid.*: 527): "Community reaction to mental health facilities is almost certainly more a response to the users than to the facility itself. For this reason we regard beliefs about the mentally ill to be a vital component of any model of attitudes toward facilities."
Further, residents that display overtly abnormal behaviour are looked upon with greater trepidation than are those who simply withdraw on account of their symptoms.

Papageorgiou (1978 as cited in Dear, Taylor and Hall 1980) characterises urban form as a product of two unfolding surfaces. The first is a 'population surface' and the second, an 'externality surface'. The structure of the externality source determines the nature of the interaction that occurs between the two surfaces. In the context of group home siting, the conceptualisation of the externality source (*i.e.*, the facility) is likely negative. In most cases this is true, although it has been noted (*e.g.*, *ibid.*; Smith and Hanham as cited in Hall and Taylor 1983) that some communities, or members within a community, attach a 'social merit' value to a group home in the community. In other words they receive a positive external benefit. Whether that positive peak in the externality field is enough to change the population surface (*e.g.*, cause others to move near to the group home or demand one in their area) is doubtful. What is more likely is that this 'social merit' value will affect the population surface only inasmuch as it will prevent residents of a host community from moving away.

It was noted earlier that people's perceptions of the mentally ill person are the greatest cause of apprehension toward group homes. With this in mind, the claim can be made that the externality surface, when affected negatively by the siting of a group home within a given community, is actually altered more by the people in the home than by the physical structure itself. So if the main reasons for community opposition to group homes are re-visited it could be said that it is the residents of group

homes who negatively affect community property values, traffic volumes, and general issues of residential satisfaction. This conclusion will be investigated more thoroughly in a later section of this chapter with a case example of a failed attempt to site a group home in Edmonton, Alberta.

The preceding discussion has outlined some of the dimensions of community opposition to community-based mental health facilities. While it is easy to paint a community with a broad brush in such discussions, it must be noted that it may be only a 'vociferous minority' (Dear, Taylor and Hall 1980; Dear and Taylor 1982) that opposes a group home siting. Further, opposition appears to be confined to within six blocks of the facility or less. This conclusion was drawn by Dear, Taylor and Hall (1980) after conducting a survey of 1,090 households in metropolitan Toronto analysing the basis of community opposition to community-based mental health facilities (*i.e.*, out-patient clinics, drop-in centres and group homes). Seven hundred and six of the households sampled were from areas of the city without a facility and 384 from areas with a facility. The results of this study are very important. The majority of respondents were "relatively favourably disposed toward community mental health care. Even when survey questions invited consideration of the negative impact of community facilities, the majority responded with 'neutral' assessments (*ibid.*: 351)." This strong neutral core was confirmed again by Taylor (1989). A major implication of the study is the shadow of doubt it casts upon some of the assumptions made about the negative impact of community based mental health facilities. One very important limitation of this study, however, that the authors themselves point out and that is cited elsewhere (Palys 1997) as a methodological caveat, is that the study was reliant upon the words of respondents and not on their actions. Aubry, Tefft, and Currie (1995) found that community residents in Winnipeg, Manitoba were highly receptive to having people with serious mental health issues as neighbours. In the case example presented later on in this chapter, it was a vociferous majority who opposed a group home in the community when a proposal was on the table to open one. A survey of this community's attitudes toward community-based mental health facilities prior to any knowledge of the proposal would have been interesting for comparison against what actually occurred once the proposal was tabled. The case example simply adds one more piece to the puzzle. The focus turns now toward the characteristics of accepting and rejecting communities.

Dear, Taylor and Hall (1980) write that people are better informed about mental illness than they were in the 1940s and '50s. They add that the 'medical model' of mental illness is now widely accepted, *i.e.*, that it is an illness like any other. A significant social distance remains, however, and this idea is corroborated by Moore Milroy (1991) who identifies a distinct group of city residents outcast from the mainstream. Among those are the "insane, the destitute, and the chronically ill" (*ibid.*: 522). Winchester and White (1988 as cited in Moore Milroy 1991: 526) categorise groups of city-dwellers according to their relationships to "economic standards, social norms, and legal codes."

The degree of power that any category of people enjoys is determined by these relationships. People with serious mental health issues tend to be economically disadvantaged, display abnormal social characteristics, and be on uneven legal footing. It was recently reported that Canadian correctional institutes house a disproportionate number of people who suffer from a mental illness (CBC Radio 1999b). They also spend more time in solitary confinement than the average in-mate. This appears to be due to abnormal actions resulting from the symptoms of their mental health condition, rather than because of any intended deviant activity. The question that arises from all of this is: What are the community characteristics that allow the social distance between people with serious mental health issues and residents of the host community to be bridged? Or could it be that an 'accepting' community does not attempt to bridge the social distance?

Taylor *et al.* (1984) discuss the development and testing of a model to predict aggregate neighbourhood responses to community mental health facilities (*e.g.*, group homes and boarding homes) in Toronto. The authors define community response conceptually as being a function of neighbourhood land use mix, socio-economic status, demographic structure, community homogeneity, community stability, and population density. The authors developed and tested their model with the hypothesis that "homogeneous and non-transient communities of middle to higher socio-economic status with a predominance of families with young children and relatively low population density will exhibit the strongest rejection of community mental health care" (*ibid.*: 38).

Three neighbourhood factors emerged as consistent and significant predictors of community response: transience, scarcity of children, and economic status (Taylor *et al.* 1984). In other words, in neighbourhoods where residents tended to be more transient, have fewer children, and where economic status was not very high, group homes would likely receive a better reception. Perhaps a better way to state the last point is that in such neighbourhoods, group homes and residents would not receive a reception, good or bad. 'Accepting' communities would be better characterised as being 'non-rejecting' communities. Returning to the idea of social distance, it can be said that non-rejecting neighbourhoods simply do not try to bridge the social distance between community members. In rejecting communities, social distance between community members is simply less tolerable.

The concentration of psychiatric ex-patients and support service agencies in the inner cores of cities may be the result of community opposition limiting the dispersal of community mental health facilities into more stable residential areas outside of the inner core. It may also be the aggregate result of individual choices being made by people with serious mental health issues and their service providers in reaction to lower inner city rents and the proximity to other services and amenities. It is likely the result of both of these things. Moore Milroy (1991) observes that the 1950s and '60s were a time of inner city decline. The 1950s and '60s also saw the beginning of the de-institutionalisation

movement and the entrance onto the urban landscape of ex-patients. What is unclear is whether the inner city decline referred to by Moore Milroy was a result of the 'public city' or whether it provided the catalyst for it.

Discussion in this section has centred on group homes and board-and-care homes, the most outwardly visible of the housing models for people suffering from serious mental health issues. The predominant model in the 1990s has been the supported housing model where integrated apartment living is the norm. Given that individual apartments interspersed within the larger community are not as conspicuous as a group home, one would assume that community opposition would not exist. One might also assume that residents of supported housing would disperse away from the inner core if it was community opposition that prohibited them from doing so before. The question that requires answering is whether it is individual choice or structural constraints (or both) that keep people with serious mental health issues in the inner city. In the next section, our attention turns to a more in-depth look at the NIMBY syndrome and strategies for overcoming barriers to community-based mental health housing.

2.3 Encountering the NIMBY syndrome

Dear (1992: 288) defines NIMBY as "the protectionist attitudes of and oppositional tactics adopted by community groups facing an unwelcome development in their neighbourhood." Community mental health facilities are not the only targets of NIMBY reactions. Shopping malls, landfill sites, prisons, homeless shelters, hospitals, and schools are also focal points for neighbourhood 'protectionist' attitudes. The local siting of mental health facilities has been a source of community opposition for some time. Moore Milroy (1991) writes that in Ontario, asylums were most often built in peripheral areas surrounding cities because peace and tranquillity were considered important components of psychiatric treatment. It is likely that NIMBY reactions were also a factor in determining the peripheral location of asylums. It is difficult to discern a single cause of things. Burgess (1898: 86 as cited in Dear 1992: 289) relates the following local reaction to the siting of a late-nineteenth century asylum in Canada:

> The chief grounds on which the plaintiffs based their [opposition to the new asylum] were that the erection of the building and the maintenance and carrying on of an asylum on the site chosen constituted a public nuisance, and was a source of injury and damage to them, decreasing the value of their property, especially as sites for villas and elegant dwellings, and that they, the plaintiffs, would be exposed to constant annoyance, inconvenience, and danger, with great risk of disease through the contamination of the air and the pollution of the Rivers St. Lawrence and St. Pierre by sewage from the hospital.

The same resistant pleas that were outlined earlier in this chapter are clear in the above quotation. Decreasing property values and danger from residents of the facility are still contentions today. Concerns over disease transmitted from mental health facilities through air and water contamination are reserved for the history books.

To reiterate, the perceived threat to property values, issues of neighbourhood security, and community character are key points raised by opponents. However, studies conducted on real estate transactions near community mental health facilities have not illuminated any clear linkage between the facility and proximal property values (Dear 1992). Concerns over facility operating procedures (*e.g.*, staff training and ratio to residents) are often raised by people concerned with personal safety. Opponents may raise a number of community character-related arguments such as increased traffic or the negative influence of facility residents on neighbourhood children. The arena for community opposition in Canada and North America is typically the zoning hearing (*ibid.*). The tool for opponents is often the zoning ordinance. Zoning issues will be reviewed more closely in the next section of this chapter.

Wenocur and Belcher (1990) have identified three strategies for avoiding community resistance. The first is to take a 'high profile approach' entailing a careful community outreach and education effort targeting community leaders and people with local influence. Media coverage is important in this approach to avoiding community resistance. The underlying belief is that in the long run, an informed and supportive community will enhance the possibilities for facility residents to integrate with the community. This approach can backfire, however, resulting in a more effective mobilisation of opposition (*ibid.*; Dear 1992).

The second strategy for avoiding community resistance is to adopt a 'low profile approach'. By this method, the facility proponent purchases or rents the housing in advance and ensures that it meets zoning requirements and then moves in quietly and establishes the supportive housing program. Local residents learn gradually of the group home's existence. Proponents of this low profile approach contend that the apprehensions of local residents dissipate through real rather than imagined encounters with group home residents (*ibid.*). A study conducted in Charlottetown, Prince Edward Island showed that people who are unaware of the existence of a social housing project in their neighbourhood are more likely to believe that such a project would have a negative impact on the neighbourhood than are people who are aware of a project (Energy Pathways Inc. 1994). As with the high profile approach, a low profile strategy can backfire. The perceived 'sneakiness' of this approach can anger the community and prompt movement toward restrictive legislation that might limit future housing developments (Wenocur and Belcher 1990).

The third strategy is a combination of the two approaches that involves informing a small group of local individuals who either need the information or who might oppose the group home (*e.g.*, leader of the neighbourhood association, local planner, local alderman).

Wenocur and Belcher (*ibid.*) found that oppositional encounters were much more likely if local residents were informed about the housing program in advance of its opening. They also discovered that the likelihood of no opposition emerging was considerably greater if neighbourhood leaders were not informed in advance of opening. The low profile approach appears to be the wisest. This finding is compatible with Dear, Taylor and Hall (1980) who found that once a mental health facility opens, the anticipatory apprehensions of the host community often subside, with experience dispelling many fears. The Charlottetown example presented above corroborates this finding. If project proponents can just sneak past the gate and avoid the anticipatory apprehensions of host community members, they will likely win them over after the home opens and real co-existence begins.

Ideological differences underlie the three strategies for dodging community opposition to group homes. In the high profile approach, there may be an assumption made that group home residents need permission from host community members to locate there. As mentioned earlier in the chapter, the focus of opposition arguments may be on the facility while the real source of apprehension is the residents. Alternatively, the high profile outreach approach may be used for strategic reasons and not ideological ones. Although, if Wenocur and Belcher's results are telling, the high profile approach should not be used for strategic purposes. The low profile approach may be grounded in the idea that group home residents need not seek permission to move into a neighbourhood. This approach could be used strictly for strategic reasons as well. In some jurisdictions, the low-profile approach is not an option. For example, in the Edmonton group home siting case presented later in the chapter, a zoning variance was required to open the proposed group home and with that a public notice was made and a meeting held. Aubry, Tefft and Currie (1995: 50) warn that:

> the adoption of a low profile in neighbourhoods may also impact negatively the neighbourhood integration of tenants by encouraging them to remain all but hidden from neighbours. At minimum, it does not contribute to facilitating contact between tenants and neighbours.

With the move toward a supported housing model in community mental health, an escape from NIMBY is conceivable. Regular apartments make up the bulk of the housing component in the supported housing model. Support services are provided by support co-ordinators from off-site.

When supported housing occurs in market rent units, NIMBY will not be an issue. When supported housing occurs in non-profit apartments, it may still occur. NIMBY is one of the greatest

obstacles to non-profit housing organisations (Manifold 1994). The difference in this case, however, is that NIMBY sentiments are not focussed on the residents with mental health issues. Those with mental health issues are integrated with other tenants and the 'psychiatric stigma' is not as great a factor. There are strategies for mitigating the impacts of NIMBY when developing generic social housing (*e.g.*, *ibid.*; Energy Pathways Inc. 1994) but these will not be explored here. On balance the 'conflict costs' (Wolch 1980) associated with the development of supported housing are considerably less than with congregate living arrangements. The discussion will now turn to the structural mechanism that has become a tool for opponents of community mental health facilities, the exclusionary zoning ordinance.

2.4 Zoning and the Arms of Government

The de-institutionalisation of psychiatric patients across North America began in the 1960s. While central governments (*i.e.*, national and provincial) have been the formulators of de-institutionalisation policy statements, it has been the local governments (*i.e.*, municipalities) that have had to interpret and orchestrate this shift. The de-institutionalisation movement began for two reasons. First, it is less costly to shelter and care for psychiatric patients in community-based facilities such as group homes than it is in large psychiatric hospitals (Warner 1989; O'Brien 1991). Second, the community mental health movement, led by advocates and later joined by people with serious mental health issues themselves, extolled community-based care for humanitarian reasons. These two thrusts occurred at the same time.

Moving to the municipal arm of government, Laws (1994) argues that socially marginalised people (*e.g.*, those with serious mental health issues) are vulnerable to urban planning measures in two primary ways. First, the land-use zoning ordinance can be used in an exclusionary fashion, closing areas of the city to certain groups of people. Second, land-use regulations can be used to redefine areas of the city. Laws (*ibid.*) uses the example of the urban redevelopment scheme, converting blighted spaces into office complexes or retail and entertainment blocks. In the second way, marginalised people are vulnerable because blighted spaces provide important affordable housing stock for people earning low incomes. These blighted (low-cost) areas are typically in the frame of the central business district and permit people without an automobile easier access to urban amenities. To understand how exclusionary zoning by-laws affect people with serious mental health issues, consider the example of Metropolitan Toronto.

In September 1978, the Ontario Secretariat for Social Development introduced its 'as-of-right' policy concerning the location of group homes (Dear and Laws 1986). Earlier that year, the City of Toronto passed a by-law that allowed for the establishment of group homes in all residential areas.

North York passed similar legislation but excluded homes for ex-offenders and addicts from areas of the city zoned for single-family residences. In 1979, Scarborough introduced a by-law permitting group homes for the mentally retarded to locate in residential areas. However, by not referring to any other groups of people (*e.g.*, those with mental health issues), this by-law excluded them. So in Metro Toronto, two of the suburban municipalities had by 1979 used exclusionary zoning by-laws to limit the as-of-right establishment of group homes deemed undesirable (*ibid.*). This was done despite the provincial as-of-right policy toward group homes and the as-of-right policy adopted by Metropolitan Toronto in June 1979. Metro Toronto's policy was modelled after the City of Toronto's and it complied with the provincial legislation.

Until 1981, suburban municipalities in Metro Toronto were successful in having the Ontario Municipal Board (OMB) approve by-laws that did not comply completely with either provincial or metropolitan policy. In April, 1983, Metro Council amended its as-of-right policy to take into account the greatest of concerns raised by its municipalities. Local municipalities were given the options of:

1. specifying the type of building in which a group home could operate;
2. setting distance requirements between group homes; and
3. restricting correctional homes to arterial roads (*ibid.*: 10).

By and large, the as-of-right principle was maintained in this amendment and on November 1, 1984, the OMB announced that it supported Metro Toronto's amendment and that the amended as-of-right policy on the location of group homes would apply to the metropolitan region. This decision formed an important precedent for other Ontario municipalities.

Exclusionary zoning practices are detrimental to the establishment of mental health group homes because they raise a warning flag in would-be host communities and summon community opposition efforts when a variance is applied for by group home proponents and a public meeting is scheduled. Zoning designations that permit only single-family dwellings and non-commercial uses, for example, were perhaps created for good reason. However, these designations were often made prior to the conceptualisation of group home living arrangements, the trademark of the de-institutionalisation movement. Notwithstanding the many definitions of family (see Eichler 1997), group home co-habitants were not considered a family unit. Group homes were also opposed on the grounds of being commercial enterprises, generating profit for the homeowner. Laws (1994: 17) states that "the legal structure of local state planning gave opponents a 'legitimate' avenue of protest if they focused their attention on the building."

As discussed earlier, objections that focussed on these issues were more likely expressions of trepidation toward the social distance that would exist between group home residents and community residents. Laws (1994) also suggests this in her discussion of social relations and how they are

defined and reproduced through the regulation of land use. Exclusionary zoning has also been criticised by feminist planners (*e.g.*, Eichler 1995) who argue that by separating land uses, women are disadvantaged. Should they choose to remain at home, for example, they are not entitled to start a home business. Further, the distance from home to other services (*e.g.*, childcare, employment) that results from the separation of land uses can be prohibitive without an automobile.

One might ask why it is that when provincial policy encourages de-institutionalisation and the as-of-right location of group homes in residential areas, municipalities are allowed to be recalcitrant. Laws (1994: 21) suggests that this issue points to an important internal characteristic of the state; namely, "the need to legitimate state actions."

Municipal government is closest to constituents. It is wise for the provincial arm of the state to involve municipalities in decision-making and policy implementation.

There is a paradox here. On the one hand, people may support the idea of pursuing the greatest public good when it involves broad policy statements (at the provincial level, for example) such as de-institutionalisation. Not only might they support the idea, they may demand that it be so. With this idea of the greater public good resting firmly at the back of citizens' minds, municipal ordinances such as exclusionary zoning provide a back door for people to use when they do not wish to deny their feelings for the public good yet in a particular instance, choose to ignore it. While adamantly supporting broad policy statements at the macro-level, citizens can still object as frequently as they wish to its actual reification at the micro-level. Here we have a rare example of a situation where one can have one's cake and eat it too. Filion (1992 as cited in Laws 1994) suggests that the more decentralised channels of power become, the more likely it is that social practices become exclusionary. Laws (1994: 7) states that "[h]erein lies the crux of community activism around the built form of the welfare state. In its most abstract form, the welfare state is a 'public good'. But when it comes to 'building' the welfare state, a conflict emerges in the 'private market'."

The City of Toronto preceded both the province and its metropolitan regional government in drafting as-of-right legislation for the location of group homes. Was it the case that the City of Toronto was simply more socially conscious than other municipalities? It is difficult to say. As noted earlier, downtown Toronto experienced a saturation of group homes and boarding homes for de-institutionalised persons. In light of this and the fact that gentrification was becoming an increasingly popular downtown trend in the 1970s and '80s (Ley 1991), it may have been rational for the City of Toronto to want to distribute community mental health facilities more widely across the city. As-of-right legislation was a step towards re-distributing people with serious mental health issues and other marginalised groups away from the inner city.

This section has once again focussed on congregate living situations for people with serious mental health issues. However, the focus of this thesis is on supported individualised living arrangements (*i.e.*, supported housing). Attention has been given to the history of congregate living and the obstacles faced by community mental health facilities because it is important to understand the historical development of mental health housing in order to appreciate the newer supported housing model. Plainly put, supported housing is in many ways much simpler to implement. Supported housing is not immune to community opposition and municipal processes, however. Earlier, NIMBY responses to general social housing developments which house people with serious mental health issues, among other tenants, were discussed. In the context of the latest discussion of municipal planning processes, the development of general social housing can be limited by exclusionary community practices. Goulet (1999) discusses how in Quebec - where municipalities that accept social housing must contribute to its funding – wealthier communities that have traditionally been able to keep social housing out, are not required to spend anything on it. This problem is a result of shifting the responsibility for social housing from the national to provincial, and finally to municipal governments. If this problem is not addressed, a 'race to the bottom' could occur between provinces and between municipalities; the winners being those with the least social housing. This could have dire consequences for residents of subsidised supported housing.

In the following section, an example of community opposition to a proposed group home for people with serious mental health issues will be presented. The example is from Edmonton, Alberta. In Alberta, the provincial department of health made a policy move similar to that of Ontario, expressing that patients from psychiatric hospitals must be re-integrated into communities. At the municipal level the effectuation of this policy statement has met with community opposition.

2.5 Case Example – Walker Way Inc.[2]

In 1995, the company *Walker Way Inc.* was started for the purpose of operating a group home for people suffering from chronic mental illness. In October of that year, a proposal went forward to the City of Edmonton, Alberta for a variance to the County of Parkland land use bylaw, in order to allow for a group home for 10 women in a single detached home of adequate size to house 12 people. The Big Lake area, site of the proposed group home, is an upper middle class area where homes are located on 'acreages' ranging in size from two to 10 or more acres. This peri-urban setting was chosen because it would situate residents outside of the inner city, where most group homes are located, and

[2] All of the information for this section was taken from the records of Donna and Bill Walker (the proponents of the group home discussed in this section). The records included letters and transcripts from the City of Edmonton Planning and Development department as well as newspaper and magazine articles.

provide a quiet home environment. The prospective home was situated on 10 acres of land and the intention was to have some farm animals and gardens as well as tennis courts and a one-hole golf course, with which the property was already equipped.

The proposal met the requirements outlined in the provincial *Personal Care Home Program* for staffing and other operating procedures. The *Walker Way Inc.* group home proposal was submitted shortly after the *Provincial Mental Health Board*, in its provincial policy framework *Mental Health Reform*, stated that the number of long-term institutional beds would be reduced by up to 50 percent over the following five years. The proposal met provincial guidelines for operation and could not have been advanced at a more appropriate time, according to provincial priorities for mental health reform. The barriers to implementation occurred at the local level.

The application for variance received the approval of the Development Officer at the City of Edmonton. However, as is common practice with applications to institute non-conforming land-uses, notice of an appeal period was distributed to Big Lake residents. Four letters of appeal were received by the City's Planning and Development department from Big Lake households and at the ensuing public hearing, members of 42 of the subdivision's 44 households were present. It was not a 'vocal minority' that opposed this development, but a vocal majority.

The four letters of appeal received by the City exhibited the same concerns discussed earlier in this chapter. In three of the four letters, residents expressed concern over the professional qualifications of the group home staff. It was expressed that staff should be required to have medical qualifications of some kind. Two letters noted that the group home would be a commercial use and therefore should not be permitted in the residential area. Below are some quotes taken from the appeal letters submitted to the City of Edmonton:

> I am a single mother raising two children on my own and Big Lake Estates was a safe place to do it until now – it worries me.
>
> All my savings put into the building of my home, which is a year old, will be affected by reduction of property value because of being immediate neighbour with the above mentioned property.
>
> We own a three acre property which backs on to the proposed group home. We are parents of two little girls ages nine and seven. **Please** understand that our children mean the world to us.
>
> We are pleading with you not to let this group home take place. Our safety is in your hands. The fear is in our backyards!
>
> NO ONE in Big Lake has a business running out of there home!
>
> So we ask you to please reconsider allowing the approval of this Group home to enter our Subdivision for the safe keeping of our four young children and the other many children in our area. Our dreams would be tarnished in raising our kids here if this is to be approved.

We are also concerned with the required qualifications of staff members of the development. The safety of the patients warrents the hiring of professionals in the health care field. We are concerned that the development does not comply with the single family dwelling nature of our neighbourhood.

At the appeal hearing, proponents of the group home presented evidence from a number of sources that property values would not decline, that neighbourhood safety would not be threatened and noise and competition for parking would be non-issues. The evidence on property values was taken largely from work by Michael Dear and his associates (discussed earlier in the chapter). The following are some examples of the evidence presented to address concerns over personal safety:

The percentage of murders among people who have been mental patients is slightly lower than that in the general population. What seems to be true is that violent people will be violent whether they are sane or insane. – Psychiatrist Donald Lunde in his book *Murder and Madness*

Despite popular opinion to the contrary, violent behaviour of any severity is rare in schizophrenics – they figure very little in the statistics for violent crime. Indeed most patients are extremely timid, dislike any show of anger and are sometimes very distressed by any irritability or show of anger by their relatives. – Dr. Brenda Lintner in *Living with Schizophrenia*

Studies done in Britain, Canada and The U.S.A. in the last 25 years show very little evidence of a correlation between mental illness and violent crimes; much less a causal relationship that mental illness causes criminality. – statement made by Dr. C.D. Webster, Head of Psychiatry at the Clarke Institute of Psychiatry and leading international expert in criminal behaviour amongst the mentally ill

Many of the arguments tabled by community members were based on misconceptions of the personae of people with chronic mental illness. A Canadian Broadcasting Corporation television documentary was shown at the hearing by the lawyer representing Big Lake residents, depicting two men suffering from schizophrenia who had been on and off drugs, had episodes of violence, and were in and out of hostels, hospitals, and jail. This documentary depicted a common stereotype of the mentally ill person but did not depict the people who would reside in the proposed group home. The lawyer also argued that the County of Parkland land use bylaw did not list group homes as an authorised use. Further, Edmonton's City Council had listed permitted discretionary uses. Group homes were not listed. The lawyer argued that if a use is neither permitted nor discretionary, then an application can not be dealt with by the Development Officer or the Subdivision and Development Appeal Board.

Once all parties were given the chance to speak, the Appeal Board deliberated as follows:

In the opinion of the Board the proposed development is of an intensity that is out of scale with the character of this low density rural country estate subdivision. The proposed development is a commercial use. Indeed, given the number of residents and the number of staff persons required to work there, it represents a very intensive commercial use.

> Further, the owners of the development would not be resident on the site, which is not characteristic of the vast majority of parcels in the subdivision. On the basis of the evidence provided the proposed development is likely to have a negative impact on property values in the area.
>
> For these reasons the development is refused.

This case example illustrates many of the points discussed throughout this chapter. The proponents of the group home took a low profile approach to establishing a group home. They did not reach out to the would-be host community prior to seeking a zoning variance. That is not to say that a high profile approach would have resulted in a success for *Walker Way Inc.*. The opposition included 42 out of 44 Big Lake households. It is likely that this proposal would have failed, no matter what the profile of approach. Looking carefully at the concerns voiced by respondents, it is clear that an education campaign of some kind was needed. The community did not understand the nature of mental illness and of the residents who would occupy the group home. Given their level of understanding of mental illness, their concerns are understandable. On whose shoulders rests the burden of community education? Some would suggest that it is the role of planners (*e.g.*, Hodge 1991).

In this example, the most prominent concerns voiced (*i.e.*, safety and the undesirability of residents) were not the reasons for refusal. Residents who may have answered positively if asked whether they supported the provincial policy toward community re-integration of the mentally ill, were able to find a back-door for their private interests. In municipal land-use legislation - the tool used by the lawyer representing Big Lake residents - a solution was found. It was noted earlier that group homes are less likely to be rejected in transient communities, typical of the inner city, and that even in stable residential areas, opposition might be restricted to a vocal minority. Although the case of *Walker Way Inc.* is but one example of community opposition to a group home proposal, the intensity of the opposition (*i.e.*, the number of vocal households) suggests that if stable communities in urban areas are resistant to group homes, the same may apply with greater force to stable communities in peri-urban areas.

The publisher of *Alberta Report*, in a *Letter from the Publisher* (Byfield 1995: 2), denounced Big Lake residents and exhorted that *Walker Way Inc.* try finding a site for its group home in the country where people are more welcoming and do not operate on a "class system". He characterised Big Lake as:

> one of those estate developments which are sold as 'country living', but which are usually characterised by perfect white fences, immense lawns, and an unpoetic aversion to pigs, mud, rusty equipment, manure piles, weedy ditches and wild saskatoons growing up through old tractor tires.

Apart from this subjective view of the prospects for country living, not a great deal has been written about the housing experience of people with serious mental health issues in small towns and rural areas. Small towns will be examined in this study.

Research reviewed to this point has focussed on either the objective experience of space by residents of mental health housing (*e.g.*, clustering, dispersal) or the subjective experiences of host community residents to group homes and boarding houses. In the next section, two shifts will occur. First, the subjective housing experience of people with serious mental health issues will become the focus of discussion. Second, supported housing, instead of supportive or custodial congregate living arrangements, will be discussed with more detail than it has been to this point.

2.6 Location – the Subject

In 1977 Dear stated in a seminal paper, *Psychiatric Patients and the Inner City*, that before action is taken to re-organise the residential and service landscape of psychiatric ex-patients, more research would need to "include consideration of patient viewpoints of the ghetto, and of the characteristics of the accepting or rejecting host community (594)."
Dear and his colleagues, whose research has been reviewed in this chapter, did a thorough job of looking at the characteristics of rejecting and non-rejecting communities. The consideration of patient viewpoints, however, has been scarcely reported in the academic literature.

In 1989 Taylor, Elliott, and Kearns stated in their paper, *The Housing Experience of Chronically Mentally Disabled Clients in Hamilton, Ontario*, that "previous studies have focussed on aggregate housing outcomes for the chronically mentally disabled in terms of ghetto formation and homelessness. Little attention has been paid to details of the residential history and current housing experience of clients.... (147)."

In 1996 Boydell *et al.* stated in their report, *An Exploration of the Desirability of Housing Location by Consumers of Psychiatric Services*, that "the desirability of the surrounding neighbourhood as a place to live has not been investigated in any great detail....To our knowledge, there has been no other research investigating the perception of housing location by people with serious mental illness (10)."

By these accounts, a thrust of important research that was identified in 1977 had been given scant attention over the twenty years following. The present review of literature has revealed no new published material addressing the experience of housing location by people with serious mental health issues since the report by Boydell *et al.* (1996). Recently, Hall (1999) stated that researchers do not pay close enough attention to the location characteristics of supported housing. In this section, a discussion of housing location will occur looking at the subjective experience of residents in supported

housing. To ease the transition in the reader's mind from the preceding discussion of objective space and host community characteristics to the subjective experience of housing location by residents, the link between health and the experience of 'place' will be briefly discussed.

The World Health Organisation has incorporated new perspectives into its definition of health (*i.e.*, "a state of complete physical, social and mental wellbeing and not merely the absence of disease or infirmity (Lee 1982 as cited in Kearns 1993: 142)"). This points to a renewed emphasis on the social environment in health (Kearns 1993). Kearns (*ibid.*) has argued for a renewed role for place in a 'post-medical' geography of health. White (1981 as discussed in Kearns 1987) proposes a socio-ecological model of health involving an interaction between a population and its social, cultural, and physical environment. The relations between people and their environments have a profound impact on health. "This contemporary understanding of health involves a situated quality which is contingent upon the configuration of elements within a given environment (Kearns 1993: 142)."

The *Healthy Communities* movement in Canada is a manifestation of this contemporary understanding of health. Inquiries that tap into subjective experiences are needed in order to understand the synergy that produces a healthy place from an individual's experience with the social, cultural, and physical environment. In this study, the 'configuration of elements' within the homes and neighbourhoods of residents living in supported housing will be examined. To end this chapter, literature that looks at the housing experience of people with serious mental health issues from a subjective point of view will be reviewed.

In Hamilton, Ontario, Taylor, Elliott, and Kearns (1989) conducted a study of the living situation and housing experience of people with serious mental health issues. The study looked at the housing situation and residential history of 66 people using face-to-face interviews. Quantitative and qualitative data were gathered and analysed. White's model of health was used as a theoretical framework for the study. Although the study did not look exclusively at residents of supported housing (*i.e.*, people in congregate living arrangements with linked support services also participated), the methodology presents a notable shift toward subjective research in the area of housing and mental health.

The quantitative and qualitative results of their study explicitly link housing satisfaction with respondents' overall ability to cope in their community. The following two narrative accounts, drawn from previous research by Kearns (1987 as cited in Taylor, Elliott, and Kearns 1989: 153) demonstrate this link:

> I'm depressed because I'm not living where I'd like to be. My housing conditions are awful. Always have been in recent years. The rooms are always small. They're never well looked after. We're packed in like rats. There are mice and bugs where I'm living now. I never seem to be in a place I really want. I always get tired of places, so end up going to another one hoping it will be

> better. But it isn't, so I move on. It makes it worse because I'm used to better conditions. Right now I'm on Wellington. There's too much traffic and it's a slum. I just sit there and feel I'm just totally in the wrong place.
>
> I've found that if I don't have a good living situation, I'll end up back in hospital. I'm serious when I tell people I get suicidal if I don't have a good place to live.

Despite efforts to improve their living situation, respondents frequently had to accept unsatisfactory conditions. For the chronically mentally disabled, concluded the authors, the primary cause of stress is inadequate housing conditions (Taylor, Elliott, and Kearns 1989). Even with modest housing expectations, respondents reported problems of housing availability, accessibility, and affordability.

It is important to draw upon the personal accounts of people with serious mental health issues in research that investigates their housing experience. Boydell *et al.* (1996) do that in their study of the desirability of housing location in Toronto. Their research relies entirely upon the accounts of residents in supported housing. Although the definition of supported housing used by Boydell *et al.* differs slightly from the one used in this study (*i.e.*, some of the participants, although residing in housing where support services are de-linked from the home, were in housing developments exclusively for tenants with mental health issues), the findings of their study are telling and easily transferable. The results of their study, incorporating the responses of 60 individuals to a semi-structured one-to-one interview process, illustrate how residents "feel about where they live, what they like and dislike about it, and what their ideal neighbourhood would look like (*ibid.*: 11)."

All 60 participants in this study indicated that the neighbourhood they lived in was critical to their health and wellbeing. The majority of tenants found the surrounding neighbourhood less appealing than the immediate neighbourhood inside their building. The majority preferred to live in residential areas rather than commercial ones, although a few preferred mixed areas. Tenants felt that they were less integrated with the surrounding neighbourhood than they were with their immediate neighbourhood. Safety was an issue of concern for many respondents in the surrounding neighbourhood but not in the immediate one, although this varied between low-class, lower-middle class, and middle-class neighbourhoods. Transportation, followed by shopping, banking, and the availability of cheap restaurants and coffee shops were considered the most important community services and supports. A particularly interesting finding of this research was that in several cases tenants felt uncomfortable in housing with other marginalised groups (*e.g.*, criminal offenders, abused women). Instead, they would prefer to be among others who share a common psychiatric history. In a thematic analysis of interview responses, several themes were revealed. Residents 'making do' with their neighbourhood environment was prevalent, as was 'tolerance' and 'gratitude.' 'Encountering

and accommodating stigma' was another theme that emerged across the respondents' narratives (Boydell *et al.* 1996).

In their discussion of the program, policy and research implications of their work, they state that first and foremost, "it should be recognised that consumers of psychiatric services are able to determine and express their own needs and preferences (*ibid.*: 74)." Indeed these perceptions are the best predictors of housing success. Richardson (1990: 117), in her discussion of narrative in sociology, states that:

> although narrative has been rhetorically marginalised, justified within conventional sociology during "exploratory" research or when used as human "filler" to "flesh out" statistical findings, I will argue that narrative is quintessential to the understanding and communication of the sociological.

The understanding and communication afforded by individuals' related experience is equally as important in planning research. In the inherently political practice of planning, where communication is a means to an end as well as an end in itself, planning research that incorporates 'voices from the borderlands' is important (Sandercock 1998).

> If we want to achieve social justice and respect for cultural diversity in multicultural cities, then we need to theorise a productive politics of difference. And if we want to foster a more democratic, inclusionary process for planning, then we need to start listening to the voices of difference (*ibid.*: 109).

Sandercock's definition of multiculturalism is expanded slightly by including people with serious mental health issues, but it keeps with the spirit of her argument. The conclusion here is that if planning as a practice is to incorporate the various and disparate voices in a community, planning research must also make a shift toward representing those same voices in a meaningful way. Objective abstractions of urban and regional space are insufficient for informing practising planners of the experience of citizens. Robust and systematic research that incorporates the perspectives of people with serious mental health issues on their housing environment should be of interest to planners. Boydell and her colleagues have conducted such research. The research conducted for this thesis also takes this approach. One weakness in the work done by Boydell *et al.* (1996) is that they neglected to propose courses of action based upon the findings of their research. A critical component of this thesis is the avenues for action that are determined based on what residents say and what decision makers in the mental health and housing fields advise.

2.7 Conclusion

The literature reviewed in this chapter has accorded with four themes: the location of housing for people with serious mental health issues across urban space, community attitudes toward mental

health facilities, zoning issues and the political paradox, and the subjective housing experience of people with serious mental health issues. A brief discussion of the contemporary 'post-medical' definition of health was also included.

A number of areas remain underrepresented in the literature on housing and mental health. First, research conducted in small and mid-size Canadian cities is scarce. Second, research on the housing experience of people with serious mental health issues in small towns is absent. People may choose to remain in smaller settlements because of kinship, familiarity, and quality of life (Everitt and Gill 1993) and a definite link exists between these and the contemporary concept of health as a socio-ecological construct.

It is understood that both mental health support services (*e.g.*, Thurston-Hicks, Paine, and Hollifield 1998; Stout 1998) and affordable housing (Wellington and Guelph Housing Committee 1999) are less prevalent in small towns; however, the experience of residents of supported housing has not been systematically investigated, to my knowledge. One anecdotal account from an anonymous woman in her late twenties with schizophrenia reads that "before I came to Edmonton I worked in a small town with the mentally handicapped but word just sort of got around about me that I suffered from the illness (*schizophrenia*) and so I moved to the city (1993: 6)."

Third, research that focuses on residents' perspectives of their housing environment, particularly the neighbourhood characteristics, housing design, and residential history, rarely appears in the literature. Buttimer (1980 as interpreted by Kearns 1993: 141) claims that "explorations of the insider's experience of and interaction with place should inform planners' decisions."

Fourth, compared with research on group homes and other congregate living arrangements, research that looks at supported housing is not as common. This is not surprising, given that it is the newest model of housing for people with serious mental health issues. The research undertaken for this thesis will address these four areas. In the next chapter, the different models of housing for people with serious mental health issues will be examined. The focus in the next chapter is not on the spatial aspects of housing, but on the internal environment. The philosophical underpinnings of the evolution of mental health housing will also be reviewed.

CHAPTER THREE

HOUSING AND HEALTH: THE EVOLUTION OF HOUSING FOR PEOPLE WITH SERIOUS MENTAL HEALTH ISSUES

3.1 Introduction

The qualities of housing environment and the state of household health are connected. This connection is the subject of much research in the field of housing and mental health. In this chapter housing and health will be examined and the differential effects of housing on health among residents of custodial, supportive and supported housing for people with serious mental health issues. Following a discussion of these three different community-based housing models, the 'best practices' literature will be reviewed. Its assertions about housing and support for people with serious mental health issues will be highlighted. Finally, homelessness among people with mental illness will be examined.

3.2 Housing and Health

Debates over the lack of affordable housing and homelessness often occur without direct reference to the link that exists between housing and health. Environmental factors associated with housing, both physical and socio-cultural, contribute to the decrement or continued good health of residents. This section looks at the link between housing and health generally. This is an important starting point for the chapter, before moving into a discussion of housing specifically for people with serious mental health issues.

The link between health and physical environment is not new. City planning grew out of the ill health of industrial cities in Britain during the early nineteenth century where there was widespread concern over fresh air, pure water, green open space, sunlight, and how the lack of these contributed to physical ailments (Lindheim and Syme 1983). By the late nineteenth century, these concerns had spread to all major cities of the western industrialised world. In 1875, Benjamin Ward Richardson developed the idea of *Hygeia* (City of Health), a utopian community incorporating natural ventilation, sunlight, and gardens for each house. Ebenezer Howard introduced the *Garden City* concept in 1898 advocating the development of low-density, planned communities that combined the advantages of both rural and urban living (*ibid.*; Hugo-Brunt 1972). *Garden City* was to separate noxious industry from the other aspects of a community. Both new town planning and suburban development have applied Howard's concepts liberally. In 1920, Le Corbusier introduced *Radiant City*, consisting of skyscrapers surrounded by parkland. His model subsequently influenced the design of many public housing projects. Marmot (1982 as cited in Lindheim and Syme 1983: 336) remarks that: "Light, air

and sunlight, fresh water, adequate disposal for waste, and provision of generous greenery was the planners' antidote to the evils of industrialisation."

In 1957 Pond (as cited in Duvall and Booth 1978) noted that limited scientific evidence existed to support the widely held belief in an interdependence between housing quality and health. Kasl and Harburg (1975 as cited in Duvall and Booth 1978) concluded the same almost two decades later. In 1978 Duvall and Booth, citing inconsistent results and methodological deficiencies in the literature, reported on their study examining perceived adequacy of space and privacy; structural deficiencies of the dwelling; and non-structural deficiencies of the dwelling such as noise, cold and pests. Their study population comprised women in Toronto, Ontario. They determined that the health of women was adversely affected by three types of environmental factors. These were space problems and the availability of privacy, major and minor structural deficiencies in the condition of the home, and the non-structural deficiencies of excessive noise, lack of heat during winter months, and the presence of pests. Of particular interest is the link that they found between measures of mental health and the presence of excessive noise and space and privacy problems. This connection is corroborated by Lowry (1991) and Ineichen (1993). The authors stressed that only four to 14 percent of the variance in physical and mental health could be explained by environmental factors, a modest but significant effect.

In a more recent study of the effect of housing 'stressors'[3] on the health of marginalised populations in urban New Zealand, Kearns, Smith, and Abbott (1991) found that housing stress is significantly related to perceived health and mental distress. For example, inadequate housing revealed a significant relationship with higher psychiatric symptom levels (Kearns and Smith 1993). The authors also determined, however, that dwelling conditions and the experience of being inadequately housed may not in themselves be key predictors of health and wellbeing. More widespread economic and social deprivation are the key predictors (Kearns, Smith and Abbott 1991). Although housing stress is not the key predictor of health and wellbeing, there is a significant relationship between the two. Kearns and Smith (1993: 278) summarise the significance of the interrelationship between socio-economic status, housing, and health by stating that:

> Among populations that are seriously constrained in the housing market, this relationship (*i.e., between inadequate housing and poor health*) may be attenuated by the provision of adequate and affordable housing.

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[3] In a factor analysis, housing stressors clustered into three dimensions: **dwelling condition**, *i.e.*, physical housing problems, state of repair, access to utilities; **health/comfort**, *i.e.*, warmth, space, prevalence of pests, satisfaction of residents with their dwelling and neighbourhood, dwelling related health problems; and **expense**, *i.e.*, rent as a percent of household income, weekly rental amount.

It is not only the dwelling itself that will affect residents' physical and social wellbeing, but also the surrounding neighbourhood. Positive externalities associated with proximity to shops, services, jobs, recreation or negative externalities associated with proximity to pollution, noise, traffic, and crime, can all contribute to personal wellbeing (Smith, Kearns and Abbott 1992). Further, residential mobility can be either a source of, or a response to housing stress. If residential mobility is a result of unfettered personal choice, it can represent an attempt to improve personal wellbeing. If it is the result of forces beyond one's control (*e.g.*, increase in rent, eviction), it can diminish one's wellbeing (Kearns and Smith 1994).

Lindheim and Syme (1983) have noted the importance of considering social environment in a discussion of environments and health. Cassel (1976 as cited in Lindheim and Syme 1983) found that a lack of meaningful social contacts resulted in higher rates of schizophrenia, tuberculosis, alcoholism, accidents, and suicide. This was confirmed by a person with schizophrenia (Peterson 1982) who stressed that loneliness and a lack of meaningful social activity leads to a real deterioration in mental health. A substantial literature (*e.g.*, Holmes and Rahe 1967, Tyroler and Cassel 1964 and Weiss 1973 as cited in Lindheim and Syme 1983) connects changes in one's place of residence, job, social status, and marital status with higher rates of many diseases, including schizophrenia. Lindheim and Syme make the pivotal argument that healthy environments are not necessarily ones that fit idealised images drawn up by planners and architects. Rather, healthy environments provide "a range of opportunities for inhabitants to shape the conditions that affect their lives (*ibid.*: 338)."

They present evidence that disease occurs more frequently when:

> (a) supportive ties between people are interrupted, (b) people occupy low positions in a hierarchy, resulting in feelings of low self-esteem, less opportunity for meaningful participation, and less control over conditions affecting their lives, and (c) people are disconnected from their biological, personal, and historical past (*ibid.*: 353).

One of the problems associated with urbanisation is that it diminishes the likelihood that supportive social relationships can exist. The movement of people from rural areas and small towns to cities for employment and the promise of higher living standards can result in profound changes to interpersonal relationships. While rural exchanges tend to involve face-to-face contacts between people who meet and interact frequently and in different phases of activity, urban contacts are often more superficial and utilitarian rather than personal and emotional. The quality of interpersonal relationships and a connection to cultural heritage are important to personal wellbeing and health. As such, involuntary migration from a familiar town to an anonymous city can have adverse effects. As discussed in the previous chapter, people in rural areas who suffer from serious mental health issues may be pulled toward cities to receive support services. Given the impact that interrupted supportive personal ties and disconnection from one's biological, personal and historical past can have on health

and wellbeing, it is easy to understand the negative consequences this type of move can bring. Some prefer city life, however. Others perhaps seek anonymity. It is sometimes the case that people with serious mental health issues wish to move away from their small town to a larger city because the 'entire town' may know that they are ill and this can make living there uncomfortable (Czarny 1999a).

In 1996, Doyle, Burnside and Scott published *The Single Parents' Housing Study*, which was grounded in Lindheim's and Syme's (1983) three-point conceptualisation of the determinants of health. The purpose of the study was to determine the characteristics of a health-promoting housing environment. The focus of the research was the social environment of housing. Single parents in co-operative, public, non-profit, and market rent housing were interviewed to explore the health promoting qualities of housing environment. The hypothesis investigated was that "the stability provided by social housing developments with subsidised rents would lead to differences in the lives of the families involved, by offering opportunities to expand social networks and take on new roles (Doyle, Burnside and Scott 1996: 2)."

Presumably, heightened housing stability, expanded social networks, and new roles would lead to better health and wellbeing. The results showed that *influence* (*e.g.*, freedom to express opinions about how housing is run and the knowledge that one's opinion is taken into account in management issues) proved to be the most significant predictor of respondents' belief that their housing was good for their physical and mental health, as well as for the health of their children. Income was the most important predictor of wellbeing. This keeps with the research reviewed earlier in this section as well as other literature that reviews the link between psychological distress and class experiences (*e.g.*, Brown and Harris 1978 and Turner and Noh 1983 as cited in Byrne *et al.* 1986). As Doyle, Burnside and Scott note in their executive summary (1996: 2):

> The major influences on health and well-being are macro-level factors that determine socio-economic status – it is these that disrupt ties, assign low positions and deprive people of respect and the ability to control their lives. Housing was treated in this study as a mid-level variable that could mediate those factors to the degree that it was a health-promoting environment.

In this section, literature that investigates the general connection between housing and health was reviewed. The link can be broadened beyond the dwelling to include the neighbourhood setting as well. The contribution of a housing environment to personal health and wellbeing may in fact be only a modest one (although some research suggests that the social environment of housing makes a greater contribution than the physical). Socio-economic status is still the greatest predictor of health and wellbeing. Smith, Kearns and Abbott (1992) and Kearns and Smith (1993) note that an important addition to research on housing and health would be a focus on ethnographic accounts of residents' housing experiences. The research conducted for this thesis focuses on residents' experiences.

As aptly noted by Simmons (1990: *xi*), there has been an enormous change in the general paradigm of mental health:

> Whereas until the 1950s it was assumed that mental illness required treatment by psychiatrists in a hospital setting, by the 1960s the antipsychiatry movement had begun to question the very nature of mental illness, and, in Thomas Szasz's famous phrase, to talk about the "myth of mental illness."

In the following sections, the evolution of housing for people with serious mental health issues will be presented and the link between different housing models and residents' wellbeing will be debated.

3.3 Housing the Mentally Ill (pre-1930)

Insane asylums began to be built in Ontario in the mid-1800s, beginning in 1850 with one on Queen Street in Toronto. The second provincial asylum was opened in Kingston in 1856 and the third in 1870, located in London (Heseltine 1983). Twelve asylums, or as they came to be more properly known, mental health hospitals, were built. They ranged in capacity from 235 patients in Woodstock to 1,550 in Whitby (Simmons 1990). These institutions served a number of purposes, not all related to mental health. They provided treatment, shelter, asylum, and custody services for a diverse clinical population. This population included the 'insane', criminals, vagrants, the retarded, physically ill persons, and others considered unfit for society at large (Heseltine 1983). These asylums were a dumping ground, as capacity permitted, for the undesirables of society. They played a complementary role at this stage in history to the correctional system and its prisons. The office of the Provincial Secretary, where from asylums were administered before 1930, was also charged with administering prisons, charities, and other public institutions (Simmons 1990). Administrators were easily tempted to hide other manners of undesirable citizen away in these asylums than those with true mental illness. An example of this is the notorious Grace Marks, a house-keeper convicted in 1843 of murdering her employer, the wealthy Thomas Kinnear and his head house-keeper and lover, Nancy Montgomery. Initially Marks was imprisoned in Toronto but was moved to the insane asylum in Kingston after it opened. The following excerpt is taken from Margaret Atwood's novel *Alias Grace* (1996: 33). It depicts the thoughts of the protagonist, Grace Marks, shortly after being transferred to the Kingston asylum for no apparent reason:

> They wouldn't know mad when they saw it in any case, because a good portion of the women in the Asylum were no madder than the Queen of England. Many were sane enough when sober, as their madness came out of a bottle, which is a kind I knew very well. One of them was in there to get away from her husband, who beat her black and blue, he was the mad one but nobody would lock him up; and another said she went mad in the autumns, as she had no house and it was warm in the Asylum, and if she didn't do a fair job of running mad she would freeze to death; but then in the spring she would become sane again because it was good weather and she could go off and

> tramp in the woods and fish, and as she was part Red Indian she was handy at such things. I would like to do that myself if I knew how, and if not afraid of the bears.

Although Atwood has added some artistic quality to the story, the life of Marks was well researched before writing. Her main factual reference on the life of Grace Marks was Susanna Moodie's 1853 book, *Life in the Clearings*.

Asylums quickly became overcrowded. The number of staff was too low and their role was custodial in nature. Heseltine cites an example of this low staff-to-patient ratio where in 1878 there were about 390 patients under the care of 14 attending staff, or 'keepers' as they were called, at the Rockwood Asylum in Kingston (Kingston Psychiatric Hospital 1981 as cited in Heseltine 1983). The patient population continued to rise through the twentieth century and custodial care remained the key tactic to managing the mentally ill.

3.4 Housing the Mentally Ill (1930s-1960s)

The mental health system is known for its stagnation and administrative inertia. Mental illness does not attract the same degree of sympathy from others as physical disability, for example. There is a mythology about mental illness that invokes fear. This is one of the reasons why the greater public has been content for so long to leave the mentally ill in the unquestioned care of those who would volunteer to care for them (*i.e.*, psychiatrists and more recently psychologists, social workers, rehabilitative therapists, *etc.*).

An important change occurred when in 1931 the provincial mental health service was transferred from the office of the Provincial Secretary to the Department of Health (Simmons 1990). A new director was also appointed for hospital services and he brought with him a new spirit for innovation. This new director, Dr. B.T. McGhie, began by establishing a network of mental health clinics associated with the mental hospitals and a network of 'approved homes' that provided residences for people who could live outside of hospital. He also started a probationary system where patients were released from hospital into the care of family or friends (*ibid.*).

The approved homes program relieved some of the overcrowding in psychiatric hospitals; however, the problem persisted. In 1948 the Department of National Health and Welfare described psychiatric hospitals as 'snake pits' with bars, locks, and restraints, essentially 'herding' ever-increasing numbers of patients into their confines (Richman and Harris 1983 as cited in Heseltine 1983). This 'warehousing' was partly due to the fact that mental hospitals were understaffed and operating on insufficient budgets. Further, many people who were not in need of institutional supervision remained in the psychiatric hospitals simply because there was nowhere else to go. The approved homes made strides toward addressing this problem, but were insufficient. Bear in mind that

during this time period universal health insurance did not exist and so it was often those with the fewest resources who remained in psychiatric hospitals indefinitely. The cost of hospital stays was covered by the Ontario government while community-based facilities like approved homes were not.

During the 1950s, another segment of innovation occurred and some of the psychiatric hospitals in Ontario established outpatient and travelling clinics. As well, general hospital psychiatric units began to appear (*ibid.*). With these changes began a new era in mental health.

3.5 Housing People with Serious Mental Health Issues (1960s to present)

During the 1950s, western countries began to take a close look at their mental health care systems. A gradual shift began away from the provision of custodial care in large mental hospitals towards short-term care in general hospital psychiatric units, travelling clinics, and community-based housing and support services. The use of approved homes increased dramatically. Between 1952 and 1965, the number of patients in approved homes rose from 735 to 1,688 (Ontario Department of Health Annual Reports as cited in Heseltine 1983).

Also during this time, new psychotropic medications were introduced that effectively controlled many of the symptoms of mental illness that previously prohibited patients from moving into community-based care facilities. With these new medications, outpatient care and community-based care options became very viable. The total number of hospital beds dedicated to mental health in Ontario was about 16,000 in the early 1960s (*ibid.*). By the end of March 1982, there were only 4,514 patients registered in provincial psychiatric hospitals. Psychiatric hospital units are far more costly to maintain than their community-based equivalents. So even though there was a move toward community-based care afoot for ideological reasons, perhaps the greatest motivation (if not the most widely cited) for the move to community was financial.

The establishment of new community-based services did not keep pace with de-institutionalisation, however. Many newly discharged patients received inadequate care in the community as services were stretched beyond capacity. This is still the case today. Chronic under-funding has been a problem in the mental health system from its outset.

In 1964, the Ministry of Health attempted to rectify the problem of insufficient capacity by passing the *Homes for Special Care Act* (*ibid.*). These homes for discharged psychiatric patients ranged from lodging houses and licensed nursing homes to licensed residential care. Homes for Special Care are still present and they will be discussed in more detail later on.

The community mental health movement, whose origins can be credited in part to a seminal report published in 1963 by the Canadian Mental Health Association called, ***More for the Mind***, was what really propelled community-based housing and support services. Another important factor was

the introduction of universal health insurance in Ontario in 1972. This allowed citizens the choice of whether to seek community-based or hospital care. Prior to this, under the Ontario Hospital Insurance Plan (1959), every citizen was assured of hospital care regardless of income level. Community-based care was not included. So the economically disadvantaged found their way into hospital care while the mentally ill with some income or support from family and friends could receive care in their communities.

The evolution of community mental health care has many facets. The underlying theme, however, is the idea that long-term hospital care is not the best method of rehabilitation for most people with mental illness. The community mental health movement placed great emphasis on the empowerment of people with serious mental health issues and on comfortable and safe housing and support within a community setting. Now the focus will turn toward community-based housing and support services in Ontario following de-institutionalisation.

3.6 Community-Based Housing for People with Serious Mental Health Issues

The government of Ontario is 'getting out of the business of housing'. Presently, the impacts of this move on the availability of housing for people with mental illness, who, incidentally, are also likely to be drawing on social assistance and be in need of affordable housing will be discussed. Many in this sub-population require support services that are either linked to or separate from their homes. Another administrative issue to bear in mind is that the government of Ontario is in the midst of downloading the responsibility for social housing to municipal governments.

Housing stability is an issue for people who are living with low incomes or paying a large proportion of their income on rent. The figure cited recently to represent the number of Ontario tenants who are at risk of losing their homes is 300,000 (Record 1999). A remarkable proportion of these 'precariously' housed people suffer with serious mental health issues. Stable housing is an essential component of a high quality of life. This point can be made more forcibly with respect to the mentally ill sub-population because their mental health will seriously deteriorate if stability in housing and support services is not ensured. Carling notes (1995: 23) that "relapse, in fact, is a reality in living with a psychiatric disability." In communities where strong and stable support services exist, however, relapse into an acute state of mental illness is not as disruptive to an individual's life as it is in communities where support services are unstable or absent. A person's housing, work, and social network are far less likely to be irreparably disrupted.

The cost of housing is not the only factor in secure tenure for people with serious mental health issues. There are different types of supportive and supported housing for people with mental illness and a logical connection can be made linking individual choice between the various types of

residence and stability. If a person must live in a residential and support environment that is not appealing, it can be said that this arrangement is not as stable as someone else's who has chosen a type of residence suitable to his or her tastes. Choice is inextricably linked to stability and stability, in turn, to mental health. People suffering from mental illness must have choice and stability in their housing.

There is evidence to support the importance of decent and affordable housing associated with adequate supports, in improving community integration and quality of life for people with serious mental health issues (OFCMHAP and CMHA 1998). If the permanent housing needs of this group are not addressed in policy and practice, their situation will deteriorate. Having established that choice and stability are essential to mental health, this section will examine different types of community-based housing that exist for people with serious mental health issues. The processes and outcomes that lead to community integration and an improved quality of life will be discussed in the context of different housing styles. Three general categories of housing, proposed by Parkinson, Nelson, and Horgan (1998), will be compared and discussed. They are custodial, supportive, and supported housing (see Table 3.1).

In the following two sections, these housing styles will be compared according to physical/architectural and social dimensions. Each type of housing differs according to these dimensions and as a result, residents of each experience different levels of community integration and quality of life. Following this, a discussion of housing qualities (social and architectural/physical) that increase resident quality of life and integration will occur. This discussion will transcend the three-part typology of housing (*i.e.*, custodial, supportive, and supported).

One of the dangers of comparing pre-set categories and determining which category is best, is that innovative new approaches to housing that perhaps rest somewhere between the categories can be overlooked. On the other hand, a discussion of housing alternatives without defined categories would result in a lengthy comparison of an unlimited variety of arrangements. The heuristic strengths of the three-part housing typology will be used at the beginning and then the qualities that should be present in any housing arrangement for people with mental illness, without appeal to the typology, will be examined. The notion of choice and a range of housing styles is important. Individual preferences for housing should be realised among those with serious mental health issues, as among any segment of society.

Table 3.1: Defining Characteristics of the Three Approaches to Housing

Defining Characteristics	Type of Housing		
	Custodial	Supportive	Supported
Profit Orientation of the Support-Provider	• Support-provider offers housing as a for-profit business	• Support is provided by a non-profit agency	• Support is provided by a non-profit agency
Nature and Terms of Support Provided	• In-house staff provide care services (e.g., meals, cleaning, medication) • Rehabilitation services (e.g., skills training, social skills training, supportive counselling, encouragement of outside activities) may be provided by staff from outside the setting	• Consumer survivors accept rehabilitation services (e.g., skills training, social skills training, supportive counselling, encouragement of outside activities) as a condition of housing • Rehabilitation services may be provided by in-house staff or staff from outside the setting	• Staff from outside the setting may provide rehabilitation services (e.g., skills training, social skills training, supportive counselling, encouragement of outside activities) as requested or chosen by individual residents • Rehabilitation services provided are individualised and tailored to each person
Degree of Consumer/Survivor Empowerment (choice and decision-making control)	• Consumer survivors have little choice over the type of housing, who their living companions are, or the support they receive • Staff have control over most of the decisions in the residence	• Consumer survivors have little choice over the type of housing, who their living companions are, or the support they receive • Staff and consumer survivors make most decisions together	• Consumer survivors have complete control over the type of housing, who their living companions are, and the support they receive • Consumer survivors have control over all decisions regarding their housing

Source: Parkinson, Nelson and Horgan 1998, p. 8

Custodial Model

The custodial approach to sheltering former psychiatric patients was the first following the start of de-institutionalisation in the late 1950s and early 1960s. This approach is characteristic of board-and-care homes, Homes for Special Care, and nursing homes (Trainor *et al.* 1993: 494). Private care-providers provide these institutional type residences for-profit. They are not designed to offer

mental health rehabilitation services, simply supervised housing. Staff are typically responsible for care services such as meal preparation, dispensing medication, and cleaning, although supportive counselling may be provided on an informal basis. Support co-ordinators from outside agencies may also agree with the home and its residents to provide counselling services. An average number of residents in custodial housing is 17 (Wilson and Kouzi 1990 and Nelson *et al.* 1997 as cited in Parkinson, Nelson, and Horgan 1998).

The inadequacies of custodial housing models are well known (*e.g.*, Nelson *et al.* 1994; Trainor *et al.* 1993; Lehman, Slaughter, and Myers 1991; Baker and Douglas 1990). Trainor *et al.* (1993) have asserted that people with serious mental health issues often prefer the freedom of the streets to living in restrictive custodial settings. In custodial settings, residents follow a daily regimen of eating, sleeping and interacting with one another. While there may be many house rules to follow, residents often have no instrumental roles. They may not be involved in doing chores, participating in rehabilitation programs, or other activities such as decision-making. The focus in these for-profit homes is often on long-term care and not rehabilitation. In this sense, they do not differ from provincial psychiatric hospitals. One resident of a board-and-care home noted (Allen 1974: 5):

> 'in the community' does not mean – as is frequently inferred from this phrase – 'in a less impersonal, more humane environment.' There are many aspects of board and care home living that 'institutionalize' a person just as much as does some hospital care.

The main motivation of the community mental health movement is the integration of people with serious mental health issues into regular society. Without an emphasis on support services and instrumental community roles (*e.g.*, paid or volunteer work in the community, decision-making power and responsibilities in the home), community-based housing and support falls short.

Supportive Housing

In the late 1960s, there was movement toward increasing community services for people with serious mental health issues. The fundamental difference between custodial and supportive housing is that the latter incorporates rehabilitation into the residential environment. Supportive housing presents a continuum of residential facilities, with residents graduating from homes with high support to ones with lower support as their condition improves. The desired end of this housing system is to see residents eventually move out on their own, drawing on a flexible support system as needed. Examples of supportive housing facilities where residence is permanent and not contingent upon support needs are more commonplace today than in the past (Nelson, Hall and Walsh-Bowers 1995). This move toward making supportive housing permanent housing reflects ever-changing philosophies of resident care and empowerment, changes that hinge upon the wellbeing of residents.

The two most prominent types of supportive housing are group homes and supportive apartments. As many as six to 12 people may reside in a group home and in apartments, the standard occupancy is one or two. Supportive housing is generally run by non-profit agencies and the staff is usually trained in counselling or other rehabilitative skills. The move away from custodial settings toward supportive housing represented a positive shift for people with serious mental health issues. However, many custodial care homes still exist today.

Supported Housing

Supported housing emerged in the 1990s. This new model of housing focuses on person-centred support, self-help, and natural supports with a de-emphasis on professional services (Parkinson, Nelson, and Horgan 1998). This model represents an important move away from the 'medical model' of community residential settings. The idea behind supported housing is that by empowering people to 'choose, get, and keep' the housing and support services they want, they will experience their residence as a *home* rather than as *housing* (Carling 1993 as cited in Parkinson, Nelson, and Horgan 1998). Indeed, Srebnik *et al.* (1995: 139) concluded that "the relationship of choice to community success over time demonstrated that choice was positively related to housing satisfaction, residential stability, and psychological well-being."

The supported housing approach recognises that people challenged by severe and persistent mental illness still desire normal things. Hogan and Carling (1992: 216) present a case for the shift toward supported housing:

> The mental health system's emphasis on a 'continuum' of options, intended to allow movement to clients through the system, is now understood to be a problematic approach for many individuals who need both reduced stress and increased continuity of supports. Also, it has become clear that a facility-based approach (relying on group homes, halfway houses, and so forth) is too costly to meet the needs of the large number of individuals with psychiatric disabilities who need housing. There is growing recognition that separate or special housing is much more likely to meet with community resistance, such as zoning battles (Ridgway, 1987), and is less likely to facilitate client participation in community life, than is the use of integrated, 'normal' housing (Carling and Ridgway, 1987). Finally, and perhaps most fundamentally, there is increasing recognition that people need 'homes', not housing (Carling, in press; Nagy and Gates, in press).

The intention of custodial, supportive, and most recently, supported housing, has always been de-institutionalisation and integration of people with serious mental health issues with the greater community. These models, particularly the latter two, were products of the community mental health movement. They would likely have emerged in the absence of this movement because they are less expensive than institutional care. The difference may have been the time to their emergence. The

degree to which community-based housing alternatives held to the 'medical model' would likely have been higher had the community mental health movement not emerged.

All three models of housing are practised today; however, supported housing is beginning to dominate. As mentioned earlier, a range of housing alternatives is needed to provide choice in housing and support service. However, the custodial model need not persist. It offers no benefit to residents that supportive housing cannot. There are two features that really distinguish supported housing from supportive housing. The first is the 'choose, get, keep' philosophy of supported housing. The second is that in supported housing, housing and support services are de-linked. Each person chooses the kind of housing desired and the type and frequency of support services.

3.7 The Physical/Architectural Dimension of Mental Health Housing

If it is understood what physical characteristics of housing design appeal to residents, then they can be planned for. Favourable characteristics can be built into the housing. The qualitative results of a study of board-and-care homes, supportive group homes, and supportive apartments by Nelson *et al.* (1995) revealed two themes. Participants generally felt positively about their housing situation and there was a general need for more privacy (*ibid.*).

There are two important things here. First are the findings themselves (*i.e.*, generally positive feelings and need for privacy). Second, there is a commonality between the housing concerns of residents in each of the three types of housing. In the custodial setting (board-and-care homes), the supportive group homes and the supportive apartments, the same concerns arose. Supported housing was not included in this study. Residents of all manners of housing had generally positive feelings about their housing situation and residents wanted more privacy.

Residents from all types of housing appreciated the affordability of their home, its location relative to essential services and facilities, and residents thought that their home provided a safe learning environment "within which basic life skills could be acquired" (*ibid.*: 228). It was generally felt that the housing offered a good a transition between the psychiatric hospital and independent living. Two points worth noting here are that residents considered their housing to be transitory and the findings transcend the different housing models.

Privacy was an issue. Some group home residents complained about sharing bedrooms, some residents in supportive apartments disliked having a roommate(s), and some board-and-care residents complained about sharing bedrooms and general over-crowding. Again, the issue transcends the different types of housing. The issue considered in the following sections is whether, given that some of the same issues arise in different types of housing, a difference in magnitude can be detected. It is hypothesised that although the same concerns arise across the different housing models, the concerns

will be most pronounced in custodial settings, second most in supportive housing, and least consequential in supported housing.

Custodial Model

In a longitudinal study of residents' emotional wellbeing and personal empowerment, Nelson, Hall, and Walsh-Bowers (1998) found that different types of housing were associated with different outcomes. They identified issues of privacy, number of residents, safety, and maintenance as significant in residents' responses. Negative affect, dissatisfaction with quality of life, and lack of privacy, were consequences of poor physical design. Serious privacy issues were raised in custodial care housing. In some of these homes, as many as four unrelated adults can share a bedroom (Czarny 1999b). Homes for people with serious mental health issues with fewer residents are associated with positive views of the social environment, less psychological distance from other residents and staff, and less anxiety and passivity. Fewer residents can also lead to greater self-sufficiency (Nelson *et al.* 1994; Nelson, Hall, and Walsh-Bowers 1997 and 1998). Homes where residents have their own bedroom are linked to positive affect and emotional wellbeing. A two-factor theory of emotional wellbeing consisting of pain-avoidance and growth needs was tested by Nelson, Hall, and Walsh-Bowers (1998) to understand how housing characteristics affected residents. They found that when residents "fail to have their basic pain-avoidance needs met for stable and predictable housing because of poor-quality housing conditions and a lack of privacy, they experience emotional stress and possibly psychiatric symptoms (*ibid.*: 59)."
Their results show, however, that no matter how appealing the physical design higher order needs for personal growth can not be satisfied through design.

Community integration is an objective of mental health housing. Custodial care homes tend to bear a negative stigma. Unlike supportive apartments or supported housing that does not stand out differently from normal housing, custodial care homes are often obvious in appearance. The stigma of custodial homes can lead to negative feelings in the immediate community and to the misunderstanding of mental illness and the people who suffer from it. They appear as little psychiatric institutions planted in residential areas.

Supportive Housing

The physical environment of a home affects interaction between residents. The theory of understaffing (Barker and Gump 1964 as cited in Nelson, Hall, and Walsh-Bowers 1998) postulates that the size of a facility and the degree of resident involvement in its operation are inversely related. As a home increases in size – for example, to the size of a custodial care home – it becomes less of a

home and more closely resembles a "holding facility" (Nelson and Smith-Fowler 1987 as cited in Nelson, Hall, and Walsh-Bowers 1998: 67). Supportive group homes are generally smaller than custodial settings and as a result, greater interaction between residents and staff occurs. In accordance with the theory of understaffing, the smaller size of the home implies fewer staff. Fewer staff implies a more active role for residents in the home.

Lack of privacy tends to be less of an issue in supportive housing than in custodial care homes. Nelson, Hall, and Walsh-Bowers (1998: 66) recommend that "even in small, well-kept supportive residences, a ratio of two or more residents per bedroom must be regarded as unsatisfactory."

With respect to safety, Lehman, Slaughter, and Myers (1991) note that safety is not noticeably higher in supportive group homes and apartments than in custodial board-and-care homes (in terms of robberies and assaults). This is an interesting and counter-intuitive finding.

After facilitating a housing design charrette, Johnson (1997) found that both private and common space are important components of supportive housing. Some participants proposed that social space be incorporated into work areas (*e.g.*, laundry rooms, kitchens). They also suggested that homes have common spaces of different sizes, so that different group sizes can comfortably be accommodated (*ibid.*).

Negative stigma is an issue with supportive housing, as with custodial homes. Neighbourhoods are often reluctant to accommodate group homes and housing that is openly 'dedicated' to people with mental illness (see Chapter Two). Supportive apartments dispersed within apartment buildings housing a variety of socio-economic groups typically draw the least amount of attention from neighbours.

Supported Housing

Supported housing is a model that emphasises 'normalcy' and resident choice with de-linked support services and increased opportunity for self-help. Resident independence and integration into the community is paramount in supported housing. One of the successes of supported housing is that it reduces or eliminates negative stigma associated with housing for the mentally ill. Supported housing is typically apartment units rented either at market value or at a subsidised rent (*i.e.*, Rent-Geared-to-Income). Baker and Douglas (1990) discovered that people with serious mental health issues who were enrolled in a community support services program and living in the worst residential environments had the greatest number of unmet service needs. Further, poor housing showed significant relationships with poor community adjustment outcomes. Whatever the support received,

it was found that those living in inappropriate or physically inferior housing displayed more maladaptive behaviours.

Most people with serious mental health issues want to live in their own apartment. Research documents this (Keck 1990, Livingston, Srebnik, King and Gordon 1992, Tanzman, Wilson and Yoe 1992, Yeich, Mowbray, Bybee and Cohen 1994 as cited in Ogilvie 1997). It has been determined that people with serious mental health issues want services such as help acquiring housing. A major barrier to independent living is the lack of affordable housing and inadequate rent allowances in government assistance programs (*e.g.*, Ontario Works, Canada Pension Plan Disability Benefits, Ontario Disability Support Plan).

Having stated that most people with serious mental health issues prefer living alone, it must be noted that those same people also reported wanting help from case managers to deal with emotional upsets and making friends. In the next section, the social dimension of mental health housing will be discussed. The physical/architectural and social dimensions overlap considerably in their effects on the wellbeing of residents. It is still interesting to consider the two in isolation.

3.8 The Social Dimension of Mental Health Housing

Social support, control in decision-making, quality of life, personal growth, staff management-style: these are all themes and outcomes that derive from evaluation research on the different types of housing for people with serious mental health issues. Social support from living companions, staff, and people outside of the residence is very important to the quality of life and positive affect of residents (Baker, Jodrey and Intagliata 1992, Earls and Nelson 1988, Nelson *et al.* 1992 and 1995, Hall and Nelson 1996 as cited in Nelson, Hall and Walsh-Bowers 1998). Friends and living companions are the people with whom residents most often socialise and recreate. In the previous section it was stated that the physical dimension of housing did not satisfy personal growth needs. Earls and Nelson (1988) note that residents reporting a greater frequency of supportive interaction had a tendency to report a higher positive affect. They did not test the hypothesis that the greater the frequency of negative interaction, the greater the tendency to report negative affect. That would be an interesting investigation, as the authors so acknowledge. What follows is a discussion of the social dimension of mental health housing, divided by housing type.

Custodial Model

The power relationship between staff and residents in any mental health housing arrangement is very important. The degree to which residents feel empowered to make decisions concerning their lives and their residential environment is worth examining. In custodial care homes, the balance of

power rests with the staff. The management style in these homes can be imposing. What is important to realise, however, is that if management is participatory, it is by choice of the owner/operator of the home, not by right of the residents. Therein lies the greatest flaw in the decision-making structure of custodial care homes.

Segal and Moyles (1979 as cited in Nelson, Hall and Walsh-Bowers 1998) reported that residents in settings where management was staff-centred showed greater dependency than in settings with a more resident-centred management structure. Kruzich and Berg (1985 as cited in Nelson, Hall and Walsh-Bowers 1998) found that the rigidity of daily routine, de-personalisation and block treatment of residents, and the social distance between residents and staff, were inversely related to residents' self-sufficiency. It is clearly documented that custodial care homes are inadequate in meeting the growth needs of people with serious mental health issues. In many cases, they are inadequate in meeting their pain-avoidance needs (*e.g.*, overcrowding is commonplace, with as many as four people in a bedroom). Social support networks and peer network size are correlated with positive affect (*ibid.*; Earls and Nelson 1988), however, it is likely that the negative aspects of custodial settings outweigh the network size that exists in these homes by virtue of the large number of residents in them (*i.e.*, average of 17 residents).

Supportive Housing

Supportive housing provides a more empowering environment for residents leading to a higher quality of life and general satisfaction. There are exceptions to this generalisation. For example, Hodgins, Cyr, and Gaston (1990) discovered some very negative impacts of supportive apartments on residents. They found that the supervised (supportive) apartments evaluated in their research were like mini-asylums with no staff. Residents received little support and the congregation of many residents with mental health issues into one apartment complex made for a stressful living environment. Disturbing behaviour (*e.g.*, attempted suicides, violence, drug/alcohol abuse) by fellow residents also contributed to a stressful living environment.

Supportive housing has received many positive social reviews. In their evaluation of supportive apartments, Nelson, Hall, and Walsh-Bowers (1995) discovered that residents' role involvement in the community and staff-rated independent functioning increased significantly. McCarthy and Nelson (1991 as cited in Nelson, Hall and Walsh-Bowers 1995) found similar results with residents of supportive group homes. Both of these studies showed positive changes in residents' personal coping strategies and in inter-personal relationships within peer networks. While evaluations of supportive apartments and group homes were generally positive, friction between house/roommates was an issue. Some respondents were troubled by the psychiatric problems of their living

companion(s). People with serious mental health issues do not have a monopoly on roommate tensions. Friction between housemates is common among people in general. Senior citizens residing in homes for the elderly have exhibited depression or expressed concern over living with other seniors in a disadvantaged state.

Residents of supportive group homes have expressed resentment toward 'paternalistic' treatment by staff members (McCarthy and Nelson 1993). On the one hand residents expressed, according to quantitative data, that they had considerable freedom and control in their residence. When qualitative data in the same study was analysed, however, it became clear that while residents had input into decision-making, staff ultimately made the final decisions. Staff also had unilateral control over such things as chore schedules and meal times. Democratic decision-making, even with respect to daily routines (*e.g.*, cooking, cleaning), is important in the development of competence (*ibid.*).

To make the transition from this discussion of the social dimension of supportive housing to the next section on supported housing, consider the following excerpt from Nelson, Hall, and Walsh-Bowers (1995: 16):

> Supportive apartments do not meet the criteria of consumer choice and normalisation which underlie the philosophy of "supported housing" (Hogan and Carling 1992). In supportive apartments as in group homes, consumer/survivors are residents, not tenants; while they can express preferences, they do not have control over the choice of their living companions.

Supported Housing

The supported housing model recognises that when people have control over decision-making and participate in their residential environment, they experience personal growth and general wellbeing. Financially, supported housing is less expensive than custodial and supportive housing facilities.

Supported housing, while empowering residents to 'choose, get, and keep' their homes, can also be associated with negative attributes, particularly isolation. With the de-linking of support and housing that characterises this model, residents in a one-bedroom apartment without a roommate, for example, may experience loneliness. The informal support present in a group living arrangement is absent. Ideally, one would remedy this problem of isolation by living with a roommate. Given the philosophy of supported housing, that roommate would be chosen, not assigned.

Another remedy for isolation that is employed by a number of mental health agencies, is to assist clients with finding jobs, paid or volunteer. There are many social benefits to living in supported housing, the most notable being genuine empowerment. But there are also disadvantages. This thesis explores the housing experience of people in supported housing. The advantages and

disadvantages, according to residents, will be discussed in later chapters. What should be clear to the reader by now is that both supportive and supported housing have advantages and disadvantages. This will be discussed in the next section. The custodial model of housing offers no positive attributes that supportive housing does not. However, it does present more drawbacks.

3.9 Discussion without the Typology

Grouping different styles of housing into categories, as in the past sections and in much of the literature on housing for the mentally ill, serves a number of purposes. One is that it makes a discussion of alternatives manageable. A second purpose is that it allows people to associate different categories with a paradigm in the mental health service field. For example, custodial models are associated with the medical model that dominated in mental health prior to the mid-1960s. Supportive housing coincides with a consumer empowerment paradigm and a move toward more integrated living. Supported housing can be paired with the patients' rights movement and the ever more pronounced consumer empowerment paradigm.

To discuss the qualities of good supportive and supported housing, however, the categories must be transcended, looking at housing qualities. It is important to realise that though on average, certain qualities may appear more readily in a given category, they are also likely to appear in others. If they do not now, they could in the future. Most importantly, a range of choices for people with serious mental health issues must exist. Imagine how absurd a researcher would appear if he or she did a study of quality of life among the general population attempting to determine whether it was highest in apartments, single-detached homes or co-operative housing projects. The absurdity would not be in the study itself, but in its recommendations should the author recommend something like:

> Based on my findings, I recommend that we stop building single-detached homes, apartments and other residential developments, except co-operative housing projects, because on average, this is the type of residential setting people seem to think that they would prefer.

In the past sections, the physical/architectural and social dimensions of custodial, supportive, and supported housing were discussed. Housing for people with serious mental health issues should be designed for privacy as well as common living. At the very least, individuals require a bedroom for themselves. Staff management style and resident empowerment were discussed and it is clear that empowerment and autonomy is important to residents, as it is to most human beings. Personal growth was discussed and it was determined that personal growth does not result from the physical/architectural dimension of housing, but from the social, particularly the strength of social and peer support networks. The physical/architectural dimension does contribute to general wellbeing and by association, health. So does the social dimension.

Both supportive and supported housing have important roles to play in satisfying the range of preferences among people with serious mental health issues for independent or group living. The custodial model should be abandoned as it offers nothing that supportive or supported housing can not. It does present unique problems that do not exist in the other two models of housing.

The next section presents the most widely accepted 'best practices' in housing and support for people with serious mental health issues.

3.10 Best Practices in Housing and Community Support

In 1997, the *Best Practices in Mental Health Reform Project* was published and has since been the standard reference for mental health agencies and planners. The project was funded by the *Federal/Provincial/Territorial Advisory Network on Mental Health*, which includes officials from Health Canada and from the provinces and territories. This network of decision-makers acts as an intergovernmental forum for national collaboration on mental health issues. The *Health Systems Research Unit* of the *Clarke Institute of Psychiatry* (HSRU) was commissioned to complete the project.

In this section, the best practices in housing and community support will be presented. Housing and community support is only one element in the spectrum covered by the best practices literature. First, the conclusions of the HSRU with respect to housing and community support will be presented with a summary of the results of their literature review on alternative practices. Second, a case example of a supported housing partnership in British Columbia will be described. This case example was thought to be a good approximation of best practices in supported housing.

To address the housing and support needs of people with serious mental health issues, best practices indicate that:

> a range of different housing alternatives needs to be provided, but that there should be a shift in resources and emphasis to supported housing. The supported housing approach encompasses use of generic housing widely dispersed in the community, provision of flexible individualised supports which vary in intensity, consumer choice, open-ended tenure and provision of case management regardless of whether a client moves or is hospitalised. While supported housing is appropriate for many individuals, an array of staffed community residential housing must also be available for those with special needs. Studies have found that assertive community treatment is effective for very difficult-to-house populations such as the homeless (HSRU 1997c: 6).

HSRU notes that there must be a variety of housing alternatives available, ranging from supervised community residences (*e.g.*, supportive housing) to supported housing, with emphasis on supported housing (*ibid.*).

The findings yielded by their review of literature showed that community-based housing and care is equally or more effective than institutional care and that further research in this area is

unnecessary (HSRU 1997a). Also, a growing body of knowledge is developing to substantiate the claim that supported housing is the most widely acceptable model of housing and community support. Research findings summarised by HSRU (*ibid.*) show that:

- Supported housing is preferred by consumers, in part because it allows choice to be exercised;
- Supported housing can serve a wide variety of individuals with severe mental illness, including homeless individuals; and
- Assertive case management programs can successfully support individuals in various housing arrangements.

Although the supported housing model is the most popular, Bachrach (1994 as cited in HSRU 1997a) warns that no single model can satisfy the needs of all long-term mental health consumers. For example, in a two-year follow-up evaluation of a housing program in Hamilton, Ontario, where residents lived in bachelor apartments with flexible support provided from the Hamilton Psychiatric Hospital, it was discovered that most men preferred independent living while most women preferred living in a group setting (Kirkpatrick and Younger 1995). The reason most cited by women for this preference for group living was safety. Many women with serious mental health issues have histories of violence and abuse. A full range of housing - from tertiary care in psychiatric hospitals to group homes with 24-hour support to supported housing – is needed to satisfy all types of demand. It is not clear, however, what proportion of people would be best served by supported housing arrangements and what proportion by arrangements such as group homes.

Planners and policy-makers are also warned not to embrace supported housing simply because it is the most cost-effective model and then to re-direct the savings away from the mental health system and perhaps, in-so-doing, under-fund the support component of the supported housing model. This occurred following de-institutionalisation. After moving patients from institutions to the community, politicians may forget their concomitant commitments to direct savings toward building community capacity for mental health care. What occurs is an increase in the number of homeless people with serious mental health issues. "Experience suggests that if necessary support components are not made available and/or not funded appropriately, supported housing is likely to turn into another version of the custodial living arrangements of the past (HSRU 1997a: 48)."

The *B.C. Housing/Mental Health Partnership Program* in the Lower Mainland, British Columbia, is cited as a good approximation of best practice in supported housing (HSRU 1997b). In response to a recognition by B.C. Housing that mental health problems were affecting housing retention by many tenants, and that people with serious mental health issues were having difficulty accessing subsidised housing, a partnership was formed with the Ministry of Health. A social housing provider and advocate (1999) in Guelph, Ontario notes that the success rate for finding and keeping

housing is much lower among people with serious mental health issues than among other groups. Even when housing is found, eviction is a barrier to success.

The B.C. project stemming from this inter-ministerial partnership served to 'demystify' mental illness for a major public landlord, resulting in increased access to affordable housing for people with serious mental health issues. A protocol agreement between the two ministries outlines the responsibilities of each partner. The B.C. Housing Management Commission (BCHMC) in the Ministry of Municipal Affairs and Housing is the supplier of housing and the Mental Health Division (MHD) of the Ministry of Health provides program staff, known as 'health services consultants', who provide support to tenants and to housing staff. From 1991 to 1997, BCHMC made 300 subsidised housing units available for people with serious mental health issues. The functions of this partnership program are:

- to increase access to subsidised housing units administered by BCHMC for individuals with severe and persistent mental illness;
- to assist current BCHMC tenants who exhibit behavioural problems and/or mental illness to maintain their unit and access appropriate support services;
- to educate BCHMC staff about mental illness and to teach BCHMC staff how to manage tenants with behavioural problems or mental illness; and
- to provide critical incident stress debriefing to BCHMC staff and tenants exposed to traumatic events (HSRU 1997b: 55).

In the B.C. example, residents are offered 'normal' housing dispersed in the community. In an effort to encourage integration, the number of residents with serious mental health issues is limited in any property to a maximum of 10 percent. Preferences for single occupancy are respected with most units being bachelor apartments. Supports are flexible and not linked to specific locations. The program is supported by formal agreements and policy between the two ministries and resources for program staff were obtained by reallocation within the Ministry of Health (HSRU 1997b). The success of this program has made it a best practice model in B.C. and the Ministries of Health and of Municipal Affairs and Housing are extending the agreement to all existing and newly developed subsidised housing units (over 75,000 units) managed by B.C. Housing and other non-profit housing organisations.

This program successfully engaged the co-operation of landlords by identifying and responding to their needs; namely, stable tenants who pay the rent on time. Further, if tenants displayed psychiatric symptoms that were disturbing to landlords or other residents, landlords could immediately contact a health services consultant linked to their property. A neutral administrative body (*i.e.*, Mental Health Division) was used so that no perception of preferential treatment would exist among different mental health centres and housing projects. In an attempt to minimise stigma, program staff were called 'health service consultants' instead of mental health workers (*ibid.*).

One important caveat given by the HSRU (1997c) about applying best practices models is that they are not 'detailed blueprints'. They provide a general program of action to be tailored to the circumstances of a region and its mental health system. The planning principle is one of cultural relevance and suitability given local conditions (Bachrach 1984 as cited in HSRU 1997c). In the final section of this chapter the condition of homelessness among people with serious mental health issues will be discussed.

3.11 Homelessness and Mental Illness

The plight of homeless Canadians has received a great deal of attention over the past few years. The scope of homelessness in Canada has been cast as perhaps our greatest national embarrassment. In this section, homelessness among people with serious mental health issues will be discussed. Housing options for this population will also be reviewed.

Figures vary concerning the proportion of homeless people who have a mental health issue. Recently, the Mayor's Homelessness Action Task Force (1999) in Toronto concluded that between 30 and 35 percent of homeless people are living with mental illness. They also found that the proportion is much higher (*i.e.*, 75 percent) among homeless single women. It is difficult to reach consensus on the proportion of homeless people who suffer from mental illness. Definitions of homelessness vary considerably, ranging from an inclusion of those who are precariously housed to a strict focus upon those using emergency shelters and hostels. Different definitions of mental illness and differences in research methodology are two more issues confounding attempts at certainty and generalisability. This is not terribly discouraging, however, because the proportion of homeless people with mental health issues will vary widely between regions and states, depending on local infrastructure. For example, an area with a well-developed mental health network will see a smaller proportion of its homeless suffering from mental health issues. Definitions of homelessness can be contentious for political reasons as well. The broader the definition of homelessness, the larger the problem. Morrissey and Gounis (1988) discuss some of the political controversies that have occurred in the United States around counting the homeless.

It is not the aim of this thesis to look, in any great detail, at homelessness. This has been done by other authors (*e.g.*, *ibid.*; Mental Health Policy Research Group 1997; Dietrich *et al.* 1999; Botschner 1998; Smith 1999). It is sufficient to say that a significant and recognisable proportion of homeless people suffer from serious mental health issues. In Chapter Five estimates of the proportion of homeless people with serious mental health issues in the study area will be presented.

There is some harmony in what researchers consider to be the 'pathways' into homelessness. The breakdown of close personal relationships, physical and mental health issues, insufficient income,

inadequate housing, and limited choices are all catalysts to homelessness (Dietrich *et al.* 1999; Mayor's Homelessness Action Task Force 1999; Mental Health Policy Research Group 1997). A lack of community supports for people with serious mental health issues is also a problem. The lack of community supports paired with a general lack of affordable housing makes supported housing a challenge to implement. For many years it has been widely believed that de-institutionalisation is a major cause of homelessness among people with mental illness. The issue has been that ex-patients are discharged into the community without adequate community support programs in place to receive them. A study done in Toronto (Mental Health Policy Research Group 1997) challenges this notion. In this study of the 'pathways into homelessness', only six percent of the homeless people in the sample had been in a psychiatric facility in the year prior to their experience of homelessness. Research by Jim Ward Associates (1991 as cited in Botschner 1998) concluded that the major impact of de-institutionalisation occurred about twenty years ago. Botschner (*ibid.*) cautions that in Wellington and Dufferin Counties, the picture is less clear given the ongoing mental health reform in the province. Indeed, in 2004 the London Psychiatric Hospital (LPH) is to close. The Regional Municipality of Waterloo and the County of Wellington are both within the catchment area of LPH. If the capacity of the community mental health systems is not increased by the time LPH closes, the number of homeless people with serious mental health issues will increase. The point to remember here is that in any discussion of the impact of de-institutionalisation upon the homeless population, local context must be considered.

The Mental Health Policy Research Group (1997) found that only three percent of those interviewed had lost their housing because of mental illness. It makes sense that mental illness by itself would not be a direct cause of homelessness. However, mental illness does limit people's ability to work and earn a living. Social assistance and housing allowances today are insufficient for meeting the cost of housing in Ontario. Most people with serious mental health issues rely on some form of social assistance for their livelihood. The plight of people with mental health issues is not entirely different from that of other disadvantaged groups like single mothers, children, and recent immigrants. There is simply not enough income, not enough housing, and not enough community support services (Dietrich *et al.* 1999). What really distinguishes the predicament of people with mental illness from these other groups is that without adequate mental health support services to complement housing, the risk of losing housing increases. The risk of re-institutionalisation also rises. Eviction can be a serious barrier to maintaining housing if mental health support services are absent.

Most published literature on mental health and homelessness looks at urban areas. Botschner (1998), in his study of homelessness among people with severe mental health problems in Wellington

and Dufferin counties, identifies some important service delivery issues pertaining to rural areas and small towns.

> Subtle differences in the ways that people view social and service relationships, implicates the importance of a sensitivity to local cultural differences. For example, rural case managers have spoken of the fact that in the northern part of Wellington county, connections to family, however difficult, tend to remain strong (*ibid.*: 19).

According to one rural advocate, inadequate housing and transportation are the two biggest issues in rural areas (Cole 1999). Geographic isolation, lower service density, transportation issues, and cultural differences make mental health support services more of a challenge to provide. In keeping with the earlier discussion of health and place, it is interesting to note Botschner's (*ibid.*: 22) recommendation that "service should be planned and implemented in such a way as to take into account clients' mental or emotional 'place', their present capabilities, and the physical settings in which they feel most at ease."

Having now established that homelessness is an important concern in the mental health community, the question remains how best to provide housing for this group. The answer given in the 'best practices' literature is that "a wide range of housing options with varying degrees of supervision and support is needed (HSRU 1997a: 46)."

Researchers agree that the needs of the homeless mentally ill are complex and diverse. Outreach models using assertive community treatment are important in ensuring stability in housing and support for homeless people suffering from serious mental health issues. A range of different housing and support alternatives is necessary to adequately house those homeless people who suffer from mental illness. Supported housing is one suitable model of housing for many in this population.

3.12 Conclusion

In this chapter, the link between housing and health was made. Reference was made to both the physical and social qualities of housing and their effects on residents' health. The evolution of housing for people with serious mental health issues was charted, from asylums in the mid-1800s to the present day debate over different models of community-based housing and support. The model of housing and support most advocated for today is supported housing which de-links the housing from the support provider. Housing is generic and integrated within the community and support services are flexible, provided by mental health support agencies. The 'best practices' literature echoes the confidence in this model of housing but adds that a range of housing and support alternatives is necessary to satisfy the varied demands of people with serious mental health issues. Homelessness

among people with serious mental health issues was discussed and some distinction was made of the rural experience.

In the field of housing and mental health a considerable amount of research has been aimed at evaluating the processes and outcomes of group living arrangements, such as supportive group homes and custodial board-and-care homes. Much less has been done in the area of supported housing. Still less work has looked critically at the experiential knowledge of residents, a source of knowledge that is very important to the study of housing and mental health (Nelson *et al.* 1994; HSRU 1997c). This thesis looks at the housing experience of people living in supported housing in small and mid-size cities and towns. The focus in on neighbourhood characteristics and the physical and social characteristics of supported housing, from the point of view of residents.

In the next chapter, the policy environment surrounding housing and mental health will be examined. It is a time of mental health reform in Ontario and across the country. It is interesting to review the evolution of mental health and housing policy and how it keeps pace with the academy and the perspectives of mental health advocates.

CHAPTER FOUR
MENTAL HEALTH AND HOUSING POLICY

4.1 Introduction

There is evidence that government has recognised the connection between quality of life and health. In a vision of health for Ontario, the Premier's Council on Health Strategy listed health care as only one among many factors influencing health (Ministry of Health 1993). Areas that affect general quality of life have been highlighted in recent health reform policies. Education, housing, employment programs, programs that create new jobs and new opportunities, and programs that improve the quality of our physical and social environments are key components of Ontario's health reform policies.

The Premier's Council on Health Strategy, in determining Ontario's vision for health care reform, cited Japan and Sweden as examples of where far less is spent on health care per person and where citizens live longer and healthier lives. This is attributable to healthy public policies that incorporate broad socio-economic indicators in health monitoring and subsequent policy goals. In 1993, the NDP government in a background statement to its highly regarded mental health reform policy *Putting People First* (*ibid.*: 4) noted that:

> Ontario has one of the best health care systems in the world, yet there are growing signs our system isn't working the way it should. For the past 10 years, spending on health care has increased significantly each year. Ontario is now spending $17 billion – more than 32% of the total provincial budget – on hospitals, physicians' services, laboratory tests, drugs and community-based services.
>
> We might be able to justify this huge investment in illness care if the people of Ontario were becoming healthier. But that is not the case. A number of key studies over the past five years have shown that spending more on illness care doesn't necessarily improve health.
>
> So, instead, the Government of Ontario has endorsed the vision of a system that focuses less on treatment and more on health, more on co-ordination than on growth, more on effectiveness than past practice, more on the community than on institutions, and more on people than on services. This vision is now guiding the reform of the entire health care system, including mental health reform.

This vision of mental health care reform is still favoured by mental health agencies, advocates, and consumers in Ontario. The most recent mental health policies drafted by the present government (Ministry of Health 1999a,b) have, for the most part, built upon the NDP's policy perspective. Some incongruencies exist, however, and they will be discussed below.

Across Canada, the same shift is occurring in health policy and mental health reform policy more specifically (*e.g.*, Nasir 1995; [Alberta] Provincial Mental Health Board 1996; [British

Columbia] Ministry of Health and Ministry Responsible for Seniors 1998). Policy makers have long acknowledged the need for an appropriate balance between institutional 'illness care' and community-based sectors. In 1995, little evidence existed in Canada to support the claim that an actual shift in that direction had occurred (Wanke *et al.* 1995). Since 1995, progress has been made, however, policies tend to be more ambitious than reform activity. In Ontario, mental health reform has been 'planned to death' over recent years. Action has lurched forward infrequently and sometimes inconsistently with plans.

Below, a review of mental health policy over the past decade and a half will occur. Also, a discussion of general housing policy will help to complete the picture of Ontario's mental health and housing policy environment. Supported housing, the reader will remember, consists of two components. The first is adequate and affordable housing, engendering the physical and social requirements for housing-related health. The second is de-linked mental health support services, provided in-house by community-based agencies.

4.2 Mental Health Reform in Ontario

A number of reports have been written about the mental health system in Ontario since the early 1980s and each has built upon the previous reports. In 1983, the Heseltine Report: *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective* recommended that the Ontario Ministry of Health pursue the goals of a "balanced and comprehensive mental health care system" and "a separation of treatment and accommodation (CMHA 1999: 9)."

The Graham Report (1988): *Building Community Support for People* built upon Heseltine's recommendations and presented a strong case for a system of community-focused mental health services in Ontario. Within its 19 recommendations, 11 essential services were discussed and among those were residential support and housing (Ministry of Health 1996a). People with serious mental health issues were to be the target population served by mental health reform because it was and still is believed that if capacity is developed to meet their needs, the needs of those with milder forms of mental distress will also be met.

Following the release of the Graham Report, District Health Councils (DHCs) began to develop five-year plans for mental health services, involving people with serious mental health issues and family members in the process. A *DHC Planning Review Group* was then created to review the plans of all DHCs, ensuring that they followed the recommendations of the Graham Report. This led to the publication in 1993 of *Putting People First: The Reform of Mental Health Services in Ontario* (Ministry of Health), a ten-year mental health reform strategy. This document advanced a common vision for reform in Ontario and established measurable targets and timelines such as fiscal shifts from

institution to community, bed ratios, hospitalisation rates, and key service ratios (CMHA 1999). Housing was identified as one of four key components in the mental health reform strategy. The other three key components were case management, crisis intervention, and initiatives by people with serious mental health issues and family members.

Benchmarks for housing and support were developed following the publication of *Putting People First*. These benchmarks along with the targets and timelines put forward in 1993 formed the basis for the Systems Design planning process that was completed by all DHCs in 1996. In the study area of this thesis, two plans were completed: one by the Wellington-Dufferin DHC, and one by the Waterloo Region DHC. On April 1, 1998, the two DHCs merged. The study area for this thesis coincides with District boundaries for the new Waterloo Region – Wellington-Dufferin DHC.

In early 1998, the half-way point in the 10-year reform strategy initiated by the NDP government, the Honourable Elizabeth Witmer, Minister of Health, commissioned a review of progress. The response from the mental health community was that the principles and direction of mental health reform were still sound. The major concern was that the current government needed to take the next steps in the implementation of reform by designing a clear implementation strategy for the second five years and most importantly, take action (CMHA 1999).

In 1999, *Making it Happen* was published by the Ministry of Health in response to this need for a clear implementation strategy. It is the policy that presently guides mental health planning. It builds upon previous reform initiatives and maintains the benchmark figures and targets outlined previously. Its recommendations on service delivery and co-ordination follow closely the best practices literature reviewed in Chapter Three (HSRU 1997a,b,c).

The goals for the implementation plan are to ensure that core mental health services and supports:

- are provided within a comprehensive service continuum developed to meet client needs and based on best practices;
- are part of the broader health and social services service continuum;
- are organised and co-ordinated to ensure that clients have access to the services that best meet their needs;
- are appropriately linked to other services and supports within geographic areas;
- facilitate a shared service approach to serving the needs of individuals with serious mental illness who have multiple service needs;
- achieve clear system/service responsibility and accountability through the development of explicit operational goals and performance indicators; and
- are simplified and streamlined according to the client's needs.

In 2002, the Ministry of Health will review the implementation plan and revise its strategies and program funding priorities as necessary (Ministry of Health 1999a).

In *Making it Happen*, the Ministry of Health reiterates its commitment to look at the provision of community-based treatment services to people with serious mental health issues and, in addition, to look at substantive solutions to the housing needs of this group. The document states that "support services will be individualised and flexible, with respect to type, amount and continuity of service, to meet the unique and changing wants and needs of the client to assist them in developing and maintaining independence (*ibid.*: 26)." The Ministry of Health also anticipates increased demand in these areas as the reduction of psychiatric beds proceeds according to the plans of the Health Services Restructuring Commission. The Ministry has established a *Mental Health Housing Steering Committee* to oversee the development of housing policy and implementation that will include:

- developing better housing definitions, utilising the expertise of current supportive/supervised housing providers, to cover the housing continuum; and
- surveying, analysing and reforming the supportive and supervised housing sectors.

Nelson, Lord, and Ochocka (1996, 1997, and 1998) present a different perspective on the evolution of mental health policy. Their study, *Shifting the Paradigm in Community Mental Health: A Community Study of Implementation and Change*, was done in Kitchener-Waterloo and occurred in three phases over three years. The study was done collaboratively with three community mental health agencies and the Waterloo Region District Health Council to study the process of planning and implementing change in an evolving policy environment. The researchers begin by defining what they mean by a 'paradigm shift' and this definition serves as a framework for the study.

> A paradigm shift "involves a fundamental change in one's assumptions and values about an issue, not simply improving upon an existing framework....For us, a paradigm shift in community mental health includes the following three values: a) stakeholder participation and empowerment, b) community support and integration, and c) access to valued resources (Nelson, Lord, and Ochocka 1996: 1)."

In Table 4.1 the traditional paradigm in mental health services is compared to the emerging paradigm, based on these three values. The table depicts a change within the traditional paradigm from an 'institutional-medical model' to a 'community treatment-rehabilitation model' (*ibid.*). This represents an improvement within the existing framework but not a genuine paradigm shift. The basic assumptions of the traditional paradigm still hold.

Table 4.1: Changing Paradigms in Community Mental Health

Key Values	Traditional Paradigm		Emerging Paradigm
	Medical – Institutional	Community Treatment – Rehabilitation	Community Integration – Empowerment
Stakeholder Participation and Empowerment	Lack of voice and choice of consumer/survivors and family members Consumer/survivor dependence on professionals, patient role Professional role as expert	Consumer/survivors and family members have input, but professional is still in control Consumer/survivor dependence on professionals, client role Professional role as expert	Increased power, choice, and control of consumer/survivors in their relationships with professionals, consumer/survivor and family participation Autonomous consumer/survivor organisations, citizen role Professional role focuses on collaboration and enabling
Community Support and Integration	Professional services Institutional locus Stigma, focus on illness	Professional, paraprofessional, and volunteer services Community locus Stigma, focus on psychosocial deficits	Self-help/mutual aid, individualised and informal supports Integration in community settings and social support networks Focus on whole person, recognition of strengths and potential for growth and recovery
Access to Valued Resources	Segregated institutions Sheltered workshops	Residential continuum of housing programs Vocational training and placement	Supported housing Supported employment and education

Source: Nelson, Lord, and Ochocka 1996, p.6

In the traditional paradigm, people with serious mental health issues are in a dependency relationship with professionals who hold power and expertise. Whereas once this professional power was held primarily in institutions, it has now moved into the community. 'Community-based' is not synonymous with empowerment. In the traditional paradigm, people with serious mental health issues are stigmatised by their separation from mainstream society (*e.g.*, in group homes or psychiatric

institutions, sheltered workshops, daily activity). In the emerging paradigm, the focus is on the "whole person and acceptance and integration into community settings and natural support networks (*ibid.*)."

Access to valued resources like regular housing, employment, and friendship in normal community settings is the goal of the emerging paradigm.

The authors note that policy documents at the provincial and local level show an evolution over time from a medical-institutional to a community treatment-rehabilitation approach. Documents in the 1990s reflect the values of the emerging paradigm although elements of the community treatment-rehabilitation approach are still present. Key informants in their study questioned whether the language of policy, reflecting the emerging paradigm, was actually being translated into action (*ibid.*). For example, with the reduction of funding to and in some cases closures of psychiatric hospitals, staff resources there are being 're-packaged' as community alternatives, such as Assertive Community Treatment (ACT) teams. ACT teams are strongly advocated for in *Making it Happen*. In January 2000, the Waterloo Region ACT team operating out of the London/St. Thomas Psychiatric Hospital began serving patients in Waterloo Region.

> Thus, in the changing policy context, there continues to be competition for scarce resources between the medical-institutional sector (still the strongest force), the community treatment and rehabilitation sector, and non-service supports controlled by consumer/survivors and family members and based on an emerging paradigm (still the weakest force) (*ibid.*: 4).

The systems design plans developed collaboratively with the mental health community in 1996 have been put on the back shelf as recent discussions focus on institutional issues (*e.g.*, ACT teams, local hospital psychiatric beds). People with serious mental health issues have described ACT teams as a "hospital without walls" and as "demeaning" (Nelson, Lord, and Ochocka 1998: 2). With this focus on institutional concerns, attention is moving away from the issue of access to valued resources, such as housing and employment initiatives. Mental health funding continues to be channelled into professional services such as ACT teams and psychiatric beds in local hospitals, rather than into provincial psychiatric hospitals. The forces behind these changes are the Ministry of Health, the Health Services Restructuring Commission (created by the Ministry), and provincial psychiatric hospitals (*ibid.*).

While mental health reform policy has been progressive since the early 1980s in advocating for community-based mental health services, the implementation of policies appears to be more dependent upon political factors. While a policy may read well, the implementation stage can play out in a number of directions depending upon political forces such as the government in power and a strong lobby from the medical profession. Funds that are being re-distributed from institutions to

communities are still largely caught up in treatment services like psychiatric beds in local hospitals and ACT teams. Access to valued resources for people with serious mental health issues needs to remain a high priority. The paradigm shift that is written in policy must be translated into practice.

4.3 Housing in Ontario

Access to adequate housing is a human right. Skaburskis and Brunner (1999) found that housing affordability figured among the top four problems faced by planning directors in Canadian urban areas. The study included urban areas with populations of at least 10,000 in 1991. Canada lacks a federal policy on homelessness (Lero 1998 as cited in Barber 1998). Canada has preferred to deal with social issues like housing on a crisis by crisis basis, without foresight (Barber 1998). Homelessness used to be associated with single men, often old. Two-parent families, single mothers, and senior citizens are now frequent among the homeless. People who have completed post-secondary education are also among the rank and file of homeless Canadians.

The Ontario Non-Profit Housing Association (ONPHA) and the Co-operative Housing Federation of Canada (CHFC) have recently published a report on the state of the housing crisis in Ontario (ONPHA and CHFC 1999). A discussion of affordable housing is imperative in any look at supported housing for people with serious mental health issues, given that adequate and affordable housing is one of its two key components.

A three percent vacancy rate is widely accepted as the minimum acceptable to ensure a competitive rental market. In 1998, the average vacancy rate for apartments fell from 2.8 to 2.6 percent in Ontario. This downward trend is likely to continue (*ibid.*). In October 1998, seven of the 11 municipalities in the province had vacancy rates below three percent. Even municipalities with moderate to high vacancy rates that have been on the increase since 1994 (*e.g.*, Sudbury, North Bay and Peterborough) have exhibited average rent increases over the same period. When the rental market is tight, market theory dictates an increase in rent. The opposite should be true as well. Collusion by landlords in well-organised landlord associations could be a factor in this unlikely trend.

There is a growing gap between the rich and poor in Canada (Yalnizyan 1998). In 1973, the richest 10 percent of families with children under 18 years earned 21 times more than the poorest 10 percent. In 1996, the richest 10 percent of families made 314 times more than the poorest 10 percent. The middle class has also shrunk considerably over that time. The growing gap is also evident when we look at housing tenure. In Ontario, between 1990 and 1995, total owner household incomes increased by six percent. During that same time tenant incomes declined by four percent. The decline for tenant families was greater, at five percent (ONPHA and CHFC 1999). The average income for Ontario homeowners is twice that of tenants. The perception that Toronto is the only place

experiencing a housing crisis is dissolved by the finding that Barrie, Hamilton-Wentworth, North Bay, Peterborough, Kingston, and Sudbury all have higher proportions of tenants than Toronto who are paying greater than 30 percent of their income (a measure of 'core need' in housing) on rent. Between 1991 and 1996 the proportion of tenant households paying more than 50 percent of their gross income on housing rose by 47 percent. Almost one in four tenants can now be considered at potential risk of homelessness (*ibid.*). One job loss, one injury, one mental health relapse, or one relationship problem can lead one into homelessness. People with serious mental health issues are among the most vulnerable to these kinds of shocks.

The collapse of rental housing production has had a precipitous effect on the availability and affordability of rental housing. The housing sector, which is constitutionally a provincial responsibility, saw a dramatic change in 1995 when the Ontario government cancelled the non-profit and co-operative housing programs. In 1993, the federal government also cancelled its commitment to co-finance new social housing, which it had done since the end of World War Two. Non-profit and co-operative housing helped to meet the need for rental housing during the first half of this decade as private production diminished. In 1997, a Canada Mortgage and Housing Corporation report (as cited in ONPHA and CHFC 1999) showed that the rental demand in Ontario will be between 12,000 and 20,000 new units annually between 1996 and 2001 and above 20,000 units after 2001. If the rate of rental construction continues at the 1998 level, only 6,000 of the approximately 80,000 units needed will be built. Based on the historic annual rate of non-profit and co-operative housing development before cancellation in 1995, 54,250 units would have been developed by 2001 (*ibid.*). Although still short of the mark, it is a more optimistic picture.

The loss of rental stock to conversion and demolition exacerbates the housing crisis in Ontario. With the repeal of the *Rental Housing Protection Act* in 1998, it is easier for rental property owners to convert or demolish rental properties, making room for more lucrative land uses. The private rent supplement program, administered by the provincial housing authorities, is also suffering. Due to both government decisions and landlords simply deciding not to renew their rent supplement contracts, more than 3,000 low-income subsidies had disappeared from the program by the end of 1998 (*ibid.*). ONPHA and CHFC (*ibid.*: 15) make some recommendations for government action at all three levels:

> The Government of Ontario must demonstrate its commitment to ending the homelessness and housing crisis by implementing a provincial housing strategy that includes: - clear targets for new non-profit and co-op units for low-income tenants,

- clear targets for new supportive housing units, with support services,
- additional funding for services for homeless people and low-income tenants,
- adequate social assistance rates, including the shelter component,

- action to stimulate new private rental supply,
- additional funding for rent supplements and Rent-Geared-to-Income (RGI) funding for new and existing units,
- restoring lost rent supplements and RGI funding for existing units, and
- preserving existing affordable housing through legislative reform, including effective rent controls and controls on the demolition and conversion of private rental housing.

This strategy should be publicly reviewed by a standing committee of the Legislature every six months.

The Government of Canada must demonstrate its commitment to ending the homelessness and housing crisis by implementing a national housing strategy that includes targets for new units and additional funding for new supply and services. This strategy should be publicly reviewed by a standing committee of the Legislature every six months.

Municipal Governments in Ontario, with the support of provincial funds, should continue to develop local housing strategies that address new supply, services, zoning and protection for affordable housing, including supportive housing. These strategies should be publicly reviewed by local authorities every six months.

With the tremendous waiting lists for subsidised housing, it is unlikely that the housing needs of people with serious mental health issues will be met. Social housing has been shifted from the Province to the municipal tax base except for a small amount of narrowly defined supportive housing projects for the mentally ill. The responsibility for these have been assumed by the Ministry of Health, where before it was a joint responsibility of the Ministries of Health and of Municipal Affairs and Housing. Placing the cost of social housing on the municipal tax base is likely to be met with community resistance (OFCMHA and CMHA 1998) and as discussed in Chapter Two, result in a 'race to the bottom'.

The recent passing of the *Tenant Protection Act* has caused some alarm in the mental health community (*ibid.*), and the tenant population at large. The Act allows for:

- the removal of rent control for initial rent or vacant units, thus enabling landlords to seek the highest offer for vacant or new rental units;
- the ability of landlords to engage current tenants in negotiating rent increases above the guidelines established for any additional prescribed service, facility, privilege, accommodation or thing;
- the use of 'income information' by landlords to determine the occupancy of residential accommodation, which in fact facilitates discrimination by landlords against applicants who have a limited income or receive social assistance; and
- an end to the conversion protection for rental housing.

The passing of the *Tenant Protection Act* coupled with the government's failure to implement an adequate rent supplement program will increase the difficulty of people with serious mental health issues in accessing the private rental market. Further, the *Tenant Protection Act* may all but eliminate

the option of living in boarding and rooming houses for people with serious mental health issues. McCreary (1998 as cited in OFCMHA and CMHA 1998: 13-14) indicates that:

> ....with the abolition of rent control in Ontario, the boarding home market may change again. Just as the housing crisis of the 1980's led to "under-housing", forcing those who used to live in self-contained apartments to move into boarding houses, so will dramatically increased rents allow boarding home operators to obtain higher rents from a higher-income, employed clientele. Boarding home operators will become more selective in choosing tenants, and current tenants will be forced into the most substandard housing or onto the street.
>
> Further, with the....abolition of Part IV of the Landlord and Tenant Act and its replacement with the Tenant Protection Act, tenants rights which were previously secured as roomers and boarders under the Landlord and Tenant Act may vanish. Boarding home tenants will be doubly vulnerable: to the existent abuses..., and to new abuses caused by the removal of regular, tenant enforcement mechanisms, such as apartment inspections by the [municipal] Department of Buildings and Inspections. Furthermore under the Tenant Protection Act, which will implement an administrative law system, a landlord and tenant tribunal will not have the jurisdiction to hear individual human rights complaints. Complaints will be heard, then, only before a Human Rights Board of Inquiry, resulting in lengthy delay and no real relief for tenants.

The private for-profit sector is not addressing the present demand for affordable housing. Uncontrolled rents paired with a housing demand that has been left unmet for many years have produced a housing crisis. The Province of Ontario has begun to address this crisis. In a news release dated March 23, 1999, the Ministry of Community and Social Services announced that the **Province Commits Additional $100 Million to Help Homeless in Ontario**. Some of the highlights of this provincial initiative are:

- a commitment to spend $50 million on rent supplements that will come from signing the Social Housing Agreement with Ottawa;
- **an additional $45 million to develop housing spaces and supports to housing for people with mental illness**;
- eliminating the impact of the Provincial Sales Tax (PST) on affordable multi-residential rental construction. Builders will receive a grant equal to the PST paid on building materials, up to $2,000 per rental unit. The province's contribution of $4 million, coupled with similar federal provisions related to the Goods and Services Tax could generate up to 4,000 units;
- making public lands available to create at minimum 500 units of affordable rental housing; and
- commissioning a design competition to encourage the private sector to develop solutions for affordable housing.

4.4 Conclusion

In this chapter, mental health and housing policy has been reviewed. While mental health policy reads adequately in terms of community-based mental health care and the 'emerging paradigm', there is evidence that political forces play a decisive role in implementation and action. Current policy endorses best practices models for a range of housing and support options, with a shift toward supported housing. However, there is still a preponderance of funding being channelled into

quasi-institutional community-based support services. Initiatives by people with serious mental health issues and family members are still under-funded.

Supported housing requires affordable and adequate housing. The housing crisis in Ontario was reviewed, as were the implications for people with serious mental health issues. The provincial government has taken some initiatives to resolve the problem. The solutions envisioned by the present government are rooted in private sector initiatives. Fostering innovation in the private sector is a necessary step in stabilising the housing crisis. However, it will be insufficient for closing the wide gap between those who have adequate housing and those who need it. In closing, the reader should remain mindful that in any discussion of housing for the economically or socially disadvantaged, it is a fair assumption that those who suffer from serious mental health issues are among the most disadvantaged. Stigma, heightened emotional distress, uncharacteristically low-income and the often impaired ability to carry out daily activities makes this group of people particularly vulnerable.

PART II

SUPPORTED HOUSING FOR PEOPLE WITH SERIOUS MENTAL HEALTH ISSUES IN WATERLOO REGION AND WELLINGTON - DUFFERIN

CHAPTER FIVE
DISTRICT PROFILE OF HOUSING AND SUPPORT

5.1 Introduction

This study area for this thesis follows the boundaries of the Waterloo Region – Wellington-Dufferin District Health Council's[4] (DHC) catchment area (District). The District comprises the Regional Municipality of Waterloo (Waterloo Region) and the counties of Wellington (including the city of Guelph) and Dufferin (see Figure 5.1). The Waterloo Region – Wellington-Dufferin District covers 5,520 square kilometres and comprises a mix of urban and rural communities (Waterloo Region – Wellington-Dufferin District Health Council 2000). In Waterloo Region, over 85 percent of the population reside in one the region's three cities, Cambridge, Kitchener, or Waterloo. In the counties of Wellington and Dufferin, less than 55 percent of the population reside in Guelph or Orangeville, the two largest urban centres in the counties. The size and rural nature of Wellington and Dufferin are made even clearer by their population density of roughly 54 people per square kilometre compared to 308 people per square kilometre in Waterloo Region (*ibid.*).

A partnership was developed between the author and the DHC to conduct this study. The geographic boundaries of the DHC were used to delimit the study area. In return for resources to complete this study, the author completed a report for the DHC that included a housing inventory for people with serious mental health issues in the District. Material taken from this document appears below.

In this chapter, a profile of housing for people with serious mental health issues in the District will be given to orient the reader to the study area and its housing and mental health resources.

5.2 Housing for People with Serious Mental Health Issues[5]

In 1996, community capacity was assessed and plans were made for improving mental health services in Waterloo Region and Wellington-Dufferin through a mental health system design planning process. This profile is the result of a project that was recently undertaken to update some of the

[4] District Health Councils advise the Ontario Minister of Health on health matters in each Council's geographic area and make recommendations on resource distribution to address health needs in their community. They provide advice on the integration of health services in their community and address health planning needs identified by Council or by the Minister of Health.

[5] The material in this section has been taken from a report completed for the Waterloo Region – Wellington-Dufferin District Health Council by the author in January 2000, entitled *Housing for People with Serious Mental Health Issues in Waterloo Region and Wellington-Dufferin*. See Appendix A for letter of permission from DHC.

Waterloo Region – Wellington – Dufferin District Health Council

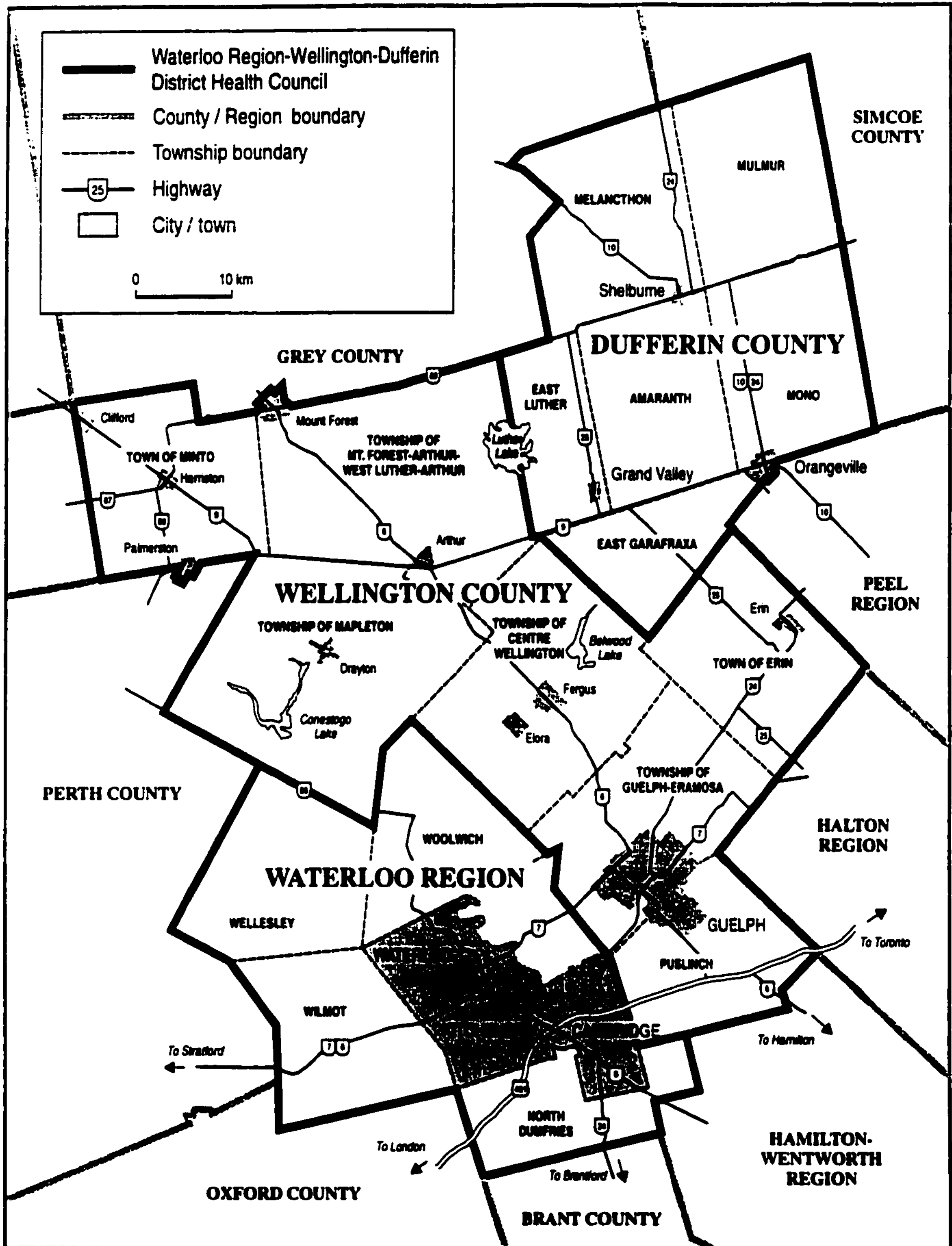

Figure 5.1: District Map – Study Area
Source: Waterloo Region – Wellington-Dufferin District Health Council 1998

system design work that was done in 1996, namely that which addressed supportive and supported housing.

What follows is a review of provincial benchmark figures for housing and support services and how housing and support in the District compares with these provincial guideposts. Other housing trends that concern people with serious mental health issues, such as access to non-profit housing and homelessness, will also be discussed.

Benchmarks for Housing and Support Services

Based on the overall prevalence rate, according to the Ontario Mental Health Survey, approximately two percent of the population suffers from a serious mental illness (Ministry of Health 1994 as cited in Wellington-Dufferin District Health Council 1996). Applying this rate to the adult population (*i.e.*, 16 years and older) in Waterloo Region suggests that, using 1996 census data, approximately 6,219 adults suffer from a serious mental illness (see Table 5.3). Applying the same rate to Wellington-Dufferin suggests that approximately 3,303 adults suffer from a serious mental illness (see Table 5.4).

In *Putting People First* (Ministry of Health 1993), the Ministry set a number of targets – or critical success factors – to be used in monitoring shifts in service throughout the reform of the mental health system. After surveying practices in other provinces and jurisdictions it was determined that setting multiple targets, rather than a single one, would be more just and effective. To this end, specific and measurable five- and 10-year benchmarks for housing and support services for people with serious mental health issues were outlined in 1996 by the Ministry. The five-year benchmark for housing and support services (1998: five years after the commitment in *Putting People First* to benchmarking in mental health reform) for Waterloo Region was 415 residential spaces and the 10-year target (2003) is 829 spaces (see Table 5.5). For Wellington-Dufferin the five-year benchmark was 220 residential spaces and the 10-year target (2003) is 440 spaces (see Table 5.6). These figures were calculated using 1996 census data.

The methodology used to calculate these benchmark figures was adapted from the experiences in Dane County, Franklin County, and New York State in the United States and from Greater Vancouver in Canada. The following assumptions guide the calculation of housing and support service benchmarks in Ontario (Ministry of Health 1996b: 4):

1. Estimated rates of service utilisation by people with severe mental illness/severe mental health problems were calculated using two scenarios. In the first scenario it is assumed that 0.4 percent of the adult population uses mental health services.

2. Given that the above 0.4 percent is considered low relative to other opinions about level of need, a second scenario was developed which uses a 0.8 percent utilisation rate.

3. Housing supports (in the form of beds or spaces) should be made available to approximately one third of people with serious mental illness who are currently using mental health services.

The most conservative figure (0.4 percent utilisation rate) was used to calculate the 1998 benchmark and the second figure (0.8 percent) is used to calculate the 2003 target. In *Making it Happen* (Ministry of Health 1999a,b) the Ministry states that there is a continued acceptance of the provincial benchmarks outlined above for housing and support services. The provincial benchmarks and targets are to be used only as initial estimates, augmented by local experience and demand.

Table 5.3: Estimate of Adult Population with Serious Mental Illness in Waterloo Region

City of Cambridge		Kitchener-Waterloo		Townships		Total	
Adult Population	With Serious Mental Illness	Adult Population	With Serious Mental Illness	Adult Population	With Serious Mental Illness	Adult Population	With Serious Mental Illness
76,455	1,529	199,033	3,981	35,437	709	310,925	6,219

Source: Author, using Statistics Canada 1998 (1996 census data)

Table 5.4: Estimate of Adult Population with Serious Mental Illness in Wellington-Dufferin

City of Guelph		Rural Wellington		Dufferin		Total	
Adult Population	With Serious Mental Illness	Adult Population	With Serious Mental Illness	Adult Population	With Serious Mental Illness	Adult Population	With Serious Mental Illness
74,977	1,500	56,565	1,131	33,602	672	165,144	3,303

Source: Author, using Statistics Canada 1998 (1996 census data)

Housing and Support in Waterloo Region and Wellington-Dufferin

An inventory of housing for people with serious mental health issues was created using a telephone and mail-out interview process. The typology of housing approaches for people receiving mental health support services that was introduced in Chapter Three (refer back to Table 3.1), developed by Parkinson, Nelson and Horgan (1998), was used to classify different housing and support arrangements as either custodial, supportive, or supported. This type of classification schema is important because when communities visit the benchmark figures and assess how close they are to meeting them, they must first consider what types of housing and support models are acceptable and in

Table 5.5: Benchmarks for Housing and Support Services – Waterloo Region

City of Cambridge					Kitchener-Waterloo					Townships					Total				
Total Adult Pop. 1996	Using mental health services 1996		Bench-mark[1]	Target[2]	Total Adult Pop. 1996	Using mental health services 1996		Bench-mark[1]	Target[2]	Total Adult Pop. 1996	Using mental health services 1996		Bench-mark[1]	Target[2]	Total Adult Pop. 1996	Using mental health services 1996		Bench-mark[1]	Target[2]
	0.4%	0.8%	1998	2003		0.4%	0.8%	1998	2003		0.4%	0.8%	1998	2003		0.4%	0.8%	1998	2003
76455	306	612	102	204	199033	796	1592	265	530	35437	142	283	47	94	310925	1244	2487	415	829

Source: Author, using Statistics Canada 1998 (1996 Census data)

[1] This five-year benchmark figure for 1998 is calculated by first assuming that 0.4 percent of the adult population uses mental health services and then dividing that proportion of the adult population by three (the proportion of people who use mental health services that are assumed to be in need of housing supports).

[2] This ten-year target figure for 2003 is calculated by first assuming that 0.8 percent of the adult population uses mental health services and then dividing that proportion of the adult population by three (the proportion of people who use mental health services that are assumed to be in need of housing supports).

Table 5.6: Benchmarks for Housing and Support Services – Wellington-Dufferin

City of Guelph					Rural Wellington					Dufferin					Total				
Total Adult Pop. 1996	Using mental health services 1996		Bench-mark[1]	Target[2]	Total Adult Pop. 1996	Using mental health services 1996		Bench-mark[1]	Target[2]	Total Adult Pop. 1996	Using mental health services 1996		Bench-mark[1]	Target[2]	Total Adult Pop. 1996	Using mental health services 1996		Bench-mark[1]	Target[2]
	0.4%	0.8%	1998	2003		0.4%	0.8%	1998	2003		0.4%	0.8%	1998	2003		0.4%	0.8%	1998	2003
74977	300	600	100	200	56565	226	453	75	150	33602	134	269	45	90	165144	661	1321	220	440

Source: Author, using Statistics Canada 1998 (1996 Census data)

[1] This five-year benchmark figure for 1998 is calculated by first assuming that 0.4 percent of the adult population uses mental health services and then dividing that proportion of the adult population by three (the proportion of people who use mental health services that are assumed to be in need of housing supports).

[2] This ten-year target figure for 2003 is calculated by first assuming that 0.8 percent of the adult population uses mental health services and then dividing that proportion of the adult population by three (the proportion of people who use mental health services that are assumed to be in need of housing supports).

what proportions. Every typology is a simplification. This typology, like others, sees many exceptions and unclear cases. It is nonetheless a very important and thoughtfully derived tool.

Custodial Housing:

Waterloo Region

Homes for Special Care (HSC) and lodging covered under the *Domiciliary Hostel* program (DomCare) are two of the most prevalent types of custodial care homes for people with serious mental health issues. Both types of housing are operated for profit. They make up the majority of custodial care housing in Waterloo Region. HSC is a program that started about 30 years ago as part of the Province of Ontario's de-institutionalisation policy. The criteria for acceptance into HSC are that a person be 17 years or older, have a serious mental illness, require supervision on a 24-hour basis and assistance with medication. The Ministry of Health enters into a contract with the HSC operator, whereby the owner/operator receives a $34.50 *per diem* rate for each resident from the Ministry to cover the costs of operating the homes (*e.g.*, capital costs, room and board for residents). Residents themselves receive a $112.00/month comfort allowance for discretionary spending. Clothing, medication, and other essentials are obtained through vouchers processed in Toronto by the Ministry of Health (Allen 1997). In Waterloo Region, there are roughly 50 adults with serious mental health issues living in three HSC facilities.

The DomCare program is governed under the Ministry of Community and Social Services Act. As of January 1998, participation in the provincial DomCare program became discretionary on the part of municipalities. Participating municipalities enter into a 'purchase of service agreement' with home operators where operators receive a *per diem* rate for each resident. The Ministry of Community and Social Services evaluates *per diem* rates on an annual basis. It is currently $34.50 and it has not gone up since 1993. Participating municipalities pay 20 percent of the program cost and the Province pays the remainder (Parry 1999). At present, DomCare homes are being viewed as housing primarily for people with serious mental health issues (Blowes 1998). When a person comes to a DomCare home and his or her income is insufficient to cover the cost of room and board (*i.e.*, $34.50/day), his or her monthly income is given to the home operator and the difference is paid by the municipality/province. Like the HSC program, the DomCare program also provides a monthly allowance of $112.00 to residents. However, the voucher program for articles like clothing and medication that is an important part of the HSC system is not replicated in the DomCare program. In Waterloo Region, there are roughly 110 adults with serious mental health issues living in 12 homes operating within the DomCare program.

Wellington-Dufferin

In Wellington-Dufferin, there are no HSC and the DomCare program operated by Wellington County Social Services targets people over 50 years of age. Although the DomCare program is not dedicated to housing people with serious mental health issues, *Woolwich Lodge* houses 35 people, about 23 of who suffer from a serious mental health issue. This is a higher proportion of people with serious mental health issues than in the nine other domiciliary hostels operated by Wellington County Social Services. *Woolwich Lodge* is located in the City of Guelph.

Supportive Housing:

Waterloo Region

About 60 people live in non-profit supportive apartments, bungalows or group homes in Waterloo Region that are dedicated to people with serious mental health issues. Waterloo Regional Homes for Mental Health Inc. (WRH) owns and operates the majority of the supportive housing stock. The House of Friendship owns and operates one group home. There are two non-profit apartment developments that provide many of the features of supportive housing as detailed by Parkinson, Nelson, and Horgan (1998). One is owned and operated by the YWCA and the other by the House of Friendship. Although they do not fit entirely within the typology for supportive housing used for this inventory, and will not be included in the summation of mental health supportive housing spaces; they are very important examples of supportive living environments that do not exist solely for mental health support purposes.

Wellington-Dufferin

No supportive housing exists in rural Wellington or Dufferin County. Two supportive housing developments exist in the city of Guelph that are dedicated to people with serious mental health issues and one exists that is not dedicated but has a majority of residents who suffer from a serious mental health issue. In total roughly 21 adults with serious mental health issues reside in supportive housing in the city of Guelph. Another housing development, *Yorkhaven Place*, does not fit well within the typology of mental health housing used for this inventory. However, it is an important example of a supportive living environment for people with serious mental health issues.

Supported Housing:

In the housing and support typology developed by Parkinson, Nelson, and Horgan (1998), one of the distinguishing features of supported housing is that people have complete control over the type of housing they live in. Affordable rental housing is in very short supply in Waterloo Region and Wellington-Dufferin, as in most of the province, and the reader should note that people with serious mental health issues in most cases have very little real control over the type of housing they live in. Supported housing comprises two components: affordable, adequate housing that is integrated within the community and individualised mental health support services that are de-linked from the housing itself. If a person is receiving mental health services but the housing is inadequate or unaffordable, then that living situation should not be considered a sufficient step toward meeting the Ministry's benchmarks for supportive/supported housing.

Waterloo Region

To determine the number of people living in supported housing arrangements the two local mental health support agencies were surveyed by mail (*i.e.*, Canadian Mental Health Association, Waterloo Regional Branch (CMHA-WR) and Waterloo Regional Homes for Mental Health Inc. (WRH)). There are two people reportedly living in co-operative housing and receiving mental health support services in Cambridge, three in Kitchener-Waterloo, and none in the townships of Waterloo Region. Two people are in municipal and private non-profit housing developments and receiving mental health support in Cambridge, 18 in Kitchener-Waterloo, and none in the townships. Seven people are living in non-profit housing administered by the South Waterloo Housing Authorities in Cambridge, while 35 people are in housing administered by the North Waterloo Housing Authority in Kitchener-Waterloo. There were no people reportedly living in housing administered by the Housing Authorities and receiving mental health support services in the townships of Waterloo Region. Within Waterloo Region roughly 144 people are estimated to be living in market rent housing and receiving case management support.

Wellington-Dufferin

To determine the number of people living in supported housing arrangements the three local mental health support agencies were surveyed by mail (*i.e.*, Canadian Mental Health Association, Wellington-Dufferin Branch (CMHA-WD), Community Mental Health Clinic (CMHC), and Homewood Health Centre (HHC)). In the City of Guelph, 11 people are reportedly living in co-

operative housing and receiving mental health support services. 55 people are in municipal and private non-profit housing developments and receiving mental health support, and 31 people are living in non-profit housing administered by the Wellington and Guelph Housing Authority.

In rural Wellington County, eight people are reportedly living in private non-profit housing developments. Eleven people are living in non-profit housing administered by the Wellington and Guelph Housing Authority and receiving mental health support from a support co-ordinator. In Dufferin County, two people are living in municipal non-profit housing and 19 people are in non-profit housing administered by the Dufferin County Housing Authority. Across Wellington-Dufferin at least 296 people (figures were not available for some parts of rural Wellington and all of Dufferin) are estimated to be living in market rent housing and receiving case management support.

Total Number of People in Supportive and Supported Housing

The number of people in custodial, supportive, and supported housing has been outlined above. Before communities can measure the difference between the number of people in supportive/supported housing in Waterloo Region and Wellington-Dufferin and what the benchmark figures propose, some normative decisions must be made. Most academics and community mental health workers believe that the custodial model of housing and support is inappropriate. This view is also presented in the Waterloo Region System Design Plan (Waterloo Region Mental Health Reform Project Steering Committee 1996). Further, the custodial approach to housing and support is not advanced in the best practices literature. Supportive housing (*e.g.*, group homes operated by non-profit agencies linked with mental health support services) is a necessary part of the housing and support continuum that should exist in a community. Supported housing should comprise the greater proportion of housing and support in a community.

According to a report published by the Ontario Non-Profit Housing Association and the Co-operative Housing Federation of Canada (1999), almost half (roughly 44 percent) of all tenants in Ontario are paying more than they can afford for rent. People with serious mental health issues are more likely than average to be earning a low income or collecting social assistance (Wellington-Dufferin District Health Council 1996). Given that 44 percent of all tenants in Ontario are paying more for rent than they can afford, and that people with serious mental health issues are more likely to be earning an inadequate income, an estimate can be made of the number of people with serious mental health issues living in unaffordable market rent. A reasonable estimate is 60 percent (Czarny 1999c).

Waterloo Region:

If 60 percent of adults living in market rent apartments are excluded from the count, the number of adults with serious mental health issues who are living in supportive/supported housing in Waterloo Region is 185 (see Table 5.7). If this is compared to the 1998 benchmark figure (*i.e.*, 415 spaces) the benchmark has been missed for 1998 by 230 people. Compared to the 2003 target for housing and support services (*i.e.*, 829 spaces), over the next four years supportive/supported housing for another 644 people is needed in Waterloo Region.

Wellington-Dufferin:

If 60 percent of adults living in market rent apartments are excluded from the count, the number of adults with serious mental health issues who are living in supportive/supported housing in Wellington-Dufferin is 276 (see Table 5.8). If this is compared to the 1998 benchmark figure (*i.e.*, 220 spaces) the benchmark has been met for 1998. Compared to the 2003 target for housing and support services (*i.e.*, 440 spaces), over the next four years supportive/supported housing for another 164 people is needed in Wellington-Dufferin.

Table 5.7: Supportive/Supported Housing in Waterloo Region

	Number of People and Location
Supportive Housing	**60**
• Kurelek (WRH) • Concord (WRH) • Madison (WRH) • Cambridge (WRH) • Apartments (WRH) • Bungalows (WRH) • Cramer House	6 (Kitchener) 8 (Kitchener) 8 (Kitchener) 8 (Cambridge) 12 (Kitchener) 12 (Kitchener) 6 (Kitchener)
Supported Housing	**125**
• In co-operatives	5 (across Waterloo Region)
• In municipal or private non-profits	20 (across Waterloo Region)
• In North and South Waterloo Housing Authorities non-profit housing	42 (across Waterloo Region)
• In affordable Market Rent housing (estimate – 40 % of total in market rent housing)	58 (across Waterloo Region)
Total Supportive/Supported Housing	**185**

Table 5.8: Supportive/Supported Housing in Wellington-Dufferin

	Number of People and Location
Supportive Housing	**21**
• Dunara • Discovery House • Dwelling House	8 (City of Guelph) 8 (City of Guelph) 5 (City of Guelph)
Supported Housing	**255**
• In co-operatives • In municipal or private non-profits • In Wellington-Guelph Housing Authority non-profit housing • In affordable Market Rent housing (estimate – 40 % of total in market rent housing)	11 (City of Guelph) 65 (across Wellington-Dufferin) 61 (across Wellington-Dufferin) 118 (across Wellington-Dufferin)
Total Supportive/Supported Housing	**276**

Access to Non-Profit Housing

As noted in Tables 5.3 and 5.4, the number of adults in Waterloo Region and Wellington-Dufferin estimated to have a serious mental illness is 9,522 (*i.e.*, 6,219 in Waterloo Region and 3,303 in Wellington-Dufferin). People with serious mental health issues are "more likely to be unemployed, on public assistance, have low incomes, and given the low incomes they are more likely to have disadvantaged living conditions (Wellington-Dufferin District Health Council 1996: 14)."
With this in mind, the availability of affordable and rent-geared-to-income housing is particularly important to this group of people. Affordable and adequate housing is an essential component of the supported housing model. If a person is living in a home that is not affordable and is receiving mental health support services, this is insufficient. If a person is living in inadequate housing (*e.g.*, temporary, rooming house, an apartment that is in disrepair or is too small) and is receiving mental health support services, this is also insufficient.

Supported housing is adequate and affordable housing coupled with flexible mental health support services. Many people with serious mental health issues choose not to receive support

services in their homes or at all. Housing that is adequate and affordable is nonetheless important for this group of people.

Homelessness

Figures vary concerning the proportion of homeless people who have a mental health issue. Recently, the Mayor's Homelessness Action Task Force (1999) in Toronto concluded that between 30 and 35 percent of homeless people are living with mental illness. They also found that this proportion is much higher (*i.e.*, 75 percent) among homeless single women. Dietrich *et al.* (1999) estimated that in Waterloo Region between three and five out of every 1,000 people are or will be homeless over the course of a year. By this estimate, roughly 1,244 adults (16 years and older) in Waterloo Region are or will be homeless over the course of a year. Based on the 30-35 percent figure cited by the Toronto Task Force, between 373 and 435 of those homeless adults will suffer from a serious mental health issue. The precarious tenure of housing is also an important issue to recognise in Waterloo Region, as elsewhere (Kirk 1999). Dietrich *et al.* (*ibid.*) have asserted that 41.2 percent of tenant households in Waterloo Region pay more than 30 percent of their income on rental accommodation.

Botschner (1998) made the very conservative estimate that in Wellington-Dufferin, approximately one person per 1,000 was literally homeless, that is, without shelter of any kind, at least once over the course of a year. By this estimate, roughly 165 adults were without shelter of any kind at some point over the course of a year in Wellington-Dufferin. A very conservative estimate of adults needing mental health services who are without shelter of any kind in Wellington-Dufferin ranges from 50 to 58 based on the 30-35 percent figure cited by the Toronto Task Force. People with mental health issues are the most in need of help securing safe, adequate, and affordable housing (Smith 1999). Unlike in Toronto, the homeless population in Wellington-Dufferin is largely hidden because they are precariously housed rather than living on the street. Those who are precariously housed are in need of special attention in Wellington-Dufferin (*ibid.*).

Homelessness and precarious housing are both serious issues in Waterloo Region and Wellington-Dufferin. People with serious mental health issues in particular, need support in finding and keeping adequate affordable housing.

5.3 Conclusion

In this chapter, the study area was introduced and provincial benchmark figures for housing and support services were presented. Housing and support in the District was discussed in relation to these provincial guidelines. Other housing trends affecting people who suffer from serious mental

health issues such as access to non-profit housing and homelessness were also discussed. The following chapter will introduce the methodology used to complete this study.

CHAPTER SIX
METHODOLOGY

6.1 Introduction

A case has been made for why it is important to understand the perspectives of residents in supported housing throughout the preceding chapters. In Waterloo Region and Wellington-Dufferin, there is a critical shortage of affordable housing. The capacity of local agencies to provide support services in-house to people with serious mental health issues is strained. As the community considers ways of meeting local need for supported housing, it is important to consider the issues raised and solutions proposed by residents themselves. In this research, one-to-one interviews were chosen as the best way to gain an understanding of resident perspectives. A rationale will be provided below.

In order to ensure that realistic courses of action could be taken upon the results of this study, housing and mental health service providers and professional planners were involved in a focus group to discuss their perspectives and to comment upon resident perspectives. Academics are excellent idea generators but are often criticised for their lack of knowledge of the way things 'really work'. This does not mean that the recommendations made by academics are without value, simply that alone, they may be an insufficient culmination to a study conducted with aspirations of affecting change within the study community. The focus group held for this study was an attempt to draw on the experience of local professionals in order to come up with realisable courses of action. The gap between academic recommendations and real action by practitioners can be bridged quite easily. In social research, it is particularly important that this gap be minimised. Witty (1999) has stressed the importance of 'detailed dialogue' between academic writers and practitioners to ensure the relevance of both academic and professional work.

In this chapter, the research methodology and methods employed in this study will be presented for the reader's information and scrutiny. In the following section, a general discussion of methodology will occur. Following that, the stages of research and the methods used will be presented.

6.2 Methodology

Observation in social science means more than 'just looking'. It is purposive (Palys 1997). There are two basic methodologies with which one can undertake observation. One is qualitative; the second is quantitative. The difference between these two methodologies, or paradigms, is well known to most researchers. They differ in their views of reality, in their views of the relationship that a

researcher should assume with those being researched, and in their reproof or acceptance of the researcher's values in the research project (Creswell 1994).

This study has proceeded from the premise that intellectual activity in the social sciences should attempt to improve the 'realities of life' (Cloke, Philo, and Sadler 1991) for research participants, in a tangible way. The qualitative paradigm holds that reality is experiential and that it occurs where subjects and objects interact, in different ways for different sets of interactions. In this study, a qualitative research design was adopted to try to elicit from participants their views and experiences. The goal was to understand specific circumstances and how and why things actually happen in the complex world of the research participants, acknowledging that experiences are situational and conditional (Rubin and Rubin 1995). Finally, recommendations for improvements to the realities of life of people in supported housing were developed using qualitative techniques and drawing also from ideas published in academic and professional literature.

6.3 Research Stages

The research for this study proceeded in two distinct stages. The first stage consisted of one-to-one interviews with residents of supported housing in the cities and townships of Waterloo Region and Wellington-Dufferin. The second stage - a focus group session held with housing and mental health service providers and planners - occurred after the analysis of the one-to-one interview data was completed.

One-to-One Interviews with Residents of Supported Housing

The objectives of this stage of the research were to:

- Develop a better understanding of the positive aspects of housing and areas of concern, according to residents of supported housing;
- Develop a better understanding of the perspectives of residents on how their housing situation might be improved; and
- Develop a better understanding of the housing history of residents and issues of affordability and choice.

Thirty-one interviews took place with residents of supported housing from July through October, 1999. Fourteen single men, 14 single women, and three couples were interviewed. The age of participants ranged from early-20s to mid-50s. Of those interviewed, four men and three women were living in small towns, in Wellington-Dufferin, with town populations ranging from roughly 3,300 to 8,900 people. Interviews took place at locations of the participants' choosing. Most interviews took place in the participants' homes. Some occurred in coffee shops or at local mental health agency offices. Interviews ranged in duration from 45 minutes to two hours. Most interviews lasted about

1.25 hours. A stipend of $10.00 was given to participants as compensation for their time. The analysis of interview transcripts was completed by November 21, five days prior to the focus group meeting with mental health and housing service providers and planners.

Ideally, in many types of qualitative research (*e.g.*, grounded theory) a theoretical sampling technique will be used where participants are not all chosen ahead of time but are chosen as the research progresses and as themes emerge to be explored (*e.g.*, Strauss 1987). In other words, participants will be chosen purposively according to how well they might assist the researcher with his or her investigation of emerging concepts and themes. Participants will continue to be interviewed until saturation is achieved along all major themes and concepts. Once the researcher believes that little new information is being uncovered by further interviews, that stage of the research ends. Participants are not statistically representative but are chosen from the population whose collective experience is being investigated. In qualitative research, it is still important to represent the diversity of experiences within the population being studied; however, the focus is not upon a statistically representative sample as in quantitative research designs.

In this study, pure theoretical sampling was not done. In other words, participants were not chosen according to emerging themes and concepts as the study progressed. Further, a fixed number of interviews were conducted instead of interviewing until saturation. Participants were chosen purposively, however. They were selected in an attempt to represent the diversity of the study population using a method suggested by Morse (1994 as cited in Palys 1997) known as 'maximum variety sampling'. This non-probabilistic method of sampling emphasises sampling for diversity instead of for the 'typical' respondent that is sought with random sampling. This technique was useful in this study where the goal was to uncover the variety of human experience among residents of supported housing as well as some of the commonalities of that experience across different socio-demographic groups and across space (*i.e.*, in both towns and cities). The reasons why this maximum variety sampling technique was used rather than a purely theoretical approach will be clarified later in this section.

Single men and single women, with and without children, were asked to participate in the study, as were couples. A mix of people in non-profit and market rent housing were sought as participants, representing a variety of housing types and rental arrangements. Although it was initially intended that half of the participants would be from small towns and half from cities, this did not occur. There were simply not enough prospective participants in small towns to achieve this balance. This is an unfortunate drawback. It is not surprising, however, as many people with serious mental health issues move to cities from small towns to access mental health support services or for other reasons that were discussed earlier in the literature review.

Prospective interview participants were approached through their mental health support workers (support co-ordinators). To re-iterate, in the supported housing model residents live in normal housing and receive support services, to the degree that they choose, from support co-ordinators employed by local mental health service agencies. Support co-ordinators from all of the five mental health support agencies in the study area were approached. After explaining the objectives of the study and the criteria for selecting participants (see Appendix B), support co-ordinators circulated letters of information and consent forms (see Appendix C) to prospective participants with whom they worked. If prospective participants agreed to participate, the support co-ordinator would forward the completed consent form by mail or FAX. Participants were then contacted by phone to schedule an interview time and location that suited him or her.

This process of approaching prospective research participants worked well. However, it was a very lengthy and many times, a frustrating process. Support co-ordinators are extremely busy people and the turnaround time between first contact with them and when completed consent forms began to trickle in was very long; in many cases as long as two or three months. Due to the complexity of finding interview participants, a pure theoretical sampling procedure would not have been feasible in this study. If a few people had been interviewed and then support co-ordinators contacted with new selection criteria for the next participants, and so on throughout the research process until saturation of all major themes and concepts had occurred, the time taken to complete the interviews would have been prohibitive. More likely still, the assistance from support co-ordinators would have ceased after a time and the study would not have been completed at all.

A one-to-one interview process was used in this study. The use of a one-to-one (face-to-face) interview technique has been advocated for by many authors (*e.g.*, Robson 1993; Palys 1997) because of the flexibility it allows and the rich narrative detail that can be captured. With a sufficiently open-ended structure, one-to-one interviews can allow for important phenomenological input from respondents (Palys 1997). The interview schedule assumed a semi-structured design, where a set of questions were worked out in advance and modified slightly depending upon the flow of the conversation with individual residents.

Rubin and Rubin (1995) distinguish between two broad types of qualitative interviewing: cultural and topical. In cultural interviewing, the style of questioning is relaxed and the focus of questions is on the norms, values, rules of behaviour, and understandings of a group. Topical interviews, on the other hand, are more narrowly focussed and are based on a set of linked questions prompted by preliminary observation, literature review, or preliminary interviews. In topical interviews, questions are worded broadly enough to encourage participants to express their knowledge

and ideas, but narrowly enough to provide the interviewer with the data required to meet the objectives of the study (*ibid.*). The interviews conducted for this study were topical.

The dimensions of residents' housing experiences that were investigated during the interviews were dimensions that appear prominently in the academic literature on housing and mental health. These dimensions were used to focus the inquiry and give it boundaries for later comparison during the development of themes and integrative theory (Morse 1994). Focussing upon these dimensions will also facilitate a comparison of results with previous research. Unlike in quantitative research, a theoretical framework, *per se*, should not be used to guide data collection and analysis (*ibid.*).

Interview questions were predominantly open-ended with a small number of closed questions used as summary questions at the end of each section of the interview. The closed questions were used as a means of 'methods triangulation' (Patton 1990). If responses to open-ended questions within a section of the interview were at odds with the quantitative question at the end of the section, further investigation could be undertaken. In most cases, the qualitative and quantitative responses were in order. Following advice from Palys (1997), interview questions were funnelled, with broad questions at the beginning of each section followed by successively narrower questions. Closed questions were asked at the end of each section to ensure that the pre-determined response categories would not influence the residents' responses to open-ended questions.

As mentioned earlier, the major dimensions of residents' housing experiences that were investigated during the one-to-one interviews have featured prominently in the academic literature. There were four dimensions investigated: physical housing environment, social housing environment, housing affordability and choice, and housing history. The physical and social housing environments were investigated at two scales: the neighbourhood scale and the individual place of residence (*e.g.*, one's apartment and building). Under each of these dimensions specific areas of interest were listed and questions drawn up to address each of these areas of interest (see Appendix D for some notes on the thought process that led to the development of the interview schedule). Some areas of interest that were investigated stemmed from housing concerns raised at local mental health housing working group meetings (*i.e.*, Wellington-Dufferin Working Group on Housing and Homelessness and the Waterloo Region Mental Health Housing Sub-Committee).

The interview schedule itself can be reviewed in Appendix E. Many of the questions that appear in the interview schedule are original to this study. Many were also drawn from other published interview schedules where researchers studied housing for people with serious mental health issues. This was done for easy comparison of the results with those of other authors, as well as for reasons of simple convenience. While each question that was taken from another researcher's work will not be identified here, the authors are cited in the reference section at the end of this thesis

(Boydell *et.al.* 1996; Clarke Consulting Group 1995; Taylor, Elliott, and Kearns 1989). Once the interview schedule was drafted, it was reviewed by the thesis advisory committee, a health planner, a manager at a local mental health agency and then tested with a colleague who is a resident of supported housing.

In most cases, the interviews with residents were recorded on micro-cassette. In cases where residents did not want to be recorded or where the surroundings were too noisy to achieve a good quality recording, detailed notes were taken instead. All interviews were then transcribed into digital format. Using the analysis techniques recommended by Rubin and Rubin (1995), three general steps were followed: grouping into one category all interview data that spoke to one theme or concept; comparing material within categories to search for variations and nuances in meaning; and comparing across categories to discover connections between themes. More specifically, the following steps occurred:

1. The interview transcripts were separated into different files according to the dimensions outlined earlier (*i.e.*, physical/place of residence, physical/neighbourhood, social/place of residence, social/neighbourhood, housing affordability and choice, housing history, other).

2. The transcript files were then printed in hard copy form and read. Notes were taken on concepts and themes that seemed to be apparent in the data.

3. The list of preliminary concepts and themes were given numerical codes and the transcript files were read through carefully a second time. This time, concepts and themes were given numerical codes in the margins of the transcripts and as new concepts and themes emerged, a new code was created. The transcripts were analysed several times as new codes emerged.

4. The final list of codes for each section (dimension) was then read and similar codes were collapsed into single categories. Categories that recurred less than three or four times were discarded.

5. The material within each category was then examined for variations in meaning by re-analysing relevant parts of the transcript files (*i.e.*, those parts bearing a numerical code placing them within the category being analysed).

6. The themes that emerged from within each category are outlined and discussed in Chapter Seven of this thesis, as are the integrative themes that cut across several categories.

In order to establish the trustworthiness of qualitative data Lincoln and Guba (1985) have proposed four 'trustworthiness criteria'. Each will be discussed below as it applies to this study.

Credibility:

Similar to the quantitative researcher's accountability for internal validity, the qualitative researcher must show that he or she has represented the multiple constructions presented by

interviewees in a credible manner (*ibid.*). Do the researcher's re-constructions from the data accurately represent the constructions conveyed by interview participants?

Three methods were used to increase the credibility of interview findings. As discussed earlier, methods triangulation was used and a comparison done of the responses to closed and open-ended questions. Simple counting methods (Silverman 1993) were used on categories of data, as discussed above, and categories appearing infrequently were discarded. The third method used to increase credibility was a member check, a technique where the researcher consults with members of the sample or study population once analysis is complete, or at least significantly underway. The member check allows participants to compare the researcher's re-constructions with their original constructions. Ideally, member checks involve meeting with participants again, either individually or in a group meeting. This was not the case in this study. It was felt that residents had given a generous amount of time for the initial interview. A second round of one-to-one meetings seemed too imposing. If the member check had been conducted in a group setting, participants would have lost their anonymity. Instead, participants were sent a typed summary of the research results, highlighting key themes. They were asked to provide feedback on this summary if they had any concerns with the reported results. Little feedback was received and feedback that was received was positive. It was not surprising that little feedback was received, given that the onus was on the participants to phone the researcher with comments. No changes were made to the initial analysis.

According to Lincoln and Guba (1985), the member check is the most crucial technique for establishing credibility. There are dissenting opinions, however. Silverman (1993) advises against member checks, fearing that they will open the results of a structured analysis up to whimsical last minute changes on account of member feedback.

Transferability:

Akin to the quantitative researcher's pursuit of generalisability, transferability differs in that it does not proceed on the notion that there are some basic rules of nature that govern situations under all circumstances. While the researcher can know the context in which his or her study population operates, he or she can not know the context in other areas to where results may be transferred. Lincoln and Guba (1985: 298) write:

> The original inquirer cannot know the sites to which transferability might be sought, but the appliers can and do. The best advice to give to anyone seeking to make a transfer is to accumulate empirical evidence about contextual similarity; the responsibility of the original investigator ends in providing sufficient descriptive data to make such similarity judgements possible.

To increase the likelihood that results from this study can be transferred to other sites, a thick description (Lincoln and Guba 1985) of the study parameters, the basis for research questions, and the study area has been included in this thesis. This information paired with the extensive literature review included in this thesis should give researchers, policy-makers, or other stakeholders in other areas the information they need to judge the transferability of these results.

Dependability:

Similar to the quantitative researcher's need to account for reliability, the interpretive or qualitative researcher must take into account both "factors of instability and factors of phenomenal or design induced change (*ibid.*: 299)."

It has been noted by Guba (1981 as cited in Lincoln and Guba 1985) that a demonstration of credibility may be sufficient to establish dependability. Credibility was discussed above. Silverman (1993) adds that pre-testing one's interview schedule can build the dependability of a study's results as well. As noted earlier, the interview schedule for this study was pre-tested.

Confirmability:

Like objectivity in quantitative research, confirmability addresses the question of whether the researcher has told readers enough about the study to judge the adequacy of the process and to assess whether the findings flow from the data (Robson 1993).

The major technique for establishing confirmability is the confirmability audit, where an outside observer (auditor) follows a researcher's research process from start to finish and confirms its reliability (Lincoln and Guba 1985). For this an audit trail must be maintained. Halpern (1983 as cited in *ibid.*) has listed six audit trail categories for researchers to be mindful of when conducting their analyses. They are: raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, materials relating to intentions and dispositions, and instrument development information. Although an audit might never be conducted for a particular study, organising research and analysis materials in such a way as to facilitate one should it occur can help researchers systematise, relate, prioritise, and cross-reference data prior to writing. Triangulation is also a method to ensure confirmability. This was discussed earlier.

Focus Group with Housing and Mental Health Service Providers and Planners

The objectives of this second and final data collection stage of the research were to:

- Develop a better understanding of the housing situation in the study area and the implementation environment around supported housing; and

- Determine ways of improving the supported housing environment, drawing on professional experiences as well as the knowledge conveyed by residents during stage one of the research.

From 9:00 to 12:00 P.M. on November 26, 1999, a focus group discussion was held with housing and mental health service providers and municipal planners from Waterloo Region and the counties of Wellington and Dufferin (see Appendix F for a list of participants and observers). Eleven people participated in the focus group discussion and three people observed. The discussion was moderated by the author. The focus group convened in the office of the Waterloo Region – Wellington-Dufferin District Health Council in the city of Guelph. The analysis of data stemming from the discussion occurred during the two weeks following the meeting. All participants were sent a greeting card with a note of thanks one week after the focus group meeting.

Participants were selected for the focus group according to their expertise in either of the mental health, housing, or planning fields. Participants were all from the same general target population (*i.e.*, housing and mental health professionals) and there were no apparent conflicts or power struggles between them. This kind of comfort level and group dynamic ensures that people are less likely to hold back information in their responses (Dean 1994). Most participants were known to the author through work with local housing groups and committees and so participants were also chosen on the basis of their expressed interests and community activity. Most participants knew one another. Once participants were selected, they were contacted by telephone roughly one month prior to the meeting date and asked if they wished to participate. About two weeks after telephone contact, a letter of information (see Appendix G) and map to the District Health Council office was mailed to each participant. Participants signed a consent form on the day of the meeting (see Appendix G).

Focus groups, as a research method, offer a means of exploring a topic in qualitative depth with a small group of participants chosen from a narrowly defined target population (*ibid.*). They provide an effective way of exploring alternative courses of action (Stewart and Shamdasani 1990) in sufficient depth as participants build upon one another's comments and either support or debate the ideas raised by their peers. A focus group was used in this study because it was felt that the synergistic effect of having a group of individuals discussing the same issues in an informal fashion would add a great deal of depth and creative insight to the responses offered.

A moderator's guide was written and circulated to participants with a reminder note five days prior to the meeting so that they could ponder the questions that they would be asked to respond to in the focus group (see Appendix H). The questions were written to reflect the objectives of this stage of the research. These were outlined earlier. All were present at the focus group meeting. There were no cancellations. A micro-cassette recorder with microphone was used to record the meeting. As a

final note on process, a book written by Richard Krueger entitled *Moderating Focus Groups* (1998) acted as the primary learning tool before moderating this focus group.

The analysis procedure for the data collected during the focus group was fairly simple. Micro-cassettes were transcribed and the transcripts were read through several times before summarising the full range of responses given by participants. Recurring themes were given due emphasis in the write-up. Summaries of the results were mailed to participants who were invited to provide feedback on them. The feedback that was received was positive and no changes were made. The final results have since been shared with local mental health and housing groups and the findings have been confirmed by members' comments there as well. This is encouraging.

6.4 Conclusion

In this chapter, the methodology adopted for this study was discussed and the stages of research clearly outlined. In the next chapter, the results of this research will be presented and the findings discussed in relation to what has been written in the published literature.

CHAPTER SEVEN
THE EXPERIENCE OF RESIDENTS IN SUPPORTED HOUSING

7.1 Introduction

In this chapter, the results of interviews held with residents of supported housing in Waterloo Region – Wellington-Dufferin will be presented. The chapter is organised according to the four dimensions investigated during interviews (*i.e.*, physical housing environment, social housing environment, housing affordability and choice, and housing history). Under each of these headings, results are organised under major themes and concepts that occurred during the interviews. A summary of results and discussion occurs at the end of the chapter.

7.2 Place of Residence: Structural and Design Issues

Most participants were satisfied with the structure and design of their place of residence. However, there is a sizeable minority of people who were dissatisfied with their housing. Most of the people who were dissatisfied with their place of residence were living in developments that they characterised as being almost exclusively occupied by low-income households. While a few participants expressed that they were delighted with their home, most described their place of residence with terms such as "alright, OK, fine the way it is, pretty good."

One recurrent expression of dissatisfaction was captured well by one resident who said:

> We're just living here because we have no option. We don't really like it, you know. It's embarrassing to have visitors here or family from abroad, you know, come and visit. The problem is the rent is within the stipulated income bracket, or a little bit above what disability pays us. If we could find better housing at a moderate price, we would move.

The concepts and themes that emerged from resident responses around the structure and design of their places of residence are divided into four categories: maintenance, design, privacy and noise, and making do. Participants were also asked how they would change the structure and design of their place of residence if they could. Responses in each of these categories are explored below.

Maintenance

Notwithstanding the fact that most participants expressed general satisfaction with their place of residence, concerns with maintenance and structural deterioration were raised very frequently. Nearly all of those interviewed in small towns reported some form of structural deterioration. One small town resident, commenting on the apartment's state of repair reported that:

> ....there's a wall falling down. I think it can almost be condemned, you know. An animal can crawl through the wall in the basement, on this side, right into the basement.... They've got jacks holding the main beams up and stuff like that....you can see cracks in the wall, you know. You can see a bit of light coming through.

Frequently, city residents also raised concerns with structural deterioration and property maintenance issues:

> The building is like a tattered run down place.
>
> The hallways are, the carpets are filthy. In the hallways, the walls are dirty and pencil-lined with chipped paint and stuff like that. The garbage shoots are really bad. They smell really bad and people leave garbage all over the floor.

Some of the most frequently raised concerns with structure and maintenance were cracking and crumbling walls, water damage, mould and rotting wood, old appliances, and poorly maintained laundry facilities. In one case, a resident of a high rise apartment reported that there was only one elevator in the building and it was frequently out of service.

> I can't climb six flights of stairs anymore. I've got arthritis in my knees and everything. I mostly walk with a cane. What am I supposed to do unless we can try getting on that elevator. I can't go up these stairs. There's no way; I'm in too much pain.

On a number of occasions participants expressed the concern that while the outside of their building was well maintained, the inside of the building was not. This gives the outward signal that all is well, while inside disrepair can be a serious issue.

> There's lots of trees and stuff like that. Looks nice on the outside, but when you go inside, it's terrible.
>
> They've made improvements (to the outside of the property)....but you know, improvements are not only necessary outside, but also inside.
>
> It's well maintained on the exterior, but on the inside it takes my landlord a little bit of time.

Concerns of poor insulation and cold winters were raised by some participants. On a number of occasions, participants expressed that they could not afford to pay the hydro bill to heat their apartment in the wintertime, and further, that the apartment was poorly insulated to begin with.

> I would like to see the place a little warmer in the winter somehow, without causing me any further expense. But I have conquered that in one way. I have an electric blanket. They're great to have in the winter. I guess for $375.00 a month and the old building it is, I'll just have to grin and bear it. I feel that since I've got an electric blanket in the bedroom, I can shut off the heat in the bedroom and sleep with the electric blanket at night. It costs less hydro than it does for the electric baseboard to be running. It could be warmer in the winter; that's one thing.

Another resident noted that he wore warm clothes around his apartment in the winter and only turned the heat on if he was expecting visitors, in which case he turned it on for a couple of hours before they arrived and for the duration of their visit.

Some participants reported having problems with cockroaches and mice, although pests were not a frequently cited concern. In one extreme case, one apartment was so seriously infested that the resident had to throw out all of the beds, couches, and some other furniture because they were full of cockroaches.

On a number of occasions, participants expressed that other tenants were negligent in maintaining their building. It was even expressed that the building itself had potential if residents showed respect for their living environment. Participants who expressed this concern were living in developments that they characterised as being almost exclusively occupied by low-income households.

> The corridor up to the apartment, they (management) make an effort to maintain it, however, the people that live here don't care. It's neglected by the tenants. The outdoors are beautiful. It's very nicely maintained. And then there's the tenants who litter excessively. I've lived in high rent apartments and the tenants pitch in to keep the place nice. Here, there's no respect, no consideration.

Although many participants raised serious concerns about structural problems, many respondents felt that their place of residence was well maintained. Even those that reported serious structural problems often reported that their landlord or property manager was quick to respond to maintenance calls. It seems that in most cases, the issue in not an unresponsive landlord or property manager; but rather, it is an issue of poor capital replacement. This finding holds for residents of both small towns and cities, although serious structural problems were identified by almost every small town respondent. A maintenance person might respond on the same day to a complaint of a broken old stove, for example, and replace it with another stove that is roughly the same age and liable to have the same problems sooner than later. Leaky windows are caulked rather than replaced. Mouldy cupboards are painted over.

Many participants were genuinely satisfied, with both the structural condition of their place of residence and with the responsiveness of their landlord to maintenance calls. This statement by one resident captures well the sentiments of many respondents:

> I've had very few problems here, and when something did need to be fixed, he (landlord) was over usually the same day or the next day. We made arrangements and the problem was fixed.

The vast majority of participants remarked that the outside of their building was well maintained.

> I like how they did the exterior with the brick. I think that's nice to look at. It's nicely landscaped with trees.

Indeed, the vast majority of structural problems were reported to be inside of the building, as mentioned earlier. When one resident was asked if she liked the way her building looked from the outside, she responded:

> Yes I do. It's so deceiving. You would not think it would be like what it is inside.

It was not surprising then that when participants were asked whether they feel that their building fits in with the rest of their neighbourhood, the majority said yes. Those that responded negatively often noted that theirs was the only apartment building in the area, or something to that effect, and not that the place stood out because it was poorly maintained or dilapidated.

Design

Most participants expressed general satisfaction with the design of their place of residence. A few spoke more emphatically about their satisfaction with the design. A resident of a co-operative housing community was particularly pleased with its design:

> I love it (the design). I love the outside architecture. I like the way the architects designed it. I think it's aesthetically appealing. It looks nice. I think it looks a little bit classy to me. And I like my hall; it's really unique. It's hell to paint, mind you. But it's a unique hall when you come in, you know. Yeah, I'm very comfortable with it.

Another resident spoke of how her building fit within the surrounding neighbourhood:

> It looks friendly to me. And also, it's not a huge building. It's a good size. It seems to fit in well with the neighbourhood. It's clean. It's not run down in any way. It's bright too. It

> looks cosy to me from the outside. You know, it's not cold looking. It's a fairly inviting place to me. I think it's a great place.

Participants most often referred to the design of their place of residence as being 'OK' or 'fine the way it is'. Some people expressed that they really liked the open concept design of their place, while others preferred many separate spaces. The most common sentiment relayed by participants was that the design of their place of residence suited their needs nicely.

> I like this because it feels cosy. Everything's fairly....it's not clustered. It's just right for me, it's just right for my stuff....it just holds everything I need. It's alright.

Some of the most popular design features highlighted by participants were adequate cupboard space, kitchen size, storage space, and windows. Participants also appreciated having a nice and well-landscaped yard as well as a nice view from their apartment windows. By far the most popular design feature was the balcony, patio, or porch. Most of the residents interviewed spent a great deal of time at home on account of their mental health issues, and really did enjoy having a balcony, patio, or porch on which to sit, smoke, drink coffee, and depending on the living arrangement, socialise with others.

People were asked whether they felt that they have enough common area in their place of residence. This was interpreted differently by different people as meaning living room space within the apartment or common rooms within the building. In any case, of the respondents who reported having a common area in their building where neighbours could get together, only those living in co-operative housing appeared to use them. In the other instances common rooms existed for community use, but remained unused.

> When I was shown the apartment, I was told, "this is the meeting room. I don't think you'll ever use it so we don't need to see it."

One exception was found in a building where a common room existed and was used occasionally for parties and church services, but it must be rented on a daily basis. It was not for general community use.

Generally, people were satisfied with the design of their place of residence. However, a notable proportion of respondents expressed concerns related to design. The most common concern relayed was a general lack of space. Some felt that their apartment was too small.

> The living room is the bedroom. Over three people in the apartment and it's crowded. It's just too small. But for the price, when you're on disability it's hard to move into places that are more expensive, unless you go in with someone.

> If it (the building) was owned by one person with a family, it would be great. So all those apartments would be rooms, with other rooms leading up to them, and it would be real nice. For apartments, it's a little small.

The most common concern with space was kitchen size. Time and again, participants made it clear that there was not enough space in the kitchen. A couple of participants did not even have kitchens, having their appliances in the hallway and in the corner of the living room.

Mothers who were interviewed raised the concern of insufficient space for their children. In a couple of instances, children were sharing bedrooms with each other and with their mother. In other instances, mothers with joint custody of their children or who had children who visit frequently have not enough space for them.

> The problem is, I have five children. I wouldn't be able to have them all over at one time and that bothers me. Plus, I have my daughter coming every other weekend to visit overnight, so the place just isn't big enough.

One of the problems faced by parents with joint custody or children who come for overnight visits, is that the children are not recognised by the Ontario Disability Support Plan or other social assistance and pension plans in the calculation of shelter allowance. A person with joint custody of her or his child is given a shelter allowance for one person, not one person with a child.

Another space-related concern that was raised a number of times was the lack of storage space, particularly for seasonal items such as Christmas decorations and bicycles. Bicycle storage space on the ground level of apartment buildings was also an important consideration.

A couple of participants pointed out that there were not enough windows in their apartments and that ventilation and air circulation was poor as a result. One resident with asthma was particularly sensitive to this issue and another found it so unbearably hot in the apartment during summer months that he was looking for new accommodation.

Many of the people interviewed live in walk-up apartments and have expressed concern with the fact that as they age, it was becoming or will become more difficult to climb the stairs. Many of these walk-up units are among the most affordable apartments on the rental market.

> I don't like the stairs. There's 18 stairs. Not that I'm incapacitated. I still use my legs but I'm thinking in my old age.

Privacy and Noise

The vast majority of participants said that they had enough privacy in their place of residence. Often, privacy was equated with there being no penetrating noise from neighbours. For example, one resident, when asked if he felt that he had enough privacy, responded:

> Yes. You don't hear too much of the neighbours below us.
>
> Yeah, no trouble with noise. Sometimes you can hear people turn the water on and off.

Some participants were concerned that perhaps they had too much privacy and expressed feelings of loneliness. This theme will be returned to in a later section, as it is an important one. When asked about whether she had enough privacy, one resident responded:

> Yeah, I do (have enough privacy). And that's something that's very important to me. I need to have my privacy. I'm glad I'm living in the unit I'm living in on a fairly quiet floor. Maybe even too much privacy sometimes. Because living alone can be challenging. It can be lonely....

Some people felt a lack of privacy in their place of residence and again, they often equated lack of privacy with hearing noise from neighbours.

> You can hear normal volume voices from the next room (apartment) and the couple argues. So I turn up the T.V.. You can hear the person upstairs going to the washroom.

It became sufficiently clear throughout the interviews that the structure of the building and how soundproof the construction was between apartments were most equated with a perception of privacy.

Some participants, particularly those living in developments that they characterised as being almost exclusively occupied by low-income households, drew a link between lack of privacy and undesirable or gossipy neighbours.

> You don't get privacy here. There's sometimes when I just want to sit outside on my front step by myself with my tea and just veg, you know. Then you get on with other people. "Hi, hello, how are you", that's OK. But I mean then they want to talk about, "well gee, Betty just did this...." I don't care. I don't want to know about it. It's their life not mine. And I find that I've got to tell people more than once. Like excuse me, mind your business. More than once, and I don't really think you should have to do that, but unfortunately a lot of people are hard-headed in that respect and especially around here when it comes to privacy. You don't get it. Living here is not the place to live if you want to continue being a private person. They won't allow you.

> Privacy, there is no such thing. Everybody's looking at everybody in my building.

Improving Design

Rather than simply ask what they did and did not like about their places of residence, participants were asked to propose how they would change the design of their places if they were given the opportunity. Featuring most prominently among resident-proposed improvements were the addition of more space for storage, living area, or a dining room. Enlarging the kitchen was also a widely cited improvement. The addition of a porch, balcony, or deck was also a frequent proposal. General painting and decorating, both inside and outside were suggestions as were general repairs to and replacements of such things as windows, appliances, and carpets. Better insulation and soundproofing were also suggested as things that participants would do to improve their places if they could. Finally, a number of participants suggested adding new and larger windows to increase air circulation and ventilation as well as natural lighting.

Making do

Prompted by findings from Boydell *et al.* (1996) that people in supported housing are often 'making do', or accommodating to their environment, responses that revealed this theme were coded. Indeed, on many occasions participants exhibited that they were simply making do in their places of residence and were even, in some cases, very grateful for what they had. The high frequency with which structural concerns were raised by participants paired with the fact that most participants expressed general satisfaction with their place of residence provided some evidence that many are making do with their place of residence.

> I think I should be happy with what I've got. I think the building is not too bad. It's the inside that counts. The only thing that I'm concerned about that the landlord does is fix this wall (large crack), because it's starting to affect another wall on this side, you know. So that's getting kind of dangerous, you know. That's the main concern that I have.

> Well, this ain't the best looking house in town. But you know, I have a roof over my head and for the government to give me money to help me out, to live, I'm very happy and grateful for it.

7.3 Place of Residence: Social Issues

A narrow majority of participants expressed general satisfaction with their relationships with other people in their place of residence. One person was delighted; however, the majority used expressions such as "OK, pretty good, friendly, happy with the way it is" to describe their feelings toward the people in their building.

Almost as many people expressed mixed feelings or felt terrible or unhappy about their relationship with others in the building.

> I've made gestures to them like good morning, or whatever. I see them and I give them a wave but they just go their own way.

> I wish there were more people in this building that I wanted to interact socially with.

Almost all of the people living in developments that they characterised as being almost exclusively occupied by low-income households reported mixed or negative feelings about their relationship with others in their place of residence.

In almost every case, when participants spoke of other people in their place of residence, whether positively or negatively, they spoke of others in their building but not of those sharing their apartment (*e.g.*, children, partner, roommate). This is important to keep in mind when reading through this section on social relationships.

The concepts and themes that emerged from resident responses around the social environment of their places of residence are divided into six categories: interaction with others, fitting in, desired social change, safety, landlord and tenant relations, and integrated vs. segregated living. All of these will be explored in turn below.

Interaction with Others

Participants reported both good and bad relations with fellow tenants. Those reporting positive relationships with neighbours liked that they were able to exchange pleasantries, say hello, and speak briefly in the halls. As one resident put it:

> We don't chat long but just enough to know that we live together in the building.

A resident of co-operative housing noted that:

> What I like most is that you can run into people in the hall and they don't just pass you by. They say hi and the pleasantries that you like.

Those expressing negative feelings toward their relationship with other tenants raised concerns with noise, gossip, and carelessness and disrespect for property.

> People spit on the floor. People put cigarettes out on the floor. They put garbage beside the dumpster. Trash is littered everywhere.

Some stated that other tenants were not friendly, and told of being ignored when making an effort at conversation. Another issue emerged that was related to this; namely, that many tenants in low-income buildings are recent immigrants and as such, a communication barrier was reported to exist between tenants.

> They're all from other countries. If they could speak English a little better, then I'm sure it would be a little easier. I would get to know them better.

Many people responded that they did not know the other people in their building. A recurrent concept was that of neighbours 'keeping to themselves'. This concept surfaced in positive, negative, and neutral contexts. In a positive context, when participants were asked what they like about others in the building, they occasionally responded as this tenant did:

> Most of them leave me alone and keep to themselves.

Earlier in the conversation, that same tenant noted that he liked to keep to himself. This type of reclusive behaviour was communicated by other tenants as well and may have something to do with a history of stigmatisation or negative interactions with others.

> I'm a rather solitary individual now. Because of all the slights I've received, both from family and friends, I'm finding a solitary existence the most profitable one.

It is likely that in a positive social environment, this desirability of keeping to oneself and of others keeping to themselves would diminish.

One resident used the concept of others keeping to themselves in a negative context, suggesting a desire for more social interaction with his neighbours:

> They (other residents) like to mind their own business around here. I mean they'll talk to you but they won't go too far, you know. They just go so far. There's sort of a barrier I guess.

Feelings of loneliness were expressed outright by many respondents, and in latent terms by many others (*e.g.*, many accounts of reclusive behaviour were interpreted as loneliness). The tendency for some participants to be reclusive was discussed above. The following discussion will focus on those who stated explicitly that their living arrangement made them lonely. When asked how he would change his relationship with the other people in his building if he could, one resident answered:

> I'd just like to get to know them, you know. Like I talk to the lady beside me. When I see her out I say hi and goodbye, but that's about it. I don't know the other people too well. I've only been here a year and a month. I know the superintendent and one neighbour. Well, what are you going to do, there's 88 units, go around asking heh, you want to be friends?

One very important theme that emerged while talking to participants who live alone and experience loneliness was that even in nice apartment units, loneliness could make the apartment undesirable.

> I like it here but I don't. It's very lonely here.
>
> I feel lonely because I don't have much companionship with other people. I feel a lot of disconnection from the community, you know. I mean if there were more activities I could go to in town and help with mental health. But I just wish I had more company.... If there were someone sharing the apartment I would feel much better, someone that I could trust. Otherwise I like the apartment. It's very nice. It makes you dislike the apartment, because of the loneliness, you know. So companionship is the main thing I'm missing.

It was encouraging to learn that some people experienced enough social interaction in their place of residence to suit their wants. Those that did express this point of view were typically people with partners or people who live in co-operative housing. Reclusive people often reported having enough social interaction as well, although as discussed above, loneliness may still be an issue with reclusive people.

> I would like to keep it the way it is (level of interaction with neighbours). The less people know about me, the better off I am. I'm a very private type of person.

On a few occasions, participants said that they were pleased with the sense of community in their place of residence. One resident of a housing co-operative relayed a particularly strong sense of community:

> It is nice to sit outside and just chit-chat. That's nice here and you do get that. Everybody that's moved has missed that. Or talking to the kids. The kids will sit down and talk to you. So that is a really nice thing about the summer here, or even in the winter, when somebody will come out and help you shovel. You know, so that is a nice thing here. And everybody that's moved has missed that, that going out into the parking lot and talking to somebody, or sitting out on your porch and talking to somebody. I think the up-side of co-operative housing is really good. It's really an up-side. It's worth it.... I can feel useful here. Like I've met friends and I've babysat my friends' kids. It's a place where somebody with a mental illness can feel useful.

The majority of participants would like to have more social interaction with others in their place of residence. It was often the case that participants knew some of their neighbours well enough to say hello, but not much beyond that. For the most part, people want closer interaction:

> I'd like to have someone in for coffee every once in a while. I'd like to have a friend. I had a friend in the building but she moved.

> I'd like to maybe talk to them (others in the building), have them in the apartment, have a coffee with them or something, you know.

Even people who live in developments where they considered the other residents to be largely undesirable expressed a desire for more social interaction, if the people were different.

> I wish there were more people in this building that I wanted to have social interaction with.

> I would say that if everybody could get along, there should be more (social interaction). There should be more. Because then people will understand exactly what this feels like and what that feels like and they'd actually want to help each other out, as opposed to knocking each other down.

Fitting in

When asked whether they felt like they 'fit in' with the other people in their places of residence, most participants felt that they did, at least to some degree. Those that felt like they did not fit in reported a number of reasons for feeling this way. Low self-esteem was one reason offered by a few participants.

> Sometimes I feel like I don't measure up. It's part of self-esteem.

> I don't think I'm as intelligent as they are, because I'm not working. They all seem to find something to do.

Others pointed out that the stigma associated with having a mental illness caused them to feel apart from the other residents.

> No (I don't feel like I fit in), because of my mental problems. There's such a stigma attached. You feel singled out. It's the same wherever I go though. I don't tell people about it. People tend to just turn away from you when they find out.

Other people echoed this concern and stressed that they did not tell others in their buildings about their mental health issues. Mental illness does not typically attract the same kind of sympathy as a physical disability, for example. As one resident noted:

> Well, I've been accepted although there are people that don't understand me. They think I'm lazy and live off the government. Because you can't see it (mental illness). I don't have a wheelchair.

A number of other participants, particularly those who live in developments where most or all of the people who live there are paid through some form of social assistance, noted that they 'fit-out'. Notably, people who are receiving a long-term disability pension, for example, did not identify with others on social assistance.

> I kind of feel like I fit-out. Like I feel as though I'm pretty ambitious and sort of a bit out of sync with people here in the building. Like I'm trying to do whatever I can to get off social assistance. I don't know if and when I'll be able to accomplish this but that would be a nice long-term goal for me. And I think there are people here who will be on it forever.

> I'm trying to rebuild my life. Except for a few people, they're at a just getting by stage and happy to stay like that. Or they're the type of people that are looking to be cared for by someone else, like a free ticket.

Desired Social Change

When asked how they would change their relationship with the other people in their places of residence if given the opportunity, most participants emphasised having more communication and understanding among tenants. More social interaction was the most desired change. Developing understanding of mental health issues among other residents was particularly well articulated throughout many interviews. Some proposals of how to achieve greater understanding and communication included having building meetings and through education efforts directed at other residents. The two passages below illustrate vividly the core of what was said by many people.

> I would change it to more of an open understanding. Either mind your business or become friends with me. I would change it so that there isn't any animosity, you know, more understanding and less animosity.

> I think I'd like them (other residents) to understand where I come from, that I'm not just lazy and living off the government, but that I have a major mental illness. You don't get on CPP Disability for nothing you know. And I would educate people that we're (people with mental health issues) human beings. It's an illness that we didn't ask for. Like I didn't think when I was a teenager, oh, I'd like to get schizophrenia and alcoholism and mood disorder. I didn't wish that on myself. So education, definitely education.

Safety

About two-thirds of those interviewed reported that they felt safe in their place of residence. Many reported feeling unsafe in their homes. Concerns for safety were raised more frequently by participants in a study similar to this one that was conducted in Toronto by Boydell *et al.* (1996). One's level of concern for safety is believed to be associated with feeling a lower sense of commitment to one's neighbourhood and harbouring a desire to move away (Enns and Wilson 1999). With this association in mind, it is interesting to note that with only two exceptions, participants who reported feeling unsafe in their place of residence were precisely those who had described some of the greatest feelings of disconnection from their communities and pronounced desires to move away. It is important to note here that most people did not cite physical features such as poor locks as the reasons for their safety concerns. It had more to do with their uncertainty with the people living around them.

> I have a very violent ex-husband and I don't believe that people around here would actually help shield me from that. They'd say, "oh yeah, Heather still lives here. She lives down there." That kind of thing.

Landlord and Tenant Relations

Participants' comments on their relations with landlords, superintendents, or co-op co-ordinators were generally very positive. Some of the most frequent accolades given were friendliness, being understanding (*e.g.*, of mental health issues), and swift response to maintenance calls. The most notable negative comment directed at landlords, superintendents, and co-op co-ordinators was that they were occasionally not understanding of mental health issues. One resident, when asked how she would change her relationship with the landlord if she could, said:

> I'd have her ease up and understand that if someone does have an issue; if they suffer from depression, be a little more understanding and not so hard on them. You know, work with them, not against them. Be a support without patronising.

Almost all of the changes that participants said they would like to see in their relationship with their landlords were based on improved communication. First of all, better communication would lead the landlord to better understand participants' mental health issues. Second, better communication would lead to repairs and maintenance being done more quickly. Third, better communication would provide residents with opportunities to give input on how their building or community might be improved.

Integrated Living

Almost every person interviewed said that they prefer living in housing that is normal and integrated with the rest of the community. Many participants have experience living in housing dedicated to people with mental health issues and time and again, they reported that living in group homes or apartments where everyone has a mental health issue can be very stressful.

> It's too taxing, too hard to deal with. Your home should be a place where you retreat to and feel comfortable. It shouldn't be a place of stress, or as little stress as possible. And I've done that before too, tried living in situations where I'm with other consumer/survivors, and it's never worked out for me. I've always wanted to get out of there.

People stressed that they enjoy the diversity of the broader community and living in regular housing. Some also raised the alarm of discrimination when asked about how they would feel living in dedicated mental health housing. Participants also noted that they like to feel normal and average, feelings that can be perpetuated by living in regular housing within the community. The desire to feel integrated was also expressed along two dimensions by two participants who live in housing that is explicitly for people with fixed incomes. First, they expressed a desire to live in housing that is integrated socially and economically, and second, they did not like the idea of living in housing that is dedicated to people with mental health issues. People want to live like everyone else.

Four participants expressed a desire to live in housing that is dedicated to people with mental health issues or at least where a significant proportion of residents were living with mental health issues. The main reason for this desire, stated by all four participants, is that there would be more understanding and positive social interaction in dedicated mental health housing.

> It would be better (living in a building with others who have mental health issues) because I find them very very friendly, and it helps you out in a way if you're having a rough time or something. They wouldn't figure oh, you're just crazy or whatever. They wouldn't just call the police right away and get them to come and get you and send you to the psychiatric ward at the hospital. They would sit and talk if somebody's having a problem or upset or whatever.

7.4 Neighbourhood: Physical Characteristics

The vast majority of participants were pleased with their neighbourhoods as places to live, expressing that their neighbourhoods were "nice, not too bad, pretty good areas with good people," and often "quiet." Of the few that did report unhappiness with their neighbourhood, most were living in buildings that they characterised as being almost entirely occupied by low-income people. This is one example of a response from an unhappy resident:

> Other people (in the neighbourhood) look at this residence as being basic low-life. If you have a high esteem or fairly healthy self-esteem before you come here, you'll lose it quickly as a result of the way other people treat you and look down on you because you're living here.

In the following sections, residents' views on the accessibility and importance of community services and supports will be elaborated. As well, some of the recurrent references made by participants to both positive and negative features of their neighbourhoods will be described.

Accessibility and the Importance of Community Services and Supports

Services such as shopping, public transportation, banks, schools, medical clinics and social places are accessible to most people in cities. Many of these are also accessible in small towns. Participants were asked which services were accessible to them by foot within their neighbourhood and also, which services they believed were most important to have accessible in a neighbourhood, even if such services did not exist in theirs. First of all, it is important to recognise that walking is the most common primary mode of transportation among those interviewed, with public transit being second. A serious issue in small towns is the absence of efficient and inexpensive transportation, both for travel within town and between towns and the larger urban centres.

It is sufficient to say that most important services were accessible, by walking, to most of the people interviewed. Obviously, those people with automobiles expressed that having services within walking distance was not as grave a concern. One suburban resident who was quite pleased with his apartment and neighbourhood said that:

> Without a car, I don't think I'd want to live out here. It's too far out.

Participants were asked which services they felt were most important to have within walking distance in their neighbourhoods, even if they did not have those services in their present neighbourhood. Shopping was rated the most important community service, medical services (non-psychiatric) was rated the most important community support, and restaurants and coffee shops were the most desired social or recreational places (see Table 7.1). It was often expressed that having mental health services located in the neighbourhood was of little consequence, because support workers are mobile and in most cases visit people in their homes or a coffee shop, for example. One interesting observation is that friends ranked higher in importance than family as an informal community support. This finding is consistent with what was found in Toronto by Boydell *et al.* (1996) in their study of the desirability of supported housing locations.

Table 7.1: The Importance of Having Community Services and Supports Within Walking Distance

		Rank
Community Services	Shopping	1
	Public Transit	2
	Banks	3
	Schools	4
Community Supports	Medical Services (non-psychiatric)	1
	Mental Health Services	2
	Friends	3
	Family	4
Social and Recreational Places	Restaurants and Coffee Shops	1
	Places to Socialise	2
	Parks and Open Spaces	3
	Recreational Places	4

Participants were asked what other services they would like to have accessible to them, within reasonable walking distance, in their neighbourhoods. Responses ranged widely from a dance hall to affordable clothing stores. The most common service that participants felt would be a welcome addition to their neighbourhood was a grocery store. Other common responses included a mental health drop-in centre, coffee shops, movie theatres, and recreation places like a swimming pool, arena, or gym. One single mother suggested that a community centre like the *Onward Willow* centre in Guelph would be helpful and well received.

> They (Onward Willow) cover just about everything. They've got extra-curricular activities for kids. They've got programs where single moms can meet each other and have a common place to go to and meet while their kids can play. I think it targets lower income people, and it targets people that can't afford to spend $300.00 for karate lessons, for example. It provides them for free.

Easy access to services, which for most respondents means walking, figures largely in their satisfaction with the neighbourhood. The people that were happiest with their neighbourhoods stressed the importance of service accessibility.

> That's a good thing about this area where we live right now: our doctor is right across the road, our pharmacy is a block away. We've got three grocery stores within walking distance, because we don't have a car. The dentist is across the road, the eye doctor, everything. I work right next door, so that's why we don't want to move either. It's excellent. The bus stop is across the road. There's just everything around here.

> It's got the location. This is what's kept us here. That made up for the other problems with the building, like all the bugs in the cupboards that took awhile to get rid of, the mice, and we had cockroaches.

Conversely, some participants reported on the inconvenience of living away from services and relying on public transportation, rides from friends and family, or very long walks.

> This is way out on the fringe. If I had things (services) close by I wouldn't have to depend on family and friends for half of the things I do. A lot of times, just getting out and doing something interesting, not necessarily something that has to be done like groceries, but something like taking the kids out to Pizza Hut.

Notable Neighbourhood Features

As mentioned earlier, most participants had a positive perception of their neighbourhoods as places to live. Some recurring positive neighbourhood features from conversations with residents include first and foremost, proximity to services. Quiet neighbourhoods were appreciated by many participants, as were neighbourhoods with well-set natural features such as nice trees or a nearby river or park. The most undesirable neighbourhood features were distance from services, noise and traffic, and to a lesser extent, crime and vandalism.

7.5 Neighbourhood: Social Characteristics

By and large, participants reported that they were mostly satisfied with the people in their neighbourhoods. There were no emphatic responses one way or the other; that is, overly positive or negative. More indifference toward the social characteristics of the neighbourhood seemed to exist than toward the social aspects of one's place of residence. Most often, participants said that neighbours 'keep to themselves.' This concept, when discussed with participants, held negative, positive, or neutral connotations. Most often, the concept was used neutrally. Participants said that they simply did not know their neighbours and that they kept to themselves.

> I really don't know (what the other people in the neighbourhood are like). I really don't spread myself that far.

A few people displayed some desire for more social interaction with people in their neighbourhood when they used the concept of neighbours keeping to themselves.

> I think people just stay in their homes and don't come out, or come out only when they have to. The neighbourhood could be a little friendlier.

When used positively, a fair number of participants, often those who revealed a reclusive nature themselves, said that they liked the fact that people in their neighbourhood kept to themselves.

> They keep to themselves; I keep to myself. It's how I like it.

While most participants noted that people in their neighbourhoods tended to keep to themselves, many also spoke of noticeable positive features of their neighbourhood social environment, such as general friendliness.

> I don't know very many people but the people I do know are friendly. If I happen to meet a neighbour and say hello, it's basically on a hello, how are you basis. That's all I know them by.

> The people are friendly. When you walk on the sidewalk, people say good morning.

Residents of low-income buildings were often quick to clarify the distinction between neighbours within their place of residence and those without, noting a better social relationship with their surrounding neighbourhood than with their immediate one (*i.e.*, inside their building).

The concept of diversity came out a number of times in interviews with participants. A variety of age and ethnic groups within the neighbourhood were seen as a positive feature by many.

> It's quite the neighbourhood. Any type of person you want to meet, they're in this neighbourhood. And I really like that. It's a real quilt of different nationalities.

There were few instances where participants reported negatively on the social character of their neighbourhoods. Those that did typically characterised their surrounding neighbourhood as being a low-income neighbourhood and cited cases of vandalism and minor disturbances.

In the following sections, themes related to the social characteristics of people's neighbourhoods will be presented. They are organised into five categories: interaction with others, fitting in, desired social change, safety, and ideal neighbourhood.

Interaction with Others

Most participants expressed a desire for more social interaction with the people in their surrounding neighbourhoods. After reading carefully through resident responses, however, it became clear that the neighbourhood scale was not so important as was simply the desire for more social interaction. Although the scale was important when discussing people's places of residence (*i.e.*, people were clear about wanting more interaction with others in their buildings), it was not so important at the level of the neighbourhood. The people that were most expressive about their desire for more social interaction with others in their neighbourhood were those who did not like the people in their place of residence (*e.g.*, many of those living in 'low-income buildings').

> I wouldn't mind having more. Not with people in my building but with people away from my building.

When asked how they would change their neighbourhood if they had the ability to do so, many participants said that they would like to have more friends in the neighbourhood. Again, looking more carefully at these responses, the neighbourhood scale did not seem as important as it was in discussing desired social changes in people's places of residence. Although, to be sure, having a friend close by is better than having one who lives far away.

As mentioned above, most people interviewed desired more social interaction in their neighbourhoods. As discussed, the neighbourhood scale may not have been all that important in affecting people's responses. A considerable number of participants did report having enough social interaction in their neighbourhood already. These people, although responding differently to the issue of neighbourhood social interaction, may not in fact be all that different from those who desired more neighbourhood interaction. They simply thought more critically of the neighbourhood scale. Many of the people that said the current level of neighbourhood social interaction was 'fine the way it is' noted in other parts of the interview that they desired more social involvement at some scale such as in their place of residence or at a mental health drop-in centre.

Fitting In

Most participants felt that they fit in with the other people in their neighbourhoods; however, fitting in on the neighbourhood scale was not a terribly important issue to most people. Answers, although positive, rang with ambivalence:

> I guess I feel I do. There's not a lot of interaction.
>
> I guess. I'm an average person walking down the street. I'd say I fit in.
>
> I guess I fit in. I'm still here. I get along with anybody usually.

There is one notable group of participants that felt like they did not fit in with others in their neighbourhoods. They felt that their mental health issues separated them from the neighbourhood.

> It's like a jigsaw puzzle and a piece that doesn't fit right. You feel like you just don't fit in with them because you're sick.

Although only reported on a couple of occasions, residents of low-income neighbourhoods felt that they do not fit in with others in their neighbourhood, saying that most people in their neighbourhood are on social assistance. Though they themselves reported being on a form of social assistance for long-term disabilities, they were reluctant to say that they fit in with others on other forms of social assistance.

> In a way I do (fit in), in a way I don't. I'm on long-term disability pension, so in a way I do, but in a way I don't.

This coincides with what was reported earlier at the scale of people's places of residence.

Desired Social Change

People were asked to discuss anything that they really liked about others in their neighbourhood and also, how they would change people in their neighbourhood if they could. On the positive end, many people reported general kindness and friendliness as things that they liked about people in their neighbourhoods. Some also noted the diversity of their neighbourhoods. Others liked the fact that they live in active communities where their neighbours jog, walk dogs, *etc.*.

The most clearly pronounced social change desired by many participants in their neighbourhoods was an increase in understanding of what mental illness is and a concomitant rise in the degree of acceptance of people with mental health issues by their communities.

> I think we should be understood and integrated.... The heart should go out more toward people that are suffering and people should try and help.

> There's a need for integration in the community, where the community accepts you and understands that you have a disability or an illness, but that it's being controlled by medication. That way you can try and live a full life, you know, which is not possible right now because of the stigma, social status and income level.

One resident felt it important to note that sympathy is not the same as understanding. People want to be understood.

Safety

Neighbourhood safety was perceived to be high by the vast majority of participants. Again, the study conducted by Boydell *et al.* (1996) in Toronto found more participants concerned with neighbourhood safety. In this study, many participants expressed that their neighbourhood was safe but that they did not feel comfortable walking around outside at night. A small proportion of people reported that they did not feel that their neighbourhood was safe. All of the people who felt that their neighbourhood was unsafe were women. They also stressed that it was mainly at night that they were most concerned with neighbourhood safety.

Ideal Neighbourhood

When participants were asked to describe their ideal neighbourhood, for the most part, they did so in physical terms. There were rarely references made to social characteristics in their ideal neighbourhood. Time and again, participants described their ideal neighbourhood as being the absence of a neighbourhood. Many people, both residents of cities and small towns, would prefer to live in the country, with a house and a piece of land. Privacy, peace, and distance from neighbours were key traits of this country environment. A few people also placed their country home in northern Ontario where they could enjoy lakes, trees, and the rocky landscape.

Equally as popular was living in residential districts of the city. Many people would like to see themselves in a house or condominium in a newer residential development. However, whether their aspirations were rural or urban, participants consistently expressed the importance of having access to services. In the case of country dwellings, people often placed their ideal home near a town or on the outskirts. For people whose ideal home would be in the city, they often stressed that while a residential district would be ideal, a traditional suburb with its poor proximity to services would not be.

Three people actually wanted to stay put. One cited the diversity of her present neighbourhood as the reason. One liked the diversity of the neighbourhood and proximity to services, while the third person stressed proximity to services.

> At one time I would have said live out in the country, but I'm so used to the city now and close to everything, and not having a car, I wouldn't want to live in any other part of the city. I'm not one to keep moving all the time.

> I like Waterloo, especially being on foot. We used to have a car, so it wasn't as difficult to get the shopping done. But when you don't have a vehicle and you have to get your groceries home and you don't want to take a cab all the time, this neighbourhood is perfect. Maybe this apartment building isn't the best but the neighbourhood is really good.

7.6 Housing Affordability and Choice

The supported housing model is composed of two important components: adequate and affordable housing and flexible individualised mental health support services. When the rent paid for housing is in excess of 30 percent of one's income, that housing is considered precarious. In other words, the resident(s) are at risk of becoming homeless, and at the very least, are living with feelings of insecurity. Money that should be spent on food, education, transportation, and other lifestyle expenses is being channelled instead into housing costs. Only eight out of 31 interview participants reported living in housing where their rent is subsidised (*i.e.*, rent-geared-to-income). These people were paying roughly 30 percent of their income on rent. Twenty-three participants are in housing rented at the market rate. Their proportion of monthly income spent on rent (including utilities) ranges from 34 to 60 percent with the average proportion at 48 percent (see Table 7.2). The woman paying 60 percent of her monthly income on rent has four school-age children in her care. The woman paying 34 percent of her income on rent is one of only three residents interviewed who is able to do paid work in order to supplement her disability pension earnings. People with serious mental health issues, as much as they would like to work, find it difficult or impossible to do so.

Table 7.2: Proportion of Monthly Income Spent on Rent (ranked categorically according to frequency)

Proportion of income spent on rent and utilities	Rank
34 or 35 %	4
36 – 40 %	4
41 – 45 %	3
46 – 50 %	2
51 – 55 %	1
56 – 60 %	4

One of the tenets of supported housing is that residents, rather than living exclusively in dedicated housing for people with mental health issues, get to choose their home in the community and then receive support, to the degree they request, from a local mental health agency. Given the scarcity of subsidised housing and the tight rental market, people on fixed incomes have little or no real choice in where they live. Below, the issues around choice will be presented. Participants' perspectives will also be presented on whether their housing appeals to them as a home or simply as a place to live for now.

Choice

Affordability was cited by many people as the sole reason for choosing their current place of residence. As one resident recounted:

> I thought it would be better to live over on Bridgeport Road but I didn't get that place, because of the money.

Affordability was cited many times in conjunction with other reasons. For example:

> I had to find something quickly and this came up. It was $475.00 plus hydro. And I thought, well, most of the other places are over $500.00, so I just grabbed it.

Many people said that "it just happened" that they ended up in their present place of residence. Very often, participants noted that they needed a place really quickly and so happened upon their current residence. One person recounted that he had just moved into town and needed a place quickly

and one couple was escaping from a landlady who had intentions of evicting them. As one resident of subsidised housing told:

> I was in a shelter at the time and I wanted a place NOW. And I was almost willing to accept anything.

It was encouraging to learn that some participants chose their place for its positive physical or social environment. One rural resident noted that she chose her place because the setting was peaceful, the place was cute looking, and the price was right. Another resident, this time in the city, said that she chose that neighbourhood because she had lived there at another point in her past and had enjoyed the area. People cited convenient location as a reason for choosing their place. A resident of co-operative housing shared the reason for moving into the co-op:

> I've lived before where there's been a regular landlord and I've never found them to be that supportive. I had a friend that lived here in the co-op about four or five years ago and he brought me along one time to pick some material up from his apartment and I saw the place then and I liked it. I was willing to pay more to have a nicer place. I was paying about $550.00 here up until about six months ago, and then I got rent-geared-to-income. So that made it even better. I like it a lot here. The people are nice, there's not a lot of trouble going on, and they pretty well make sure that everybody helps in keeping the place up.

Another resident captured his satisfaction with his current place very succinctly:

> It's cosy, it's comfortable and it's close to downtown. The rent is reasonable and the landlord understands (mental illness).

A number of participants stated explicitly that they had no choice but to live in their current place. Most of these residents were living in subsidised housing and spoke of their desperate state before moving in. One resident spoke of consistent discrimination by landlords on account of his source of income (*i.e.*, disability pension) and so he finally 'chose' his current place.

> It's the only one that would accept me with my disability pension after looking for a year.

Home?

There were roughly an equal number of people who said that their current place felt like home and those who asserted that it was just a place to live for now. People that thought of their place as a home expressed positive sentiments about it. Those that would rather look forward to other places of

residence elaborated that they simply did not like their current place, for reasons discussed in earlier sections. Reference was again made to loneliness.

> (I think of it as just a place to live for now) because I'm by myself. I don't think anybody should be alone.

Most people pictured themselves living in their current place of residence two years into the future. Many did not picture themselves living in the same place two years later. Those that did were generally pleased with their home. However, there was a notable group that felt they had no choice, that they could not afford any better. One resident of a federal co-operative housing development had this to say:

> I'd love to (stay in this place) if I could. It's in the government's hands. It depends on whether they keep hold of it (the co-op) or let it go. It's insecure. I could be out in the street like my fellows you know.

People who did not picture themselves living in their current place in two years stated that they were hopeful that they would find a better place to live that was still within their budget. Others were concerned that they might have to move because of rising rents in their current place.

When people were asked whether they could picture themselves in the same place of residence five years into the future, many of the same reasons were cited, positive or negative. Many people simply did not have an answer and others stated explicitly that they did not plan that far ahead. Many participants noted that they were tired of moving and wished to stay put.

7.7 Housing History

There was no distinguishable difference between residents of small towns and cities with respect to the number of years they reported being in their current place of residence. The average number of years reported was three. The average number of years that people had lived in their present neighbourhood was higher, at four and a half years. The median number of times that people reported having moved over the past three years was once. The highest number of moves over the past three years was seven, and this frequency was reported by a single-mother with two children.

> When I separated, I moved. Then I was hospitalised. Every time I moved, I went from rock bottom to better, and then I tried to improve my housing situation. It wouldn't work, then I would fall back down. And then I would try and improve my housing again. Money....money is a big issue. I took a one-bedroom apartment once out of desperation. And then finally I got into this government-assisted housing. I'm just trying to get by.

When asked how she felt about having moved seven times over the past three years, not surprisingly she said:

> Awful. It's embarrassing. It's very unstable.

When people were asked how they felt about moving a multiple number of times over the course of three years, the most common response was "I hate moving." Participants also said that moving is stressful and could adversely affect their mental health. Others noted their age and that while at a younger age moving may have been exciting, they "are getting too old to move." The circumstances under which moving occurs will have a great deal to do with one's attitude toward moving. As one resident said:

> I don't like moving, but yet, I want to move from where I am now.

Below, the reasons people gave for moving over the past three years will be presented. Also, a brief account of the frequency of homelessness among respondents will be given. Finally, participants' accounts of discrimination by landlords will be discussed.

Reasons for Moving

Among the reasons that people gave for moving, rising rents in previous housing was the most cited. Strained relationships were also the cause of a number of moves. For example, people were asked to move away from the family home, couples broke up, or relationships with roommates took a turn for the worse. On a few occasions, participants moved away from the family home because they themselves wanted more independence. Some participants said that their mental illness caused them to move, either through their own mental influence or because landlords or co-habitants asked them to leave. As one resident noted of a major subsidised housing provider:

> Subsidised housing is good because it's geared to your income. But they kicked me out because I got sick you know. I think it was mainly the elderly people in the building that were complaining. I think they should have staff on duty or something to deal with people that are getting sick, because I have ups and downs. I started a relationship with someone, it ended, and I got sick. And I lost my subsidised housing just because I got sick.

This resident went from an affordable subsidised apartment to a market rent apartment because of his mental illness. He is now paying roughly 55 percent of his monthly income on rent.

Homelessness

Fifteen out of the 31 interview participants have lived in emergency hostels, and a disproportionate number of those were women. Two people reported having lived in rooming and boarding houses during stages of their lives. Eight people reported having spent time living on the street, without shelter of any kind. A number of respondents who have never lived in emergency or temporary housing, or who have never spent time living on the street, said that their strong ties to family and friends saved them from that plight.

Discrimination

Many people reported feelings that they had been discriminated against in past searches for housing. The most common basis for discrimination was when landlords found out about their source of income, namely, social assistance (*e.g.*, disability pension). Others felt discriminated against because they were single mothers. People did not mention discrimination on the basis of their mental health as often as I thought they might. The reason for this became clear, however. Many people noted that they never mention mental health issues to prospective (or current) landlords.

7.8 Summary and Discussion of Findings

Place of Residence: Structural and Design Issues

Most participants were satisfied with the structure and design of their places of residence, using such terms as "alright, OK, fine the way it is, pretty good" to describe their places. However, there was a sizeable minority of people who are dissatisfied. Most of these people are living in developments that they characterised as being almost exclusively occupied by low-income households.

Despite the fact that most participants expressed that they are satisfied with their places of residence, they very frequently raised concerns with the structural condition of their housing. These concerns were especially well pronounced by small town residents, although it was also a widely cited concern in the cities. In many cases participants reported that maintenance calls are answered fairly quickly. However, maintenance often consists of 'band aid' repairs and so the major structural concerns remain an issue. Physically inferior housing does bear a direct relationship to poor community adaptation (Baker and Douglas 1990). Residents living in predominantly low-income buildings often reported that other tenants have no pride in the building and are negligent toward the physical environment within the building. On a number of occasions participants expressed the concern that while the outside of the property is well maintained, the inside is not. This gives the outward signal that all is well, while inside all is not.

Most participants expressed that the design of their place of residence is 'OK' or 'fine the way it is.' The most common design-related concern was that there is not enough space in the place of residence, particularly kitchen and storage space. Mothers with children expressed concern with space for their children as well. Of the respondents who reported having a common area within their building where neighbours can get together, only those living in co-operative housing appear to use them. In other instances, common rooms exist but remain unused.

The vast majority of participants reported that they have enough privacy. In mental health housing studies, privacy has typically been discussed in terms of people having their own bedrooms versus shared rooms (*e.g.*, Nelson *et al.* 1994). According to what participants said during interviews in this study, once this basic spatial aspect of privacy is satisfied, the issue of privacy moves to a new dimension. Namely, noise from neighbouring apartments and gossipy neighbours become the forces working against one's sense of privacy. Some people did report a lack of privacy and attributed it to these two forces. They were typically residents of housing that they characterised as being occupied by mostly low-income households. When residents' basic 'pain avoidance needs' for stable housing are not met due to a lack of privacy and poor housing conditions, they experience emotional stress and possibly psychiatric symptoms (Nelson, Hall, and Walsh-Bowers 1998). Residents of housing developments that they characterised as being occupied by mostly low-income households often reported poor housing conditions and a lack of privacy. It is important to note, however, that the degree to which physical characteristics of housing are responsible for the deterioration of physical and mental health is relatively small compared to more widespread economic and social deprivation (Duvall and Booth 1978; Kearns, Smith, and Abbott 1991).

Some participants were also concerned that they have too much privacy and discussed feelings of loneliness. While people's basic pain avoidance needs can be met through the physical qualities of housing, 'personal growth' needs can only be met through social characteristics, particularly the strength of one's social and peer support networks (*ibid.*). Although many people with serious mental health issues prefer living alone, in supported housing, they often want help from their case managers with making friends (Ogilvie 1997).

The high frequency with which structural concerns were raised by participants, paired with the fact that most participants expressed general satisfaction with their place of residence provides evidence that many are simply 'making do' with their place of residence. This finding is consistent with the thematic analysis of qualitative data conducted by Boydell *et al.* (1996) in their study of the housing experience of Toronto residents in supported housing.

Place of Residence: Social Issues

A narrow majority of participants expressed that they are satisfied with their relationships with other people in their place of residence. Most residents in developments that they characterised as being almost exclusively occupied by low-income households were not happy with their relationships with others in the building. Boydell *et al.* (*ibid.*) also found that in many cases, tenants felt uncomfortable in housing with other marginalised groups.

One of the things that participants liked about their relationships with others are the pleasantries exchanged in the hallway. Residents of low-income buildings did not like the carelessness of other tenants, the gossip, or the noise.

Participants often used the concept of others 'keeping to themselves' to describe their relations with fellow tenants. This concept was used with three different connotations: positive, negative, and neutral. In a positive sense, participants sometimes noted that other tenants leave them alone. In a negative sense, some felt that other tenants who keep to themselves contribute to their feelings of loneliness. Used in a neutral context, participants sometimes stated that others keep to themselves, and they did not attach either a positive or negative meaning to the statement. People that are reclusive tended to use the concept of others keeping to themselves in a positive light. However, this is likely due in large part to a history of being slighted by others and of being misunderstood. Boydell *et al.* (*ibid.*) noted that several tenants who participated in their study exhibited 'passing strategies' to manage their 'spoiled identities' (Goffman 1963 as cited in Boydell *et al.* 1996). One such strategy was keeping to oneself. Reclusive behaviour is certainly a contributing factor to loneliness. Difficulty making and keeping friends is one of the most frequently cited effects of stigma on people with mental health issues (Wahl and Harman 1989).

Feelings of loneliness were expressed in many ways by many participants. It became clear that while the physical characteristics of an apartment might be satisfactory to people, loneliness can negate any sense of satisfaction or feelings of 'home'. Those who reported having enough social interaction within their place of residence are typically those with partners or those in co-operative housing. Co-op supporters are cited elsewhere (Sewell 1994: 180) as saying that "while any form of income-mixed housing will achieve a social mix, co-operative housing achieves social *integration*, that is, households from varying backgrounds actively meet and associate with each other."

Most participants felt that they fit in with others in their place of residence. Some pointed out that the stigma associated with having a mental illness causes them to feel apart from others and that more mutual understanding would lead to concern for one another. Many reported that they simply do not tell others about their mental health issue due to the common lack of understanding. A number of

participants noted that they 'fit-out' with others in their place of residence. These were typically residents of developments where most are low-income households.

About two-thirds of those interviewed reported that they feel safe in their place of residence. The rest did not. Safety was linked to social conditions more so than to physical features of housing.

Most participants reported having positive relationships with their landlords, co-op co-ordinators, or superintendents. The most notable positive comments were that landlords are friendly, understanding, or quick responding to maintenance calls. The most notable negative comment was that landlords are not understanding (*e.g.*, of mental health issues). The most common desired change to landlord and tenant relations was better communication. There were three reasons for this: better understanding of mental health issues, quicker response to maintenance calls, and increased potential for resident input into improvements to the building and community.

Almost all participants expressed that integrated housing is preferable to housing that is dedicated to people with mental health issues or people with fixed incomes. People noted that living in housing where all residents have a mental health issue could be very stressful. This corroborates what was reported by Hodgins, Cyr, and Gaston (1990); namely, that the congregation of a large number of residents with mental health issues into one housing development contributes to a stressful living environment. This point was raised with respect to housing dedicated to people on fixed incomes as well. A small number of participants did, however, express a desire to live in housing where there were more people with mental health issues. The reasons given for this desire were that in such an environment, there would be more understanding and positive social interaction. Similarly, Boydell *et al.* (1996) reported that several of their interview participants would prefer to be among others who share a common psychiatric history.

Neighbourhood: Physical Characteristics

The vast majority of participants were satisfied with their neighbourhoods as places to live. Walking and public transit were the most common primary means of transportation for participants. A very significant issue in small towns was the absence of efficient and inexpensive transportation both within town and between towns and cities. This accords with the feelings of one rural social advocate in Wellington County who cited inadequate transportation (and housing) as the biggest issues in rural areas (Cole 1999).

Most residents in both cities and small towns noted that most services are accessible to them by foot. Shopping was the most important community service to have within walking distance, while non-psychiatric medical services were the most important community support. Mental health services are more mobile than other medical services, and so it was not as important to have mental health

service agencies accessible by foot. The most important social or recreational places to have within walking distance were restaurants and coffee shops. Easy access to services figured largely in participants' satisfaction with their neighbourhood. The characteristics of one's home neighbourhood (*e.g.*, proximity to shops and services) can contribute to or detract from one's personal wellbeing (Smith, Kearns, and Abbott 1992).

Neighbourhood: Social Characteristics

Most participants expressed that they are mostly satisfied with the people in their neighbourhoods. They expressed a great deal of indifference toward others in their neighbourhood, unlike the feelings expressed toward others in their places of residence. Social characteristics did not appear to be as important on a neighbourhood scale as they were in people's own buildings. The comments made by most participants about the social characteristics of their neighbourhoods were directed more toward the community at large. Again, the neighbourhood scale was not particularly relevant in a social context. Similarly, Boydell *et al.* (1996) found that tenants in Toronto felt less integrated with their surrounding neighbourhood than with the environment within their own buildings.

Some people did express that they enjoyed the diversity of people in their neighbourhood, and general friendliness. Most people wanted more social interaction with people in the community. The most common desired community social change that people expressed was the desire for more understanding and the concomitant rise in the degree of acceptance of people with mental health issues by their communities. Community diversity and service accessibility were the most widely cited qualities of people's ideal neighbourhoods.

Housing Affordability and Choice

Twenty-three out of 31 participants pay market rent for their housing, ranging in cost from 34 to 60 percent of their monthly income. People have little real choice in where they live, given the scarcity of subsidised housing and tight rental markets. People that did report reasons for choosing their place of residence noted that it was the most affordable place they could find, that they needed a place quickly, or that the location was convenient.

Roughly half of all participants expressed that their place of residence feels like home. The other half thought of it as just a place to live for now. People who did not feel at home often raised the issue of feeling lonely. Feelings of insecurity were also prominent among people who felt at home and those that did not in their current place. Feelings of insecurity are attributable to steady increases in rent without any increases to the shelter allowance of disability pensions. The idea advanced by

Carling (1995) and others; that residents of supported housing get to 'choose, get, and keep' their housing, is unrealistic in the current rental housing market in Ontario.

Housing History

Participants consistently indicated that they hate moving and that moving is stressful, particularly if it is under adverse circumstances (*e.g.*, rising rent, eviction). Rising rent was the most commonly cited reason for people moving. This is a trend that will continue as long as shelter allowances remain fixed at the current level. People also reported having to move from their housing (market rent and non-profit) because of their mental health issues. Fittingly, Kearns and Smith (1994) make the point that residential mobility can represent an attempt to improve personal wellbeing, but if the result of forces beyond one's control (*e.g.*, rising rent, eviction) it can harm one's wellbeing.

Fifteen out of 31 participants have lived in emergency hostels, and a disproportionate number of those are women. Eight people reported having spent time living on the street, without shelter of any kind. Support from family or friends was cited by a number of participants as the main reason why they had never experienced homelessness.

Discrimination by landlords against residents was reported by many. The most common basis for discrimination was by source of income (*e.g.*, disability pension or other form of fixed income). Single mothers also reported being discriminated against. Mental health issues, contrary to what one might think, were not as often cited as the basis for discrimination while residents searched for housing. The reason for this is because most residents do not tell prospective landlords about their mental health issues, for fear that they will be denied housing. This is yet another example of how people with serious mental health issues manage stigma by adopting 'passing strategies' (Boydell *et al.* 1996). Reluctance to admit one's mental health issues is one of the most widely cited effects of stigma (Wahl and Harman 1989). It is a difficult situation to be in because on the one hand, residents would like landlords to understand while on the other, it is risky to be too forthright at the beginning about one's mental health.

Integrative Themes

Before closing this chapter and moving onto the focus group proceedings in Chapter Eight, there are four integrative themes that spanned most sections of the above analysis and that capture the most widely cited concerns of participants:

1. **Loneliness**

   Participants desire more social interaction, particularly in their place of residence.

2. **Making do**

   Participants express satisfaction with housing that is not affordable, where their tenure may not be secure, and where social and structural conditions are not very good.

3. **Desire to be understood**

   There is a general desire to develop understanding (*e.g.*, of mental health issues) among other residents, with landlords, and with the community at large.

4. **Desire for integration**

   Residents of housing that is almost exclusively occupied by low-income households do not identify with their communities. As well, most participants do not want to live in housing that is dedicated to people with mental health issues. Diversity is a community characteristic that is desired by many participants. There was one exception in this study where a resident was pleased with the housing community in a building where residents all earned fixed incomes. Anecdotal evidence from others outside of this study also suggests that developments exclusively for people on fixed incomes can achieve a strong sense of community if a conscious effort is made through programming.

CHAPTER EIGHT
CREATING AND IMPROVING SUPPORTED HOUSING

8.1 Introduction

This chapter presents the results from the focus group discussion that was held with housing and mental health service providers and municipal planners. While the ideas summarised in this chapter may read as though they are the author's, the views presented below are the participants'. They are organised according to the topic headings that guided the discussion and the themes that emerged during the discussion. There is a summary of the findings from the focus group at the end of the chapter.

8.2 Forecast of the Social Housing Situation for 2003[6]

When forecasting the social housing situation for 2003 in Waterloo Region and Wellington-Dufferin, the general consensus reached by focus group participants was that no new government-initiated social housing programs would lead to the construction of new housing. All three levels of government will stay out of the social housing construction business. Between now and 2003, the creation of new social housing will be the result of private non-profit agencies undertaking conversions of existing structures to create affordable housing. There is no reason to believe that in the current environment, the private for-profit sector will address the need for affordable housing through new development.

Below, the insights offered by focus group participants about current activity in the social housing realm will be presented. They are organised according to activity in three different sectors: public, private for-profit, and private non-profit. Finally, some of the activity that is taking place specifically in the area of mental health housing will be presented. This discussion will help the reader to understand the forecast for 2003 that was presented above.

Public Sector

There is no expressed intention by any level of government to build more social housing. Despite the fact that the provincial Social Housing Committee stated in a report in November 1998 that they were going to protect the number of rent-geared-to-income units available in each

[6] The year 2003 is used here because the Ministry of Health has set a target for housing and support for people with serious mental health issues for 2003. Both general social/affordable housing and dedicated supportive housing are important in meeting that target.

community, some government administered social housing units have recently been sold. This is a trend that may continue, with the Province selling its housing assets off before transferring the administration of housing to municipalities in the coming years. It is the view of the provincial government that if they get out of rent control and remove the barriers and the red tape, private sector developers will build more affordable rental housing stock. But this has not happened.

The Province has allocated 10,000 rent supplement units across Ontario on the basis of need. This is not nearly sufficient to meet the demand for affordable housing. Another issue with rent supplement programs is that they rely on co-operation with private sector landlords, who due to the tight rental market and ever-rising demand for housing, are perhaps not going to see any benefit to participating in a rent supplement program for people on fixed incomes. As one person from a local Housing Authority noted, landlords who used to rent out two- and three-bedroom units to parents with children can now occupy those units with singles and couples who use the extra room(s) as office space.

When private sector landlords partner with local Housing Authorities to participate in the rent supplement program, it is Housing Authority policy to offer two candidates for each vacant apartment. However, they are going up to seven or eight offers per vacant unit because landlords run credit checks and other background checks on prospective tenants and if they do not have an unblemished record, they will not rent them the apartment. If the Housing Authorities insist too heavily on their corporate policy of two offers, the landlords will just withdraw from the program. The supply of rental housing is so low that there is little incentive for landlords to remain with the rent supplement program.

At the local level, municipalities do not have the resources to construct more housing. They will fund the administration of what exists and try to partner with the private sector to spur new development and initiate pilot projects, but cannot themselves engage in new construction. The former *Rental Housing Protection Act* placed controls on demolition, conversions to condominiums, or conversion to other uses, but when it was replaced with the *Tenant Protection Act*, those controls disappeared. At the municipal level, the city of Toronto tried to put policies in their Official Plan to compensate for that loss of protection, but when the policies were challenged before the Ontario Municipal Board they had to rescind them. So the issue is not simply that no supply is coming, but also that the existing stock of affordable housing is in danger. Another municipal policy issue is that planning policies can only really affect built form and density. And density does not equal affordability. You can have luxury townhouses and apartment buildings that by no means qualify as affordable housing. The problem is that the planning field cannot govern the price at which these developments come onto the market. Municipalities that are inclined to give tax breaks to developers

for higher density developments, in the hopes of fostering the development of affordable housing, will have to be careful that they do not end up subsidising high price luxury condominiums.

The concern was raised by participants that housing policy should remain a provincial responsibility so that municipalities are not left with the option of planning social housing out of their community and dissolving the existing stock. Participants stressed that without some large-scale government intervention that addresses social and affordable housing there will only be small gains in stock achieved. Most of those small gains will be contributed by the private non-profit sector.

Private Non-Profit Sector

The private non-profit sector is busy working to meet the housing need in this area, however the gains made in terms of number of units is small. Over the next year, one private non-profit housing provider in the city of Guelph said that his organisation would be creating about 20 new social housing communities. These communities will be created by converting existing residential, commercial, and industrial structures into housing. Each community will provide housing for about three or four people. Similar initiatives are underway in the Region of Waterloo. Participants agreed that while these small steps forward are positive, they are not nearly sufficient to meet the need for new affordable housing stock.

An important issue related to the provincial rent supplement program is that private non-profit housing corporations are not allowed to participate in the program. In other words, a housing co-op where say 50 percent of its units are rented at market value, can not enter into a rent supplement agreement with any of those market rent units. So while local Housing Authorities are having trouble keeping private sector landlords as participants in the rent supplement program, there is a pool of market rent housing operated by private non-profit housing corporations who are willing to participate. Another issue is that rent supplements are attached to a housing unit, and not to the household living in it. So when a household moves or is given notice to move out of rent supplement housing because it is being sold, for example, that supplement does not follow them to their new home. Rent supplements should be attached to individuals (households), not properties.

Private For-Profit Sector

Participants agreed that the private for-profit sector has not picked up, in the area of affordable housing, where governments have left off. There are insufficient incentives for developers to build affordable rental housing and there is still a lot of mistrust among developers toward government on account of the uncertainty of government policies and activity. The political environment is too unstable and there is sufficient demand for other types of housing that developers need not worry

about tapping the low-income market. As one participant noted, the most affordable type of housing that developers are inclined to build involves a rent-to-own provision:

> Local builders will build homes where you still have to come up with your down payment of $3,500, or something like that, to get in, and then you rent for the first year and after that you can purchase the unit or you're mandated to get out. If you get out, then somebody else comes along and moves in. So they're pushing home ownership and it's coming in at $135,000 - $150,000 a unit.

Housing for People with Serious Mental Health Issues

One participant from the mental health community noted that the small gains in affordable housing being made by the private non-profit sector do not begin to approach the need set out in the Ministry of Health benchmark figures (see Chapter Five) for housing and support. It was stressed that the Province should fund its benchmarks for housing and support as it has begun to do with hospital bed targets for people with mental health issues. It was also noted that in the current environment, when rent supplement landlords have the luxury of screening seven or eight prospective residents for one apartment, people with mental health issues are not the ones getting the units.

8.3 Increasing Supported Housing

Increasing supported housing for people with serious mental health issues involves increasing the capacity of mental health agencies to provide support services as well as increasing the supply of affordable and adequate housing. The two go together. Funding has recently been committed by the Province to support Assertive Community Treatment (ACT) teams that provide mental health support services to people in their homes. However, proper progress toward meeting the provincial housing and support benchmarks can only be made if both housing and support are increased for people with serious mental health issues. Support is only half of the picture. The reader is referred back to the discussion of shifting paradigms in Chapter Four and some of the issues surrounding ACT teams as a substitute for other community mental health support services. In the absence of adequate provincial initiatives for housing to meet its mental health housing and support benchmarks, communities will need to rely upon inter-agency partnerships and positive working relationships. The focus of this section will be the insights offered by participants on partnerships and working relationships to achieve more supported housing.

Both private and public sector landlords want to have a working relationship with mental health agencies so that if a tenant(s) exhibits mental health related issues they have someone to phone who will intervene. As one participant stated:

In the long run, what they (landlords) want is to have somebody to call, an organisation to call that will make an attempt to intervene in the event that there are problems. And if you make that commitment as an organisation, they're more likely to enter into an agreement with you. I think too many landlords speak about experiences where they've had an agreement with an organisation or they've agreed to house somebody, and then they feel rather abandoned when the chips are down and the person's become ill again and they don't know how to deal with the situation.

A number of considerations were raised with respect to this type of working relationship. First, mental health support agencies must have the resources to form these types of partnerships with landlords. The ability of mental health agency staff to commit to being 'on call' at all hours of the day, for example, takes resources. And resources are limited in the mental health field, as per housing. Another very critical concern is a basic human rights issue, and that is that people should have the right to housing, without promise of being attached to mental health services. It was expressed that with such a partnership between mental health agencies and housing providers (public or private), tenants might essentially be forced to maintain their link to mental health support services indefinitely. Housing should not be conditional upon receiving mental health support for a lifetime.

Local Housing Authority representatives reported having good working relationships with mental health agencies in the past when placing tenants with mental health issues in public housing. However, they stressed that the strongest and most trustworthy working relationships are formed with individuals at the agencies, and not through formal arrangements with agencies themselves. One concern was that many of the people with whom the strongest relationships were formed had moved on to other positions. It is important to try to re-kindle working relationships between people at the various housing and support service agencies. One social housing provider noted the importance of long-term commitment between housing and support service agencies:

There has to be long-term commitment, and that means endurance, and that means long-term planning and contractual relationships where the service providers have commitments on a government level, whether it be municipal, provincial, or federal, to couple with the housing providers.... But when the service providers back out, we (housing providers) lose out, because our communities suddenly become explosive and implosive. And it's a very direct link.

One example of a past partnership between a local Housing Authority and two mental health agencies was described:

Initially with our program, we were trying to come up with a way to guarantee a winning situation, so we partnered with Waterloo Regional Homes for Mental Health and CMHA

> (Canadian Mental Health Association) to try and come up with a program where we would look at each applicant individually who had serious mental health issues, make sure there were supports in place so that we could then go to a private landlord and more or less guarantee that there would be someone that they could call. And we would meet on a regular basis with both agencies and review a number of clients that they would probably have referred to us, or some of the clients came straight to us through the application process and the linkage was made after the fact. But then there became an issue about the fact that we were discriminating against this client population because of having this support requirement, as it was seen, and so that kind of program, that intense concentrated housing of that client group has sort of gone by the wayside. And now the applications come straight through the application process, and we try to make the connection or become aware of the connections between the agencies and then we make some contact through the workers. So, it's still there but in a much different form, and in my opinion, from a placement perspective, not as successful a form as it was before.

As discussed earlier, the concern within the mental health community with this program was that housing was perceived to be conditional upon receiving mental health support.

One municipal non-profit housing provider presented the idea of having a 'head lease' program, where a mental health agency could have a number of units set aside for them in a housing development and they fill the units with people who receive support services from them. Currently, the municipal non-profit housing provider operates a head lease program like this with a local service agency for people who are developmentally challenged, and it is working well. The same concern arises here as before; namely, that the tenant would be required by the very nature of the head lease to remain connected to the mental health support service agency for the duration of tenancy.

Amid the discussion of forming working relationships between housing providers and support service agencies, the point was raised that service agreements need to address working relationships, trust, and tolerance. But with no housing units available (long wait lists) paired with the fact that people with mental health issues often do not pass the credit checks anyway when a unit does become available, agencies do not have time to build partnerships to secure scarce housing.

Non-profit housing providers with provincial operating agreements use a central co-ordinated access, modified chronological waiting list. The idea was raised that a modifier could be added that included people with serious mental health issues. Presently with the modified chronological waiting list, 10 percent of units are supposed to be set aside by each provider for certain disadvantaged groups: youth, homeless, and newcomers. This kind of adjustment would be up to individual municipalities and would also depend on the agreement drafted between the Province and municipalities for administering social housing. As one housing provider noted with respect to the 10 percent minimum for recognised disadvantaged groups:

> We have no problem with that as a minimum. And what we're glad about is that there's no definition of the maximum. And if you can build good positive relationships between the various partner agencies (mental health agencies), you'll find that 10 percent is not a relevant figure. Thirty percent of our tenants have identifiable, current, active, day-to-day, week-to-week links with mental health service providers.

Another sobering perspective was brought forward with respect to forming partnerships and modifying waiting lists:

> We've got such a long waiting list. Why trouble ourselves with all these negotiated partnerships. And what happens if the government changes and what happens if.... It's much easier, same as in the private sector, to go to the place of least resistance or least trouble, and I feel that there is a danger there.

8.4 Programs for Community and Resident Participation

People want to live in their own place but do not want to feel like they are alone. In housing communities, they want privacy with a community centre. Participants gave accounts of the different ways in which tenants become involved with their community.

The involvement of residents on tenant-driven committees responsible for various things from organising social events to property maintenance was reported by a number of housing providers. Community rooms or areas are important ingredients in creating a sense of community centre. It was agreed that common rooms, in and of themselves, are insufficient. There must also be programming to bring tenants into the common areas and into contact with one another. This programming must also be tenant driven.

> If the management has control of the community centre then the tenant community will always be rebelling against that. The community has to have control of its community centre, otherwise don't call it a community centre.

If communities are responsible for programming at their community centre, and if programming does occur regularly and people use the common areas, vandalism of those areas should not be as regular an occurrence.

One non-profit housing provider reported a mentoring program used in her community, where new residents are shown around by senior residents, resulting in an easier integration into the community. Housing providers also orchestrate in-house education forums where a community agency may come in such as a mental health agency, and talk about an issue of interest to community members. A particularly successful partnership was reported between a local Housing Authority and

Onward Willow, a community agency, where the Housing Authority dedicated a townhouse unit in one of their communities as a community centre. *Onward Willow* oversees the programming.

One housing provider who has been successful in fostering community noted the importance of community common areas and the importance of tenant involvement on the tenant selection committee. Tenants must be given the opportunity to select their community. Otherwise, the community will not come together.

> Sometimes people are in loneliness, and they want to not be lonely, but if they can't trust the people around them they'd rather be lonely than insecure. So you get all this coupling of various things. So it's a multi-layered, multi-faceted thing. And if you don't have the housing providers working in good partnership with service providers and working in good partnership with the community itself, the actual people who are the community, then you will have the isolation. Even if you have good intentions, people will isolate because they don't feel safe and secure.

It is also important to have significant representation on the Board of Directors of past and present tenants, and to foster a real sense of understanding between the Board, staff, community agencies, and residents, so that each player realises the importance of their role in the community. Non-profit organisations are typically staff-driven, even though there may be a larger number of volunteers than of paid staff. Paid staff members are the ones with the time and the sense of accountability. To improve the community environment, everyone at all levels of the organisation must understand the importance of their role and the roles of others.

One of the biggest issues reported with respect to achieving community involvement in non-profit housing, was the difference between the desire to have tenant involvement and the actualisation of it. Regular meetings with other housing and service providers and tenant leaders to discuss community activities around the District could help narrow the gap between concept and reality. Also, there is a need for more paid people to deliver service, on a contract or salary basis, or by honorarium. A participant who reported a very elaborate community infrastructure at her housing community reported that paid staff work with residents to facilitate community affairs. This approach has been quite successful.

There is also a need for general community commitment. As one housing provider said:

> It is difficult because people generally step up for that kind of thing when there's something they want to have or something that is concerning them. To actually have community development, development of a community where there is potluck rather than meeting, where there's gathering rather than confrontation, that takes a long time.

8.5 When Mental Health Problems Arise

One of the problems that housing providers reported was that they do not have staff to deal with specific problems, like mental health issues, within the housing community. Here again, the importance of working relationships between housing providers and mental health agencies was stressed. For-profit and non-profit want the same thing: to have a resource person to call if problems arise. One local Housing Authority reported that they had become engaged in a partnership with a local mental health agency two years earlier and that the relationship has remained strong and has in fact prevented a couple of evictions.

As one participant noted, however, 'there's no magic' with respect to dealing with tenant issues around mental health. A mental health worker can attempt to intervene but housing providers must also understand there is often no quick fix and that the problem may take time and care to work through. Educating landlords and housing staff is an important component of the working relationship. One participant told of an initiative by the Wellington and Guelph *Working Group on Housing and Homelessness* to educate landlords and property managers in the community about mental health issues.

> What we did was put together some information packages on different mental health agencies, CMHA, CMHC (Community Mental Health Clinic), and other services. And there was a CMHA worker that was willing to meet with these various landlords or property managers to let them know what was available in the community. I think it was successful in some areas. I think it helped them to be a bit more sensitive to what was happening in their building, that eviction was not necessarily the first thing to look at.

Another interesting program that was explained by one participant was the development by residents and mental health support workers of a crisis plan, where once developed, individuals can begin to pick up early warning signs that their mental health is deteriorating. It is a really empowering tool for individuals and if landlords and property managers were briefed on the process, they might be able to play a big role in picking up some of the early signs of a tenant's deteriorating mental health. It would also help landlords and property managers to develop a better understanding of mental health issues and what tenants are and are not experiencing.

One housing provider described the process of intervention in their community when a person with mental health issues behaves in a way that worries other tenants. She described it as a two-part process, where the first step is to deal directly with the tenant, and then with the other people. She described the community's problem-solving capacity:

> The other tenants will kind of know what this person needs and know what they can do. And the initial thing is to say kick them out because we don't want to live with them. But then after awhile they say, well then where will they go, and they realise there's nowhere else to go and that they would also lose the good parts of them as a neighbour. And so that really works well, the community problem-solving, but it's really hard to do. Because you just want to fix it and it's a lot harder to put it back to the group and say well, how can we fix this problem within the group?

8.6 Summary and Discussion of Findings

Forecast of the Social Housing Situation for 2003

When forecasting the social housing situation for 2003 in Waterloo Region and Wellington-Dufferin, the general consensus reached by focus group participants was that no new government-initiated social housing programs would lead to the construction of new housing. All three levels of government will stay out of the social housing construction business. Between now and 2003, the creation of new social housing will be the result of private non-profit agencies undertaking conversions of existing structures to create affordable housing. There is no reason to believe that in the current environment, the private for-profit sector will address the need for affordable housing through new development.

Not only will government not build new housing but they are also beginning to sell some of the present stock. It is the view of the provincial government that if they get out of rent control and remove barriers and red tape, private sector developers will build more affordable housing. This has not happened and there is still a degree of mistrust among developers of the political environment around housing and there are no incentives to build affordable housing. With the disappearance of the *Rental Housing Protection Act*, affordable rental housing is being converted to higher priced apartments or condominiums and municipal policies have not been able to mitigate against that successfully. This was also emphasised by the Ontario Non-Profit Housing Association and Co-operative Housing Federation of Canada (1999) in a recent advocacy paper.

Landlords participating in the rent supplement program are continuing to lose interest in the program, especially given the low vacancy rates and high demand for housing. They are able to discriminate against prospective rent supplement tenants through credit history checks and other kinds of background checks, and people with mental health issues are not getting into rent supplement housing. Again, these findings confirm what has been reported elsewhere (*i.e., ibid.* and OFCMHA and CMHA 1998).

Only small gains in social housing will occur without large-scale government intervention and these gains will be achieved primarily in the private non-profit sector through conversions of existing structures to housing.

The Ministry of Health should fund its benchmarks for mental health housing and support.

Increasing Supported Housing

In the absence of provincial commitment to fund its benchmarks for housing and support, the community will have to do the best it can through positive working relationships and partnerships between housing providers and mental health agencies to ensure more supported housing.

Private and public sector landlords want to have working relationships with mental health agencies to know that if a mental health issue arises with one of their tenants, they will have someone to call for advice or intervention. Formalised partnerships - such as the partnership occurring between the Ministries of Housing and of Health in British Columbia, cited in the best practices literature reviewed in Chapter Three – can ensure that these kinds of important working relationships persist. Two issues arise when such partnerships are considered. One is that mental health agencies must have sufficient resources to ensure such partnerships, and secondly, housing should not be conditional upon a person receiving mental health support services for the duration of their tenancy.

Good working relationships between housing and mental health agencies will require long-term commitments, preferably on a contractual basis at the government level.

There is the possibility of modifying the chronological waiting lists for housing to ensure that a proportion of available units are made available to people with serious mental health issues. This is currently done for youth, homeless people, and newcomers. This type of action would be up to municipalities.

Programs for Community and Resident Participation

People with mental health issues, like anyone else, want to live in their own place but do not want to feel like they are alone. Common areas, resident-led programming, and real resident involvement in tenant selection are important components of creating community centre. Interestingly, the results of a study of housing among single parents - conducted in 1996 by Doyle, Burnside, and Scott – revealed that influence (*e.g.*, freedom to express opinions about how housing is run and the knowledge that one's opinion is taken into account in management issues) proved to be the most significant predictor of the respondents' belief that their housing was good for their physical and mental health.

Also, incentives and recognition for involvement by residents and volunteers are important. Good relationships between the Board of Directors, residents, community service agencies, and staff are important to ensure a stable and centred community.

When Mental Health Problems Arise

Strong relationships built on trust and understanding must be fostered between housing providers and mental health agencies for when mental health issues arise. Staff resources are an issue here again. Educating landlords and other community members about mental health issues is an important component of building a strong community for people with mental health issues. Community problem solving when mental health issues surface with a tenant is important. It will involve both the resident and others in the community in a two-part process.

PART III

CONCLUSION AND RECOMMENDATIONS

CHAPTER NINE
CONCLUSION AND RECOMMENDATIONS

9.1 Conclusion

This study developed an understanding of the housing environment of supported housing residents in the Waterloo Region – Wellington-Dufferin District. One-to-one interviews with District residents were used to investigate four dimensions of the housing environment that have featured prominently in academic literature. These dimensions are physical housing environment, social housing environment, housing affordability and choice, and housing history. The discussion of housing environment occurred at two scales: the neighbourhood scale and the individual place of residence.

A focus group discussion was held with housing and mental health service providers and municipal planners in the second stage of this research. The perspectives of professionals on a variety of issues surrounding supported housing were sought during this meeting. The final results and recommendations stemming from the study are being shared with a number of local decision-making groups. These include the *Mental Health Housing Sub-Committee* (of the Waterloo Region Housing Coalition), *Waterloo Region Housing Coalition*, *Mental Health Co-ordination Group* of Waterloo Region, *Working Group on Housing and Homelessness* (of the Wellington and Guelph Housing Committee), *Wellington and Guelph Housing Committee*, and the *Waterloo Region – Wellington-Dufferin District Health Council*, the agency that provided the resources to conduct this study.

The literature reviewed in Chapter Two dealt with congregate living situations such as group homes and custodial board-and-care homes. These types of housing tend to be concentrated downtown. Dear (1977) noted that research was needed which looked at whether people with serious mental health issues preferred to be clustered in the central core, or to disperse more widely throughout the city. The question of whether it is individual choice or structural constraints that keeps people with serious mental health issues in the inner city remained unanswered. This research suggests that proximity to services is very important. This proximity may be to the downtown core, but can also mean living in newer residential neighbourhoods that include service nodes. It may also mean living in the countryside with a town very close by. Participants often made it clear that they either did choose or would choose to live near services, and often this meant living in the inner city.

The impact of zoning by-laws and community attitudes toward mental health housing was also discussed in Chapter Two, again pertaining mostly to congregate living situations. An escape from NIMBY responses and zoning battles was conceivable with the move toward a supported housing

model. Special group homes do not conform to the supported housing model that relies mainly upon regular apartments for housing, paired with flexible support services provided by off-site mental health support co-ordinators. NIMBY responses may still stifle the construction of general non-profit housing developments in many communities. However, these responses are not aimed at people with serious mental health issues specifically. While zoning battles and NIMBY responses are no longer as threatening, discrimination and exclusion still slow the establishment of supported housing. Instead of NIMBY-style discrimination against mental health housing developments, a type of 'Not-In-My-Building' discrimination by landlords occurs. A lack of understanding by neighbours in a building can also constrain people with serious mental health issues.

In Chapter Three, the connection was made between housing and health. The literature was reviewed on the physical and social dimensions of three mental health housing models – custodial, supportive, and supported. These dimensions were also explored in the research conducted for this thesis. The best practices literature for mental health reform echoes the research literature in advocating for an emphasis on supported housing. The best practices literature also adds that a range of housing is needed to appeal to the needs and wants of the variety of people suffering from mental health issues. Supported housing does not appeal to everyone. Supportive housing that empowers residents and that has a strong community centre is still an important part of the range of housing that should exist in any community. In this study, a minority of participants said that they would like to live in housing with more people that suffer from serious mental health issues. These participants felt that this would provide for a less lonely and more understanding community. Supportive housing – particularly supportive apartments – can satisfy the needs of this minority. Custodial care homes that do not have a rehabilitation focus, and that provide no physical or social comforts that supportive housing does not, should not persist as a model of housing and mental health support.

There is still a great deal of progress to be made toward meeting the Ministry of Health 2003 target for mental health housing and support in Waterloo Region and Wellington-Dufferin (Walker 2000). Residents of supported housing had grave concerns about affordability and the social environment, including loneliness and a desire for more understanding and integrated communities. Housing providers, planners, and mental health advocates confirmed that constructing new housing is a grim prospect. Further, without large-scale reinvestment by the federal or provincial governments in housing, only small gains will be made. These small gains are occurring mostly through initiatives taken by private non-profit housing agencies. There is a ray of hope in developing working relationships and partnerships between agencies. However, without government involvement or private sector building the housing gap will not close, no matter how well the non-profit community works together.

There are 17 recommendations that stem from the results of this study. They are directed at planners, mental health agencies, housing providers, administrators, and decision-makers. They are aimed at creating more supported housing and improving what already exists. The recommendations are organised under four headings: advocacy, policy, partnerships, and improving community integration. Many of the recommendations are made with the knowledge that they may not be ideal; but given the current context, they are the most realistic courses of action that can be recommended. Many of the recommendations involve partnerships and in partnerships all parties gain, but not without compromise.

9.2 Recommendations

Advocacy

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

Most residents of supported housing are in market rent housing that is not affordable to them. In this study, rising rents in their previous housing was the most common reason participants cited for moving. Moving is stressful and disturbs people's establishment of a home.

Precedents exist elsewhere. The United States operates a nation-wide rent supplement program called the *Section 8 Existing Housing Program* (or informally as the Section 8 certificate program), administered by the Department of Housing and Urban Development (HUD). The subsidy program targets income-eligible households and reduces rent to 30 percent of household income (Newman *et al.* 1994). Housing units must meet two criteria for HUD to approve the subsidy. Rent must be equal to or less than fair market rent and the housing unit must meet HUD housing quality standards. Because the subsidy is tied to individuals, an individual can apply for subsidy without having to move. If the individual moves, the new place must meet the HUD criteria in order to maintain the subsidy certificate. A model similar to this should be looked at for Ontario. The model would need to discriminate between different levels of need, acknowledging that the number of people who would qualify for a subsidy may be greater than funding available for rent subsidies.

2. Continue to strengthen education campaigns targeting private and public sector landlords and other residents to 'demystify mental illness'.

Participants in this study emphasised their desire for more understanding among landlords and other tenants. By strengthening educational campaigns, it is likely that mental health agencies can improve housing stability and community integration for people with serious mental health issues.

Further, education campaigns may cause landlords to be less reluctant to rent to people with serious mental health issues and lead to more open communication between landlords and tenants who receive support services. Dialogue between mental health agencies and landlords could occur at landlord association meetings, for example. The Mental Health Housing Sub-Committee of the Waterloo Region Housing Coalition has considered this option. The Working Group on Housing and Homelessness, a sub-committee of the Wellington and Guelph Housing Committee, has initiated a mental health education initiative with private and public sector landlords.

3. **Lobby the federal and provincial governments to transfer new money to municipalities for social housing within appropriate regulatory frameworks.**

Lobbying the governments to increase funding for social housing is a continuing effort. Two examples of recent lobby efforts include reports published by the Ontario Non-Profit Housing Association and Co-operative Housing Federation of Canada (1999) and the Ontario Federation of Community Mental Health and Addiction Services with the Canadian Mental Health Association, Ontario Division (1998).

In January 2000, the Ontario government allocated funding for 129 rent supplement units in Waterloo Region and 73 in Wellington-Dufferin (Ministry of Municipal Affairs and Housing 2000). In response to this allocation, Frenette (as cited in Record 2000) notes that with low vacancy rates and low rent caps imposed by the rent supplement program, it will be difficult to find private sector landlords who will participate in the program.

The current legislation that governs the rent supplement program dictates that private non-profit housing providers (*e.g.*, housing co-operatives), that combine market rent with non-profit units in their developments, cannot participate in the program. Only market rent landlords can enter into a rent supplement agreement under the provincial program. In light of these concerns and the concern raised earlier about subsidies being associated with properties instead of people, lobby efforts must also target the frameworks that regulate government transfers to municipalities for social housing.

4. **Use benchmark data referred to in Chapter Five to lobby the Ministry of Health to fund its 2003 target for housing and support.**

Between now and 2003, supported and supportive housing for at least another 644 people is needed in Waterloo Region, and for at least 164 more people in Wellington-Dufferin (Walker 2000).

Rent supplements (linked to individual households and not to properties) are one option for the Ministry of Health to consider for meeting its commitment to address the housing and support needs of people with serious mental health issues (Ministry of Health 1999a,b).

Policy

1. Ensure, through municipal bylaws, that new and existing lodging homes meet residents' needs for privacy, safety and autonomy.

Many people with serious mental health issues live in lodging homes. Focus group participants in this study indicated that conversions by non-profit agencies are the greatest source of new social housing in the District. Municipalities should ensure, with formal regulations, that these homes meet residents' needs for privacy, safety and autonomy. The Housing Development Group (1999: 9), a coalition of housing and mental health agencies in Hamilton-Wentworth, recommended that the following be enforced for new and existing lodging homes:

- single, locked rooms;
- places to securely store belongings;
- choice of living companions within homes and where rooms are shared through screening and matching;
- liberal access to kitchen and laundry facilities;
- a neutral and responsive complaints process;
- access to financial assistance outside the lodging home;
- improved record keeping and policies and procedures;
- stronger enforcement and consequences;
- smaller homes, providing a home-like atmosphere;
- there be a grandfather process which enables existing lodging homes to meet these standards; and
- mental health support services be provided by local agencies and tailored to individuals' needs.

2. Minimise barriers to creating new affordable housing, while still ensuring that municipal bylaws exist to ensure that residents' needs for privacy, safety and autonomy are met.

It was stated in the focus group that one of the reasons why non-profit housing organisations are able to successfully convert as many structures to social housing as they have, is because of positive working relationships with city planners. Proposals for conversion are well received by planners and the approval time very short. This is the result of dialogue and good working relations.

It was also noted in the focus group that municipalities are in a position to enter into pilot projects with local housing innovators and private developers. Minimising 'red-tape' is important but must not occur at the expense of residents' needs for privacy, safety and autonomy.

3. **Pursue formal agreements (protocols) where mental health agencies provide dependable support service in housing communities and housing providers ensure placements for people with mental health issues.**

The best practices model for supported housing (*i.e.*, British Columbia example) described in Chapter Three, where a formal agreement exists between the Ministry of Health and the Ministry of Municipal Affairs and Housing, should be adapted to this area. Adapted to Ontario, this model would rely more on agreements at the municipal than the provincial level. Focus group participants stressed the importance of forging formal agreements between mental health agencies and housing providers, at the government level. Protocols are presently being drafted between the Province and Consolidated Municipal Service Managers (CMSMs) for the administration of social housing. With all the activity around housing administration at the municipal level, it is an excellent time to formalise agreements between mental health support agencies and housing providers. This could ensure an increase in the supply of supported housing. The agreement drafted between the Province and CMSMs for the administration of social housing should address this.

4. **Pursue policy-based solutions to stop the conversion and demolition of affordable rental housing stock.**

When the Province dispensed with the *Rental Housing Protection Act* and decided not to replace rental housing protection stipulations in the *Tenant Protection Act*, municipalities lost their ability to regulate rental housing (Jylanne 2000). Demolition is still regulated under the *Planning Act*; however, the validity of Official Plan policies restricting the conversion of affordable rental housing stock is unclear (Richardson 2000). Although local Official Plans do contain policies restricting the conversion of affordable rental stock to higher priced housing (*e.g.*, condominiums); an Official Plan amendment adopted in Toronto has brought the validity of these policies into question.

Toronto's City Council adopted Official Plan Amendment Two (OPA 2) to try and harmonise rental housing protection policies across the seven amalgamated municipalities (*ibid.*). In June 1999, that amendment was appealed to the Ontario Municipal Board (OMB) because it appeared to be in conflict with provincial policy in the housing sector. In September 1999, the OMB determined that Toronto's OPA 2 was 'illegal and invalid'. Prior to this appeal to the OMB, local Official Plan policies restricting conversions of affordable rental stock were upheld in Waterloo Region. Their validity and legality are now in question.

OPA 2 is still an 'action' for Toronto's City Council, and City solicitors have investigated and begun an appeal of the OMB ruling in the courts (Patterson 2000). Hamilton and Ottawa-Carleton have joined Toronto in its legal challenge of the OMB decision. Most municipalities in the province

have not joined and await the outcome of this challenge. Toronto, Hamilton, and Ottawa-Carleton have a significant stock of affordable rental housing that could be lost if the court ruling does not fall in their favour. Other municipalities, such as the Regional Municipality of Waterloo, have less to lose (Richardson 2000).

Municipalities across the province should vocalise their support for the direction of OPA 2 and join the legal action being pursued by Toronto, Hamilton, and Ottawa-Carleton. Another hopeful initiative to protect affordable housing is the drafting of an independent member bill by a Liberal member of provincial parliament. Neither the appeal of the OMB decision nor the independent member bill are short-term solutions. While municipalities await the outcome of these actions, planners will have to rely on negotiated settlements when conversion proposals come before them. For example, planners in York Region recently negotiated a settlement that included a tenant relocation package (Patterson 2000). An OMB hearing was required in this instance as well.

5. Modify the chronological waiting lists for housing to ensure that a minimum proportion of available non-profit housing units is set aside for people with serious mental health issues.

Modifiers already exist to ensure that at least 10 percent of available non-profit housing units are allocated to youth, homeless, and newcomers. With the present activity occurring in municipalities around the administration of social housing, it is an excellent time for mental health agencies and housing administrators to work together to ensure that at least 10 percent of available non-profit units are allocated to people with serious mental health issues.

Those suffering from mental illness are more likely than average "to be unemployed, on public assistance, have low incomes, and given low incomes they are more likely to have disadvantaged living conditions (Wellington-Dufferin District Health Council 1996: 14)." Further, supported housing residents who participated in this study expressed the difficulties of finding appropriate housing due to their mental illness and associated stigma. Focus group participants also explained that rent supplement landlords are in a position to discriminate against prospective tenants by screening as many as seven or eight people for an available unit. Participants noted that, in these cases, people with serious mental health issues were not getting the housing.

6. Reform Homes for Special Care and Domiciliary Hostels to meet residents' needs for privacy, safety and autonomy.

Homes for Special Care and Domiciliary Hostels provide housing to roughly 152 people with serious mental health issues in Waterloo Region and 23 people in Wellington-Dufferin (Walker 2000). Despite the problems associated with custodial housing, it would be catastrophic if all of the custodial

housing in the District suddenly closed. In 1994, Nelson *et al.* suggested that some custodial housing developments might be able to convert to non-profit housing co-ops or apartments. As an example, they cited the conversion of the infamous Channan Court boarding home in Toronto (the setting of Pat Capponi's book (1992)) to a housing co-op managed by residents.

Conversion is an option that could be pursued in some custodial homes. At a minimum, residents' needs for privacy, safety and autonomy should be ensured through bylaw reform, as discussed earlier.

Partnerships

1. **Ensure regular dialogue between private sector developers, municipal, and provincial government to understand what developers' concerns are with respect to building affordable housing and what each level of government can do to alleviate these concerns.**

Focus group participants explained that private sector developers are reluctant to build affordable housing because of the uncertainty of government policy. If the provincial or federal governments are motivated to build affordable housing (*e.g.*, rent supplements and incentives for new construction), there is no guarantee that this support will not be revoked following an election or new budget. There are no easy solutions to engage the private sector in building affordable housing. However, without a regular dialogue it will be even more difficult for all parties to understand one another's concerns.

The forum that was held in February 2000 in Waterloo Region to bring developers, government, and community agencies together around housing was an excellent initiative. A similar forum is being considered in Guelph for later this year.

2. **Establish informal working relationships, in the absence of formal policies, between housing providers and mental health agencies where dependable support service is provided in housing communities and placements for people with mental health issues are ensured.**

Ideally, formal policies should be written to strengthen partnerships between housing providers and mental health agencies. As mentioned earlier, formal policies reassure both parties. For example, mental health agencies are assured housing for the people they serve and housing providers are assured that should a mental health problem arise with any tenant in their housing development, they have a contact person to phone at a mental health agency for advice or intervention.

In the absence of formal policies, informal working relationships will have to be established and a sense of trust and mutual understanding developed between housing and mental health service providers. Focus group participants discussed working relationships between housing and mental

health service providers that have worked in the past and others that are succeeding presently. The primary attribute of successful working relationships is trust between individuals. It is the individuals working within the agencies, more than agencies themselves, who develop the lasting working relationships.

Improving Community Integration

1. **Improve community solidarity in housing developments by ensuring opportunities for resident involvement in management, committees, and tenant selection.**

Supported housing residents who participated in this study seek more social interaction in their place of residence and greater understanding among landlords and other tenants. They also desire integration with a diverse community of people from different socio-economic, ethnic, and age groups. Involvement in management, committees, and tenant selection can help residents develop a better social network and allow them to select their community and share their ideas for improvements.

2. **Improve community solidarity in housing developments by providing common areas for tenants to gather while also facilitating programming in these areas.**

Common areas with resident led programming will begin to address loneliness and people's desire for community integration and understanding. Tenants should be responsible for programming in their community centres in order for it to be sustainable and relevant to their practical and social needs. However, staff should facilitate this. A system of committees and leadership positions should be set up to ensure accountability and continuity in programming. An effort must be made to foster, recognise, and reward tenant involvement.

3. **Discuss community development and community problem solving within housing developments on a regular basis.**

Focus group participants noted the importance of meeting with other housing providers and housing support agencies (*e.g.*, mental health agencies) on a regular basis to discuss community development and problem solving techniques. It was evident from focus group participants that different housing communities were at varying stages of development. Some were very well developed in the area of community problem solving (*e.g.*, Lincoln Road Non-Profit Housing), while others were stronger in resident involvement at the management level (*e.g.*, Matrix Affordable Homes for the Disadvantaged Inc.). Regular meetings would allow housing workers and support agencies to transfer knowledge, share new ideas and concerns, and strengthen working relationships.

4. **Maintain a registry among mental health agencies where single people who want a roommate can find others in order to address the serious problems of loneliness and affordability among residents who live alone.**

Loneliness was one of the integrative themes that emerged from interviews with residents of supported housing. Housing affordability was another primary concern. If a roommate registry was maintained and shared among local mental health agencies, it could alleviate loneliness among residents. Living with a roommate would also begin to address the issue of housing affordability, particularly in market rent housing where the majority of participants in this study were living.

5. **Respect residents' desire for community diversity and integration when creating new housing or improving what exists.**

Study participants were clear about their desire to live in diverse and integrated communities. Significant resident involvement on selection committees allows residents to effectively select their community. When new housing communities are created through property conversions, landlords should ensure that prospective residents are allowed to select their living companions.

9.3 Future Research

Researchers have recognised the need to develop a better understanding of residents' perspectives on their housing experience for more than 20 years (Dear 1977; Taylor Elliott, and Kearns 1989; Boydell *et al.* 1996). This thesis made a modest attempt to improve that understanding.

It was hoped that this study would produce a solid comparison of the housing experience of residents of supported housing in small towns and mid-size cities. Due to the small number of people with serious mental health issues that live in small towns, only seven participants out of 31 were residents of small towns. The quality of interviews with these residents was good but perhaps insufficient for making any strong claims about differences in the housing experience of small town versus city residents. In this study the similarities between the experiences of small town and city dwellers were easier to ascertain.

The literature on supported housing is limited and further research is needed that concentrates on this model of housing and support. Most research has focussed on the more traditional approaches to housing and support, usually group living arrangements (Parkinson, Nelson, and Horgan 1999).

As research on supported housing proceeds, it must be recognised by researchers that people with serious mental health issues are capable of determining and expressing their own needs and preferences. Residents' perceptions also serve as the best predictors of success in housing (Boydell *et*

al. 1996). It is important that research designs reflect this. Residents' perceptions are best captured through qualitative research.

Further research investigating supported housing in small towns and rural areas would help to clarify the impact of rural and small town settings on residents' housing experience. The study area would need to be very large since this District was not large enough to draw a sufficiently sized group of small town participants. Alternatively, research methods that go into greater depth with fewer participants could be used. Parkinson, Nelson, and Horgan (1999: 160) note that "research from different geographic locations would provide information on the impact of diverse communities, urban and rural landscapes, government policies, and housing stock options."

In this study, a minority of participants said that they would like to live in housing with others suffering from similar mental health issues. The majority preferred living in integrated housing. This split has been recognised by other researchers as well (*e.g.*, Boydell *et al.* 1996; Johnson 1997). Research that explores the reasons behind each of these preferences would be useful in planning for a range of housing choices.

Partnerships between mental health agencies and housing providers, whether formal or informal, are pivotal to creating new supported housing. Research which looks at developing policy-based partnerships and partnerships based on informal working relationships would be very useful.

The social characteristics of housing communities were investigated in this study. One thing that was made abundantly clear by participants was the importance of social interaction, understanding, and integration within housing communities. Research aimed at discovering practicable ways of enhancing community centre for residents should be pursued.

Carling (1993 as cited in Parkinson, Nelson, and Horgan 1999) has suggested that a research and evaluation component be built in to the development of supported housing, providing a basis for continuous learning and improvement. Nelson *et al.* (1994) identify participatory action research as a valuable alternative to traditional research designs. In participatory action research, stakeholders in the research collectively design, implement, and make use of the research to affect change. The researcher still plays an important role; however, it changes to that of a facilitator and resource person.

In future studies, methods that further transcend the subject-object dualism that restricts researchers' abilities to empathise with those researched, would be most appropriate. As much as possible, studies should be composed of meaningful dialogue between the researcher and 'subject'. Finally, research in the area of housing for people with serious mental health issues should be done by researchers who are committed to helping improve the lived experience of this group of people. Researchers should feel an obligation to share what they learn with as broad an audience as possible. It is imperative that researchers carry their learning beyond the academic community.

APPENDIX A
LETTER OF PERMISSION FROM DHC

Waterloo Region ~ Wellington ~ Dufferin
DISTRICT HEALTH COUNCIL

Ryan Walker
132 Brighton Street. Unit 23
Waterloo. Ontario
N2J 4S6

February 17, 2000

Dear Ryan,

This is to advise you that the Waterloo Region-Wellington-Dufferin District Health Council authorizes you to reproduce sections of the report 'Housing for People with Serious Mental Health Issues in Waterloo Region and Wellington-Dufferin' in your Master of Arts Thesis and authorizes the National Library of Canada to reproduce. loan. distribute or sell copies of the thesis in microform, paper or electronic formats.

Thank you again for your excellent work, and all the best in completing your thesis.

Sincerely,

Susan Burns
Executive Director

Waterloo Region ~ Wellington ~ Dufferin District Health Council
251 Woodlawn Road West. Unit 118
Guelph. Ontario
N1H 8J1

Office (519) 836-7440
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APPENDIX B
SELECTION CRITERIA FOR ONE-TO-ONE INTERVIEW PARTICIPANTS

- DISTRICT HEALTH COUNCIL LETTERHEAD -

July 14, 1999

Wendy Czarny and Carmen Abel
Waterloo Regional Homes for Mental Health Inc.
501 Krug Street, Suite 112
Kitchener ON N2B 1L3

Dear Wendy and Carmen:

Further to our discussion on the telephone, here is a list of *selection criteria* for identifying participants for the housing and mental health interviews. If you have any questions or concerns, please phone me at (519) 885-3052 or (519) 836-7440 ext. 232. Thank you very much for your help and I hope that this doesn't take up too much of your time.

Selection Criteria:

1. Person is living independently (with or without a spouse/partner) in housing of his/her own choosing which is integrated with surrounding community (**not** in parents' home, homes dedicated to people with mental health issues, hostels, domicillary care, or boarding/rooming houses, etc.).

2. Support services provided to the person are not linked to the home itself (so not a group home, for example).

3. Person is a legal tenant in their home and there is no restriction on the amount of time that the person can live there (so not a shelter, for example).

4. Person has control over day-to-day decisions in his/her home and choice over roommates, if any.

5. The apartment may be non-profit, Rent-Geared-to-Income, market rent, or in a co-op.

6. I am interested in speaking with people who could be considered disadvantaged in the housing market (**for example:** because of low income, discrimination, lack of housing options, etc.).

Participants should be residents of the **Cities of Kitchener**, **Waterloo**, or **Cambridge**. If possible, could you find participants according to the following breakdown:

- **3** men with children
- **1** man without children
- **4** single women with children
- **4** women without children

Once again, thank you very much for your assistance.

Sincerely,

Ryan Walker

APPENDIX C
LETTER OF INFORMATION AND CONSENT FORM FOR ONE-TO-ONE INTERVIEWS

- DISTRICT HEALTH COUNCIL LETTERHEAD -

October 14, 1999

Dear Sir or Madam:

My name is Ryan Walker and I am working with the local District Health Council on a housing and mental health study. The study focuses on the housing experience of residents with mental health issues living independently in the community. The results of this study will illustrate the concerns residents have about their housing and its strengths. I am a student in the School of Planning at the University of Waterloo and the results of this study will be published in my thesis and as a District Health Council report. Independent living arrangements are becoming more popular among people with mental health issues and it is important to determine how residents feel that their housing situations can be improved. I would appreciate hearing your opinions on your current housing situation.

Participation in this study is voluntary and would involve an interview that would last about one hour. The interview would take place at a time that is convenient for you. We can meet at a location of your choosing (for example, a coffee shop). Most of the questions that will be asked in the interview revolve around your impressions of the home and neighborhood that you live in. Some of the questions address the affordability of your home and your housing history. You may decline answering any questions you do not wish to answer. All information you provide will be considered confidential. I would like to use a tape-recorder to record our conversation. It is more efficient than writing everything down as we speak. If you would rather not have the interview tape-recorded, however, I can take notes instead. You will not be identified by name in the District Health Council report, my thesis, or in any other publications that may result from this study. The interview transcripts will be destroyed no later than September 2000 and the audio-tapes will be erased at that time as well.

If any issues should arise either before or after the interview takes place, you should feel welcome to contact ______________ at ______________ and discuss these with her/him. It is very important for you to know that whether you decide to participate in this interview or not, your decision will have no impact on your housing or support service arrangement.

This project has been reviewed by, and received ethics clearance through, the Office of Human Research at the University of Waterloo. If you have any questions or concerns regarding your participation in this study, please contact this office at (519) 888-4567 Ext. 6005. If you would like to contact me for further clarification, you can reach me at (519) 885-7212. You may also contact my research advisor, Mark Seasons, at the University of Waterloo. His number is (519) 888-4567 ext. 5922.

If you choose to participate in an interview for this study, you will be compensated for your time with a payment of $10.00. I also ask that you complete the Consent Form on the other side of this page. Please include your telephone number on the Consent Form so that I can telephone you to arrange a time and location for our interview.

Thank you for your assistance with this project.

Sincerely,

Ryan Walker

.../2

APPENDIX C
LETTER OF INFORMATION AND CONSENT FORM FOR ONE-TO-ONE INTERVIEWS
2

CONSENT FORM

I agree to participate in an interview being conducted by Ryan Walker, who is working with the District Health Council and a student in the School of Planning at the University of Waterloo. I have made this decision based on the information I have received in the Information Letter and have had the opportunity to receive any additional details I wanted about the study. As a participant in this study, I realize that I will be asked to take part in an interview of about one hour and that I may decline answering any of the questions, if I so choose. All information that I provide will be confidential and I will not be identified in the District Health Council report, thesis or any other publications. I understand that I may withdraw this consent at any time by asking that the interview be stopped. I also understand that this project has been reviewed by and received ethics clearance through the Office of Human Research at the University of Waterloo and that I may contact this office if I have any questions or concerns about my participation in this study. I also understand that I may contact ________________ if any issues arise before or after the interview that I wish to discuss. I consent to having Ryan Walker telephone me at the number I provide below in order to arrange a time and location for our interview.

Participant's Name: ________________________

Participant's Signature: _____________________

Participant's Telephone Number: _____________

Name of Witness: _________________________

Signature of Witness: ______________________

Date: __________________________________

APPENDIX D
NOTES ON THE DEVELOPMENT OF THE ONE-TO-ONE INTERVIEW SCHEDULE

The following themes will be explored during the interviews with residents of supported housing:

1. Demography of the target population
- Age
- Gender
- Source of income
- Monthly income

2. Housing History
- Number of years/months in present residence
- Number of years/months in present neighbourhood
- Number of times moved in past three years – reasons
- Ever lived in temporary housing
- Ever been without a home
- Ever felt like you were discriminated against when searching for housing (by landlords, other residents, housing providers)

3. Housing Affordability and Choice
- Monthly rent
- Proportion of monthly income spent on rent
- Choice in selecting current place of residence
- Feelings of secure or insecure tenure
- Home or just a place to live

4. Housing Environment

a) Physical/Design
- **Place of residence**
  - Privacy
  - Space for social interaction
  - Design of living space (rooms, windows, etc.)
  - Upkeep
  - Physical appearance from outside
  - Physical appearance inside
  - Overcrowded?
- **Neighbourhood**
  - Access to services and amenities
  - Access to transportation
  - Design/appearance of neighbourhood

b) Social/Perceptual
- **Place of residence**
  - Safety
  - Fit-in with neighbours in building/living companions
  - Loneliness/isolation
  - Landlord-resident relationship (discrimination, positive support)
  - Neighbour/co-habitant – resident relationships
  - Number of living companions
  - Choice of living companions
- **Neighbourhood**
  - Safety
  - Fit-in with rest of neighbourhood
  - Neighbour-resident relationships

APPENDIX E
ONE-TO-ONE INTERVIEW SCHEDULE
HOUSING ENVIRONMENT AND HISTORY SURVEY

During this interview, when I ask about your 'place of residence' I'm referring to the apartment/room and building that you live in. When I ask about your neighborhood, I mean the neighborhood outside of your building.

To begin with, I would just like to ask you some questions about where you are currently living.

1. Would you please 'paint a picture' of your place of residence for me?

2. Would you please 'paint a picture' of your neighborhood?

<u>Housing Environment</u>
Physical/Design

3. Do you feel that your place of residence is well maintained and repaired (your room/apartment, your building)?

4. Do you like the way your place of residence is designed (e.g., the size and number of rooms, windows, floors)? Why?

5. Do you feel that you have enough privacy in your place of residence?

6. Do you feel that you have enough common area in your place of residence (e.g., where you can visit with other people)?

7. Do you like the way your place of residence looks from the outside? Why?

8. Do you feel that your building 'fits in' with the rest of the neighborhood?

9. Which word comes closest to expressing the way you feel about your place of residence?

APPENDIX E
ONE-TO-ONE INTERVIEW SCHEDULE

Delighted Pleased Mostly Satisfied Mixed Mostly Dissatisfied Unhappy Terrible

10. If you could change the way that the inside of your place of residence is designed, how would you change it?

11. If you could change the outside appearance of your place of residence, how would you change it?

12. Is there anything about the design of your place of residence that you really like?

13. Is there anything about the outside appearance of your place of residence that you really like?

14. Which of the following services are accessible to you in your neighborhood?

a) Shopping
b) Transportation
c) Banks
d) Schools
e) Work
f) Family
g) Friends
h) Places to socialize
i) Recreational places
j) Doctor's office/clinic (non-psychiatric)
k) Mental health services/support
l) Open spaces/parks
m) Restaurants/coffee shops
n) Other (Specify__________)

____
____
____

APPENDIX E
ONE-TO-ONE INTERVIEW SCHEDULE

15. On a scale of 1 to 5, please rate how important you feel it is to have the following services in your neighborhood (1 means that it is very important to you; 5 means that it is not important at all).

a) Shopping
b) Transportation
c) Banks
d) Schools
e) Work
f) Family
g) Friends
h) Places to socialize
i) Recreational places
j) Doctor's office/clinic (non-psychiatric)
k) Mental health services/support
l) Open spaces/parks
m) Restaurants/coffee shops
n) Other (Specify__________)

____
____
____

16. Are there any services, other than the ones just mentioned that you would like to have access to in your neighborhood?

17. What are your primary means of transportation (e.g., car, bus, bike, walk)?

18. Which of the following words best expresses how you feel about this particular neighborhood as a place to live?

Delighted   Pleased   Mostly Satisfied   Mixed   Mostly Dissatisfied   Unhappy   Terrible

19. If you could make changes to the neighbourhood that you live in now, how would you change it?

20. Is there anything about your neighborhood that you really like?

APPENDIX E
ONE-TO-ONE INTERVIEW SCHEDULE

Social/Perceptual

Now, I'd like to ask you some questions about the people that you interact with in your place of residence and in the neighborhood.

21. Do you live with anyone else?
    If yes, how many other people do you live with? ___
    What is your relationship to the other people that you live with?

22. Did you choose to live with these people (all of them? some of them?)?

23. Do you like living with these people (all of them? some of them?)?

24. What are the other people that live in your building like?

25. Do you feel like you 'fit in' with the other people who live in your building?

26. Is there enough social interaction for you with other people in your place of residence? Would you like more/less?

Safety is an important issue to most people.

27. Do you feel safe in your place of residence?

28. On a scale of 1 to 5, please rate how safe you feel in your place of residence (1 is very safe; 5 is very unsafe). ___

29. Which of the following words best expresses how you feel about your relationship with the other people in your place of residence?

    Delighted Pleased Mostly Satisfied Mixed Mostly Dissatisfied Unhappy Terrible

30. If you could change your relationship with the other people in your place of residence, how would you change it?

APPENDIX E
ONE-TO-ONE INTERVIEW SCHEDULE

31. Is there anything about your relationship with the other people in your place of residence that you really like?

32. Which of the following words best expresses how you feel about your relationship with your landlord?

Delighted   Pleased   Mostly Satisfied   Mixed   Mostly Dissatisfied   Unhappy   Terrible

33. If you could change your relationship with your landlord, how would you change it?

34. Is there anything about your relationship with your landlord that you really like?

35. What are the other people that live in your neighborhood like?

36. Do you feel like you 'fit in' with the other people that live in your neighborhood?

37. Is there enough social interaction for you with people in your neighbourhood? Would you like more/less?

Again, I would like to ask you a question about safety.

38. Do you feel safe in your neighbourhood?

39. On a scale of 1 to 5, please rate how safe you feel in your neighborhood (1 is very safe; 5 is very unsafe). ___

40. Which of the following words best expresses how you feel about the people in your neighbourhood?

Delighted   Pleased   Mostly Satisfied   Mixed   Mostly Dissatisfied   Unhappy   Terrible

41. If you could change the type of people that live in your neighbourhood, how would you change them?

42. Is there anything about the people in your neighborhood that you really like?

APPENDIX E
ONE-TO-ONE INTERVIEW SCHEDULE

43. If you could live wherever you like, what would that neighborhood look like and where would it be?

Housing Affordability and Choice

I would now like to ask you some questions about the affordability of your housing and the amount of choice you had in living here.

44. Why did you choose your current place of residence?

45. Does your current place of residence feel like home or do you think of it as just a place to live for now?

46. In the next 2 years, do you see yourself still living here?

47. In the next 5 years, do you see yourself still living here?

48. How much do you pay each month for rent, including utilities? ___

I would like to ask you a couple of questions about your monthly income, so that I can compare it to the amount that you pay each month for rent.

49. What is your monthly income? ___

50. What are your sources of income? (check all that apply)
    Employment ___
    Ontario Works (General Welfare Assistance) ___
    Ontario Disability Support Plan (Family benefits/disability pension) ___
    Employment Insurance ___
    Canada Pension Plan Disability Benefits ___
    Workers Compensation ___
    Other (Specify__________) ___

51. Do you spend more than 30% of your monthly income on rent?
    Yes___ No___ Don't Know___

APPENDIX E
ONE-TO-ONE INTERVIEW SCHEDULE

52. Do you spend more than 50% of your monthly income on rent?
    Yes___ No___ Don't Know___

<u>Housing History</u>
Now this is the last section of the interview. I will ask you some questions about your housing history.

53. How long have you lived in this place of residence? (years, months) ___

54. How long have you lived in this neighborhood? (years, months) ___

55. How many times have you moved in the past 3 years? ___
    Can you tell me why you moved the first time? the second time.....

56. How do feel about having moved ___ times over the last 3 years?

57. Have you ever lived in temporary housing (e.g., shelter, hostel, hotel, boarding/rooming house)?
    If yes, what types of temporary housing have you lived in?

58. Have you ever been without a place to live (i.e., homeless)?

59. Have you ever felt as though you were discriminated against while searching for housing (e.g., by landlords, other residents, housing providers)?

60. Please tell me which category your age falls into:

    <20 years
    20 – 29 years
    30 - 39 years
    40 – 49 years
    50 – 59 years
    >59 years

APPENDIX E
ONE-TO-ONE INTERVIEW SCHEDULE

61. Gender? M F

62. I've asked you a lot of questions about where you live, but is there anything else that you would like to mention about your housing situation?

63. Would you like me to mail you the results of this study when I finish in December or January?
    If yes: Can I have your mailing address?

APPENDIX F
LIST OF FOCUS GROUP PARTICIPANTS AND OBSERVERS

Focus Group Participants and Observers

Participants

1. Peggy Becker – Community Support Co-ordinator, Lincoln Road Non-Profit Housing
2. Betty Boomer – Director of Centres for Mental Health, Canadian Mental Health Association – Waterloo Region and Wellington-Dufferin
3. Kathy Brown – Senior Property Manager, Wellington and Guelph Housing Authority
4. Wendy Czarny – Executive Director, Waterloo Regional Homes for Mental Health Inc.
5. Gary Foran – General Manager, South Waterloo Housing Authority
6. Joan Jylanne – Principal Planner, Planning & Culture Department, Regional Municipality of Waterloo
7. Paul Kraehling – Planner, Planning & Business Development, City of Guelph
8. Janice Peters – Housing Manager, Dufferin County Housing Authority
9. Ed Pickersgill – President, Matrix Affordable Homes for the Disadvantaged and Co-ordinator, Silver Wood Housing Co-operative Inc.
10. Myra South – Tenant Placement Manager, North Waterloo Housing Authority
11. Blanche Walsh – Tenant Placement Manager, South Waterloo Housing Authority

Observers

1. Grant Hollett – Health Planner, Waterloo Region – Wellington-Dufferin District Health Council
2. Harriett Lenard – Health Planner, Waterloo Region – Wellington-Dufferin District Health Council
3. Marilyn Shapka – Municipal Councillor, City of Guelph

APPENDIX G
LETTER OF INFORMATION AND CONSENT FORM FOR FOCUS GROUP PARTICIPANTS

- DISTRICT HEALTH COUNCIL LETTERHEAD -

October 29, 1999

Paul Kraehling MCIP RPP
Planning & Business Development
City of Guelph
City Hall, 59 Carden Street
Guelph ON N1H 3A1

Dear Paul:

Further to our telephone conversation last week I would like to give you a brief summary of the housing and mental health study that I am conducting with the District Health Council and how you could assist me by agreeing to participate in a focus group. The first component was to create an inventory of supportive/supported housing for people with mental health issues and an estimate of unmet demand. The second was to develop a better understanding of the housing experience of people with serious mental health issues in Waterloo Region and the counties of Wellington and Dufferin. The final component of my study is a focus group with planners and local housing professionals. I would like to find out more about the current social housing environment, how we can forge partnerships to secure more supported housing for people with serious mental health issues, and how we can improve what already exists. I know that your input will be valuable in covering many of the areas that I want to cover in the focus group and I hope that you will be able to take some valuable information away from the group as well. As promised, I will send you a copy of the questions that will be covered at the focus group meeting. This will be sent to you about a week before the focus group meeting.

WHEN AND WHERE WE ARE MEETING:

Date: **Friday, November 26**

Time: **9:00 AM – 12:00 PM**

Location: **Waterloo Region – Wellington – Dufferin District Health Council office**
251 Woodlawn Road West, Unit 118
Guelph.see the attached map****

As mentioned on the telephone, I will be using the results of this research in a District Health Council report and also in my thesis for the School of Planning, University of Waterloo. With respect to confidentiality, you as an individual will not be linked directly with any comments stemming from the focus group meeting. All will be attributed to the group as a whole. With your agreement, however, your name would be published as a member of the focus group.

This project has been reviewed by, and received ethics clearance through, the Office of Human Research at the University of Waterloo. If you have any questions or concerns resulting from your participation in this focus group, please contact this office at (519) 888-4567 Ext. 6005. You may also contact my research advisor, Mark Seasons, at the University of Waterloo. His number is (519) 888-4567 ext. 5922.

Thank you very much for your help and I'll see you in a few weeks. If anything comes up and you want to get in touch with me, please phone me at (519) 885-3052 or email me at: rc2walke@fes.uwaterloo.ca

With kind regards,

Ryan Walker

APPENDIX G
LETTER OF INFORMATION AND CONSENT FORM FOR FOCUS GROUP PARTICIPANTS

CONSENT FORM
FOR RESEARCH WITH FOCUS GROUP

I agree to participate in a focus group being conducted by Ryan Walker, who is working with the District Health Council and a student in the School of Planning at the University of Waterloo. I have made this decision based on the information I have received in the Information Letter and have had the opportunity to receive any additional details I wanted about the study. As a participant in this study, I realize that I will be asked to take part in a focus group of about three hours and that I may withdraw at any time, if I so choose. All data and commentary stemming from the focus group meetings will be attributed to the focus group and my comments will not be identified individually in the District Health Council report, thesis or any other publications. I understand that I may withdraw this consent at any time by leaving the focus group. I also understand that this project has been reviewed by and received ethics clearance through the Office of Human Research at the University of Waterloo and that I may contact this office if I have any questions or concerns about my participation in this study.

Participant's Name: ________________________

Participant's Signature: ____________________

Name of Witness: ________________________

Signature of Witness: ______________________

Date: ________________________________

APPENDIX H
MODERATOR'S GUIDE – FOCUS GROUP

With the questions below I am interested in everyone's perspective based on their knowledge, interests, and areas of expertise. I realise that not everyone will be able to comment as fully on every question as others will.

1. **What is your forecast of the social housing situation for 2003[1]?**

   For example:
   - building new housing
   - new rent subsidies
   - dedicated mental health housing
   - social housing with supports (e.g., practical support)
   - other

2. **How do we get more housing (affordable and adequate) for supported housing[2]?**

   For example:
   - new housing
   - partnerships between social housing providers and mental health agencies (past partnerships and where they went wrong, new partnerships, why they can or can not work)
   - with the transition of social housing responsibility to municipalities, is there any way to ensure partnerships between social housing providers and mental health agencies through municipal policy/formal agreements?
   - other

3. **Residents that were interviewed expressed serious concerns with feelings of loneliness, isolation, and disconnection from their community. Are there any programs in place to foster community involvement or interaction among residents?**

   For example:
   - tenant involvement in management and operations in housing developments
   - social or community activities in housing developments
   - programs at mental health agencies for pairing roommates
   - other

4. **What are some of the issues that people with serious mental health issues face with respect to maintaining their housing/tenancy?**

5. **Summary of what was covered, then 'Have we missed anything?'**

---

[1] The year 2003 is used here because the Ministry of Health has set a target for housing and support for people with serious mental health issues for 2003. Both general social/affordable housing and dedicated supportive housing are important in meeting that target.
[2] **Supported housing** is regular housing (e.g., market rent apartment or non-profit housing) where the resident receives mental health support services on an individualised, flexible basis from a community-based mental health agency.

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