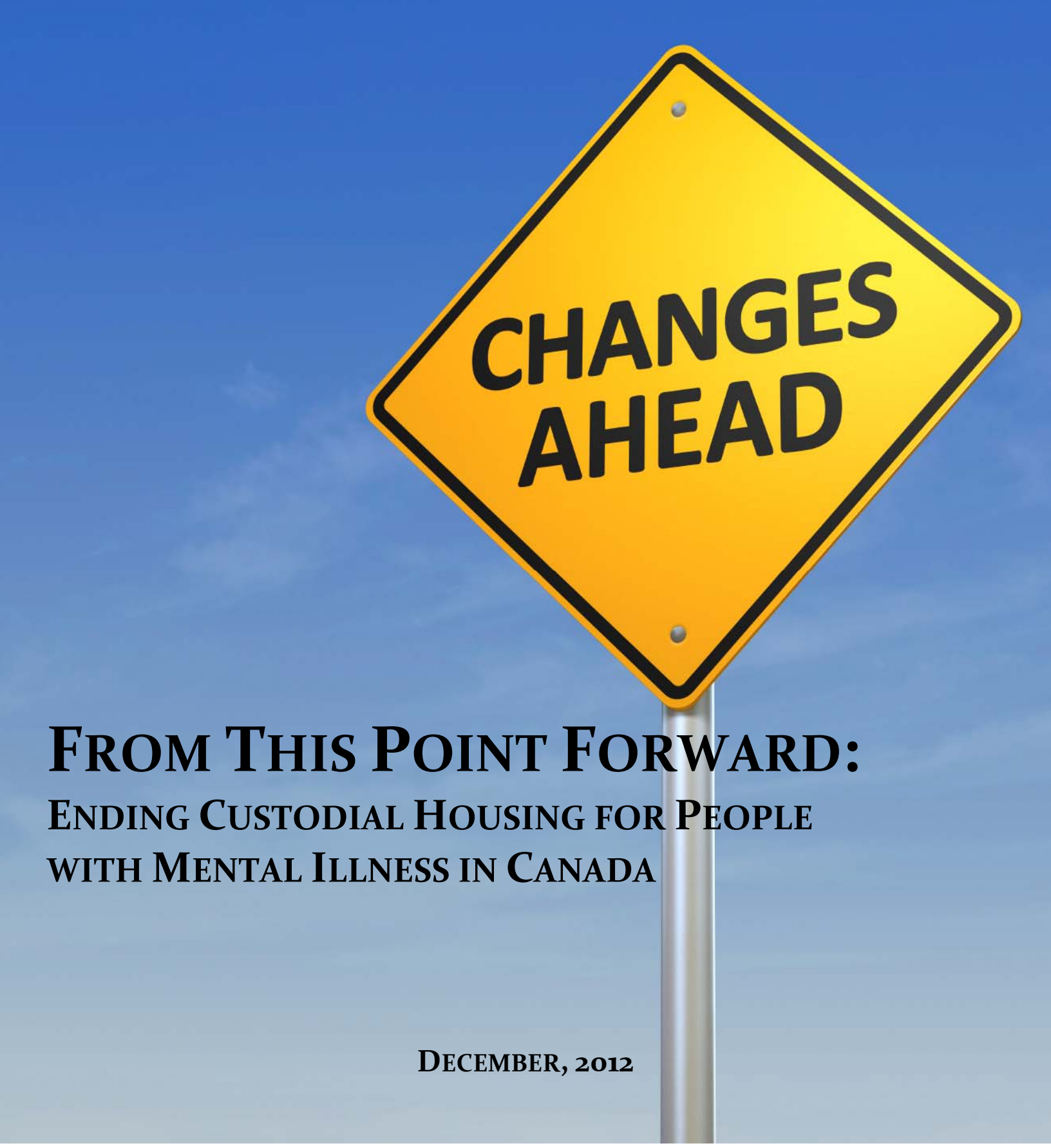

From This Point Forward:

Ending Custodial Housing for People with Mental Illness in Canada

December, 2012

camh Community Support and Research Unit
Housing·Employment·Education·Income

FROM THIS POINT FORWARD:
ENDING CUSTODIAL HOUSING FOR PEOPLE WITH MENTAL ILLNESS IN CANADA

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This is not an official position paper of the Centre for Addiction and Mental Health.

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INTRODUCTION

Housing is a health issue. With substandard housing or without housing altogether, people are not only vulnerable to many illnesses and diseases but also experience difficulties accessing health services. For people with mental illness, this is a serious problem that can have fatal outcomes.

MYTH: A roof over one's head is sufficient to prevent the health problems associated with homelessness.

The visibly homeless are only the tip of an iceberg that includes people living in overcrowded, substandard, and unaffordable housing. Resolving the housing crisis that currently exists is not as easy as simply providing housing to those without it. People need housing that is affordable, safe, in good condition, and supportive of their needs. People need a place they can call 'home.'

FACT: Housing that supports the development of independent living skills has been found to improve social support, independent functioning, self-esteem, and self-responsibility among people with mental illness (Nelson, Hall, & Walsh-Bowers, 1997).

For people with serious mental illness, housing must offer the supports they want and need in order to be considered suitable. When housing enables people to become independent, it fosters their ability to live successfully in the community, promotes recovery and well-being, and can result in cost savings for the mental health system through reduced reliance on emergency and institutional services. In short, when a person's housing fits their needs, it works for everybody.

Today, people with mental illness in Canada live in a variety of housing arrangements – some good, some bad. Despite many provinces' and territories' strides toward creating housing that best fits the needs of people with mental illness, some outdated housing models still exist. One such model is custodial housing.

What is Custodial Housing?

Custodial housing refers to models in which residents are cared for in a standardized and routinized fashion with the goal of maintenance rather than recovery. Support is oriented towards care and dependency, rather than being designed to help improve functioning or maximize independence. Both research (e.g., Lehman, Possidente, & Hawker, 1986; Lehman, Slaughter, & Myers, 1991; Horan, Muller, Winocur, & Barling, 2001) and first-person narratives (Capponi, 1992) have described custodial care models as having a negative effect on recovery and quality of life.

Custodial care facilities are typically operated by private landlords for profit. The most common are large, institutionalized settings (i.e., boarding homes; Sylvestre et al., 2006), though some custodial care is provided in small, family care homes. In most cases, though not all, rooms are shared and privacy limited. Staff in custodial care facilities are not trained to provide specialized mental health support. Residents are generally provided with a fixed range of services, including laundry, meals, and housekeeping. Their lives are fixed to routines such as set meal times. The pre-determined basket of services often limits recovery strategies that may include people cooking for themselves, and can result in some residents receiving services that they do not need.

Custodial care models are guided by many of the same assumptions that underlie older institutional models. These assumptions focus on the limitations of people living with mental illness, rather than their capacities; and they

presuppose that people with mental illness are a relatively homogeneous group who have similar needs and limitations, and therefore will benefit from identical levels of care. People are presumed to live in a static state of illness from which recovery is not anticipated. It is assumed that people with mental illness must be taken care of, that they cannot develop independent living skills, play a role in their own caretaking, make decisions for themselves, or set goals for the future. Furthermore, people living in custodial housing are expected to be there for an indefinite period, quite possibly the rest of their lives

It is important to note that some housing providers try to overcome the custodial framework in which they operate. Although it is rare, some custodial housing programs employ qualified staff who believe people can and do recover, and who work, in effect, in opposition to the custodial model to make the best of a difficult situation for residents. In such cases, residents may be supported to get involved in their community or go to outside mental health programs. The critical issue is that the fabric of custodial housing does not support these efforts towards the empowerment and independence of residents. It is for this reason, among others, that custodial housing is no longer a preferred option.

MYTH: High support housing cannot be provided using a non-custodial approach.

Custodial care models are commonly thought to be necessary for clients who need high support. This is not true. While the custodial approach tends to provide 24-hour supervision, the actual level of support from a recovery perspective is typically low. In the past 20 years, many new models that provide high support without custodial features have emerged. For example, the Mental Health Commission of Canada's *At Home/Chez Soi* project, which has provided housing to over 2,000 homeless people with mental health problems in five Canadian cities, utilizes a Housing First approach[1] while also making high supports available. This is done through the use of flexible Assertive Community Treatment teams or intensive case management teams that provide varying levels of support. Another initiative that offers high support housing through a non-custodial approach is Supportive Housing in Peel's (SHIP) High Support Housing Pilot Project, which is described in detail later in this paper. The important common features of non-custodial high support housing are private space; individualized, recovery-oriented support plans involving staff trained in recovery principles; and full legal tenancy.

The Long History of Custodial Care

When the asylum movement began in Canada in the nineteenth century, it was intended to be a progressive shift that would "provide safe settings for physical and spiritual care," as well as "shield residents from the harm and peril that commonly befell people with mental illnesses in cities and towns" (Goldner, 2002, p. 1). Efforts ultimately fell short of this vision as asylums became overcrowded, understaffed, and lacked effective methods of treating psychiatric disorders (Davis, 2006). In essence, asylums across the country had become large warehouses that provided custodial care and kept people with mental illness "out of sight, out of mind" (Davis, 2006; Nelson, Aubry, & Hutchison, 2010).

During the mid-twentieth century, new developments in the treatment of mental illness and new ideas about human rights fostered a growing belief that community-based care for people with mental illness would be more humane and therapeutic than hospital-based care. This led to drastic changes to mental health policy in the 1960s (Bachrach, 1994; Davis, 2006). Beginning with

[1] Housing First is a harm reduction approach in which tenants are not required to be abstinent or engaged in treatment when entering housing. Tenants are given a choice as to whether they want to receive services or not. By doing so, the Housing First approach immediately assists people in resolving their most serious problem – housing – without any strings attached (Kerman, Eckerle Curwood, & Sirohi, accepted).

a period of deinstitutionalization which saw the downsizing and closing of many psychiatric hospitals across the country, people with mental illness had to find new housing in the community (Sealy & Whitehead, 2006). Custodial housing became the primary approach, and many people were moved from large psychiatric institutions that offered no rehabilitation to large congregate housing settings that also offered little to no rehabilitation (Murphy, 1972; Sylvestre et al., 2006; Trainor, Morrell-Bellai, Ballantyne, & Boydell, 1993). Once again, many people with mental illness found themselves in housing that was crowded, of dismal quality, and lacking the supports needed to recover. In this manner, the era of deinstitutionalization had created a dynamic of transinstitutionalization whereby communities were unable to support the thousands of people discharged from institutions, forcing the mental health system to implement an institutional approach to care within the community. The result was the development of mini-institutions in the form of custodial boarding homes.

Both the asylum movement and deinstitutionalization can be seen as well-intentioned but deeply flawed transformations of how we house people with mental illness. As a result of a lack of knowledge about treatment during the asylum movement and poor planning during deinstitutionalization, people with mental illness have been subjected to a long history of custodial care.

Custodial Care in Canada Today

A great deal of work in the development of community housing has shown that models with a one-size-fits-all approach and which lack privacy for their residents are not effective (Trainor, Taillon, & Pandalangat, 2012). Providing people with choice and control over the location and type of housing and supports that they wish to have is critical to the success of the housing in people's lives (Nelson, Sylvestre, Aubry, George, & Trainor, 2007). Despite great efforts to develop and implement best practice housing approaches over the last forty years, substandard and non-best practice housing stock, much of it custodial housing, remains common in Canada.

Custodial housing models exist in most provinces and territories. For example, there are roughly 6,025 custodial housing beds available to people with mental illness in Ontario. This consists of 1,450 Homes for Special Care beds, 852 beds funded by Habitat Services[2], and approximately 3,723 domiciliary hostel beds[3]. In total, for every ten supportive housing units in Ontario (10,000[4]), there are six custodial housing beds.

In less populated provinces, custodial housing models are also prevalent. In New Brunswick, there are approximately 6,945 custodial care beds[5], of which 6,475 are special care homes and 470 are community residence beds.

[2] This number does not represent Habitat Services' complete housing stock portfolio (931 beds) as 79 beds are in programs that would not be considered custodial housing, such as the Eglinton Project (explained in detail on page 10) and Edmond Place (explained in detail on page 11).

[3] The domiciliary hostel program in Ontario is not dedicated solely to people with mental illness but many residents do have a mental illness. The total domiciliary hostel housing stock in Ontario is 5,100. A survey of the program in Ontario found that 73% of residents reported a mental illness (Hwang, Chiu, & Wilkins, 2009). The figure above (3,723) reflects 73% of the total Ontario stock.

[4] Of the 10,000 supportive housing units in Ontario, 8,500 are dedicated to persons with mental illness and 1,500 are dedicated to persons with addictions.

[5] Beds are not solely dedicated to people with mental illness but are commonly occupied by them.

Five Reasons for the Elimination of Custodial Housing

There are many reasons to replace Canada's custodial housing stock with models that reflect best practices. A growing body of research has emerged on housing models and consumer preferences, outlining current best practices. The development of *non-custodial, rehabilitation-oriented* housing programs has clearly demonstrated that even the most disabled mental health consumers can thrive in more independent housing if the right balance of supports is in place (Centre for Addiction and Mental Health, 2002). Unfortunately, this knowledge has not always been translated into the adoption of best practice approaches or policies, and custodial housing models continue to be the reality for too many Canadians living with serious mental illness. This section of the paper outlines five reasons why we need to move now to make changes. An in-depth look at some of the strategies to eliminate custodial housing and bring about change will follow.

1. Custodial Housing Violates Human Rights

The United Nations Convention on the Rights of Persons with Disabilities (Convention), adopted December 13, 2006, endeavors to change attitudes and approaches to persons with disabilities. It reaffirms that persons, with all types of disabilities (including mental illness), are entitled to and capable of enjoying full human rights and fundamental freedoms. These rights and freedoms include, but are not limited to, adequate living conditions, maximum independence, participation in the community, privacy, access to public transportation and buildings, and freedom from exploitation. The Convention also recognizes the right of people with disabilities to make their own decisions.

Canada originally signed the Convention in 2007 and ratified it in 2010, which means Canada is obligated to protect the rights of persons with disabilities as detailed in the document, as well as to report its progress in these areas. Canada, like all countries that join in the Convention, has committed to develop and carry out laws, policies, and administrative measures for securing the rights recognized in the Convention, while also abolishing laws, regulations, customs, and practices that constitute discrimination (United Nations, 2006, Article 4).

From the perspective of this commitment to change, the need to move forward on the elimination of custodial housing – which by its definition limits the possibility to adequate privacy, does not promote the attainment of maximum independence and ability, and does not create an environment that fosters individual decision making and preference – becomes a national human rights priority that is being monitored at the international level.

Not only do some of the features of custodial housing violate international human rights laws but they also disregard basic tenancy rights. For example, in Ontario, the Residential Tenancies Act is designed to protect the rights of tenants who rent residential properties by providing a framework for the regulation of residential rents, ensuring tenants' right to reasonable enjoyment is not interfered with, and establishing eviction protocols. In the province, however, it is not difficult to find custodial housing models that are operating under conditions that are noncompliant with laws of the Residential Tenancies Act.

FACT: It is common for people living in custodial care homes to have no private space.

A report by the Centre for Addiction and Mental Health (2002) detailed the crowded conditions that are common in custodial

housing. In 1996, some Homes for Special Care houses (a provincially regulated custodial housing program in Ontario) had as many as four people sharing one room. While fewer homes operate under these circumstances today, room sharing still exists and several homes still operate with four people per room. By crowding bedrooms, custodial housing not only inhibits the right to adequate privacy but puts people at risk of a number of health problems associated with crowded living (Public Health Agency of Canada, 2007).

2. We Can't Afford Not to Change

The belief that custodial homes provide the most cost effective way of delivering high support housing has been refuted in recent years by the development of recovery-oriented housing programs that incorporate consumer preference (i.e., independent units, integrated settings, and on-call supports) and are fiscally responsible. For example, an evaluation conducted on a new high support housing program in Toronto found that the costs of the services provided – including amenities, rent, and clinical and non-clinical supports – were approximately $76 a day per client (Kidd & Cushing, 2010). This was almost 25% lower than the provincial mean cost for high support housing. Investing in the best housing for people with mental illness (i.e., programs that promote recovery) not only gives people the opportunity to develop the skills they need to live productive lives in the community, but can be fiscally responsible, thus benefiting all involved stakeholders.

Due to a myriad of factors, such as the episodic nature of mental illness and the development of independent living skills, support needs can fluctuate over time. Recovery-oriented housing programs that offer smooth transitions to different degrees of support allow residents to access support at the appropriate level. The practice of people transitioning to the most suitable level of support prevents money from being tied up in expensive, high need supports that are not needed, and ensures that we move closer to the goal of "the right care, at the right time, in the right place" (Government of Ontario, Ministry of Health and Long-Term Care, 2012).

This becomes increasingly important as current fiscal realities dictate that the resources needed for care must be well focused and targeted. If people with serious mental illness are able to recover and/or live more independently than we have assumed, we can no longer afford to leave programs in place which predictably generate long lengths of stay. It has been suggested by Browne, Courtney, and Meehan (2004) that people with schizophrenia who are discharged to boarding homes are more likely to be re-hospitalized than those discharged to a private home. The study found that, while people with schizophrenia who were living on their own did not differ in terms of psychiatric symptoms from those living in boarding homes, the boarding home residents had significantly lower levels of social support, meaningful activities, work, and global functioning. Segal and Kotler (1993) followed residents of sheltered care settings in California and found that residents became more dependent over time.

We can no longer afford to ignore the costs associated with housing people in custodial settings for much of their lives. These costs include not only the financial costs, but also the human costs associated with the loss of social supports, independence, and work opportunities. Best practice housing models can be fiscally responsible and foster an environment where people can recover from mental illness and transition to more independent housing.

3. People Can and Do Recover from Serious Mental Illness

On a very basic level, if change is to occur, those who are able to implement change should have a shared vision of the future. We strongly believe that this outlook needs to be built on a fundamental belief in the recovery of persons living with mental illness and fortified by the values of holistic health, social

inclusion, and social justice (Foster-Fishman et al., 2007). The recently released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2012) prioritizes the recovery and well-being of people living with mental health problems and illnesses as a key strategic direction. If we are to achieve the goal of a shared national vision of recovery we will need to challenge any lingering assumptions and beliefs that individuals with mental illness are "too sick to know what they want" and/or "have reached their highest level of functioning." It is these erroneous beliefs that have been used, for many decades, to rationalize the 'warehousing' of people with serious mental illness in non-rehabilitative, custodial facilities (Centre for Addiction and Mental Health, 2002).

Outdated beliefs that underestimate the capacities of people with mental illness still underlie the operation of custodial homes. For example, in Manitoba, residential care facilities have varying levels of care, none of which focus on psychosocial rehabilitation. The five levels of care range from "minimal on-site supervision and access to supervision on a 24-hour basis" (lowest level of need) to "on-site supervision, tolerance, continuing direction, and 'stand by' or 'hands on' assistance" (highest level of need; Government of Manitoba, Manitoba Family Services and Labour, pp. 114–115). The goal for all five levels of care is "to ensure that daily activities, routines, and living patterns are appropriately maintained"[6] (Government of Manitoba, Manitoba Family Services and Labour, pp. 114–115). The focus on maintenance rather than rehabilitation and recovery make it clear why residents of custodial homes seldom move on to housing with more independence.

The concept of recovery, as it relates to mental illness, has been prominent in mental health discourse for the past 20 years. There is no single definition of recovery, but it is seen "as a process of personal growth and development, and involves overcoming the effects of being a mental health patient, with all its implications, to regain control and establish a personally fulfilling, meaningful life" (Davidson et al., 2005). Contrary to the concept of recovery, the custodial approach to housing was developed based on the assumption that people with serious mental illness do not get better and, in fact, typically get worse. Because of this, custodial care was believed to be all that was required. If we take the example of schizophrenia, the assumption that people do not recover is now known to be inaccurate. A longitudinal study by Harding, Brooks, Ashikaga, Strauss, & Brier (1987) demonstrated that in the long-term, over 50% of people with a diagnosis of schizophrenia will recover and be clinically indistinguishable from the general population.

Even for those who do continue to live with the symptoms of a serious mental illness, the picture is now very different. Recent model programs have demonstrated that peoples' capacities have been drastically underestimated. People who, as recently as seven or eight years ago, would have been assessed as needing custodial care are now living successfully and much more independently, with the help of case managers and other supports. Many mental health housing programs have adapted to this by restructuring their models.

FACT: There are housing models that are superior to the custodial care approach and better serve the needs of people with mental illness.

4. People Know What They Need to Recover

With the knowledge that people can and do recover, the shift to an understanding of the consumer of mental health services as being central to and directing of their own care is a natural progression. Recognizing the relevance and importance of consumer

[6] Only for the "individuals who are not self-directed or involved in day-to-day decision making" (lowest level of functioning) is the goal on maintenance *or* improvement.

preferences in the design and implementation of mental health housing is a compelling factor in the argument for ending custodial housing.

The body of research on consumer preferences over the last 30 years clearly indicates that the custodial housing model does not fit the needs of consumers (Trainor et al., 1993). Custodial care approaches are not effective in helping consumers live in the community (Parkinson, Nelson, & Horgan, 1999). Instead, models in which consumers' inputs are acknowledged and in which they are in control of their housing and supports are more likely to produce positive results. When people have choice and control over where they live and the supports they need to be there, they flourish in community living.

FACT: More residents of domiciliary hostels, a custodial housing program in Ontario, visited doctor's offices and health clinics than went out to parks, shopping centres, or movies in the last 12 months (Hwang et al., 2009).

Early research, which continues to be reaffirmed by more recent work (e.g., Noble & Douglas, 2004), has shown that consumers want to live independently in the community, with supports available on an as-needed basis. In a classic study by Tanzman (1993), which reviewed a total of 43 studies of mental health consumers' housing and support preferences conducted between 1986 and 1992, findings showed that there was strikingly little variation in the housing preferences of respondents. Consumers consistently reported that they preferred to live in their own house or apartment. The most preferred characteristics of living situations were freedom and autonomy, permanence, security, and privacy. Many consumers also reported that they wanted to live alone or with a spouse or romantic partner, and not with other mental health consumers. Very few respondents wanted live-in staff, reporting a strong preference for outreach staff support on an on-call basis. Consumers also emphasized the importance of material supports such as income and transportation for effective community living. To consumers, these are the supports and conditions critical to recovery – not the provision of services chosen by housing staff and not the arrangements of custodial housing.

FACT: In Ontario, Homes for Special Care (HSC) residents receive $134/month to cover all non-basic needs. This includes many consumables that affect people's social activity and community involvement (e.g., going to a café with friends for a coffee).

The research strongly indicates that the housing and support preferences of consumers are not aligned with custodial care models.

5. It Can Be Done and Has Been Done

The final reason for change is quite simply that it can be done and has been done with great success. There are several examples of exciting transformations and innovations across the country in which custodial housing has been closed and replaced by new state-of-the-art best practice housing. These examples, which will be detailed as case studies in the *Strategies* section of this paper, provide a window to the possibilities and opportunities that lie ahead for mental health housing reformers, key policy and decision makers, funders, service providers, and consumers of mental health services and their families.

STRATEGIES FOR THE ELIMINATION OF CUSTODIAL HOUSING

The problem is clearly serious but change is possible and realistic. Across the country, we see numerous examples of housing models that have moved away from a custodial care approach to one that is more reflective of best practices. Several of these are detailed in this section. Four steps are key to moving forward:

- Creating a climate for change,
- Detailing the conceptual elements of the issue and its impact on consumers,
- Developing strategies to replace custodial models with best practice housing, and
- Having in place a national action group or community of interest to support national and provincial/territorial change processes to eliminate custodial housing.

The elimination of custodial housing is a critical, preliminary step toward the creation of a strong mental health housing system that appropriately serves the needs of people and promotes their independence. The features of this reformed housing system include homes that are safe and affordable, provide adequate privacy, and offer the needed supports. People will have the freedom to choose their housing (e.g., where they want to live, who they want to live with) and the supports they receive (e.g., use of health services). The system will be flexible in that people will be able to easily transition to housing with more or less support if need be. We envision a mental health housing system in which people's homes promote recovery.

To transform the current housing system into one that offers a range of best practice models, action is needed by a number of stakeholders including different levels of government, housing providers, community mental health agencies, the private sector, and, of course, people who have lived with mental illness, as well as their families.

Transforming the housing system does not mean 'painting the ward' (see inset box below). Adopting small changes in the existing custodial system, such as improving residents' level of involvement in the community are

Painting the Ward

Closing custodial models is dependent on recognizing which models are in fact custodial, and also on recognizing what kind of changes do not constitute a move away from the custodial model. For many years these questions have been considered by reformers in mental health and other areas. We need to put our finger on what exactly constitutes the custodial model, identify its DNA if you will. We can start by looking at examples of actions that do not mean an end to custodial housing. We can group these under a term that has been used for both mental health and developmental disabilities: 'painting the ward.'

'Painting the ward' refers to cosmetic actions that make a custodial setting more pleasant, but do not change the underlying custodial character. These can include, of course, actually painting a facility or in other ways sprucing up its appearance, adding social recreation activities as part of the day, increasing contact in the community through outings, and so on. These activities may improve a custodial setting, but they do not change the basic model. They do not change the fact that people are being cared for in a facility that limits their ability to live as full citizens. Note that in the past we assumed that this kind of care was necessary, especially as levels of disability increased, but that for over 15 years there have been models that provide very high support in non-custodial settings. These settings typically have clients living in private space that they hold as tenants and can control, a very wide menu of options for support that allows a client to, for example, cook on their own if they can, or receive meals if they can't, and a clear focus on recovery and rehabilitation. The DNA of custodial models is maintenance; the DNA of non-custodial models is recovery.

insufficient. The research has demonstrated, time and time again, that consumer choice, privacy, and independence are crucial to creating an environment where people can live successfully in the community. Now is the time to give people what they want.

This section will detail how to eliminate custodial approaches to housing and replace them with best practice programs. It is a complex process requiring action on a number of fronts, but it is achievable.

Creating a Climate for Change

The most effective method for eliminating custodial housing is to defund these programs and use the funds to create new, better practice housing models. Another approach is to set criteria that existing programs must meet, and to make these criteria recovery focused. Either approach will depend on serious effort and collaboration between partners. In many jurisdictions, a climate for change must first be created.

Identifying custodial housing and making it a policy issue is the first step. Custodial models are pervasive and they have become a recognized part of the housing landscape. They blend in, and as a result can be hard to see. In some provinces the issue has been tackled by trying to improve the custodial regulations; in one case specifying that more snacks and fruit be made available in homes. This is a very clear case of "painting the ward" and misses the fundamental issues. The fundamental issue of custodial care that must be placed front and centre is that a one-size-fits-all model with little privacy and little support for rehabilitation is not what people want or need.

Wanted: Regional Leadership to Foster Change

The Mental Health Commission of Canada has identified housing as a significant problem facing people with mental illness. The *At Home/Chez Soi* initiative and the *Turning the Key* project have helped make housing a topic of conversation among politicians, housing service providers, mental health professionals, and researchers. Leadership is needed to sustain the energy for improving the housing system and addressing custodial housing.

When individuals or agencies step up to the plate, change becomes possible. Leaders will need to identify what the problem looks like in their respective regions and begin addressing a number of key questions such as:

- How much custodial stock exists in the region?
- What stock can be eliminated and replaced by best practice housing?
- How can it be done?
- Who is necessary to have on board to make change possible?

Developing position papers, similar to this one, for each province and territory will bring the issue front and centre and provide frameworks for change. In addition, position papers will enable the dissemination of the answers to the key questions listed above and begin generating conversation on how custodial housing models can be replaced with better practice models.

A national community of interest, which is led by the Centre for Addiction and Mental Health's Community Support and Research Unit with support from the Mental Health Commission of Canada, is one starting point for change. The community of interest is there to lend its support to individuals working toward change in this area.

One critical aspect of creating a climate for change is to connect the custodial housing issue with current health system priorities, and with the priorities of other branches of government. The issue of long-stay patients remaining in expensive hospital beds because there are no suitable housing options available in the community, known in some provinces as Alternate Level of Care (ALC), is a good example. Governments are often reluctant to fund high support non-custodial models when they take what might be called a 'social

services' perspective, but a comparison with hospital inpatient costs shows the non-custodial model favorably. Positioning best practice housing models as alternatives to inpatient care, and emphasizing that they promote recovery, and therefore, the continuous flow of people through the system, should resonate with many stakeholders.

> The current socioeconomic climate demands smart investments by government. In custodial housing there is little likelihood of flow-through, with many residents actually remaining in custodial housing until death. Funding models that sustain disability is not a smart investment.

Lastly, the current housing stock in Canada – both in type and quantity – reflects a long-standing resistance to investing in housing. Leadership from provincial and territorial governments is needed now more than ever to address this. Provincial and territorial governments can lead by example and commit to investing smartly in recovery-oriented housing. Governments that do so will be making fiscally responsible and morally right decisions with positive outcomes for their constituents and people with mental illness.

A Client-Centred Process

Overhauling such a significant portion of the mental health housing system will not be easy and many lives will be affected. It is crucial to be aware of how best to support residents of custodial housing during the transformation process. There are a number of considerations to ensure that the process of eliminating custodial housing is client-centred:

- Early and thorough planning: To avoid pitfalls during implementation, the transition process must be carefully laid out, and involve the participation of all stakeholder groups. These preconditions will provide opportunities to address key transition-related issues (e.g., how to accommodate residents who are resistant to moving, and the type of support needed during the transition process).
- Consumer input and good communication: Custodial housing reflects implicit assumptions about people with mental

Habitat Services and the Eglinton Project (Toronto, Ontario)

In 1987, Habitat Services (herein referred to as "Habitat") was established in response to the growing concerns about the living conditions in privately-run boarding homes in Toronto. In order to improve services and standards, the Habitat model, which uses a commercial contract between the non-profit agency and home owners to set and monitor standards, was developed. Habitat monitors services provided to tenants and administers a subsidy funding program for the homes under contract.

In its 25-year history, Habitat has progressively chipped away at the custodial housing approach by improving standards and implementing amendments to the contract that better reflect best practices (e.g., taking measures to ensure boarding home residents have tenancy rights under the *Residential Tenancy Act* and eliminating triple-occupancy bedrooms from its portfolio – Habitat now only adds single-bedroom units to its housing stock). The organization has also undertaken projects that are changing the DNA of its housing portfolio, such as the recovery-oriented pilot projects, Eglinton Project and Edmond Place (see the inset box on the next page).

Eglinton Project is a brand new 40-unit high support housing program created through a partnership between Habitat, Regeneration Community Services, the Centre for Addiction and Mental Health (CAMH), and a private sector landlord. The building consists of bachelor apartments with 24-hour support and uses best practices to support tenants to achieve optimal health and mental health stability, and to develop independent living skills. The program also promotes system flow-through by taking referrals of hospitalized Alternate Level of Care clients from CAMH and working with residents so that they can move on to housing with less support when they are ready.

illness, one of which is that they are unable to care for themselves or make their own decisions (Nelson et al., 2010). As we move away from custodial models, this attitude must be replaced by valuing consumer input and good communication with residents.

- Minimize the number of moves: Defunding custodial homes will mean many residents will be moving to new housing. Because moving is not an easy process for anyone, it is crucial to minimize the number of moves that residents undergo. Ideally, residents would go to their new housing directly from their custodial housing. This may not always be possible as funds from the custodial home may be redirected for the development of a new program, making the minimization of moves that people undergo critical to creating a smooth transition process.

Strategies for Replacing Custodial Housing Models with Best Practice Housing

Once a climate for change has been created, with the support of policymakers and funders, in partnership with community mental health agencies and housing providers, the winding down of custodial housing can occur. There are two key components that are necessary for this to be accomplished effectively: (1) changing existing funding models and (2) developing strong partnerships. Each component is explained below and is accompanied by examples of an innovative program that has effectively implemented the strategy.

If it's Broke, Fix it: Change Existing Funding Strategies

Existing funding strategies that are resistant to change, and which support housing that is outdated and unresponsive to tenants' needs, require revamping. The underlying critical factor is the way in which funding models and the attitudes of funders combine to produce funding decisions. For example, in some

Edmond Place
(Toronto, Ontario)

Given the history of the Edmond Place property, it seems fitting and just that it would eventually become a shining example of progressive housing change and a home for more than 30 people with mental illness. The Edmond Place building formerly served as one of Toronto's largest and most notorious rooming houses during the 1980s and 1990s. The rooming house contained 55 apartments with paper thin walls yet less than 10 bathrooms and was frequently in a deplorable state of repair (Balkissoon, 2010). In 1998, a fire gutted the building leaving only a derelict shell. Nine years after the fire, the city expropriated a privately owned property for social purposes for the first time and awarded Parkdale Activity-Recreation Centre (PARC) a long-term lease on the property. PARC and its members undertook extensive community engagement, and background and design work, and from the ashes of the rooming house, a phoenix – Edmond Place – was created.

Edmond Place opened in January 2011 and provides 29 permanent, affordable, self-contained apartments (20 studio and nine one-bedroom units) for people with mental illness. Habitat Services provides 31 subsidies to Edmond Place that contribute to operational costs and allow tenants to pay an affordable rent.

Neither the physical interior nor the support model is in any way reminiscent of the former rooming house as Edmond Place has adopted a recovery-oriented, best practice approach to providing support. For example, while Edmond Place offers a meal plan, tenants have the flexibility of participating in it or are supported in cooking for themselves if they so choose.

Edmond Place provides on-site housing support and 24/7 on-call emergency support to tenants using a peer support model. This approach has been shown to be effective in reducing the frequency of rehospitalizations and strengthening individuals' social networks (Trainor et al., 2012).

For more information, please see the program's website: www.edmondplace.ca/.

cases the funding of custodial programs is governed by provincial or municipal legislation or bylaws. The rules dictated by these funding arrangements may actually require the funding of custodial facilities, regardless of the wishes of the staff involved. A case in point is the Homes for Special Care Act in Ontario; its provisions require that homes be custodial. In the same province, Habitat Services uses a completely different approach. No legislation or bylaws are involved, instead a commercial contract between Habitat and the operator is used. This has allowed Habitat to be much more flexible in funding best practice housing. The Eglinton Project (see inset box on page 10) and Edmond Place (see inset box on the previous page) are examples of two projects that have benefitted from the flexibility of Habitat's commercial contract.

Formal mechanisms like contracts and legislation are one piece of the equation. The other is the attitudes of the staff doing the funding. In too many cases these staff see their role as funding custodial housing, rather than acting as rational investors and funding the best kinds of housing. Habitat Services and the Ontario Ministry of Health and Long-Term Care are two examples of staff groups moving forward as rational investors. Both have taken action to direct funds more wisely. In other provinces, such as Manitoba, a similar change is being considered.

Improving the mental health housing system also requires action and commitment on the parts of funders and policymakers. Taking stock of what is currently funded and identifying the outdated custodial models that need to be eliminated are the first steps. From there, methods for elimination must be examined. As this may include ceasing the funding of custodial housing models, a concrete course of action will have to be developed. Terminating funding of custodial housing models can occur through the non-renewal of licenses for homes. Funds can then be immediately redirected to new models that are aligned with best practices.

Wakamow Place (Moose Jaw, Saskatchewan)

A strong partnership between Moose Jaw Non-Profit Housing Corporation, Canada Mortgage and Housing Corporation, Saskatchewan Housing Corporation, City of Moose Jaw, Five Hills Health Region, Mental Health Resource Centre, Kinsmen Foundation, and Human Resources and Social Development Canada facilitated the move from a group home model to self-contained apartments. Funds were raised by selling the group home, pooling together three funding pots, and utilizing a wide range of funding programs to generate the resources needed to build the apartment building. By doing so, the partners were able to afford the costs of construction of the new facility ($1.7 million) while still capping tenants' monthly rents at $450.

Wakamow Place, which opened in 2006, offers 16 units with varying levels of care/independence. Tenants are able to transition from one level of care to another without losing the services they already have. Staff support tenants toward long-term recovery and independent living.

According to the Canada Mortgage and Housing Corporation (2011), "other Saskatchewan communities have taken note of the project's success, and are considering the Wakamow Place model as a way to meet their own affordable housing needs."

Changing some existing funding models will require the involvement of multiple parties, including but not limited to funders, policymakers, housing operators, community mental health providers, hospitals, and the private sector. Strong partnerships between these stakeholder groups can be critical to overcoming hurdles, making some projects feasible, and effecting change.

Partner with NGOs to Effectively Leverage Funds

Moving away from custodial housing models has proven to be a viable process. The fundamental challenge is that best practice housing can be more expensive than custodial

models in the short term. The creation of self-contained apartments and the provision of needed supports can raise costs and requires new funding strategies. However, there are methods for managing costs. In some cases, the most effective strategy is to leverage resources by creating partnerships.

Non-profit providers can contribute to partnerships in ways that private operators cannot. For example, partnering with a non-profit organization that is eligible for subsidized housing beds can make what was initially an unaffordable project into an affordable one. Strong partnerships can also make the pursuit of additional funding more successful. Housing projects can benefit from a partner's community connections and skilled staff members to increase the degree of viability.

An example of what is achievable through the development of partnerships comes from Moose Jaw, Saskatchewan, where eight organizations worked together to create an acclaimed best practice housing model, Wakamow Place. An innovative strategy to combine three funding pots allowed for the sale of a group home and the development of a supervised apartment living model to replace it. The model provides 16 safe, supported, and affordable apartments dedicated to persons with mental illness. It is described in more detail on the previous page.

Reallocating per diem funds after closing custodial housing facilities can help housing providers get over the financial hump. While per diem rates differ drastically across Canada (e.g., $28.00 in Manitoba; on average, $49.00 in Ontario; $75.50 in New Brunswick), the extra funds can be crucial for the involved parties to best provide the housing and supports that tenants want and need. The CAMH-SHIP High Support Housing Pilot Project is an example of funds that were previously used for custodial housing being reused for a recovery-oriented housing program for people with complex mental illness and high support needs. It is described in more detail to the right.

CAMH-SHIP High Support Housing Pilot Project (Brampton, Ontario)

In 2010, the Centre for Addiction and Mental Health (CAMH) partnered with an NGO, Supportive Housing in Peel (SHIP), on a multi-year pilot project focused on integrating persons with complex mental illness into the community. Using funding for 18 beds that were unassigned by the Ministry of Health and Long-Term Care (MOHLTC; but previously used by Homes for Special Care), the partners developed and implemented a non-custodial approach to housing with high supports. The project reflects an innovative approach to converting custodial housing stock to a best practice model of recovery-oriented housing.

The project was a product of progressive attitudes about best practice housing and supports at the MOHLTC. By redirecting its funding of a custodial home that had been closed, the partners (CAMH and SHIP) were able replace the 18 unassigned beds with 18 new beds. Without the resources that SHIP was able to bring to the table (e.g., a building, subsidized housing beds), the project would have been unachievable. The beds were partially filled by Alternate Level of Care CAMH clients (i.e., persons who had resided in hospital because there was no appropriate housing available).

While residents are not living in a scattered site housing model, which is often described as a characteristic of best practice housing, the building is made up of self-contained apartments and located in downtown Brampton. Clients have on-site support but also have the opportunity to develop and improve skills (e.g., cooking, laundry).

Partnerships between community mental health agencies and private housing operators can also result in other benefits for all involved parties. For example, the community mental health agency is able to assure the private housing provider that tenants will be supported in their homes and that the rents will be paid on time. In doing so, fears on the part of private housing providers about working with potentially challenging tenants, are relieved,

making the partnership fruitful. The community mental health agency obtains a new housing option for a number of its clients and is not burdened with maintaining the building(s). Finally, the clients benefit from the separation of housing and supports so that, should they wish to move, the supports are not bound to the home.

By working together, we can identify programs that do not work and eliminate them. This will require open-minded attitudes and, at times, some creative ideas. It will require changing funding models and creating new partnerships. It will require input and support from many stakeholders, including, but not limited to, funders, policymakers, housing operators, community mental health providers, hospitals, researchers, the private sector, persons living with mental illness, and family members. Together, we can create a better mental health housing system.

CONCLUSION

Custodial housing represents the limited thinking of an earlier era of mental health care. When Canada began the process of closing institutional beds in the mid-1950s, people with serious mental illness were seen as helpless and in need of structured care. The solution at that time was a new kind of community setting that preserved the basic features of the institution, and this meant paying private operators to take care of people. It did *not* mean investing in a wide range of supports and services designed to let people live their own lives in the community.

FACT: We can abolish custodial housing in Canada.

Things have now changed. Consumers want to live as full citizens, not as clients in institutional boarding homes, and governments can no longer afford to invest in a model that does not promote recovery and does not aim to move people forward in their lives.

We no longer need to ponder how the change to best practice housing models can be made. Projects already underway in Canada show that best practice models can be put in place for costs that are similar to, or less than, custodial care. In fact, hundreds of such projects now exist. The money we now invest in custodial care can be reinvested in best practice models, and we know how to do this.

The final and most difficult issue to address is why we are so late in fixing this situation. We need to pinch ourselves and ask: Why, in this day in age, do we tolerate a substandard approach that denies people the chance to live to their full potential? Why do we tolerate an approach that violates the UN Convention of the Rights of Persons with Disabilities? Why do we support a system reminiscent of the asylums of the 1950s?

We can stop this, and we can begin the process now.

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