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# Road to Recovery

**Client Experiences in Supportive Housing**

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Centre for Addiction and Mental Health  
Centre de toxicomanie et de santé mentale

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## Introduction

For people with severe mental illness, secure housing with supports is an important component of recovery. Not everyone with a mental illness experiences housing challenges or is in need of supportive housing, but for some individuals, particularly those leaving hospital after a long stay, specialized housing with supports can help them establish themselves and thrive in the community.

Over the last decade, research has demonstrated that many people with a mental illness face housing challenges. People with a severe mental illness are at increased risk of poverty and homelessness. According to the Mental Health Commission of Canada (MHCC), “as many as 520,700 people living with mental illness are inadequately housed in Canada and among them, as many as 119,800 are homeless” (MHCC, 2012). In addition, many people who are hospitalized due to severe mental illness face housing challenges at the point of discharge due to a lack of suitable housing options in the community. The term “alternate level of care” (ALC) is used to refer to clients who no longer need the acute care offered by a hospital but remain there due to a lack of appropriate housing options. These clients are unable to transition back into the community; meanwhile, access to psychiatric hospital care is impeded as these ALC clients occupy beds that would otherwise be available to people needing acute care. Supportive housing, then, is a critical component of the recovery of individuals with mental illness and is necessary for efficient flow within the mental health system.

## What is Supportive Housing?

“Supportive housing” refers to housing that provides supports linked to the units where people with mental illness live. Some programs offer permanent housing, while others offer transitional housing in which tenancy is limited to a set timeframe. Supports are available for varying amounts of time per day, and the types of support offered depend on the population the housing programs are serving (i.e. geriatric, addictions, or forensic clients), guiding principles, and funding levels. Leaving hospital after an extended period, some people with mental illness need support in maintaining life skills (i.e. management of finances, cooking) that may have diminished while in hospital. Others benefit from vocational, psychosocial, physical, mental health, peer, family, or other supports in the community. Case management, supportive counselling, and life skills support are among the most common supports available. In general, housing is considered “high-support” if it provides (HSHC, 2009):

- Recovery-oriented services such as supportive counseling, life skills training and social skills training, as well as client-centred care and individualized support;
- Support to complex clients;
- On-site staff trained in mental health;
- Short-term to long-term stay;
- Housing in a clustered setting;
- 24 hours of staff availability or slightly less.

A common feature of supportive housing programs is that they are designed to be rehabilitative in nature. Housing programs emphasizing rehabilitation were first widely developed in the 1970s, at a time when people with severe mental illness were increasingly living in the community as opposed to psychiatric institutions (Nelson, Aubry, and Hutchison, 2010). The development of supportive housing programs was part of a gradual shift away from the custodial models that were prevalent then and are still in use. “Custodial housing” typically refers to private boarding homes where rooms are usually shared, meals, laundry and housekeeping are provided and access to health or psychosocial supports is not coordinated (MHCC, 2012). This model is oriented towards compensating for clients’ perceived deficits, not their abilities, and encourages dependency (Nelson, 2010; CSRU, forthcoming). By contrast, supportive housing models are geared towards residents gaining independent living skills and integrating into their communities. In 2012, about a third of government-funded housing for people with mental illness in Ontario remains custodial rather than supportive (CSRU, forthcoming).

### Benefits of supportive housing

Evidence suggests that supportive housing programs provide several advantages to people with mental illness, including a reduction in hospital re-admissions, psychiatric symptoms, and substance use, as well as improved housing and financial stability, quality of life, and satisfaction with their living situation (Nelson, Aubry and Hutchison, 2010). Research and CAMH’s experience indicate that emphasis should be placed on people’s capabilities and not on their perceived deficits: “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 et al., 1997). Careful consideration of each consumer’s needs and the supports they require reduces the chance of hospital readmission and helps them re-establish themselves in the community; evidence suggests that “even the most disabled consumers can thrive in more independent housing if the right balance of supports is in place” (CAMH, 2002).

There is also a strong fiscal case for supportive housing. The cost of supportive housing programs across Canada varies significantly depending on the type and intensity of supports offered. A review of these costs shows a range from \$15 per day for a low-support housing program (Jacobs et al., 2008) to \$115 per day in a high-support program (Conference Board of Canada, 2010). Studies also show considerable range in costs of inpatient psychiatric beds depending on the type of care and province, but these costs are universally much higher: the MHCC estimates the cost of a psychiatric hospital bed at between \$330 and \$681 per day. In addition, the average cost of an ambulance ride is about \$700 and emergency room visits cost between \$200 and \$800. Individuals in supportive housing experience reductions in hospital admissions and emergency room visits.

### Challenges

There are about 10,000 supportive housing units in Ontario. Demand for these units is high, and wait times range from one to six years depending on the area (CMHA Ontario, 2008). In Toronto, the wait list for mental health and addictions housing providers currently exceeds 5,000 people for housing programs providing low or medium levels of support and 300 for those in need of high-support housing. These wait lists continue to grow while the creation of new supportive housing lags. While on wait lists, people with severe mental illness are left with inadequate levels of support, which can result in hospital re-admission, homelessness, or in some cases incarceration. Clients already in hospital and awaiting discharge routinely wait years – occasionally even decades – before suitable housing becomes available. At CAMH, as at Ontario’s other psychiatric hospitals, about 20% of clients are ALC; of those ALC clients, nearly half are waiting for high-support housing.

## Purpose of this project

Supportive housing is of great benefit to clients and the mental health and addictions system. Health outcomes improve for clients in supportive housing, and a strong system with an adequate supply of units and efficient flow also ensures that people in need can access acute care. There is an urgent need to create more supportive housing and to enhance flow into – and out of – the mental health and addictions system. But what kind of housing and supports do clients want?

In order to learn more about clients' perceptions of supportive housing and the transition from hospital to community, we spoke to 16 clients at four different supportive housing sites in Toronto (four per site) in March and April 2012. Clients who volunteered to be interviewed were given an honorarium and ten open-ended questions were asked over the course of about 30 minutes. A focus group was also held at each site, bringing together local site staff and CAMH discharge staff for a discussion of client transitions and the supportive housing system more broadly. In the following section we discuss client and staff feedback, without identifying clients or their sites.

The four supportive housing sites chosen for this project are all part of partnerships between CAMH and local agencies. They are:

- the Transitional Rehabilitation Housing Program, a collaboration between CAMH's Law and Mental Health program and the Canadian Mental Health Association Toronto;
- the Stepping Stone Project, a collaboration between CAMH's Geriatric program and LOFT Community Services;
- the program at 90 Shuter Street, a collaboration between CAMH's Schizophrenia program, Pilot Place, and Homes First;
- the program at 1011 Lansdowne, a collaboration between CAMH's Schizophrenia program and Madison Community Services.

These sites differ greatly in terms of the populations they serve as well as the types and intensity of supports they offer. This paper will not compare these models or delve into their differences; rather, we will focus directly on the experiences of people currently living in supportive housing after a hospital stay and, to a lesser extent, the staff who serve them.

## Client feedback

Evidence suggests that “consumers want to live independently in the community, with supports available on an as-needed basis” (CSRU, forthcoming). The literature is consistent on this point: when asked to define their preferred living situations, people with mental illness identify freedom, autonomy, permanent tenancy, security, and privacy as their main priorities (e.g. Tanzman, 1993; Noble & Douglas, 2004). Many indicate that they would prefer to live alone or with a loved one (as opposed to with other clients). They prefer outreach staff over live-in staff, and they would like supports to be available on an as-needed basis rather than one-size-fits-all approaches. These are the supports and conditions that are considered critical to recovery by people with mental illness.

Our interviews with clients largely confirm these research findings. Their feedback centres around a desire for security, an appreciation of autonomy and independence, and a focus on their capabilities.

### Benefits of supportive housing

#### *Improved recovery*

Many clients contrasted their current housing situation with a past experience of homelessness. The insecurity of homelessness is vividly captured in this comment by a client: “It’s much better here; you have a place to live. You don’t have to worry about half the stuff you would when you’re homeless... you have to look out for everything, you have to try to secure a bed every night, sometimes you get kicked out of places, you have to find a new bed every night and that’s kind of the hardest thing to do.” Another client mentioned that while homeless, finding shelter and sufficient food were constant challenges and he was often sick as a result. A client who has struggled with substance use issues adds: “That’s why I drank, so I could sleep on the hard ground,” but that with his housing situation taken care of, he has “kept up my end of staying away from alcohol and drugs.” In all these cases, the clients felt that secure housing gave them a chance to focus on physical and mental recovery. In fact, at all four housing sites, most participants stated that their physical and mental health has improved since moving into their new accommodations.

Housing staff note that secure housing provides clients with “an opportunity to rebuild.” Beyond rebuilding one’s physical and mental health, this can include the rebuilding of relationships. For example, many clients mentioned that they are now able to re-connect with family: “Now that I have my own place I’m more secure... I’ve even improved my relationships with family members ‘cause they can always get a hold of me.” It’s evident that recovery – in terms of both physical and mental health – is facilitated and supported by secure housing.

#### *Freedom and independence*

Some clients contrast their current living situation with their stay in hospital. These clients talked about the importance of mobility and the freedom to move about. They speak of simple pleasures like being able to go for a walk, see friends, do groceries, or order pizza whenever they like. Being able to engage in these activities independently is empowering and also a source of pride – proof that the person is on the road to independent living.

Participants also noted that because their housing situation is stable, they now have the freedom to set and act upon long-term personal goals. One client states that “here I can focus on my diagnosis, take the right medication that will help me get a job, be stable, go to school.” This desire to pursue education or employment goals was shared by many clients. Some participants stated that they were actively seeking to re-enter the work-force on a part-time basis with the help of staff at their housing site. Another noted that he now has the ability to pursue his goal of becoming a writer. He points out that although it has been a slow process, stable housing gives him the opportunity to focus on this and other objectives.

### *Access to needed supports*

Generally, clients speak positively of the supports they receive. When the topic of support was discussed, participants agreed that the level of support they are receiving now is much better matched to their level of need, and that the support they are receiving from in-house staff was helping along their recovery. As one client put it, “The support at the hospital is aimed at all levels of the disorder, and so it was way more than I needed. And the support here is closer to what a guy like me needs.”

Some clients expressed an appreciation for support with medication management. Others were particularly keen on receiving transportation supports, for example TTC metropasses, which help clients get to appointments, see friends and family, look for work or volunteering opportunities, etc. Staff at one site in particular agreed that this may be very important support to clients, but that funding issues can make it difficult to provide. Some clients also stated that income security and employment supports – for example, help navigating the ODSP system and re-entering the workforce – were important to them. One mentioned that “usually with paperwork I can do it by myself but at that time I needed a bit more help... so it was nice to have people helping because I was kind of overwhelmed.” Finally, clients also agreed that they enjoy having the option of participating in organized outings and having access to activities such as yoga – provided these activities are optional. Clients were clear on the matter of choice – they enjoy having access to supports on an as-needed, voluntary basis.

### *A step towards independent living*

The language used by clients suggests that many see their current housing situation as part of a transition towards fully independent living. Site staff have observed this as well: many clients see supportive housing as part of a pathway towards successfully living alone in permanent housing. Several stated that they would eventually like to live in regular housing and get a job or go to school. One articulated this concept by stating that: “I’d rather be here than in hospital. I’m not saying I want to spend my whole life here. I’m getting my life pretty much organized... In a few days I may buy a house even, you never know.”

Clients also appreciate supports that recognize and build on their capabilities. At the housing sites that allow tenants to cook, many of the participants described cooking for themselves as an experience that they enjoyed and in which they took great pride. One client stated that he was pleasantly surprised to learn that he could cook and take care of himself, and that this has aided his recovery: “I think overall my mental health has improved, and that’s because of being here and living on my own, now

proving that I always could live on my own.” Conversely, many clients who live at sites that don’t allow cooking mentioned a desire to do so.

Staff were supportive of this concept as well. At one site, staff referred to supportive housing as a springboard for clients who have never lived alone (or have not done so in a long time) – helping them learn or re-learn basic skills around the “activities of daily living.” At these sites, help with appointments, transportation, and food preparation (when requested) are envisioned as supports meant to “instill an independent mindset” in clients. In this context, the importance of making available recovery-oriented supports beyond basic mental health services – a basket of services that clients can access as needed – is evident.

### *Opportunities for socializing*

The literature suggests that clients generally want to live alone or with a loved one. On this issue, client feedback was mixed. Several clients expressed a belief in the benefits of being social: “Actually it’s really cool ‘cause sometimes when you don’t have anything to do or you don’t seem like you’re having a good day, you can always look toward one of the residents that enjoy living here to give you some company.” A client at the same site said that “if you were in an apartment you’d be scared a little bit. You’d be alone. I’m living with a roommate right now and I have him to talk to. I think it’s good with him around. It’s good to have a roommate.” Another client stated his belief that he is less sick because of the social contact he has at his housing site. As we’ll see below, other clients felt very differently about this issue.

### **Challenges with supportive housing**

This account has been very positive so far. This is not to say that all clients we spoke to are entirely pleased with their housing arrangements, or that every client feels that their housing situation has made them happier and healthier. Clients do face challenges, and from clients’ feedback about these challenges, we can learn a great deal about ways to improve the supportive housing system.

### *Rules and restrictions*

At one site in particular, most clients felt that their mobility was overly restricted. One client mentioned that she frequently wakes up early and would like to be able to take a shower or go for a walk, but the site’s policy is to only allow clients to get out of bed at a certain time. Along similar lines, and as mentioned above, clients at sites that don’t allow cooking were nearly unanimous in their disappointment with this. The ability to move about freely and to take care of oneself by cooking seems to be very important to clients. It should be noted that these types of restrictions are generally associated with custodial housing models and are not considered representative of best practices. (For a discussion of “best practices” in supportive housing, see Nelson, Aubry and Hutchison, 2010.)

### *Desire for privacy*

While many clients expressed appreciation for the social aspects of their housing site, some clients talked about the importance of privacy. Some who live in group settings mentioned that they would prefer to live alone, with one stating that “after living in an apartment all by myself... it’s terrible” to be sharing space with others. Another added that “the intrusiveness of the environment bothers me



a little bit.” Many clients stated that ideally they would like to live on their own, without roommates. It’s worth noting that at a site where clients each have their own private units but also have access to a common room with a television, video games, and other amenities, most clients expressed appreciation for their communal space. This suggests that balance is key – having one’s own private space but also the ability to socialize in a communal area may be the ideal situation for many clients.

### *Location problems*

Location is an ongoing challenge for one site. Clients and staff both agreed that substance use is pervasive in the neighbourhood and that there’s little to do in the area and not much in the way of amenities. It should be noted that for clients who mentioned this as an issue, even those who stated that they would prefer to live elsewhere felt that they were dealing with this challenge adequately with the help of other clients and staff. Transportation supports such as provision of subsidized transit passes could mitigate some of these issues.

### *Discrimination*

Finally, some clients and staff at two different sites noted that discrimination is a challenge – specifically, that neighbours sometimes make them feel unwanted. There is a sense that “NIMBYism” is sometimes a factor when supportive housing sites are established and that some people are not keen on having people with mental illness as neighbours. At a program located in a building that contains other types of housing, one client reports that some people “don’t like us being in the building,” with one neighbour in particular making it clear that she was unhappy sharing a building with clients.

On the whole, despite these challenges, clients report that supportive housing has improved their health and their quality of life. It has provided the stability they need to be able to pursue their goals. As one client declared, “CAMH is good at stabilizing you, then [the supportive housing provider] can do their thing... they’re equipped to find suitable accommodations for you... I’m incredibly grateful.”

## A supportive housing success story

Mike\* is 29 years old and the eldest of three siblings. His family immigrated to Canada when he was 7 years old. According to his mother, he was considered a good student and was generally well regarded by his peers and teachers. His behaviour changed abruptly after the untimely death of his father when Mike was 13 years old. He began to skip classes, using alcohol and marijuana, and dropped out of school. During this time, Mike had numerous admissions to hospital and was diagnosed with schizophrenia. After being asked to leave the family home because of his aggressive behaviour, Mike lived in shelters and on the street for the next few years until his arrest in 2007 on a charge of assault. He was found Not Criminally Responsible and admitted to the Law and Mental Health program at CAMH, and is currently under the supervision of the Ontario Review Board.

Mike spent three years as a CAMH inpatient. Significant risk factors throughout his hospital admission included lack of insight and non-compliance with medication. In 2010, he moved into a high-support housing unit created as part of a collaboration between CAMH and a local service provider. Mike shares a two-bedroom apartment with a co-resident. Staff report that Mike is social, helpful, and has created a sense of community with his co-residents. During his time in supportive housing Mike has reconnected with family members, who visit him regularly at his apartment, and he is now employed three days per week in a café. He reports that his housing situation gives him a safe space where he enjoys living and that his mental and physical health has greatly improved during his time there. He has not been re-admitted to hospital.

\* Not his real name.

## Policy recommendations

As we have seen, feedback from clients suggests that supportive housing is an important component of recovery for many individuals with severe mental illness who are transitioning to the community after a long hospital stay. This is consistent with evidence from the field. We also know that many individuals residing in psychiatric hospital beds do not need the acute care a hospital provides, and would benefit from a move to a more appropriate community setting. While these clients are in hospital, their recovery is suspended and they occupy beds that would otherwise go to individuals in need of acute care. Enhanced investment in supportive housing would have a positive impact at both the individual and system levels.

The following is a list of broad recommendations that flow from evidence in the field and the experience of clients and clinicians.

### **There is a need to create additional supportive housing and expand the types of supports that are available.**

An increase in supportive housing stock is needed. In 2006, the Senate report “Out of the Shadows At Last” recommended 50,000 new supportive housing units across the country within the next 10 years; more recently the Mental Health Commission of Canada recommended 100,000 units over 10 years as “the minimum of what is required” (MHCC, 2012). The exact number of units needed in Ontario is unknown, but the fact that 5,000 people are on the wait list for the Greater Toronto Area alone suggests that more is certainly needed.

A continuum of supportive housing should be developed. Clients vary in their needs, capabilities, and goals. Accordingly, the range of available supports should be flexible. High-support housing is particularly important, given the need to ease transitions for ALC clients from hospital to community. As part of their recovery, clients may also need lower levels of support over time, so the investments in high-support housing should be accompanied by investments in low- and medium-support housing. There is a need for both transitional housing and permanent housing. Clients’ needs should be re-assessed regularly, and transitions within the housing system should be supported. Housing that is dedicated to clients with justice system involvement is also needed.

A range of recovery-oriented supports should be available to people with mental illness. As we have seen, clients want supports that go beyond traditional mental health services. As stated by the MHCC (2012), “housing is more than bricks and mortar. Recovery-oriented supports are integral to people living with mental illness.... People living with mental illness value supports differently and identify the critical importance of factors beyond mental health services, such as help from peers, and help with employment, income, and education.” Services should match needs. This is also in keeping with the province’s Mental Health & Addictions Strategy, which notes the importance of “the right care at the right time in the right place.” In our discussions with supportive housing staff, they referred to this as “meeting clients where they’re at.”

### **There is a need for more flexibility and flow in the system as a whole.**

More flexible housing models should be piloted. An emphasis on “supported housing,” which de-links supports from the actual housing, would be a step in the right direction. In this scenario, individualized discharge plans allocate flexible funding that follows individuals as they transition from hospital to community and from high levels of support to lower (MHCC, 2012). This would ensure that service matches needs.

ALC clients on supportive housing wait lists should be prioritized. ALC clients tend to be more complex: most are experiencing serious mental illness and many also have a dual diagnosis and/or co-occurring medical conditions. Some may also have a history of risky behaviour and / or criminal justice history. With the right supports, these clients can successfully live in the community. There should be an emphasis on creating housing capacity for these marginalized clients. This would aid their recovery and also free beds for people in need of acute care.

Ensure better coordination and integration in the system. There should be better integrated policies, regulations, and information sharing between hospitals and housing providers. Partnerships between organizations should be better defined. Strategies for enhanced system coordination are described in the provincial Mental Health and Addictions Strategy (MOHLTC, 2011), the Mental Health Commission of Canada’s “Turning the Key” report (MHCC, 2012), and the Mental Health & Addictions Alternate Level of Care Advisory Committee’s “Smoothing the Path” report (MHAALCAC, 2011) among others.

## **Conclusion**

Secure housing with supports is an essential part of the recovery process for many people with mental illness. Supportive housing that focuses on capabilities, not deficits, and is tailored to the client, can ease the transition from hospital to community. Clients interviewed for this paper indicated that supportive housing has improved their health and their quality of life while providing the stability they need to be able to pursue their goals. As one client put it, “The general progress of my mental health going through the hospital and through the housing has made me more socially healthy...and healthier and happier and more outgoing.... I’m a success story.”

We also know that supportive housing is cost-effective and that a supportive housing system with an adequate supply of units and efficient flow would enhance access to mental health treatment through a reduction in ALC-designated clients. With wait lists for supportive housing growing, there is an urgent need for more supportive housing to be created in Ontario. We urge all levels of government to consider this issue.

## Principal Authors

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