This report is one of seven mental health best practices reports. The reports reflect the efforts of 44 industry representatives who formed the best practices working groups. Following literature reviews and consultation, they documented what they collectively recognized as services and strategies that produce positive health outcomes for individuals.

The Ministry of Health is grateful for the expertise and diligence these mental health consumers, family members and service providers brought to the work.

The reports on Best Practices for B.C.’s Mental Health Reform are:

- Housing
- Assertive Community Treatment
- Crisis Response/Emergency Services
- Inpatient/Outpatient Services
- Consumer Involvement and Initiatives
- Family Support and Involvement
- Psychosocial Rehabilitation and Recovery
B.C.'s MENTAL HEALTH REFORM
BEST PRACTICES FOR
HOUSING

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Important note

The principles of psychosocial rehabilitation form the philosophical foundation for all best practices in mental health. These principles emphasize both consumer involvement in developing and realizing personal care and life goals and treatment and supports that help consumers manage their symptoms and build on their strengths.

The principles of psychosocial rehabilitation are included in Appendix A of this report.
EXECUTIVE SUMMARY

The Review of Best Practices in Mental Health Reform provides the framework for this report.

As indicated in the Review of Best Practices, there has been a renewed interest in housing, resulting from the increased focus on consumer involvement and an increased emphasis on community-based services. Service providers, mental health agencies, family organizations and consumers have all indicated that housing must be given priority and viewed as a basic need. This has been substantiated by studies that identify housing as a determinant of health. A growing population of homeless individuals and the growing unavailability of affordable housing (resulting from the loss in 1993 of federal funding for social housing) has given increased impetus to this drive for housing.

A basic assumption of this report on best practices in housing is that housing is both a fundamental right and a critical determinant of a person’s health. Individuals with a serious and persistent mental illness who are unable to access appropriate, safe, affordable and secure housing will have a significantly reduced quality of life and an increased need for and reliance on emergency, support and treatment services. The lack of adequate housing directly results in increased costs within both mental health and the broader health sector, and increased service utilization places a strain on already stretched mental health resources. Studies both within our own mental health housing and from other jurisdictions, as well as the anecdotal stories of individuals who receive housing services, make it clear that housing greatly increases an individual’s ability to manage their illness, their stability and their general quality of life.

If we are to respond to this housing need, we must avoid the debate as to whether responsibility lies with the Ministry of Health or the Ministry of Social Development and Economic Security. These ministries, including municipal and federal governments, must increasingly work collaboratively and cooperatively to ensure that appropriate, affordable, safe and secure housing is made available. Funding sources are somewhat irrelevant to an individual with inadequate housing. It may also be essential for government to look at the limitations on acquiring market housing that have been created by inadequate shelter payments under the BC Benefits program. In essence, significant service needs are created and subsequent services must be provided to assist consumers in dealing with problems created by social policy decisions. Decisions about housing development should not be driven by financial assumptions.

This report draws heavily on the work presented in the Review of Best Practices. We also take the position that the strongest emphasis in any mental health housing program must be on supported housing: affordable, secure independent housing in the community that provides a consumer with access to associated support services as requested. This style of
housing not only fits the expressed preference of consumers, but also has been shown to meet both individual and system needs for increased stability and decreased reliance on other services.

In the past, consumers would move through a continuum of housing options, generally from residential to supported housing. More recently, it has been recognized that this model often has resulted in consumers being placed in settings that were more restrictive than necessary. Rather than create disruptions for consumers as moves are made through the continuum, a menu approach is supported in which consumers select the preferred alternative. It is also very difficult for smaller communities to have the critical mass or the economic resources to develop and deliver a continuum of housing options.

These concerns about disruption and restrictiveness resulted in the suggestion, especially from academics, that supported housing should be the sole approach to housing services for mental health consumers. However, this report reflects the view that while supported housing should be the priority of any mental health housing program, there is a continuing need to offer a range of options. We believe there are consumers who require a highly intensive, short-term program offered within a residential setting; and a smaller group who may require these services for the long term. We do believe, over time, as supported housing becomes available as a first choice, the level of need for a residential housing component will decrease.

As noted above, the underlying assumption of this report is that supported housing should always be the housing option of first choice. Only if a consumer does not have the necessary skills to live in this model or expresses a desire to learn skills in a group setting, should residential housing be considered. There must also be an emphasis on viewing residential services as a flow through option that assists consumers in moving to supported housing options.

The issue of homelessness is specifically identified within the Review of Best Practices. This report takes the view that homelessness is a reflection of the lack of affordable and/or appropriate housing and an associated lack of appropriate services. Individuals who find themselves homeless are often those who have a broad range of needs and who find it difficult to access and retain either market accommodation or mental health housing. While this report includes emergency housing options to address the immediate needs of this population, their needs must also be addressed by providing adequate, affordable housing and assertive case management services, as well as ensuring that supported and residential options are designed to provide flexible and individualized services to consumers with high levels of need.

It is also essential for both supported and residential housing programs to ensure that they serve consumers who have significant and unique needs. All too often, these individuals become homeless because housing services are not able to deliver programs in a way that accommodates their special needs. We have included in the report a summary of some of the special populations and their unique housing needs. Because of restraints on time and
resources in the preparation of this initial report, the issues for these populations are
merely highlighted and will require further investigation.

There is strong emphasis in the report on the psychosocial rehabilitation principles and the
recovery model as critical underpinnings to the delivery of housing services (see Appendix
A). The principles of consumer involvement, choice and self-determination and a strong
belief in the need to de-emphasize illness and instill hope by helping consumers manage
their symptoms and build on strengths, underlie all housing options. If we are to shift to a
psychosocial rehabilitation and recovery model, it will be essential to provide staff training
related to the skills and techniques required to put these principles into operation. It is also
essential to ensure involvement of consumers and families in planning, developing and
evaluating services.

The authors of the report recognize the important differences between the rural and urban
experience in housing development. Where possible, we have attempted to acknowledge
the constraints—such as the lack of a critical mass, difficulty in hiring part-time staff and
the lack of 24-hour support—that may occur in a rural environment, in which there may
not be the capability to develop a full range of housing options. It is important to
understand that, while we have described the housing components as though they are
freestanding, they may in fact be co-located in the same site.

An underlying assumption of the report is that all housing should be developed with a
view to providing accessibility for individuals with physical impairments (mobility, sight or
hearing) and should incorporate design features that maximize the potential for aging in
place.

This report attempts to set out definitions for housing services that will form the basis of a
consistent and standardized terminology across all health authorities. This will reduce
confusion and ensure that we can communicate more efficiently about planning and
development. We would also recommend that all regions review any housing terminology
currently in use and ensure that it is respectful and acceptable to consumers.

The committee hoped to provide examples of best practices in this initial report and,
indeed, made substantial efforts to collect information on existing programs. However,
given the constraints on time and resources, it was not possible for the available
information to be sufficiently representative, nor was the evaluation process adequate to
ensure an appropriate selection process. The committee decided to err on the side of
cautions and exclude actual examples from the report. However, we strongly recommend
that, within the second phase of the best practices review and linked to a focus on
evaluation, adequate time and resources be made available to allow for an objective review
of programs for possible inclusion.
While we view this report as introductory, we hope it will provide basic guidelines and operating principles for health authorities as they look to develop or re-develop their housing programs. We look forward to having the opportunity to build on this work in future reports.
1. HOUSING SERVICES

This section identifies the mission, beliefs and values, outcomes, and process goals for all mental health housing. Broadly defined housing categories include supported, residential and emergency housing.

1.1 Mission

Housing services provide a range of housing options, enabling adults with serious and persistent mental illness to reside in a safe, secure living environment that is conducive to the achievement of their personal goals.

1.2 Beliefs and values

- Clear communication among all stakeholders
- Timeliness of service delivery
- Collaborative relationship between consumer and staff
- Consumer control over decisions affecting their lives
- Availability of alternatives
- Flexibility of service over time
- Holistic approach to service planning
- Realization of individual potential
- Integration with community
- System performance measurement
- Continuous quality improvement
- Evidence-based practice
- Inclusiveness of all populations

1.3 Outcome goals

- Consumer’s living arrangement is stable in accordance with program criteria
- Consumer is safe in home environment
- Consumer achieves personal goals or receives relevant/desired support services
1.4 Process goals

- **Service accessibility**—Services will be streamlined, well communicated and understandable, enabling eligible consumers to access the appropriate housing service(s) in a timely manner.

- **Consumer involvement**—Consumers and their significant others will have the opportunity to participate actively in planning, designing, delivery and evaluation of the services they receive, both at the individual and at the program level.

- **Individualized service**—Service plans will be tailored to meet individual needs over time; inherent in this is the desirability of having a range of service options from which to choose.

- **Recovery focus**—Consumers will be supported in addressing any and all aspects of their lives which they identify as facilitating a realization of their full potential.

- **Service accountability**—The service will monitor utilization and the outcome and process goals, and use the information generated, together with current research, to inform decision making.

1.5 Housing categories

- Supported
- Residential
- Emergency
2. SUPPORTED HOUSING

2.1 Mission
Supported housing ensures the provision of affordable accommodation and the availability of a range of supported services on an as-needed basis, enabling consumers who are able to live independently to maintain their living arrangements.

2.2 Outcome goals
Consumer retains independent living arrangements by acquiring/maintaining:
- personal confidence
- social supports
- skills for daily living.

2.3 Types

Supported apartments
Rent subsidized either through BC Housing or Ministry of Health (Supported Independent Living Program).

- **Block apartments**
  - all apartments in the building occupied by a person with a mental illness (usually sponsored by a non-profit society)
  - either on-site or outreach support available
  - governed by *Residential Tenancy Act*

- **Satellite apartments/mobile homes**
  - apartments leased in private market or owned non-profit buildings/leased mobile homes
  - outreach service provided
  - governed by *Residential Tenancy Act*

- **Congregate housing**
  - self-contained smaller suites in a building designated for persons with a mental illness
  - communal food services provided on site (one meal a day minimum)
- outreach support services available
- governed by Residential Tenancy Act

Group homes
- unlicensed
- tenants share a communal home and participate in shared living arrangements and activities
- rent subsidized or rent shared
- outreach support provided

Supported hotels
- single room occupancy (SRO) hotels, leased or owned and managed by non-profit society
- on site staff support up to 24 hours per day

2.4 Access
An eligible consumer desires to live independently and is assessed as able to live safely with supports.

Consumers are first assessed as suitable or unsuitable for some form of supported housing. Only if this is unsafe or unavailable would residential housing or other options be considered.

Clinical staff need to articulate clearly the safety issue that would exclude an individual from supported housing. Elements of safety include stability of symptoms, behaviors, medications, knowing when to call for assistance, etc.

2.5 Functions
Support services are provided by staff of contracted agencies and/or directly by health authorities. These support services include food/meals, personal care, home management, leisure/recreation/socialization, medication support, crisis management, case coordination and budget management.

Consumers identify the nature and level of support services they require, on an as-needed basis. Support workers link with the consumer in their own home or in other community settings.
### 2.6 Associated standards and strategies

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<th>GOALS</th>
<th>STANDARDS</th>
<th>STRATEGY</th>
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<tr>
<td>SERVICE ACCESSIBILITY</td>
<td>Consumers and family have ready access to written information on housing and access, including application and appeal procedures.</td>
<td>Brochures and other informational tools describing housing programs, access criteria and procedures are available for consumers, families and service providers. Brochures and other informational tools are easily accessible in locations frequented by mental health consumers.</td>
</tr>
<tr>
<td></td>
<td>Application procedures are standardized and simple.</td>
<td>Basic application process is the same for all regions. Intake involves as few steps as possible. Intake is centralized where possible, given geographic considerations.</td>
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<tr>
<td></td>
<td>Organized, systematic waitlists are maintained and regularly updated.</td>
<td>Waitlists are maintained which are organized, systematic, regularly updated. Waitlists are chronological, but provide for priority placement of consumers from acute treatment settings.</td>
</tr>
<tr>
<td>CONSUMER INVOLVEMENT</td>
<td>General standards for wait times are established and adhered to.</td>
<td>Placement of consumers should occur within one month.</td>
</tr>
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<td></td>
<td>Wait list information is shared by region.</td>
<td>Wait lists are shared between regions, ideally through a common data bank.</td>
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<td>Consumers have access to housing across regional boundaries.</td>
<td>Resource allocation model is developed that permits cross regional access.</td>
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<td>Consumers/family/staff participate in program planning, design and evaluation.</td>
<td>Forums, committees, surveys are used to support and encourage consumer and family participation in program planning, design and evaluation. A public housing plan identifies future development and reflects input of families and consumers and is updated annually.</td>
</tr>
<tr>
<td></td>
<td>Consumers participate in the development of programs and services.</td>
<td>Consumers are active participants in joint staff/consumer meetings.</td>
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<td>Peer support services are promoted.</td>
<td>Opportunities for peer support services are made available.</td>
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<td></td>
<td>Consumers have control over the decisions which affect them and the ability to make choices related to services.</td>
<td>Consumers determine the level and nature of support services from a clearly identified list of services. This choice will not interfere with access to housing.</td>
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<td>Personal preferences are accommodated.</td>
<td>Consumers are involved in goal setting and decision making regarding services.</td>
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<td></td>
<td>Personal freedom is maximized.</td>
<td>Limited rules and restrictions.</td>
</tr>
<tr>
<td></td>
<td>Personal preferences accommodated.</td>
<td>Consumers are able to select preferred housing option.</td>
</tr>
<tr>
<td>INDIVIDUALIZED SERVICE</td>
<td>Programs recognize the cultural diversity of the population.</td>
<td>Consumers have access to services in their own language and accommodations are made to meet religious/cultural requirements.</td>
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<td></td>
<td>Staff and consumer develop a partnership to work toward consumer identified goals.</td>
<td>Consumer goal setting is a partnership process between staff and consumer.</td>
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<td>Individualized goal plans are based on individual needs and wants and are reviewed by a mental health professional and the consumer on a regular basis.</td>
<td>Regular reviews occur to modify and assess the individual goal plans.</td>
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<td></td>
<td>Services are offered for the span of time necessary to benefit the consumer</td>
<td>Consumers are not required to leave the program unless suitable accommodation and support services are available. The only exception would be risk to self or others which cannot be addressed with added supports.</td>
</tr>
<tr>
<td></td>
<td>Programs are flexible.</td>
<td>Programs are adapted and modified to the needs of the consumer.</td>
</tr>
<tr>
<td>RECOVERY FOCUS</td>
<td>Housing alternatives reflect the general community/neighborhood norms and are consistent with housing in the community; are in a convenient, safe and accessible location.</td>
<td>Housing is set within residential style home or apartment. Residential options do not accommodate more than 10 consumers and family care does not accommodate more than two consumers.</td>
</tr>
<tr>
<td></td>
<td>Programs and services are delivered within a psychosocial rehabilitation approach.</td>
<td>Psychosocial rehabilitation principles (Appendix A) are clearly adhered to in the delivery of services, especially an emphasis on consumer choice and self-determination.</td>
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<td></td>
<td>Emphasis is on community integration and bridging.</td>
<td>Consumers are encouraged and supported in using community rehabilitation, education, social and recreational programs.</td>
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<tr>
<td>GOALS</td>
<td>STANDARDS</td>
<td>STRATEGY</td>
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<tr>
<td>RECOVERY FOCUS continued</td>
<td>Focus is on learning basic living skills.</td>
<td>Programs emphasize consumer participation in and/or consumer-directed management of medication administration and household management, e.g., meal preparation, cleaning, laundry.</td>
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<tr>
<td></td>
<td>Staff support consumers in finding purpose and meaning in their lives, de-emphasize illness and instill hope by helping consumers manage their symptoms and build on strengths.</td>
<td>Individual planning highlights strengths.</td>
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<td>Consumer involvement with natural supports is promoted, e.g., family, friends.</td>
<td>Family and friends are actively involved where appropriate.</td>
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<td>Program uses an individualized definition of recovery based on consumer expectations.</td>
<td>Individualized goal setting tools are utilized.</td>
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<td></td>
<td>Program has good communication links and working relationships with other support networks.</td>
<td>There is clear evidence of linkages with other services and support networks through regular meetings and telephone contacts.</td>
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<tr>
<td></td>
<td>Staff have a genuine concern for the well-being of consumers, are respectful and committed to psychosocial rehabilitation principles and the recovery model.</td>
<td>Staff are educated in the principles of psychosocial rehabilitation and recovery model.</td>
</tr>
<tr>
<td>SERVICE ACCOUNTABILITY</td>
<td>Programs have a performance monitoring mechanism that includes meaningful feedback from consumers and families.</td>
<td>Consumer and family satisfaction surveys are routinely used to elicit feedback.</td>
</tr>
<tr>
<td></td>
<td>Individual goals are audited to ensure that these are genuine challenges/needs of the consumer and they are documented and tracked.</td>
<td>A tracking and monitoring system is established to regularly review progress toward individual goals and records are maintained of progress.</td>
</tr>
<tr>
<td></td>
<td>The program has a quality improvement process that monitors service delivery, documents shortcomings and initiates remedies.</td>
<td>The program has a clearly identified individual responsible for quality improvement. There is written evidence of deficiencies and remedial activities. Each residence is reviewed regularly by an external team (which might include a consumer, family member, provider and mental health staff).</td>
</tr>
<tr>
<td></td>
<td>The program is accountable for meeting service outcome and process goals and communicates this information to consumers, families and funders.</td>
<td>There is a public communication process which objectively identifies goal attainment for families, consumers and funders.</td>
</tr>
<tr>
<td></td>
<td>There are clearly articulated complaint management and appeal procedures.</td>
<td>Complaint and appeal procedures are readily accessible and well communicated to families and consumers.</td>
</tr>
<tr>
<td></td>
<td>The program uses research findings to improve services.</td>
<td>Research is routinely reviewed and used to make changes to services.</td>
</tr>
<tr>
<td></td>
<td>The program collects information related to population served and utilization.</td>
<td>Programs must report utilization at least annually to be aggregated by the health authority and forwarded to the Ministry of Health for inclusion in an annual housing report.</td>
</tr>
</tbody>
</table>

2.7 Review of current literature

Research shows that programs have the best outcomes when they help consumers to "choose, get, and keep" stable, non-segregated, decent housing and, in tandem, are encouraged to determine the level of support they will receive to support their living arrangements (Blanch and Carling, 1988). Consumer choice is associated with emotional well-being, residential stability and housing satisfaction (Best Practices in Mental Health Reform, 1997).
In general, research into housing models, or elements of housing models that produce the best outcomes, is still in its beginning phase. However, emerging evidence and the results of well controlled studies suggest that best practices in housing for people with a serious and persistent mental illness will be found in the supported housing category (Nelson et al.; Brown et al., 1991; Dixon et al.; Champney and Dzurec, 1992; Hurlburt et al, 1996). The favorable outcomes associated with supported independent living (Nelson, et al, in press) are:

- reductions in hospitalization rates (Brown et al, 1991; Burek et al, 1996)
- reduction in symptoms (Dixon et al, 1994)
- increased consumer satisfaction (Champney and Dzurec, 1992)
- increased independence, empowerment and gains in role achievement (Boydell and Everett, 1992; Nelson, Hall, and Walsh-Bowers, 1995; Nelson et al, 1997; Newman et al, 1994; Ridgway and Rapp, 1997)
- community integration (Aubrey and Myner, 1996; Boydell and Everett, 1992; Ridgway and Zipple, 1990a, 1990b).

The outcomes of improved resident satisfaction and housing stability in supported housing correlated with access to housing subsidies (Champney and Dzurec, 1992; Hurlburt et al, 1996; Newman et al, 1994; Nelson et al, in press) and consumer choice and control (Newman et al, 1994). The availability of subsidies, and the exercise of choice and control, allow consumers access to better quality and more satisfactory housing, thus resulting in a higher likelihood of longer tenure and greater satisfaction.

The risk of social isolation has been identified as one shortcoming of the supported housing approach (Champney and Dzurec, 1992; Depp et al, 1986; Friedrich, et al, 1999). Consumers have identified loneliness as the single most problematic issue in living independently; one that can, in some cases, result in a return to hospital or residential service. It is essential that services in supported housing have a significant focus on reducing social isolation through such options as shared activity groups or communal kitchens.

The level and type of support is a vital element in supported housing models and outcomes may not be obtainable without a proper level of support. Review of Best Practices for Mental Health Reform (1997) notes that, if all the components necessary to enable consumers to integrate into the community are not made available or are underfunded, supported housing arrangements are likely “...to turn into another version of the custodial living arrangements of the past.”

Nelson, et al, (in press) define supported housing not by the form of the housing, but by the nature of the support. In the supported housing model, support is person-centered, “…emphasizing self-help and natural supports and de-emphasizing professional services.
With the use of this approach, individuals can become settled and comfortable in their homes, which they choose, and supportive relationships assist them to participate in their communities and access resources they desire." (Nelson et al, in press) The supported housing model de-links services from the building and links them to the consumers according to their needs and wishes.

Ridgway and Zipple describe the concept of supported housing as a paradigm shift where the primary role of the service recipient changes from patient or client to “…community member, tenant, householder, or even home owner.” and where “normal role demands become the focus for support and skills training, and the expectation for typical behavior and normal functioning are reinforced by the (normative) environment….” (Ridgway and Zipple, 1990)

Research on consumer housing preferences shows a high preference, or perception of need, for the elements listed below. Therefore, these elements should be incorporated in policy and planning for housing development to ensure a best practices orientation:
- freedom to choose the place of residence (Blanch and Carling, 1988; Carling, 1993; Ridgway and Zipple, 1990; Tanzman, 1993)
- having their own house or apartment, in a typical residential setting (Blanch and Carling, 1988; Carling, 1993; Owen, et al, 1996)
- stable (permanent) housing (Blanch and Carling, 1988; Carling, 1993; Nelson, et al, in press; Ridgway and Zipple, 1990; Tanzman, 1993)
- living alone or with a romantic partner (Tanzman, 1993)
- outreach staff available on call to support them in their living situation (Carling, 1993; Nelson, et al, Tanzman, 1993)
- freedom to determine the nature and amount of support they will receive (Carling, 1993)
- freedom to make independent treatment and lifestyle choices (Carling, 1993)
- material supports, such as telephone, rent subsidies and transportation assistance (Tanzman, 1993).

As noted earlier, consumer choice can be realized only to the extent that the resources consumers choose are available. The literature suggests that mental health service providers need to include in their mental health program a focus on exploration of partnerships, rent supplement options or other financial arrangements aimed at assisting consumers to access housing in their community (Carling, 1993; Nelson, in press; Ridgway and Zipple, 1990; Tanzman, 1993).
For consumers living in integrated community settings, the nature and amount of support available to them is key to achieving positive outcomes. The following evidence points to best practices for achieving the desired outcomes for consumers, listed earlier:

- access to Assertive Community Treatment or Intensive Case Management reduces time in hospital, visits to hospital and risk of homelessness and increases housing stability (Klinkenberg et al, 1997; Lehman et al, 1997; Mueser et al, 1998)
- *in vivo* support is superior to support provided away from consumers' homes or other environments where they enact their social roles (Carling, 1993; La Chance, et al, 1995)
- flexible, individualized support available 24 hours a day, 365 days a year (Carling, 1993; La Chance et al, 1995)
- support aimed at fostering the personal empowerment and community integration of consumers (Carling, 1993; Nelson, in press)
- support de-linked from housing: consumers will not lose their home because they refuse or no longer require support services (Ridgway and Zipple, 1990; Nelson, in press)
- inclusion of consumers and family members as staff in the outreach teams (Besio and Mahler, 1993; Dixon, et al, 1998).

The location of supported housing is important. It should be:

- non-segregated—that is, located in ordinary residential areas and widely dispersed in the community, rather than congregated (Carling, 1993; Nelson et al, in press)
- close to community resources and transportation to facilitate the social and vocational goals of consumers (Carling, 1993; Nelson et al, in press)
- close to friends and family to counteract the potential of isolation and facilitate the building of informal support networks (Carling, 1993; Nelson et al, in press).

In a recent comprehensive literature review, Nelson et al. (in press) conclude that the supported housing model best fulfills consumer preferences and achieves the most beneficial outcomes. The reviewers emphasize the importance of using a common definition of supported housing to facilitate ongoing research into this emerging model (Nelson, in press).

### 2.8 Implementation

**Development issues**

Supported housing services can be provided through rent subsidy programs which allow consumers to acquire available market housing. These are the programs often referred to as Supported Independent Living (SIL) or a more intensively supported version known as Super SIL. This housing allows the consumer choice in the selection of an apartment to
which the rent subsidy can then be applied. There is also portability of subsidies to new accommodation within the funding health region.

The second method of providing supported housing services is through an actual increase in the supply of housing through construction of new units. These units are then subsidized through BC Housing. These projects may involve the construction of an apartment, congregate model or hotel that serves only mental health consumers or may be a mixed development serving a broader range of individuals in need of affordable housing. There is increasing emphasis on seeking some balance between mixed developments and developments solely for mental health consumers to ensure a range of choice in housing options and to avoid the potential for ghettoizing consumers.

Given the constraints on the number of new social housing units available specifically to mental health through the Homes BC program, it is essential to partner with non-profit agencies that may receive family, seniors or low income urban singles allocations to increase the potential for access to mental health consumers to these units. This partnering can take the form of providing funding for support staff in exchange for access to a predetermined number of units.

It is important to increase the supply of housing through new construction and access to existing housing through subsidies. It is also important to note that BC Housing is now involved in congregate housing developments and Single Room Occupancy (SRO) hotel acquisitions.

Supported housing can be constructed in any appropriately zoned neighborhood and does not require a public process.

Costing models

The cost to deliver services within supported housing can be quite variable, depending on whether a rent subsidy is required. However, based on a staffing standard that differentiates between regular support and intensive support services, the following average costings have been calculated for supported housing, with a rent subsidy and without. More detailed calculations are provided in Appendix E.

Rent-subsidized apartments

<table>
<thead>
<tr>
<th></th>
<th>BASIC SUPPORT</th>
<th>INTENSIVE SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average cost per consumer per day</td>
<td>1 staff : 16 consumers $21.92</td>
<td>1 staff : 5 consumers $39.76</td>
</tr>
</tbody>
</table>

Non-rent-subsidized apartments

<table>
<thead>
<tr>
<th></th>
<th>BASIC SUPPORT</th>
<th>INTENSIVE SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average cost per consumer per day</td>
<td>1 staff : 15 consumers $9.59</td>
<td>1 staff : 5 consumers $27.45</td>
</tr>
<tr>
<td>Congregate model</td>
<td></td>
<td></td>
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<tr>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BASIC SUPPORT</strong></td>
<td><strong>INTENSIVE SUPPORT</strong></td>
<td></td>
</tr>
<tr>
<td>Average cost per consumer per day</td>
<td>1 staff : 15 consumers</td>
<td>1 staff : 5 consumers</td>
</tr>
<tr>
<td></td>
<td>$37.01</td>
<td>$56.58</td>
</tr>
</tbody>
</table>

2.9 Systemic barriers and recommendations

Inadequate BC Benefits shelter payments
A significant number of consumers of mental health services receive BC Benefits. A recent survey of adult clients by Greater Vancouver Mental Health Service Society identified 65 per cent of their 3,500 adult clients as receiving BC Benefits, which provides only $325 per month for shelter. This payment level does not meet rental costs in most cities and forces consumers into inadequate, unsafe housing, often in SRO hotels. This has a significant negative impact on consumers' ability to deal with their illness and increases utilization of other costly services in both community and hospital sectors. A recent study by the Mental Patients Association found hospital stays and utilization of short stay crisis options were significantly reduced for individuals in Supported Independent Living (SIL) programs. The study of 40 consumers over a six-year period, during which consumers spent an average of four years in the SIL program, found hospital utilization was reduced by 80 per cent after individuals entered the SIL program.

**Recommendation**
1. Introduce a shelter subsidy for individuals with a serious and persistent mental illness to allow them access to market housing. This program would be a subsidy similar to the Shelter Aid For Elderly Renters (SAFER) program now in place for low-income seniors.

Portability of rent subsidies
Consumers who are in a supported housing program are unable to transfer their rent subsidy and support service to another health region. This significantly affects the ability of consumers to make choices about where they wish to live. This restriction is not in keeping with the underlying principles of consumer choice, flexible and individualized approaches to program delivery and rehabilitation. The problem is that health authorities are unwilling to transfer subsidies because this would mean a loss of future access by consumers in their region. Given that the support services are delivered by a non-profit organization in most cases, and one staff provides support for a number of consumers, it is virtually impossible to remove the funding for support on an individual basis without threatening the fiscal integrity of the organization.
is virtually impossible to remove the funding for support on an individual basis without threatening the fiscal integrity of the organization.

Recommendation
2. Strike a committee with representation from the health authorities to study this matter more fully and make recommendations to the Ministry of Health for solutions that will support consumer choice and flexibility.

Linking treatment to supported housing access
In some regions, access to supported housing is contingent on consumers accepting treatment or being involved in certain programs. This does not fit consumer choice and individualized approaches to services. There is an increasing emphasis on the need to "de-link" housing services and treatment/support services, allowing consumers access to supportive services as requested. The criterion for acceptance into mental health supported housing is that the individual is receiving assistance with their mental illness. This differentiates mental health supported housing from regular social housing. The threat of losing one’s housing is not to be used as a tool to force services. If tenancy becomes a problem, appropriate support is offered and the outcome can be the loss of tenancy, similar to regular market conditions. In SIL and other programs, support can continue to be provided even though the rent subsidy may no longer be in effect.

Recommendation
3. Accept consumers into supported housing programs based on their meeting the eligibility criteria and being willing to maintain a link to assistance with their mental illness. Utilization of other services should be a decision of the consumer on the basis of their own assessment of their needs and on a clearly articulated list of available services. It is anticipated that consumer need for support may be episodic and will vary in intensity over time.

Capital funding eligibility
The Ministry of Health is unprepared to underwrite the costs of any form of housing other than residential care facilities. This is not in keeping with the shifting emphasis from residential style facilities to more independent options, such as congregate housing with outreach support. The Ministry’s unwillingness to partner in the funding of these mid-range options significantly affects the ability to provide housing services that are in keeping with best practices and reflect the preferences of consumers.
Recommendation

4. That the Ministry of Health institute a policy change allowing capital funds to be directed to residential facility alternatives, such as congregate housing.

Some health authorities have been reluctant to be involved in the purchase and management of residential, emergency and supported housing units. The Adult Mental Health Division contracts with private operators and non-profit societies regarding facilities that offer a very valuable health service. BC Housing has been of great assistance in providing the ownership and administration of housing units and does seek partnerships with regional districts, non-profit societies, municipal governments, etc., in order to increase the housing stock.

Recommendation

5. That health authorities undertake a review whereby they are in a position to own and operate housing options for people with a serious and persistent mental illness, particularly in instances where the units are funded entirely by the province.

Lack of timely access to supported housing

Best practices would suggest that it is essential to emphasize supported housing and this report has proposed that supported housing be considered as a first choice for consumers in all instances where housing and support are required. At present, individuals are often placed in residential housing due to the lack of available supported housing. They are unable to leave residential housing when they are ready due to the lack of supported housing. This can result in their waiting for extended periods of time in more costly residential housing. It may also make a transition out of the residential setting more difficult if a person has been there a long time and has become acclimatized. The backlog of individuals waiting in residential housing for available supported housing also results in individuals at Riverview Hospital and local acute care settings being held longer than necessary in hospital beds, waiting for either supported or residential housing.

Recommendation

6. A shift away from residential housing requires a commitment on the part of the Ministry to provide supported housing to individuals with a serious and persistent mental illness who are deemed eligible. We recommend that the Ministry of Health, in collaboration with health authority representatives, establish clearly understood housing allocations for each health authority that aim to provide housing
services for a minimum of 30 per cent of persons identified as having a serious and persistent mental illness.

While this allocation formula must include the full spectrum of housing services, it should ensure an emphasis on funding supported housing. The formula should be population based, but should provide a bonusing factor for consumers who drift from other regions and other provinces to the major urban cores. It is anticipated that this will require new funding, which will need to be adjusted regularly to compensate for population increases. (The Ministry of Health has estimated that three per cent of the adult population are likely to be identified with a serious and persistent mental illness. A clear and consistent provincial definition of "serious and persistent mental illness" will also be required.)

SIL administration
Responsibility for administrating rent subsidies for the Supported Independent Housing Program currently rests with BC Housing. It receives funds from the Ministry of Health to ensure access for consumers to affordable, safe, secure and appropriate private market rental units. However, this requires the Ministry of Health to pay a 3.5 per cent fee to BC Housing to administer monies transferred to BC Housing by the Ministry. The rental subsidy funding was formerly managed, essentially cost free, by regionally-based mental health personnel who were already involved with agencies around the support services. It also ensured that regional mental health personnel were able to utilize any surpluses in a flexible manner that best met the housing needs of their region.

Recommendation
7. That the Ministry of Health transfer responsibility for management of SIL program rental subsidies to the health authorities and use the savings to provide additional rent subsidies.

Transition from residential to supported housing
Many regions have significant resources currently assigned to residential housing, in both the private and the non-profit sectors. Because of ongoing demands for these beds, it will be difficult to reduce the residential housing component until there is a reasonable complement of supportive housing units available for consumers in a region. Transition from residential to supported housing will require a period of dual funding.
Recommendation

8. That the Ministry of Health consider making available long-term bridging loans to health authorities to allow development of more supported housing prior to reduction of residential capacity. The loan would be repayable from funds recaptured over time through reductions in residential housing.

Inequitable access to social housing

Individuals with a mental illness do not have equitable access to social housing. BC Housing has developed programs targeted to individuals in particular need, such as homeless/at risk and lower income urban singles, but these do not provide mainstream housing outside the urban core for people who have a mental illness and do not fall into the seniors or family group. Single persons with a mental illness often are given access to units deemed no longer acceptable by seniors (e.g., studios). This results in younger, single consumers living in what were identified as seniors’ buildings, often with resulting conflicts between the two age groups. While it may not impede their access to housing, consumers have identified as discriminatory the fact that single mental health consumers can access housing only through a separate BC Housing wait list.

Recommendation

9. That the Ministry of Health and BC Housing, in collaboration with health authorities, jointly undertake a review of the accessibility of social housing for single individuals with a mental illness, the associated procedures and their impact on consumers. The review should focus on recommendations for ensuring equitable access and procedures that do not make consumers feel discriminated against.

Medication assistance

The mental health system has difficulty assisting consumers living in supported housing with their medications. For a number of reasons, taking medications as prescribed can be difficult for some consumers. This problem occasionally results in hospitalization, loss of housing and in consumers sometimes not being considered for independent housing.

Recommendation

10. That the Ministry of Health and health authorities explore and implement ways to assist consumers in taking their medications, as prescribed, while they are living in supported independent housing in the community.
3. RESIDENTIAL HOUSING

3.1 Mission
Residential housing ensures that a range of support services are provided to enable individuals who cannot live independently at this time and/or who chose to acquire skills and confidence in a group setting to maximize their independence.

3.2 Outcome goals
Consumer develops/maintains/increases:
- personal confidence
- social supports
- skills for daily living

3.3 Types
Community residence (fully staffed)
- licensed under Community Care Facility Act
- 24-hour support and care with professional staffing available on a daily basis
- short or long stay

Community residence (partially staffed)
- unlicensed
- on site staffing available (less than 24 hrs/day)
- short or long stay

Family care
- unlicensed
- privately-owned homes operated by a family or individual
- care and support to a maximum of two individuals

Step down home
- unlicensed or licensed
- short term housing for individuals leaving hospital
3.4 Access
Consumers must first be assessed for supported housing and, if this is unsafe or unavailable, residential housing will be considered.

Eligibility criteria
An eligible consumer:
• is unable to live independently at this time, and/or
• chooses to acquire skills and confidence in a group setting
• is willing and able to participate in the residential program
• is assessed as able to benefit from the residential program.

Exit criteria
• consumer attains personal goals
• consumer wishes to leave
• program can no longer meet individual’s needs, even with added supports, because of a clearly documented increase in psychiatric and/or medical/physical needs
• consumers will not be required to leave a residential program unless suitable accommodation and support services are available. The only exception would arise in cases where there is a risk to self, other consumers and/or staff that cannot be addressed by additional support services.

3.5 Function
Residential housing provides assistance with:
• food/meals
• personal care
• home management
• leisure/recreation/socialization
• administration of medication
• treatment/treatment support
• budget management.
3.6 Associated standards and strategies

<table>
<thead>
<tr>
<th>GOALS</th>
<th>STANDARDS</th>
<th>STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE ACCESSIBILITY</td>
<td>Consumers and family have ready access to written information on housing and services, including application and appeal procedures.</td>
<td>Brochures and other informational tools describing housing programs, and access criteria and procedures, are available for consumers, families and service providers. Brochures and other informational tools are easily accessible in locations frequented by mental health consumers.</td>
</tr>
<tr>
<td></td>
<td>Application procedures are standardized and simple.</td>
<td>Basic application process is the same for all regions. Intake involves as few steps as possible. Intake centralized where possible, given geographic considerations.</td>
</tr>
<tr>
<td></td>
<td>Organized, systematic wait lists are maintained and regularly updated.</td>
<td>Wait lists are maintained which are organized, systematic, regularly updated. Wait lists are chronological but provide for priority placement of consumers from acute treatment settings.</td>
</tr>
<tr>
<td></td>
<td>General standards for wait times are established and adhered to.</td>
<td>Placement of consumers should occur within one month.</td>
</tr>
<tr>
<td></td>
<td>Wait list information is shared by region.</td>
<td>Waitlists are shared between regions; ideally through a common data bank.</td>
</tr>
<tr>
<td>CONSUMER INVOLVEMENT</td>
<td>Consumers have access to housing across regional boundaries.</td>
<td>Resource allocation model is developed which permits cross regional access.</td>
</tr>
<tr>
<td></td>
<td>Consumers/family/staff participate in program planning, design and evaluation.</td>
<td>Forums, committees, surveys are used to support and encourage consumer and family participation in program planning, design and evaluation. A Public Housing Plan identifies future development and reflects input of families and consumers and is updated annually.</td>
</tr>
<tr>
<td></td>
<td>Consumers participate in the development of programs and services.</td>
<td>Consumers are active participants in joint staff/consumer meetings.</td>
</tr>
<tr>
<td></td>
<td>Peer support services are promoted.</td>
<td>Opportunities for peer support services are made available.</td>
</tr>
<tr>
<td></td>
<td>Consumers have control over the decisions which affect them and the ability to make choices related to services.</td>
<td>Consumers determine the level and nature of support services from a clearly identified list of services. This choice will not interfere with access to housing.</td>
</tr>
<tr>
<td></td>
<td>Personal preferences accommodated.</td>
<td>Consumers involved in goal setting and decision making regarding services.</td>
</tr>
<tr>
<td></td>
<td>Personal freedom is maximized.</td>
<td>Limited rules and restrictions.</td>
</tr>
<tr>
<td>INDIVIDUALIZED SERVICE</td>
<td>Programs recognize the cultural diversity of the population.</td>
<td>Consumers have access to services in their own language and accommodations are made to meet religious/cultural requirements.</td>
</tr>
<tr>
<td></td>
<td>Individual needs and wants are reviewed by a mental health professional and the consumer on a regular basis.</td>
<td>Regular reviews occur to modify and assess the individual goal plans.</td>
</tr>
<tr>
<td></td>
<td>Staff and consumer develop a partnership to work toward consumer-identified goals.</td>
<td>Consumer goal setting is a partnership process between staff and consumer.</td>
</tr>
<tr>
<td></td>
<td>Services are offered for the span of time necessary to benefit the consumer.</td>
<td>Consumers are not required to leave the program unless suitable accommodation and support services are available. The only exception would be risk to self or others which cannot be addressed with added supports.</td>
</tr>
</tbody>
</table>

3.7 Review of current literature

Individuals with a long history of mental illness, many acute care admissions and many discharge failures may require intensive supervised support in the community for some period of time. Also, upon discharge from a hospital setting after a lengthy admission, some people with mental illness may need a period of intensive support to regain their capacity for independent functioning and to acquire the skills and stability necessary for independent community tenure (Hawthorne et al, 1994; Lamb, 1998; Middelboe, 1997;
Rowlands et al, 1998). Hawthorne et al (1994) reviewed a residential model that used psychosocial rehabilitation principles, supportive relationships and individualized treatment for consumers who had repeated hospitalizations and repeated failures to live in the community. After one year, they found residents more likely to be employed and living independently and less likely to be homeless. There was also a significant reduction in hospital and crisis centre admissions.

While there is a substantial body of research on residential housing, the studies do not employ rigorous research designs such as random assignment or comparison groups. It is therefore extremely difficult to make any substantive conclusions about the relative effectiveness of residential models.

The literature suggests that most individuals with severe and persistent mental illness—given sufficient individualized and flexible support and the availability of suitable, affordable housing—could integrate into the community and would choose to do so. Therefore, given the choice, most consumers will elect to live in their own home; in a typical, non-segregated community setting; alone or with a romantic partner (Carling, 1993; Nelson, in press; Cook and Jonikas, 1994, Tanzman, 1993). Although skills can be effectively learned in a supported housing environment (Carling, 1993; Nelson et al., in press), some consumers may choose to spend a period of time in a group setting to develop skills for independence before moving to an integrated setting. In rehabilitation focused group homes, it has been demonstrated that consumers can achieve gains in a short time frame—from a few months to one year (Bond et al., 1989; Lipton et al. 1988; Nelson et al 1997; Wherley and Bisgaard, 1987; Nelson et al., in press). Nelson et al. (in press) recommend that, in rehabilitation oriented group living settings, care be taken to ensure that consumers are there by choice.

It is argued that no single type of housing can meet the needs of all consumers at all times and that a need exists for an array of housing with varying levels of structure and support (Best Practices, 1997; Friedrich et al, 1999).

It is also suggested that relying only on supported housing may not be advisable, particularly where community supports are scarce, fragmented or not easily accessible.

Best practices identified for residential housing models are based on an underlying assumption of consumer choice (i.e., consumers will have the prerogative to choose freely their place of residence and will be encouraged to self-determine their living arrangements and lifestyle while in their chosen residence).

We are reminded of the risk associated with grouping people according to their level of disability: "...grouping persons who share a devalued condition can fuel stigma, and creates environments that foster deviant behavior" (Ridgeway and Zipple, 1990). Also, long-term care in institution-like community facilities correlates with loss of independent functioning and reduced contact with informal support networks (Carling, 1993; Nelson and Smith Fowler, 1987; Segal and Kotler, 1993). Residential housing with a best practices orientation will preclude these detrimental outcomes.
The literature suggests that, in residential housing models incorporating best practices, the following outcomes will be obtained:

- increased competence in daily living skills/social skills (McCarthy and Nelson, 1991)
- increased quality of life (Middelboe, 1997; Okin and Pearsall, 1993)
- reduced hospital admissions/fewer symptoms (Bond et al., 1998; Hawthorne et al, 1994; Leff et al, 1994; Leff et al, 1996)
- increased housing and financial stability (Bond, 1989)
- consumer satisfaction (Tanzman, 1993; Nelson, in press)
- increased employment (Hawthorne, et al., 1994)

The following list summarizes elements that must be present in residential housing if desirable outcomes are to be achieved:

- **Social networks and social supports**
  - encourage and empower consumers to develop social support networks (Hall and Nelson, 1996, Nelson, in press)
  - encourage the development of peer support and family contact (Besio and Mahler, 1993; Dixon, et al, 1998).

- **Physical qualities of housing**
  - small and homelike (Mosher, 1999; Middelboe, 1997; Nelson et al, 1997)
  - ensures a level of privacy for consumers, especially the level of privacy afforded by single occupancy bedrooms (Carling, 1993; Owen et al, 1996; Nelson, 1997; Nelson et al, in press)
  - aesthetically pleasing and safe (Carling, 1993; Nelson, in press).

- **Location**
  - located within easy access to services and amenities, and indistinguishable from other houses in the neighborhood (Carling, 1993; Mosher, 1999).

- **Resident control and choice**
  - length of stay is determined by needs of consumers; avoidance of a “linear continuum” where a service provider’s expectations replace self-generated consumer goals for moving on (Ridgeway and Zipple, 1990; Middelboe, 1997)
- based on a consumer driven or client-centered philosophy where the plan of care is determined by the consumer (Tanzman, 1993; Ridgeway and Zipple, 1990. Nelson et al, 1997)
- based on a democratic staff management style where residents participate in decision making about aspects of managing the residence (Nelson et al, 1997)
- ideally, the type and amount of support provided should be “de-linked” from the housing (Nelson, 1997)—that is, consumers may choose to be resident, but may refuse support, and such a refusal would not affect their tenure.

- Other
  - effective treatment offered to consumers who have substance abuse problems (Goldfinger, et al, 1999; Herrel, et al, 1996)
  - staff are trained in the philosophy of client centered care (Shepherd, 1995; Mosher, 1998).

3.8 Implementation

Development issues
Capital funding for development of residential housing remains the responsibility of the Ministry of Health. Applications are put forward annually to the ministry for consideration and approval. If projects are funded, health authorities need only cover the annual operating costs related to the building (excluding mortgage) and the costs of support services. However, it can be difficult for small projects to receive needed attention when competing with large acute care projects.

One model of residential housing development that has been highly successful is the Katherine Sanford Housing Society. This society has taken on the role of building and providing ongoing property management services for all new residential housing in Vancouver and Richmond. The land is owned by the province, which ensures that public funds are building future equity in housing. It also allows the health authority to separate property ownership from services and to contract services to a variety of private and non-profit service providers on the basis of proposal calls. When contractors are not meeting standards or elect to terminate their contract, residents do not lose their housing as contractors change.

Because of the volume of housing needs, Vancouver and Richmond have created a specific society to undertake development of housing for mental health consumers on their behalf; it is also possible to receive a similar service through BC Housing.
Costing models
Cost information for residential facilities and family care homes can be extremely variable, depending on the size of the facility and the level of service required by the consumers within a residential setting. The following costings are based on an assumption of a best practice model of a six-bed home, fully capital funded and unionized. Costings are supplied for low to intensive support models. More detailed calculations are available in Appendix E.

**Community residence**

<table>
<thead>
<tr>
<th></th>
<th>Intensive Support</th>
<th>Moderate Support</th>
<th>Basic Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average cost per consumer per day</td>
<td>$141.23</td>
<td>$124.97</td>
<td>$92.46</td>
</tr>
</tbody>
</table>

3.9 Systemic barriers and recommendations

**Lack of community acceptance**
Locating residential housing can be quite problematic. Despite legislation that allows for residential housing for six persons or fewer to locate without public input or municipal approval, some communities are less accepting of this form of housing. There are often unwarranted fears based on myths regarding mental illness. After homes are developed and occupied, there are rarely any ongoing concerns on the part of neighbors.

**Recommendation**
11. That the Ministry of Health increase funding for education and communication about mental illness at the provincial level. It should emphasize de-stigmatizing mental illness and debunking the myths associated with mental illness. There also must be formal linkages with municipalities to provide information and support for locating these resources in their area.

**Loss of access to income and inadequate support funding**
Consumers are increasingly unwilling to accept residential housing as an option because it requires them to give up any independent control of their income. Consumers receive only a "comfort allowance" of $2.70 per day to cover all their personal and social expenses.
**Recommendation**

12. That the Ministry of Health ask the Ministry of Social Development and Economic Security to review the comfort allowance and user fee to allow consumers in residential housing to receive their BC Benefits payments directly. Consumers would pay a portion of shelter/food costs and retain funds adequate for personal expenses.

**Community Care Facility Act, Adult Care Regulations**

Licensing regulations allow up to two persons per room in a residential setting with an Adult Specialized Residential Care Licence. This is not in keeping with the principles of consumer choice and maximizing consumer privacy.

**Recommendation**

13. That either the Community Care Facility Act be amended to reflect one person per room in Adult Specialized Residential Care or that the Ministry of Health establish this as policy. The Ministry of Health would need to provide funding to health authorities to compensate for lost user fee revenues of $25 per day per bed reduction.

There are instances where the facility staff decline to offer a service to an individual, citing safety reasons. The outcome is that the individual, who is usually a person in great need of a residential service, ends up with little or no service and, in many instances, ends up on the streets in the urban areas. The person who requires the greatest residential service receives low cost or no service, while others who are less in need receive greater and more costly service.

**Recommendation**

14. Develop a more inclusive range of residential services to accommodate individuals who present a safety risk within the present residential facilities and who do not require hospitalization. Provide an arbitration process when there is a disagreement as to the admission of a resident into a facility.

**Restricted access to housing across health region boundaries**

With the introduction of region-based funding, increasing concerns are being expressed by health authorities about providing services to consumers who are not residents of their health region. This is problematic for consumers because it restricts their ability to make choices about where they wish to live and also may restrict the ability of consumers to
access specialized housing available in another health region that may better meet their needs.

Recommendation

15. That health authorities be required to establish policies and procedures that will maintain and support consumer choice in housing across boundaries. This planning should be coupled with the recommendations put forward below concerning macro-regional approaches to the development of housing for populations with unique needs.
4. EMERGENCY HOUSING

4.1 Mission
Emergency housing provides services to enable short-term psychiatric consumers who have no other housing or who require intensive stabilization (but not hospitalization) to return to adequate housing.

4.2 Outcome goals
- Consumer is safe
- Consumer is stable
- Consumer moves to/returns to longer-term housing

4.3 Types
Shelter/hostel accommodation
- may be licensed or unlicensed
- short-term accommodation for persons with social and behavioral problems who have no other housing options
- 24-hour staffing
- may be seasonal (cold/wet weather)

Short stay crisis/residence
- licensed under the Community Care Facility Act
- 24-hour support and care with professional staff available on a daily basis
- short-term treatment for a psychiatric crisis (an alternative to hospital)
- crisis stabilization through a structured therapeutic environment

4.4 Access
- barrier-free
Eligibility criteria
An eligible consumer:
• has no housing, or
• requires short term psychiatric stabilization, but not hospitalization

Exit criteria

Emergency shelters
• Each emergency shelter has developed exit criteria (e.g., 7–14 days is a normal length of stay).
• Individuals should have accommodation available.
• In most cases, emergency shelters provide services to a wide range of individuals including those with a serious mental illness.
• Emergency shelters may have developed differing eligibility criteria (e.g., no drug use/no drug dealing/no aggressive behavior).

Short stay crisis residences
• Individual has stabilized and can safely move to or return to adequate accommodation, or
• program can no longer meet individual’s needs because psychiatric and or physical/medical needs have increased.

4.5 Functions
Shelters provide:
• food/meals
• medication support
• linkages/case coordination
• treatment/treatment support.
### 4.6 Associated standards and strategies

<table>
<thead>
<tr>
<th>GOALS</th>
<th>STANDARDS</th>
<th>STRATEGY</th>
</tr>
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<tbody>
<tr>
<td><strong>SERVICE ACCESSIBILITY</strong></td>
<td>Consumers and family have ready access to written information on housing and access, including application and appeal procedures.</td>
<td>Brochures and other informational tools describing housing programs, and access criteria and procedures are available for consumers, families, and service providers. Brochures and other informational tools are easily accessible in locations utilized by mental health consumers.</td>
</tr>
<tr>
<td></td>
<td>Application procedures are standardized and simple.</td>
<td>Basic application process is the same for all regions. Intake involves as few steps as possible. Intake centralized where possible, given geographic considerations.</td>
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<tr>
<td></td>
<td>Organized, systematic wait lists are maintained and regularly updated.</td>
<td>Waitlists are organized, systematic, regularly updated. Waitlists are chronological, but provide for priority placement of consumers from acute treatment settings.</td>
</tr>
<tr>
<td></td>
<td>General standards for wait times are established and adhered to.</td>
<td>Placement of consumers should occur within one month.</td>
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<td></td>
<td>Wait list information is shared by regions.</td>
<td>Waitlists are shared between regions, ideally through a common data bank.</td>
</tr>
<tr>
<td>**CONSUMER INVOLVEMENT</td>
<td>Consumers have access to housing across regional boundaries.</td>
<td>Resource allocation model is developed that permits cross regional access.</td>
</tr>
<tr>
<td></td>
<td>Consumers/family/staff participate in the program planning, design and evaluation.</td>
<td>Forums, committees, surveys are used to support and encourage consumer and family participation in the program planning, design and evaluation. A public housing plan identifies future development, reflects input of families and consumers and is updated annually.</td>
</tr>
<tr>
<td></td>
<td>Consumers participate in the development of the programs and services.</td>
<td>Consumers are active participants in joint staff/consumer meetings.</td>
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<tr>
<td></td>
<td>Peer support services are promoted.</td>
<td>Opportunities are made available for peer support services.</td>
</tr>
<tr>
<td></td>
<td>Consumers have control over the decisions that affect them and the ability to make choices related to services.</td>
<td>Consumers determine the level and nature of support services from a clearly identified list of services. This choice will not interfere with access to housing.</td>
</tr>
<tr>
<td></td>
<td>Personal preferences accommodated.</td>
<td>Consumers are involved in goal setting and decision making regarding services.</td>
</tr>
<tr>
<td></td>
<td>Personal freedom is maximized.</td>
<td>Limited rules and restrictions.</td>
</tr>
<tr>
<td><strong>INDIVIDUALIZED SERVICE</strong></td>
<td>The programs recognize the cultural diversity of the population.</td>
<td>Consumers have access to services in their own language and accommodations are made to meet religious/cultural requirements.</td>
</tr>
<tr>
<td></td>
<td>Staff and consumer develop a partnership to work toward consumer identified goals.</td>
<td>Consumer goal setting is a partnership process between staff and consumer.</td>
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<td></td>
<td>Individualized goal plans are based on individual needs and wants and are reviewed by a mental health professional and the consumer on a regular basis.</td>
<td>Regular reviews occur to modify and assess the individual goal plans.</td>
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<tr>
<td></td>
<td>Services are offered for the span of time necessary to benefit the consumer.</td>
<td>Consumers are not required to leave the program unless suitable accommodation and support services are available. The only exception would be risk to self or others that cannot be addressed by added supports.</td>
</tr>
<tr>
<td></td>
<td>The programs are flexible.</td>
<td>The programs are adapted to the needs of the consumer.</td>
</tr>
<tr>
<td><strong>RECOVERY FOCUS</strong></td>
<td>Housing alternatives reflect the general community or neighborhood norms and are consistent with housing in the community are in a convenient, safe and accessible location.</td>
<td>Housing is set within residential style home or apartment. Residential options do not accommodate more than 10 consumers, and family care does not accommodate more than two consumers.</td>
</tr>
<tr>
<td><strong>RECOVERY FOCUS continued</strong></td>
<td>The programs and services are delivered within a psychosocial rehabilitation approach.</td>
<td>Psychosocial rehabilitation principles (Appendix A) are clearly adhered to in the delivery of services, emphasizing consumer choice and self-determination.</td>
</tr>
<tr>
<td></td>
<td>Community integration and bridging are emphasized.</td>
<td>Consumers are encouraged and supported to use community rehabilitation, education, social and recreational programs.</td>
</tr>
<tr>
<td></td>
<td>Focus is on learning basic living skills.</td>
<td>The programs emphasize consumer participation and/or consumer-directed management of medication and household management, e.g., meal preparation, cleaning, laundry.</td>
</tr>
<tr>
<td></td>
<td>Staff support consumers in finding</td>
<td>Individual planning highlights strengths.</td>
</tr>
</tbody>
</table>
GOALS

purpose and meaning in their lives, de-
emphasize illness and instill hope by
helping consumers manage their
symptoms and build on strengths.

Promotes consumer involvement with
natural supports, e.g., family, friends.
The program uses an individualized
definition of recovery based on consumer
expectations.
The program has good communication
links and working relationships with other
support networks.
Staff have a genuine concern for well-
being of consumers, are respectful and
committed to psychosocial rehabilitation
principles and the recovery model.

STANDARDS

Family and friends are actively involved wherever appropriate.
Individualized goal setting tools are utilized.
There is clear evidence of linkages with other services and support
networks through regular meetings and telephone contacts.
Staff are educated in the principles of psychosocial rehabilitation and
the recovery model.

STRATEGY

Consumer and family satisfaction surveys are routinely used to elicit
feedback.

A tracking and monitoring system is established to regularly review
progress toward individual goals and records are maintained of
progress.
The program clearly identifies an individual responsible for quality
improvement. There is written evidence of deficiencies and remedial
activities. Each residence is reviewed regularly by an external team
(which might include a consumer, family member, provider and mental
health staff).
A public communication process objectively identifies goal attainment
for families, consumers and funders.
Complaint and appeal procedures are readily accessible and well
communicated to families and consumers.
Research is routinely reviewed and used to make changes to services.
The programs must report utilization at least annually to be aggregated
by the health authority and forwarded to the Ministry of Health for
inclusion in an annual housing report.

SERVICE ACCOUNTABILITY

Individual goals are audited to ensure that
these are genuine challenges/needs of
the consumer; and they are documented
and tracked.

The program has a quality improvement
process that monitors service delivery,
documents shortcomings and initiates
remedies.
The program is accountable for meeting
service outcome and process goals and
communicates this information to
consumers, families and funders.
There are clearly articulated complaint
management and appeal procedures.
The program uses research findings to
improve services.
The program collects information related
to population served and utilization.

4.7 Review of current literature

While emergency housing programs must exist to provide services to the homeless and
must engage in best practices, they are clearly a stop-gap solution. Emergency shelters
should be viewed as symptomatic of the lack of affordable, appropriate, safe and secure
housing and as a reflection of an inadequate and inappropriate response to housing needs.

If we are to address appropriately the needs of people with a mental illness who are
homeless, the full range of housing options must be made available along with the
necessary assertive community treatment services to allow them to be successful in the
community. Housing options will need to ensure that they offer a flexible and tolerant
approach and avoid highly-structured environments.
Best practices for emergency shelters

Substance abuse is the strongest predictor of homelessness (Goldfinger, 1999; Olsson, 1999). Other indicators of homelessness include persistent psychiatric symptoms and impaired global functioning (Olsson, 1999). The problem of homelessness among people with severe and persistent mental illness is also linked to insufficient community support (Scott and Dixon, 1995; Mueser, et al, 1998; Goldfinger, et al, 1999; Olsson, 1999) and to poverty and lack of affordable housing (Blanch and Carling, 1988; Carling, 1993; Nelson, in press).

The documentation by Canada Mortgage and Housing Corporation (CMHC) of best practices addressing homelessness gives examples of congregate living programs, several of which refer to the needs of people with mental illness (CMHC, 1999). The projects chosen by CMHC illustrate the diversity of responses to the problem of homelessness. Lookout (Vancouver), for example, goes beyond providing emergency shelter and has developed a range of services, including transitional and permanent housing, to meet the needs of marginalized and homeless people. The data for programs addressing homelessness focus largely on the number of spaces provided (i.e., the impact of the program on homelessness rather than on the individual who is homeless). The outcomes for individual consumers, while primarily anecdotal, suggest that individuals can experience a better quality of life and well-being in a group living situation where the provision of services is guided by a best practices orientation.

Examples chosen for inclusion in the CMHC document met criteria predetermined by the researchers as fundamental to best practices in housing for the homeless:

- Homeless people develop solutions, programs and policies.
- Front-line service providers participate in the development of solutions.
- Projects have a multidimensional approach to meeting shelter and support needs.
- Projects provide a variety of services to respond to (special) populations.
- Projects challenge current beliefs and norms about the nature of the problem and possible solutions.

In the CMHC document, the housing models chosen to exemplify best practices highlighted the following elements as key to successful outcomes:

- Residents are treated like tenants and helped to assume the obligations of tenancy (e.g., paying rent, maintaining their rooms) (CMHC, StreetCity, 1999; Federation des OSBL d’habitation de Montreal, 1999).
- Consumers are involved in the design and development of housing projects (CMHC: Homeless Initiative Community Action Plan; StreetCity; Sandy Merriman House, 1999).
- Housing is provided on an unconditional basis (i.e., housing is not contingent on accepting support) (CMHC, StreetCity, 1999).
- A consumer driven philosophy empowers tenants/consumers to determine the course of their lives (CMHC, StreetCity; Sandy Merriman House, 1999).
• Service is provided flexibly and is responsive to needs of consumers (CMHC, StreetCity; Look Out; Sandy Merriman House; Look Out, 1999).

• Independence is fostered (CMHC, StreetCity; Sandy Merriman House; Lookout, 1999).

• Staff have a non-judgmental manner, offer support respectfully and empower and encourage consumers to accomplish the goals they have set for themselves (CMHC, StreetCity; Sandy Merriman House; Lookout, 1999).

• Safety and security of all consumers are emphasized (CMHC, 1999).

• Length of stay is determined by consumer (CMHC, StreetCity, FOHM, 1999).

**Best practices for short-stay crisis homes/step down residences**

By and large, consumers prefer stable accommodation of their own choosing (Ridgway and Zipple, 1990; Owen, 1996). Ideally, support for people in crisis situations would be provided in their home environment (Reding and Raphaelson, 1995; Dean, 1990). Crisis accommodations, along with hospitalization and homelessness, are the least preferred options for people with severe and persistent mental illness (Owen, et al, 1996). Several categories of psychiatric crises can be dealt with in community settings as effectively as in acute care settings (Hawthorne, et al, 1999; Mezzina and Vidoni, 1995; Sledge, et al, 1996). Admissions to hospital may be necessary for people who are at risk to themselves or to others or possess little or no control over impulses (Rakfeldt, et al, 1997; Stroul, 1988).

Given the availability of sufficient effective and flexible support in the community on an around-the-clock basis, it is possible that there would be no requirement to have purpose built short-stay and treatment facilities (Mezzina, 1995; Reding, 1995; Simington, 1996). However, consumers deflected from hospital emergency departments and referred for community-based crisis response, if homeless, will require shelter as well as crisis support (Stroul, 1988).

Where short-stay crisis homes/step down residences exist, they must be components of a coordinated crisis response system. Crisis response functions should be provided within a coordinated system of pre-crisis and ongoing flexible and individualized support (Best Practices, 1997).

Research on the effects of assertive community treatment on hospital utilization suggests that, with the availability of flexible client centered support, crises could be effectively de-escalated in the consumer’s usual living environment (Mezzina, 1995; Salkover, 1999; Stroul, 1988). Assertive community treatment programs can advantageously include consumers as staff to provide a peer support component and family members as staff to provide support to families in times of crisis (Lyons, 1996; Dixon, 1998). Crisis housing alternatives can include family care home placement, placement in facilities designated expressly for the purpose of crisis care, placement in other residential care facilities or in supported hotel rooms for temporary shelter and crisis support (Bond et al, 1989).
Best practices for crisis housing mirror some of the elements of best practices for residential housing:

- small and homelike (Rakfeldt, 1997)
- consumer-driven or client-centered philosophy where the plan of care is determined by the consumer (Rakfeldt, 1997)
- located within easy access to services and amenities and indistinguishable from other houses in the neighborhood (Carling, 1993; Mosher, 1999)
- privacy, especially single occupancy bedrooms (Carling, 1993; Owen et al, 1996; Nelson, 1997; Nelson, in press)
- a democratic staff management style where residents participate in decision making about aspects of managing the residence (Nelson et al, 1997)

However, the crisis response orientation dictates that other elements specific to the functions of crisis response be present which differ from the best practices for residential housing:

- While length of stay in residential housing may be indeterminate, in crisis housing the length of stay is short term and is determined by the time it takes to resolve the crisis. In practice, length of stay is usually no longer than six weeks and usually much shorter (Bond, 1989; Rakfeldt, 1997; Weisman, 1985).
- In residential housing, a best practice may be to “de-link” support from housing, that is, housing is not contingent on the consumer also accepting support. In housing specifically for the purpose of resolving a psychiatric crisis, the housing and support are linked.

The goal of short-term crisis treatment is to assist consumers in resolving their crises and returning to their usual level of functioning and to their former accommodation or living arrangement, if these were satisfactory. Achievement of this goal requires:

- development and maintenance of informal support and mutual aid networks (i.e., contact with family members or involvement of peer supports) (Rakfeldt, et al, 1997; Weisman, 1985)
- focus on discharge arrangements, with consumers empowered and encouraged in their efforts to find accommodation and apply for work or financial assistance (Weisman, 1985)
- cultivating a cross-region infrastructure that can facilitate resource sharing, information management and standardization of policies and procedures.

Examples of the modifications necessary to import the program from an urban to a rural centre were:

- service available in smaller centres evenings and weekends, versus 24-hour coverage in larger urban centres
• target population extended to 15 years and older in smaller centres because few services were available for the older adolescent population.

4.8 Implementation

Development issues
Capital funding for emergency shelters remains quite problematic. Since the federal government withdrew its funding in 1993, there has been no provincial program to support the development of shelters specifically designed to serve the needs of mental health consumers. Shelters developed by the Ministry of Social Development and Economic Security tend to be for the general population. In 1999, BC Housing agreed to support emergency shelter projects that provide long-stay supported housing as part of the project. While they will not cover capital or shelter operating costs for the emergency shelter portion of the building, they do support overall development costs and can make a project financially feasible, depending on the contributions toward land acquisition.

Short-stay crisis housing is funded by the Ministry of Health as a residential facility because it provides for 24-hour care. Applications are put forward annually for consideration and approval. If projects are funded, health authorities need only cover the annual building costs, excluding mortgage and the costs of support services.

Costing models

Emergency shelters
It is virtually impossible to provide any realistic model for costing an emergency shelter, given the broad range in possible size and funding configurations.

Short-stay crisis homes
While cost is widely variable depending on size, it is most likely that regions will develop homes in the range of six to eight beds to allow for community integration. Costs are provided based on an eight-bed model and more detailed calculations are available in Appendix E.

<table>
<thead>
<tr>
<th>Average cost per consumer per day</th>
<th>Short-stay Crisis Home</th>
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<td>$231.03</td>
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</table>

38 Best Practices for B.C.'s Mental Health Reform
4.9 Systemic barriers and recommendations

Lack of community acceptance
Locating emergency housing is frequently more difficult than locating residential housing because of the community's heightened concerns. Individuals who are in a housing or psychiatric crisis are viewed by neighbors as less stable. Emergency shelters are usually seen as part of the resource base of a downtown urban core and this makes it difficult to locate shelters away from city centres, which may be very frightening for people with a mental illness. Crisis short-stay and step down residences face the same problems identified for any residential housing.

Recommendation
16. That the Ministry of Health increase funding at the provincial level for education and communication about mental illness. The focus should be on de-stigmatizing mental illness and debunking the myths. Formal linkages with municipalities are also needed to provide information and support for locating these resources in their area.

Confusion about capital and operating funding
Both capital and operations funding for emergency shelters are extremely complex, with a wide range of potential partners. It is difficult to understand where to go for capital funding and how ongoing operating funds should be identified. The two significant partners are often the Ministry of Social Development and Economic Security and the Ministry of Health. They have now been joined by BC Housing, which has allocated funding for the development of emergency shelters that have second-stage independent housing attached.

Recommendation
17. That the Ministry of Health ensure improved coordination between ministries in the allocation of capital funding and operating dollars. The Ministry of Health should also provide a succinct document for health authorities that explains the roles of the various partners in emergency shelter development and operation.

Responsiveness to cold/wet weather in emergency accommodation
There is a lack of formal planning to deal with cold/wet weather and the impact this will have on consumers who are homeless.
**Recommendation**

18. That all shelters be developed with the flexibility to accommodate seasonal change in demand. This is now a funding requirement of BC Housing and should be a policy requirement of the Ministry of Health. It is critical that funding for increased seasonal operations be factored into funding allocations for shelters.

**Inability to discharge**

The lack of safe, affordable, secure and appropriate resources often makes it difficult for a shelter to discharge a consumer, except back to the street. In many cases, emergency shelters hold the person awaiting a suitable option and this results in decreased access to the resource by others who are also homeless. In many cases, indeed, the cost of providing services to a consumer in a shelter setting will be significantly higher than the costs of a supported housing option.

**Recommendation**

19. That the Ministry of Health advocate strongly, both at higher levels of government and within the Ministry of Health, for adequate funding to be directed, on a priority basis, to the development of supported housing options.

**High need/low resources**

Often the consumers with the greatest needs are served within emergency shelter settings because all the other options have failed them. This results in those with the greatest need being served in settings that traditionally have received the least amount of funding. Shelters have been expected to operate with minimal staffing and to provide a wide array of assessment and linking services and social activities. Due to lack of staff and the inability to effectively intervene in the life of a consumer prior to discharge, we frequently see the “revolving door” syndrome in which consumers return routinely to the shelter for services.

**Recommendation**

20. That the Adult Mental Health Division, in collaboration with health authorities, establish minimum standards for shelter operations in the areas of staffing and programs, health and safety and maintenance.
5. POPULATIONS WITH SPECIALIZED SERVICE NEEDS

The purpose of this section is to identify for health authorities groups of individuals who will require special attention in planning, development and delivering housing services. The regular stream of housing often fails to meet the specialized needs of individuals in these population groups.

The report merely highlights the most significant issues identified for each of the population groups and provides broad suggestions for action. The working group did not have the time or the resources to address thoroughly each of the population groups and further research and development efforts should be collaboratively undertaken by the ministry and health authorities.

While the suggested actions are specific to the unique needs of the various population groups, some common themes were evident:
- need for adequate education and training for staff about the unique needs
- need for increased availability of housing
- need to address isolation and safety issues
- inter-ministerial jurisdictional issues.

All regions should have core housing services that address residential, emergency and supportive housing needs and should, wherever possible, integrate individuals with special needs into this existing housing. Many individuals with special needs can have their housing needs met by some accommodations in existing residential, emergency or supportive housing services. A focus of the work in this area should be to identify mechanisms that promote and support the successful integration of these special populations into existing housing services.

There are, however, some individuals within these special populations who have significant needs that require highly specialized, distinct and separate housing services. These distinct and highly specialized services need a provincial strategy for planning, development and funding, which will ensure balanced resource development across the province and promote inter-regional access. Without a provincial strategy, regions are unlikely to direct scarce resources to serve special populations, given the drift of consumers from other regions to these resources.

Some existing initiatives that are underway model this approach (e.g., the organic brain syndrome facility development at Seven Oaks, which will serve all of Vancouver Island). Work is also underway to develop a framework for a facility to serve individuals who remain unserved in any existing options.
Recommendations

21. That the Ministry of Health, in collaboration with health authorities, take a primary role in planning and funding highly specialized resources.

22. That these highly specialized facilities be treated in a similar fashion to tertiary services; the health authorities in which the facility is located would hold the funds, but would operate the housing service according to a set of principles agreed on by the partner regions who would need to access the housing service. This would ensure balanced resource development and promote inter-regional access.

5.1 Persons with a mental illness and substance misuse

Issues

- Need more housing that incorporates treatment for both mental illness and substance misuse.
- Staff must have training in both mental illness and alcohol/drug treatment.
- Housing must incorporate or be linked to a detox capability.
- Lack of neighborhood acceptance of housing for this population.
- The separation of alcohol and drug program development and funding in the Ministry for Children and Families from planning for dual diagnosis individuals in the Ministry of Health.

Suggested actions:

Establish mechanisms to ensure closer linkage of alcohol and drug program planning, development and delivery with planning for mental health, both by the ministry and regional health authorities.

All health authorities ensure the development of some capability for a housing service for individuals with a mental illness and substance misuse.

The Ministry of Health support a public education campaign related to mental illness and substance misuse.
5.2 Intercultural

Issues

- Lack of safe, affordable, secure housing.
- Isolation within available housing.
- Concerns about having food, traditions and cultural issues addressed.
- Difficulty supplying shared housing caused by lack of adequate numbers from any given ethnic group.

Suggested actions:

Focus on supported housing and family care models, with providers and services geared to the cultural needs of the consumer.

Ensure that staff who provide housing support services are trained and educated about cultural needs.

Where populations are significant, develop a capability for intercultural mental health workers to provide support and education to housing providers.

Where populations are significant, develop specialized housing to meet the needs of specific cultural groups.

5.3 Persons with organic brain syndrome (OBS)

Issues

- Lack of housing options results in placing individuals with OBS in inappropriate settings (e.g., continuing care facilities).
- Secure settings may be required, resulting in neighborhood concerns.
- Treatment requires highly specialized training and knowledge on the part of staff members.
- Individuals with OBS do not function well within the mental health residential structure, yet often have high levels of medical need.
- The high costs of delivering care, and the potential for a specialized facility to draw consumers from other regions, acts as a disincentive to development of this specialized service by health authorities.
Suggested actions:

The Ministry of Health develop a clear definition of OBS, clearly identify the responsible program area and assign the necessary funding.

Conduct a survey at the provincial level to determine level of need for services.

Regional health authorities work collaboratively to develop cost effective multi-care level facilities to serve a number of regions.

Make specialized training available to staff.

Health authorities have direct access to specialized facilities, such as Skelleem Village.

5.4 Youth

Issues

- Lack of both supported housing and residential housing services for youth (ages 16 to 18) with mental illness as they move from the Ministry for Children and Families to the Ministry of Health.
- Available emergency resources for youth with mental illness are inadequate.
- Jurisdictional issues between the Ministry for Children and Families and the Ministry of Health over responsibilities for youth result in lack of services.

Suggested actions:

The Ministry for Children and Families and the Ministry of Health develop protocols focusing housing needs, treatment needs and issues related to transfers between ministries.

Develop improved and increased emergency housing and treatment options for youth, separate from adult-oriented shelters and away from the urban cores.

5.5 Families

Issues

- The lack of housing services for families means that children of parents with a mental illness may be dislocated from their family.
Suggested actions:

Develop housing services including residential, emergency and supported housing to support the maintenance of the family unit.

Make respite care available for children of parents with a mental illness.

5.6 Women

Issues

- Women are at risk in co-educational emergency shelters.
- Lack of housing for women and their children that avoids disruption of the family unit.
- Lack of women-only housing for those women with abuse or trauma histories who desire housing separated from men.
- Lack of available housing for single women, especially those in crisis who are escaping violence.
- Women with a mental illness are not be served by transition houses, which often have low staffing levels.

Suggested actions:

Health authorities actively develop housing options designed to meet women’s needs for women-only housing and housing for women and their children. This should include the development of women-only emergency shelters and safe houses.

Encourage collaboration between health authorities and the Ministry of Women’s Equality to develop emergency housing models for women who are victims of violence and have a mental illness.

The Ministry of Health offer training to transition housing staff related to mental illness to increase the knowledge base and increase the capability for service.

Health authorities actively investigate housing models such as family care, which may be particularly supportive to women, and to women and their children.

Encourage collaboration between health authorities and the Ministry for Children and Families to design jointly funded housing that will maintain the family unit.
5.7 Elderly

Issues

- Planning for elderly services must differentiate the needs of individuals who have a mental illness and are aging in place from those of individuals with psychogeriatric concerns.
- Elderly persons with mental illness in continuing care facilities may be victimized, or may be aggressive themselves, and put others at risk.
- Continuing care facilities are too large to serve individuals with a mental illness appropriately and staff do not have the specialized training and knowledge to serve this population.
- Elderly persons with mental illness are sometimes not accepted for admission to continuing care facilities because of their behavior.
- Elderly persons in mental health housing do not receive adequate support to age in place and suffer unnecessary housing disruptions.
- Elderly persons are frequently sent to hospital and remain there because of a lack of short-stay crisis beds to deal with psychiatric and medical concerns.

Suggested actions:

- Make funding available to develop smaller, homier facilities that could serve elderly individuals with a mental illness (e.g., the Adards Home model in Tasmania).
- Provide training and education for staff in continuing care facilities to support their knowledge of mental illness and their ability to manage behaviors.
- Develop supported housing options specifically for seniors with design features that will promote and support aging in place.
- Health authorities develop a short-stay crisis capability specifically for the elderly.
- Health authorities review the level of home support available to older persons to ensure that they are maintained in their own homes as long as possible.
- Health authorities promote aging in place by ensuring funding to provide added care services during serious illness and to provide palliative care.
5.8 Persons with a borderline mental handicap (IQ=71-84)

Issues

- The arbitrary assignment to the Adult Mental Health Division (Ministry of Health) of responsibility for individuals with IQs above 70 results in denied access to specialized housing services provided by the Ministry for Children and Families (e.g., intensive family care or residential homes for two to four people, respite and crisis stabilization). This also makes the services of mental health support teams unavailable to these individuals.

- Mental health housing staff do not have the knowledge and expertise to serve this population and are often unwilling/unable to accept referrals.

- Persons with a mental handicap may not mix well in residential facilities, given their low tolerance for stimuli and their need for different care and programs, more structure and different activity and training programs.

Suggested actions:

Review the mandate and policies of the Ministry for Children and Families jointly with the Ministry of Health to ensure better service for this population.

The Ministry of Health and the Ministry for Children and Families develop jointly funded housing services specifically designed to meet the needs of this population or develop protocols that will allow the integration of this population into the housing services provided by the Ministry for Children and Families.

Ensure the availability of enhanced community supports for this population within a supported housing model. This can be supported through a geographical clustering of units.

Coordinate services to meet complex service needs.

5.9 Persons involved with the criminal justice system

Issues

- Government policy now directs that individuals with a forensic history who have a mental illness be provided with housing services through the Adult Mental Health Division without any increase in funding or capacity to an already overloaded system and with limited policies and procedures in place for collaborative services.
• Individuals with a forensic history are perceived as more difficult to house and may be in some cases, resulting in their delayed access to housing.
• A lack of suitable housing may force individuals in the Forensic Psychiatric Institute to remain in an institutional setting.
• Housing options may be limited by negative perceptions on the part of neighbors.
• Mental health housing services operate on a voluntary model that may be in conflict with an imposed placement.

Suggested actions:

The Ministry of Health increase funding and capacity of the housing capability for health authorities to serve this population.

Provide staff in housing with education and training to better understand the needs of the population.

Develop guidelines to differentiate individuals who can be served in existing housing options and those who require specialized resources with intensive monitoring, supervision and security.

Increase coordination between Forensic Services and regional mental health services.

5.10 Persons with HIV/AIDS

Issues

• Lack of secure housing during long hospital stays that arise from medical complications.
• Need for housing that is secure and accessible and has self-contained units with bathrooms and kitchens.
• Poverty affects this group because of physical impairments and results in a lack of funds to access adequate housing.
• The persistent fears associated with HIV/AIDS are compounded by the stigma associated with mental illness.

Suggested actions:

Develop additional self-contained affordable housing with support services. Provide staff with training about HIV/AIDS to combat the myths and reduce the stigma.
Establish protocols to support security of tenure during hospitalizations.

Make staffing available to address complex medical needs and associated drug regimens.

5.11 Persons with a physical disability

Issues

• Lack of adequate, accessible housing with on site supports.
• Possibility of physical deterioration because of progressive health conditions.

Suggested actions:

Develop housing models that provide medical care, homemaker services and food services required to support integration.

Cluster housing units as a way to make the delivery of necessary health resources economically viable.

Design buildings to allow for complete accessibility.
6. ESTABLISHING COMMUNICATION NETWORKS

It is essential to set in place a communication framework that allows for ongoing, long-term communication between communities within regions, between regions and between regions and the Ministry of Health.

This framework must be a shared responsibility between the health authorities and the Ministry of Health.

6.1 Health authority responsibility

Communication at the community level
Health authorities should require that each community within the region identify a housing representative who will delegate authority and responsibility to organize, coordinate and maintain a local process of communication related to housing issues. This communication process must ensure that families, consumers and all mental health providers in housing, or with an interest in housing, participate in planning, development and evaluation.

The purpose of the communication process is to support:

- information exchange
- exchange of ideas
- identification of housing needs
- multi-year planning for housing needs
- identification of housing issues and barriers to best practices
- promoting and maintaining partnerships
- ensuring focus on best practices
- identification of a representative at the regional level.

The process of maintaining the communication should be determined by the local community; however, there should be a mechanism that allows for input on a regular basis, no less than quarterly.

Some communities have utilized ongoing housing committees with representation from service providers and seek family and consumer input through a focus group process. Other communities have relied on a combination of regular focus groups that seek input from families, consumers and service providers.
Communication at the regional level

Health authorities should ensure that formal communication opportunities occur between representatives of all local communities within the health region. The individual who has regional responsibility for mental health should assign staff to organize and coordinate a communications process that would occur no less than semi-annually. This individual would also be responsible for the routine dissemination of any housing-related information to the community housing representatives, for distribution at the community level.

Representatives from the local communities would bring forward information, issues, housing needs and plans for discussion within a larger regional context. Representation should ensure a balance of consumers, family members and service providers.

The purpose of the communication process is:

- information exchange
- exchange of ideas
- joint multi-year planning to ensure regional balance
- identification of shared housing issues and barriers
- promotion of across region partnerships and linkages
- retaining focus on best practices
- ensuring focus on evaluation and measurable outcomes
- identification of a representative at the provincial level.

The process for communication should be determined by the health authority and could include committee meetings, focus groups or a combination of the above.

Recommendation

23. That health authorities appoint a representative in each community who will have the responsibility of organizing, coordinating and maintaining a local process of communication among families, consumers, service providers and professional staff in relation to housing issues. Health authorities must also ensure formal communication among representatives of all communities, with an appropriate balance between consumer, family, service provider and staff representatives.

6.2 Ministry responsibility

Communication at the provincial level

The Ministry of Health should ensure the maintenance of the best practices process through an ongoing communication framework at the provincial level.
Recommendation

24. That the Ministry maintain a best practices committee, which would identify common issues, maintain a focus on best practices and act as a consultative body for ministry and health authorities. The committee would include consumer, family, service provider and staff representatives with an interest in the field of mental health housing. They would be nominated by the health authorities and would be selected by the Ministry of Health for up to two-year terms. An attempt would be made to balance representation over time to ensure a rural/urban balance and balance across regions.

The purpose of the best practices committee would be to continue to work already begun and to ensure ongoing communication with the Ministry of Health and other relevant ministries. The committee would be expected to meet on a regular basis (no less than six times a year) and would operate with co-chairs selected by the committee. The co-chairs would be responsible for ensuring communication with the ministry.

The role of the best practices committee would be to:

- ensure that regular (not less than once a year) communication opportunities are available between housing representatives from the regions
- meet regularly (no less than six times a year), stay aware of changing housing trends, issues and barriers and to make the ministry aware of this information.
- seek information from regional representatives about new mental health housing developments in British Columbia and new information on best practices and make the ministry and regional representatives aware of this information.
- assist the ministry in setting policies within all government services to reduce system barriers to best practices
- assist the ministry in determining appropriate provincial standards to support best practices
- act as a consultative body for health authorities seeking information related to mental health housing or planning/development issues.

The ministry should develop and maintain a provincial database on best practices examples, based on a comprehensive evaluation of programs. The database should be readily accessible through a website developed by the ministry.
7. GENERAL ISSUES AND RECOMMENDATIONS

Some general issues are highlighted in this section because of their important impact on the development of all mental health housing services.

7.1 Staff training

**Recommendation**

25. That the Ministry of Health make sufficient funding available to health authorities to support staff training in the principles of psychosocial rehabilitation and the recovery model.

7.2 Information management

**Recommendation**

26. That health authorities, in collaboration with the Ministry of Health, collectively agree on a minimum data set of information to be collected for all housing services. Information should be consistent and standardized and follow the report terminology to allow for comparisons. Information must be available in an annual summary for each health authority and for the province.

7.3 Access to housing services information and best practices updates

**Recommendation**

27. That the Ministry of Health collaborate with health authorities to develop a centralized, easily accessible housing services information centre that is available to professionals, consumers and families. It is recommended that the information be available on a website and in print format and be regularly updated and widely circulated. This would promote communication of innovative approaches and documentation of best practice program examples. Information should also include evaluations of programs in relation to best practices criteria.
7.4 Jurisdictional barriers

Jurisdictional issues frequently arise between ministries in relation to providing housing and other support services for persons with specialized service needs.

Recommendation

28. That the Ministry of Health take a lead role in establishing a well-communicated formal process for inter-ministerial planning and resource allocation for individuals with cross-ministry involvements. The process must be speedy and must ensure the inclusion of the relevant health authorities.

7.5 Capital and operating funding

There is no relationship between approvals for capital projects and the operating funds necessary to maintain the projects on an ongoing basis. This makes it extremely difficult to move development forward.

Recommendation

29. That the capital funding process, both at the Ministry of Health and through Homes BC, be coordinated with allocations for necessary support programs.

7.6 Lack of service space funding

Ambiguity and barriers remain in developing appropriate housing, because of the non-availability of funds for service space. Programs are in place that provide for units of housing, but there is no clear formula or process to gain funds to pay for clinical or staff space. Some housing units for people with a mental illness require space for the clinicians to work with the individuals, such as an interview room, an office or an examination room, but these spaces are typically not available. Mental health planners are forced to call these rooms other names, such as “storage”, in order to have an office.

Recommendation

30. That housing specifications include appropriate clinical space for working with residents of the housing units.
8. SUMMARY OF RECOMMENDATIONS

8.1 Supported housing

Inadequate BC Benefits shelter payments
1. Introduce a shelter subsidy for individuals with a serious and persistent mental illness to allow them access to market housing. This would be a subsidy program similar to the SAFER program in place for low-income seniors.

Portability of rent subsidies
2. Strike a committee with representation from the health authorities to study this matter more fully and make recommendations to the Ministry of Health for solutions that will support consumer choice and flexibility.

Linking of treatment to supported housing access
3. Accept consumers into supported housing programs based on their meeting the eligibility criteria and being willing to maintain a link to assistance with their mental illness. Utilization of other services should be a decision of the consumer on the basis of their own assessment of their needs and on a clearly articulated list of available services. It is anticipated that consumer need for support may be episodic and will vary in intensity over time.

Capital funding eligibility
4. That the Ministry of Health institute a policy change that would allow capital funds to be directed to residential facility alternatives such as congregate housing.

5. That the health authorities undertake a review that would put them in a position to own and operate housing options for people with a serious and persistent mental illness, particularly in instances where the units are 100 per cent provincially funded.

Lack of timely access to supported housing
6. A shift away from residential housing requires a commitment on the part of the Ministry of Health to provide supported housing to individuals with a serious and persistent mental illness who are deemed eligible. We recommend that the Ministry of Health, in collaboration with health authority representatives,
establish clearly understood housing allocations for each health authority whose target is providing housing services for a minimum of 30 per cent of persons identified as having a serious and persistent mental illness.

**SIL administration**
7. That the Ministry of Health transfer responsibility for managing SIL Program rental subsidies to the health authorities and use cost savings to develop more housing.

**Transition from residential to supported housing**
8. That the Ministry of Health consider making long-term bridging loans available to health authorities to allow development of more supported housing prior to reduction in residential capacity. The loans would be repayable over time, from funds recaptured through reductions in residential housing.

**Inequitable access to social housing**
9. That the Ministry of Health and BC Housing collaborate with health authorities to undertake a review of the accessibility of social housing for single individuals with a mental illness, the associated procedures and their impact on consumers. The review should focus on recommendations to ensure equitable access and procedures that do not make consumers feel discriminated against.

**Medication assistance**
10. That the Ministry of Health and health authorities explore and implement ways of helping consumers take their medications, as prescribed, while living in supported independent housing in the community.

**8.2 Residential housing**

**Lack of community acceptance**
11. That the Ministry of Health increase funding for education and communication about mental illness at the provincial level. Emphasis should be on destigmatizing mental illness and debunking the myths. Formal linkages with municipalities are also needed to provide information and support for locating residential housing in their area.
Loss of access to income and inadequate support funding
12. That the Ministry of Health ask the Ministry of Social Development and Economic Security to review the comfort allowance and user fee to allow consumers in residential housing to receive their BC Benefits payments directly. Consumers would pay a portion of shelter/food costs and retain funds for personal expenses.

Community Care Facility Act, Adult Care Regulations
13. That the Community Care Facility Act be amended to reflect one person per room in adult specialized residential care or that the Ministry of Health establish this policy. The ministry would need to provide funding to health authorities to compensate for lost user fee revenues of $25 per day per bed reduction.

14. Develop a more inclusive range of residential services to accommodate people who present a safety risk within the present residential facilities and who do not require hospitalization. An arbitration process is needed when there is a disagreement about the admission of a resident into a facility.

Restricted access to housing across health region boundaries
15. That health authorities be required to establish policies and procedures that will maintain and support consumer choice in housing across boundaries. This planning should be coupled with the recommendations put forward concerning macro-regional approaches to the development of housing for populations with unique needs.

8.3 Emergency housing

Lack of community acceptance
16. That the Ministry of Health increase funding for educational and communication about mental illness at a provincial level. The focus should be on de-stigmatizing mental illness and debunking the myths. There also needs to be formal linkages with municipalities to provide information and support for the locating of emergency and short-stay crisis housing in their area.

Confusion regarding capital and operating funding
17. That the Ministry ensure improved coordination between ministries in regard to the allocation of capital funding and operating dollars. The Ministry of Health should provide a succinct document explaining to health authorities the roles of the various partners in emergency shelter development and operation.
Responsiveness to cold/wet weather in emergency accommodation

18. That all shelters be developed with the flexibility to accommodate seasonal changes in demand. This is now a funding requirement of BCHMC and should be a policy requirement of the Ministry of Health. It is critical that funding for increased seasonal operations be factored into funding allocations for shelters.

Inability to discharge

19. That the Adult Mental Health Division advocate strongly, both at higher levels of government and within the Ministry of Health, for adequate funding to be directed, on a priority basis, to the development of supported housing options.

High needflow resources

20. That the Adult Mental Health Division collaborate with health authorities to establish minimum standards for shelter operations in the areas of staffing and programs, health and safety and maintenance.

8.4 Populations with specialized service needs

21. That the Ministry of Health, in collaboration with health authorities, take a primary role in planning and funding highly specialized resources.

22. That these highly specialized facilities be treated in a similar fashion to tertiary services; the health authorities in which the facility is located would hold the funds, but would operate the housing service according to a set of principles agreed on by the partner regions who would need to access the housing service. This would ensure balanced resource development and promote inter-regional access.

8.5 Establishing communication networks

23. That health authorities appoint a representative in each community who will have the responsibility of organizing, coordinating and maintaining a local process of communication among families, consumers, service providers and professional staff in relation to housing issues. Health authorities must also ensure formal communication among representatives of all communities, with an appropriate balance between consumer, family, service provider and staff representatives.
24. That the Ministry maintain a best practices committee, which would identify common issues, maintain a focus on best practices and act as a consultative body for ministry and health authorities. The committee would include consumer, family, service provider and staff representatives with an interest in the field of mental health housing. They would be nominated by the health authorities and would be selected by the Ministry of Health for up to two-year terms. An attempt would be made to balance representation over time to ensure a rural/urban balance and balance across regions.

8.6 General

Staff training
25. That the Ministry of Health make sufficient funding available to health authorities to support staff training in the principles of psychosocial rehabilitation and the recovery model.

Information management
26. That health authorities, in collaboration with the Ministry of Health, collectively agree on a minimum data set of information to be collected for all housing services. Information should be consistent and standardized and follow the report terminology to allow for comparisons. Information must be available in an annual summary for each health authority and for the province.

Access to housing services information and best practices updates
27. That the Ministry of Health collaborate with health authorities to develop a centralized, easily accessible housing services information centre that is available to professionals, consumers and families. It is recommended that the information be available on a website and in print format and be regularly updated and widely circulated. This would promote communication of innovative approaches and documentation of best practice program examples. Information should also include evaluations of programs in relation to best practices criteria.

Jurisdictional barriers
28. Jurisdictional issues frequently arise between ministries in relation to providing housing and other support services for persons with specialized service needs. It is recommended that the Ministry of Health take a lead role in establishing a well communicated formal process for inter-ministerial planning and resource allocation for individuals with cross ministry involvements. The process must be speedy and must ensure the inclusion of the relevant health authorities.
Capital and operating funding
29. That the capital funding process, both at the Ministry of Health and through Homes BC, be coordinated with allocations for necessary support programs.

Lack of service space funding
30. That housing specifications include appropriate clinical space for working with residents of the housing units.
APPENDIX A: PRINCIPLES OF PSYCHOSOCIAL REHABILITATION (PSR)

These principles are taken from the IAPSRS Ontario Chapter position paper on psychosocial rehabilitation and the psychosocial rehabilitation literature (Cnaan, Blankertz, Messinger and Gardner, 1988).

Client involvement
Involvement of the person with a psychiatric disability in every aspect of the rehabilitation process is critical to a positive rehabilitation outcome. Services should be based on the needs of the person.

Client involvement in the shaping and evaluation of mental health services should also be facilitated.

Self-determination
Persons with psychiatric disabilities benefit from having control over decisions that affect their lives. They have the right and the ability to make personal decisions.

Differential needs
Persons with psychiatric disabilities have needs that are ongoing, unique and multidimensional.

Utilization of full human capacity
Persons with psychiatric disabilities have the potential for growth. They have strengths and assets that can be developed to help them maintain a sense of identity, dignity, self-esteem and competence.

Personal choice
Persons with psychiatric disabilities have the ability to make choices regarding living, learning, working and social environments.

Natural supports
Involvement with the natural support network is critical to a positive rehabilitation outcome.
Peer supports
Persons with psychiatric disabilities and their families can gain support and a sense of belonging and being connected, through involvement with their respective peer groups.

Hope
Hope is an essential ingredient of PSR. Skills and supports can be developed to enable the individual to develop the confidence to take the lead in his/her rehabilitation.

Functioning
Persons with psychiatric disabilities have the capacity to improve their level of functioning.

Belonging
Belonging is an essential ingredient in a psychiatrically disabled person’s growth and development.

Outcome measurement
It is important to measure the outcome of PSR.

Commitment of staff
Genuine concern with the well-being of clients and the belief that they are capable of progress must be of paramount importance to staff.

Client/practitioner relationship
The relationship between practitioner and client is a partnership within which a client centered approach is developed.

Early intervention
Prompt crisis intervention is essential in preserving most acquired skills and community ties.

Environmental approach
Each individual has the right to live and function in the setting that is least restrictive and that approximates, as closely as possible, a regular community setting.
Changing the environment
PSR advocates normalization, as well as restructuring and re-educating the environment, to facilitate the integration of people with emotional disabilities.

No limits on participation
The PSR approach maintains no limits on the length of participation and imposes few selection criteria. Once a person has accessed a PSR program, they may be considered part of it for as long as desired.

Work centered process
Work, especially the opportunity to aspire to and achieve gainful employment, is a deeply generative and re-integrative force and must be a central theme in any rehabilitation process.

Focus on functioning and fulfillment of social roles
Rather than focusing on treatment and the client's impairment, PSR focuses on utilizing the person's strengths and abilities for overall better independent functioning and fulfillment of social roles.
APPENDIX B: ISSUES RAISED AT CONSULTATION FORUM, NOVEMBER 4-5, 1999

- Financial assistance is needed for families who house and support their family member in their own home. There was a sense of a disincentive to house a relative when no financial support is offered. The alternative is to have the relative live outside the family home.

- All the best practice reports need to share a common set of beliefs and values.

- Many participants requested advice on how to implement and change their present mental health housing program. They may contact three members of the working group, who continue with the reform of housing in their regions. The three are Arleen Pare, Wendy Powley and Dennis Suwala.

- A provincial mental health conference is needed, that includes non-profit societies, to allow people to assist one another in making changes and linkages.
APPENDIX C: PROGRAM DESCRIPTION

1. SUPPORTED HOUSING SERVICES

1.1 Supported apartments

Block apartments
Dedicated apartment buildings, or clusters of apartments in a building, may provide individuals with a greater sense of support in that everyone in the building understands the illness and its impact. It also builds in a potential social network, critical in combating loneliness, a major drawback of independent living. This model is governed by the Residential Tenancy Act.

Structure
- Size:
  - dedicated apartment building; recommended not to exceed 40 units
- Design features:
  - fully self-contained, standard-sized suite; separate bedroom preferred.
  - communal space available (e.g., recreation room with kitchen, laundry facilities)
  - front door intercom and lock system for tenant security

Service Delivery
- Programs/services:
  - clinical treatment generally provided off site by the mental health centre/team or private psychiatrist
  - outreach staff available at the request of each tenant to assist in acquiring basic living skills and to provide medication maintenance support and bridge to community services
  - support services (i.e., home support workers, meals-on-wheels) may be available to individual tenants who need assistance with maintaining their units
  - opportunities for group socializing encouraged and facilitated by outreach workers
  - tenant councils
  - communal kitchen program, coffee hours, and regular apartment group meal can be features
Staffing:
- no expectation that the resident manager would provide any “care” to residents beyond notifying the police, emergency mental health services or ambulance in the case of an emergency
- in a dedicated building, a resident manager provides building maintenance and repairs (available seven days a week)
- outreach workers available five to seven days a week.
- outreach worker/tenant ratio based on tenant needs

Satellite apartments/mobile homes
This program is designed for people to live independently in the community on a permanent basis. Apartments are individual suites in private market apartment buildings and are scattered in various locations throughout a community. Rent is subsidized through the B.C. Housing Management Commission, through either federal/provincial subsidy agreements or Ministry of Health funding (SILP units). Tenants pay up to 30 per cent of gross monthly income toward rent. This model is governed by the Residential Tenancy Act.

Structure
- Size:
  - apartments not co-located, but scattered through the community in private market apartment accommodation or units owned by a non-profit agency
  - mobile homes are stand-alone or in mobile home parks
- Design features:
  - suites with separate bedrooms preferred; can accommodate singles, couples or families

Service delivery
- Programs/services:
  - tenants receive encouragement and support for an ongoing therapeutic relationship with a general practitioner, private psychiatrist or community mental health team
  - services are dependent on client needs and can include support, health maintenance, life skills training and advocacy and are based on individualized and personal goal planning
  - some satellite apartments have a fixed geographic location, while some are portable within region/sub-region boundaries
- Staffing:
  - support services provided off site by an outreach worker
- client/staff ratio determined by client need; wide range of support available, depending on individual need
- regular support ratio is 1:15
- intensive support ratio (e.g., SUPERSIL programs) is 1:5

Congregate housing
This model is designed for individuals who want to live independently, yet prefer to have meal services offered. It offers on site food services, outreach support and opportunities for peer support and social interaction. This model is governed by the Residential Tenancy Act.

Structure
• Size:
  - building to have no more than 20 suites
• Design features:
  - tenants have their own studio-style units with washroom facilities and minimal cooking facilities (e.g., microwave, stove top, apartment size refrigerator)
  - facility includes common areas (e.g., living room, kitchen, dining room, activity space, laundry facilities)
  - facility has outdoor space (e.g., roof top, interior courtyard)
  - tenants provided with a minimum of one meal a day
  - front door intercom and lock system for tenant security

Service delivery
• Programs/services:
  - clinical treatment provided off site by the mental health centre/team or private psychiatrist
  - outreach staff available at the request of each tenant to assist in such areas as acquiring basic living skills and to provide medication maintenance support and bridge to community services
  - homemaker services may be available to individual tenants who need assistance with maintaining their units
  - opportunities for group socializing encouraged and facilitated by outreach workers
  - tenant councils
  - support services can be provided by an individual support worker or by a team of support workers

Housing
• Staffing:
  – resident manager lives on site, is responsible for managing the building and is on call during evenings and weekends for building emergencies (e.g., building maintenance, janitorial duties, supervision of cooks)
  – cooks provide meal service seven days a week
  – outreach workers available
  – outreach worker/tenant ratio should not exceed 1:15

1.2 Group homes

Unlicensed mental health group homes offer opportunities for semi-independent living with minimal support by outreach staff. Several people share a house and participate in shared living arrangements and activities. Group homes may be owned and/or administered by non-profit societies or consumer groups.

Structure
• houses, duplexes and condos, generally located in residential neighborhoods
• Size:
  – usually three to eight bedrooms
• Design features:
  – single bedrooms with separate or shared bathrooms
  – living room and usually recreation room (perhaps in basement)
  – full kitchen and dining area

Service delivery
• Programs/services:
  – no on site programs or services
  – residents responsible for shopping, cooking, cleaning, laundry, yard work and transportation
  – access to physicians and other clinicians in community
  – access to community employment, training or day activity programs
  – access to community leisure and recreation programs
  – rehabilitation focused on learning basic living and social skills
  – requires a resident council and/or written code of conduct
  – residents are expected to maintain their own living costs, including shelter costs, usually through income assistance
1.3 Supported hotels

Single room occupancy (SRO) hotels leased and managed by non-profit societies, with on site support to provide services to persons with a mental illness. Some individuals are better accommodated by this model for various reasons.

Structure

- Size:
  - dependent on hotel size
  - some or all rooms in the hotel may be designated for persons with a mental illness
- Design features:
  - small hotel rooms with bed, dresser and, in some cases, minimal food preparation equipment (apartment-sized fridge/microwave)
  - separate or shared washrooms
  - lobby area and communal social spaces where available
  - security access to promote resident safety

Service delivery

- Programs/services:
  - psychiatric treatment services available off site at a mental health centre/team or private psychiatrist
  - support services as required (e.g., home support, meals-on-wheels) to assist residents with hotel room maintenance
- Staffing:
  - staffing varies to provide support for daily living needs and linking with treatment and other services
2. RESIDENTIAL SERVICES

2.1 Community homes/residences (fully staffed)

Structure

- Location:
  - set within a residential neighborhood home
- Size:
  - six to 10 beds recommended
- Design features:
  - required to meet Community Care Facility Act, Adult Care Regulations
  - single bedrooms with separate or shared bathrooms
  - variety of social spaces that provide different rooms for different activities
    (e.g., quiet room with no television, television room, games room)
  - soundproofing
  - significant amount of yard space for gardens and other outdoor activities
  - kitchen suitable for meal preparation by residents
  - staff office/staff lounge
  - similar to single family residence design

Service delivery

- Programs/services:
  - program and services delivered within a psychosocial rehabilitation framework
  - emphasis on community integration and bridging, particularly the use of
    community rehabilitation, educational, vocational, social and recreation programs
  - clinical case management available
  - residential care plans set out client goals
  - programming individualized to each resident’s needs, based on resident’s decisions
  - rehabilitation focus on learning basic living and social skills
  - illness de-emphasized; emphasis on the resident’s strengths
  - residents encouraged to cook and clean as they are able
  - food provided
  - psychiatric services available off site
  - medication administered—programs to teach self-administration of medication
    should be supported
  - residents, family and staff have ongoing input into program design and evaluation
family involvement encouraged
medical treatment provided by either the resident’s family physician or a house physician
transportation provided if required
resident councils

• Staffing:
  minimum staffing is determined by Community Care Facility Act, Adult Care Regulations
  staffing should be adequate to meet resident’s care and service needs—will generally require professional staffing

2.2 Community homes/residences (partially staffed)

This option is suitable for clients who are able to participate in communal living in a group home without full-time staffing. Clients must also be able to manage their own medications and willing to prepare group meals on a rotating basis. This model offers some autonomy, while providing a real sense of community.

Structure
• Location:
  - set within a residential neighborhood home
• Size:
  - no more than 10 residents
• Design features:
  - single, lockable bedrooms with separate or own bathrooms
  - variety of social spaces
  - soundproofing
  - kitchen suitable for meal preparation by residents
  - security—on call system for staff when not on site; good protocol re: security
  - service delivery

Service delivery
• Programs/services:
  - emphasis on community integration and bridging
  - clinical case management provided by off site staff

Housing
• programs and services delivered within a psychosocial rehabilitation framework
• programming individualized to residential needs, based on resident decisions
• residents responsible for cooking/cleaning

• Staffing:
  • one to two staff on duty some hours each day
  • on-call protocol arranged for off duty hours

2.3 Family care home

Family care homes are designed for those individuals with a mental illness who generally require minimal care and support. In some cases, however, persons who require very specific care and rehabilitation that is best delivered in a family setting may use a family care home.

Structure

• Location:
  • located within the community and close to amenities
  • family dwelling (house or apartment)
  • unlicensed

• Size:
  • maximum two residents

• Design features:
  • single bedrooms with separate or shared bathrooms or self-contained suites
  • single family dwelling/environment, including common living, dining, kitchen, laundry and activity areas
  • family or individual provides care and support

Service delivery

• Programs/services:
  • non-clinical 24-hour care and support
  • clinical treatment provided off site by mental health centre/team/ or private psychiatrist
  • opportunities to assist in basic living skills, monitoring medication, providing bridging to community
  • food provided

Best Practices for B.C.'s Mental Health Reform
• Staffing:
  – a family or an individual

2.4 Step down home

This is a community home (possibly rental) that provides short-term housing for individuals leaving hospital. It provides both a community base from which to locate long-term housing and a home-like environment that leads to better recovery when a patient is ready for discharge but lacks suitable, immediately available long-term housing. It also allows for earlier hospital discharge. The home does not necessarily require full-time, 24-hour staffing and, therefore, may not need to be licensed.

Structure
• Size:
  – up to six beds
• Design features:
  – separate bedrooms
  – communal space available

Service Delivery
• Programs/services:
  – clinical treatment generally provided off site by the mental health centre/team or private psychiatrist
  – outreach and on-site staff are available at the request of each resident to assist in housing search and acquisition of basic living skills
  – meals provided
  – medications may be self-administered
• Staffing:
  – partial staffing
  – outreach workers may be available five to seven days a week
  – outreach workers/resident ratio based on resident needs
3. EMERGENCY HOUSING

3.1 Shelter accommodation

A shelter provides short-term accommodation for persons with serious social and behavioral problems who have no other housing options.

Structure
- Size:
  - may range in size from six beds to 60
  - may be seasonal—increasing beds for cold/wet weather
- Design features:
  - single and shared bedrooms
  - shared bathrooms, dining facilities and social spaces

Service delivery
- Programs/services:
  - clinical treatment may be available from a mental health centre/team or private psychiatrist
  - shelter may serve only persons with a mental illness or may serve a broader homeless population
  - stays are generally short term, one to two weeks, while accommodation is found
  - post-discharge outreach services may be provided to assist stabilization and reduce likelihood of a return to homelessness
- Staffing:
  - staff on site 24 hours a day who focus on linking individual with housing and other necessary community services

3.2 Short-stay crisis home/residence

A home/residential facility designed as an alternative to hospitalization for clients in a psychiatric crisis or for clients who are at risk of decompensation. They endeavor to prevent hospitalization and maintain client autonomy in a safe, supportive and supervised setting. The focus is on immediate crises and achieving stabilization and readjustment to
community living. Every effort is made to minimize disruption of the client’s ties to family, friends and community. A short-stay crisis home/residence provides a structured therapeutic environment in a residential setting.

**Structure**
- **Size:**
  Can range from family homes to larger facilities (e.g., Venture – 20 beds)
- **Design features:**
  - licensed under the *Community Care Facility Act*
  - family-style housing
  - single or shared bedrooms, shared bathrooms
  - staff offices
  - shared communal social spaces

**Service delivery**
- **Programs/services:**
  - emphasis on stabilization of the psychiatric illness
  - usually short-stay, one to seven days
- **Staffing:**
  - staffed on a 24-hour-a-day basis with professional staff available daily
  - psychiatric services generally available on site
APPENDIX D: COSTING MODELS

Costing Model
Supported Housing
Supported Apartments

<table>
<thead>
<tr>
<th></th>
<th>Rent Subsidized</th>
<th>Non-Rent Subsidized</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regular Support</td>
<td>Intensive Support</td>
</tr>
<tr>
<td>Staffing</td>
<td>1 FTE:15 consumers</td>
<td>1 FTE:5 consumers</td>
</tr>
<tr>
<td>Salary/Benefits</td>
<td>$45,000</td>
<td>$45,000</td>
</tr>
<tr>
<td>Admin (8%)</td>
<td>$3,900</td>
<td>$3,900</td>
</tr>
<tr>
<td>Consumer Program/Services ($240/yr/consumer)</td>
<td>$3,600</td>
<td>$1,200</td>
</tr>
<tr>
<td>Rent Subsidy ($375/mo)</td>
<td>$67,500</td>
<td>$22,500</td>
</tr>
<tr>
<td>Total</td>
<td>$129,000</td>
<td>$72,600</td>
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<tr>
<td>Cost/consumer/year</td>
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<tr>
<td>Cost/consumer/day</td>
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<td>$38.78</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Regular Support</th>
<th>Intensive Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>1 FTE:15 consumers</td>
<td>1 FTE:5 consumers</td>
</tr>
<tr>
<td>Salary/Benefits</td>
<td>$45,000</td>
<td>$45,000</td>
</tr>
<tr>
<td>Admin (8%)</td>
<td>$3,900</td>
<td>$3,900</td>
</tr>
<tr>
<td>Consumer Program/Services ($240/yr/consumer)</td>
<td>$3,600</td>
<td>$1,200</td>
</tr>
<tr>
<td>Rent Subsidy ($375/mo)</td>
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<td>N/A</td>
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<td>Total</td>
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<td>$50,100</td>
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<tr>
<td>Cost/consumer/year</td>
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<tr>
<td>Cost/consumer/day</td>
<td>$9.88</td>
<td>$27.45</td>
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</table>
### Staffing Breakdown:

<table>
<thead>
<tr>
<th>Position</th>
<th>Regular Staffing</th>
<th>Relief Staffing</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Outreach Staff</td>
<td>$17.62 $18.75</td>
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<tr>
<td>Cook</td>
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<tr>
<td></td>
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<td>Sub-Total</td>
<td>$47.87 $50.00</td>
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<td>$52.00</td>
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- Relief = 14.28% for BCGEU/HEU Outreach/Cook

### Staffing Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Salary</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EI Calculation</td>
<td>$259,128</td>
<td>7,992</td>
</tr>
<tr>
<td>Less: Self-Employed Contract Salary</td>
<td>48,783</td>
<td>0</td>
</tr>
<tr>
<td>Administration &amp; Co-op Salary</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CPP Calculation</td>
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<td>6,839</td>
</tr>
<tr>
<td>Less: Basic Exempt ($3,500 x 4 Staff)</td>
<td>14,000</td>
<td>0</td>
</tr>
<tr>
<td>CPP @ 2.23%</td>
<td>$213,722</td>
<td>6,839</td>
</tr>
<tr>
<td>Less: 0 Employees at max. cop ($1089.50)</td>
<td>0</td>
<td>0</td>
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<tr>
<td>WCB Calculation</td>
<td>$259,128</td>
<td>5,779</td>
</tr>
<tr>
<td>WCB @ 2.23%</td>
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<td>5,779</td>
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<tr>
<td>Other Benefits</td>
<td>$259,128</td>
<td>77,304</td>
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<td>Total Benefits</td>
<td>$45,544</td>
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### Budget Summary:

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual $</th>
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<tr>
<td>Staffing</td>
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<td>Annual Total</td>
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### Other Budgets:

- Food/Supplies (breakdown of costs)
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<thead>
<tr>
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<tbody>
<tr>
<td>Food</td>
<td>$24,500</td>
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<td>Housekeeping/laundry</td>
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<td>$50.00</td>
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<tr>
<td>TOTAL</td>
<td>$32,500</td>
<td>$53.16</td>
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### Reason for Update:

...
### Staffing Breakdown:

<table>
<thead>
<tr>
<th>Position</th>
<th>Regular Staffing</th>
<th>Relief Staffing</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Regular Rate</td>
<td>Relief Rate</td>
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<tr>
<td>Administration</td>
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<td>Management, of Care</td>
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<td>Asst Manager</td>
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<tr>
<td>Prof. Care/Weekend Relief</td>
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<tr>
<td>Health Care Worker</td>
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<tr>
<td>HCV(Contingency Hrs.)</td>
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<tr>
<td>Support Staff</td>
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<td>$0</td>
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</table>

Sub-Total: $7,800

Add: EI 3.00%

Add: CPP 3.00%

Add: WCB 2.23%

Add: Other Benefits (BCGEU) $10,012

Add: Other Benefits (BCNUHSA) $7,330

Total Staffing: $35,813

1 FTE = 2080 hrs/year

Relief: 12% for excluded manager

14.28% for BCGEU/HEU Health Care Workers/Asst. Mgr.

23% for BCNUHSA Paramedical/Nursing staff

### Budget Summary:

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual $</th>
<th>Per Diam</th>
<th>Cost per km. 0.35</th>
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<tr>
<td>Staffing</td>
<td>$207,812</td>
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<td>Food/Supplies</td>
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<td>Transportation</td>
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<td>Sub-Total</td>
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<td>$106.55</td>
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<tr>
<td>Property</td>
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<td>$10.00</td>
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</tr>
<tr>
<td>Annual Total</td>
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<td>$127.15</td>
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<tr>
<td>Less: User Fee</td>
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<tr>
<td>Monthly Payment</td>
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<tr>
<td>Monthly Payment</td>
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### Staffing Benefits

<table>
<thead>
<tr>
<th>Year:</th>
<th>Salary</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>176,762</td>
<td></td>
</tr>
<tr>
<td>Less: Self-Employed Contract Salary</td>
<td>47,728</td>
<td></td>
</tr>
<tr>
<td>Administration H: Costs</td>
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<td></td>
</tr>
<tr>
<td>CPP Calculation</td>
<td>4,903</td>
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<tr>
<td>Total Salaries (Including Relief)</td>
<td>154,044</td>
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</tr>
<tr>
<td>Less: Basic Exempt. ($3,000 x 6 Staff)</td>
<td>21,000</td>
<td></td>
</tr>
<tr>
<td>Salaries over $30,000</td>
<td>4,903</td>
<td></td>
</tr>
<tr>
<td>CPP Calculation @ 3.3%</td>
<td>133,044</td>
<td></td>
</tr>
<tr>
<td>0 - Employees at max. cont. ($1008.80)</td>
<td>4,259</td>
<td></td>
</tr>
<tr>
<td>WCB Calculation</td>
<td>4,259</td>
<td></td>
</tr>
<tr>
<td>Total Salaries (Including Relief)</td>
<td>176,762</td>
<td></td>
</tr>
<tr>
<td>WCB @ 2.23%</td>
<td>3,942</td>
<td></td>
</tr>
<tr>
<td>Other Benefits for BCGEU/HEU Employees</td>
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</tr>
<tr>
<td>Total Benefit Rate = 20.01%</td>
<td>10,812</td>
<td></td>
</tr>
<tr>
<td>Minus 9.23% provided above = 10.78%</td>
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<td></td>
</tr>
<tr>
<td>Other Benefits for BCNUHSA Employees</td>
<td>53,392</td>
<td></td>
</tr>
<tr>
<td>Total Benefit Rate = 22.97%</td>
<td>7,336</td>
<td></td>
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<tr>
<td>Minus 9.23% provided above = 13.74%</td>
<td></td>
<td></td>
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<tr>
<td>TOTAL BENEFITS</td>
<td>31,052</td>
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</table>

### Food/Supplies (Breakdown of costs)

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual $</th>
<th>Per Diam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>$13,578</td>
<td>$6.93</td>
</tr>
<tr>
<td>Housekeeping/Janitor</td>
<td>$1,639</td>
<td>0.75</td>
</tr>
<tr>
<td>Recreation</td>
<td>$1,000</td>
<td>0.45</td>
</tr>
<tr>
<td>Medical</td>
<td>$187</td>
<td>0.09</td>
</tr>
<tr>
<td>Other: Furnishings Replacement</td>
<td>$525</td>
<td>0.26</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$18,979</td>
<td>0.75</td>
</tr>
</tbody>
</table>

**Reason for Update:**
**FACT SHEET**

### Basic Support Congregate Housing

#### Units:
- 14 FTE Outreach (2080 hrs/yr x 1.4)
- 14 FTE Cook (2080 hrs/yr x 1.4)

#### Staffing Breakdown:

<table>
<thead>
<tr>
<th>Position</th>
<th>Regular Staffing</th>
<th>Relief Staffing</th>
<th>Total Hours (1,420)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach Staff</td>
<td>$17.97</td>
<td>$2,000</td>
<td>117</td>
</tr>
<tr>
<td>Cook</td>
<td>$19.77</td>
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<td>117</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$3,827</td>
</tr>
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</table>

### Staffing Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Salary</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EI Calculation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Salaries</td>
<td>114,280</td>
<td></td>
</tr>
<tr>
<td>Less: Self-Employed</td>
<td>48,713</td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>0</td>
<td></td>
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<tr>
<td>Salaries over $20,000</td>
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<tr>
<td>EI Calculation at 3.8%</td>
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<tr>
<td>CPP Calculation</td>
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<td></td>
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<tr>
<td>Total Salaries</td>
<td>100,974</td>
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<tr>
<td>Less: Basic Exempt ($3,200 x 4 Staff)</td>
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<td></td>
</tr>
<tr>
<td>Salaries over $36,000</td>
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<tr>
<td>CPP Calculation at 3.3%</td>
<td>88,974</td>
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<tr>
<td>0 - Employees at max. cont. ($1068.80)</td>
<td>0</td>
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</tr>
<tr>
<td>WCB Calculation</td>
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<td></td>
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<tr>
<td>Total Salaries</td>
<td>114,280</td>
<td></td>
</tr>
<tr>
<td>WCB at 2.23%</td>
<td>2,548</td>
<td></td>
</tr>
<tr>
<td>Other Benefits for BGGEUHEU Employees</td>
<td>12,319</td>
<td></td>
</tr>
<tr>
<td>Total Benefit Rate = 20.01%</td>
<td>114,280</td>
<td></td>
</tr>
<tr>
<td>Less 9.23% provided above = 10.78%</td>
<td>12,319</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL BENEFITS</strong></td>
<td><strong>20,140</strong></td>
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### Budget Summary:

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<thead>
<tr>
<th>Category</th>
<th>Annual $</th>
<th>Per Dym</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent (office)</td>
<td>$1,000</td>
<td>$0.17</td>
</tr>
<tr>
<td>Audit</td>
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</tr>
<tr>
<td>Telephone</td>
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<td>$0.21</td>
</tr>
<tr>
<td>Insurance</td>
<td>$1,200</td>
<td>$0.21</td>
</tr>
<tr>
<td>Recruitment/Training</td>
<td>$1,600</td>
<td>$0.26</td>
</tr>
<tr>
<td>Office Supplies</td>
<td>$1,500</td>
<td>$0.26</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$10,000</td>
<td>$1.71</td>
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</table>

### Food/Supplies (breakdown of costs)

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual $</th>
<th>Per Dym</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>$24,500</td>
<td>$4.20</td>
</tr>
<tr>
<td>Housekeeping/Laundry</td>
<td>$3,000</td>
<td>$0.51</td>
</tr>
<tr>
<td>Recreation</td>
<td>$0</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$32,500</td>
<td>$5.51</td>
</tr>
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</table>

### Reason for Update:

- [Text for update reasons]

---

1 FTE = 2080 hrs/yr
Retail: 14.28% for BGGEUHEU Outreach/Cook
### Staffing Breakdown:

<table>
<thead>
<tr>
<th>Position</th>
<th>Regular</th>
<th>Relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$22.86</td>
<td>0</td>
</tr>
<tr>
<td>Manager, of Care</td>
<td>$22.86</td>
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</tr>
<tr>
<td>Admin Manager</td>
<td>$17.60</td>
<td>0</td>
</tr>
<tr>
<td>Prof. Care/Weekend Relief</td>
<td>$24.54</td>
<td>0</td>
</tr>
<tr>
<td>Health Care Worker</td>
<td>$16.00</td>
<td>0</td>
</tr>
<tr>
<td>HCW-Daylight</td>
<td>$13.50</td>
<td>0</td>
</tr>
<tr>
<td>HCW (Contingency Hrs.)</td>
<td>$0.00</td>
<td>0</td>
</tr>
<tr>
<td>Support Staff</td>
<td>$0.00</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td>$11,680</td>
<td>$200.00</td>
</tr>
<tr>
<td><strong>Add: E.I.</strong></td>
<td>3.8%</td>
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</tr>
<tr>
<td><strong>Add: CPP</strong></td>
<td>2.7%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Add: WCB</strong></td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Add: Other Benefits (BCGEULHEU)</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Total Staffing</strong></td>
<td>$271,011</td>
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</tbody>
</table>

**1 FTE = 2088 hrs/year**
Relief: 12% for excluded manager
14.39% for BCGEULHEU Health Care Workers/Asst. Mgr
23% for BCONUHSA Paramedical/Nursing staff

### Budget Summary:

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual $</th>
<th>Per Diem</th>
<th>Cost per km.</th>
<th>0.35</th>
</tr>
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<tbody>
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<td>Staffing</td>
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<tr>
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<td>Transportation</td>
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<td><strong>Annual Total</strong></td>
<td>$529,799</td>
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<td>Less: User Fee</td>
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<td>$573,890</td>
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<td><strong>Monthly Payment</strong></td>
<td>$22,808</td>
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### Staffing Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Salaries (Including Relief)</th>
<th>CPP Calculation</th>
<th>CPP Calculation</th>
<th>WCB Calculation</th>
<th>Other Benefits for BCGEULHEU Employees</th>
<th>Other Benefits for BCONUHSA Employees</th>
<th>Total Benefit Rate</th>
<th>Annual $</th>
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<tbody>
<tr>
<td></td>
<td>230,153</td>
<td>200,804</td>
<td>179,804</td>
<td>151,832</td>
<td>106,763</td>
<td>14,672</td>
<td>22.97%</td>
<td>$3,355</td>
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### Reason for Update:

...
### Residential Housing

**Staffing Breakdown:**

<table>
<thead>
<tr>
<th>Position</th>
<th>Regular Staffing</th>
<th>Relief Staffing</th>
<th>Total Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs.</td>
<td>Rate</td>
<td>Total</td>
</tr>
<tr>
<td>Administration</td>
<td>22.88</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Manager/Of Care</td>
<td>22.88</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asst Manager</td>
<td>17.80</td>
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<td>0</td>
</tr>
<tr>
<td>Prof. Care/Weekend Relief</td>
<td>24.24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Care Worker</td>
<td>18.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HCW (On-call)</td>
<td>13.60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Support Staff</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>13.140</td>
<td>224,164</td>
<td>1,902</td>
</tr>
<tr>
<td>Add: EI</td>
<td>3.60%</td>
<td>1,063.00</td>
<td>manager</td>
</tr>
<tr>
<td>Add: CPP</td>
<td>3.20%</td>
<td>1,068.80</td>
<td>manager</td>
</tr>
<tr>
<td>Add: WCB</td>
<td>2.20%</td>
<td>-</td>
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<tr>
<td>Add: Other Benefits (BCGEUHEU)</td>
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<tr>
<td>Add: Other Benefits (BCNUHSA)</td>
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<td>Total Staffing</td>
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</tr>
</tbody>
</table>

**1 FTE = 2085 hrs/year**

**Relief:**
- 12% for excluded manager
- 14.28% for BCGEUHEU Health Care Workers/Asst. Mgr
- 23% for BCNUHSA Paramedical/Nursing staff

**Budget Summary:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual $</th>
<th>Per Dem</th>
<th>Cost per km.</th>
<th># losers</th>
<th>4,455</th>
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<td>MHE Portland</td>
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**Reason for Update:**

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**Staffing Benefits**

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<tr>
<th>Category</th>
<th>Salary</th>
<th>Benefits</th>
</tr>
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<tbody>
<tr>
<td>EI Calculation</td>
<td>258,840</td>
<td>5,947</td>
</tr>
<tr>
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<tr>
<td>CPP Calculation</td>
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<td>5,501</td>
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<td>WCB Calculation</td>
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<td>5,728</td>
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### FACILITY FACT SHEET

**Residential Housing**

<table>
<thead>
<tr>
<th>Days</th>
<th>FTE Nurse</th>
<th>FTE HCW</th>
<th>Support Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shifts</th>
<th>FTE Nurse</th>
<th>FTE HCW</th>
<th>DCC/HDW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evenings</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Certified</th>
<th>(BOGEMUHEUCN/HCNA/SHA)</th>
</tr>
</thead>
</table>

#### Staffing Breakdown:

<table>
<thead>
<tr>
<th>Position</th>
<th>Regular Staffing</th>
<th>Relief Staffing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regular</td>
<td>Relief</td>
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</tr>
<tr>
<td></td>
<td>Salary</td>
<td>Pay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regular</td>
<td>Relief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hours</td>
<td>Pay</td>
<td></td>
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<tr>
<td></td>
<td>FTE</td>
<td>Regular Pay</td>
<td>Relief Pay</td>
</tr>
<tr>
<td></td>
<td># of Hours</td>
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</tr>
<tr>
<td>Administration</td>
<td>$22.88</td>
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<td>$0</td>
</tr>
<tr>
<td>Manager (BCHN)</td>
<td>$22.88</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Asst Manager</td>
<td>$17.80</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Prof Care/Housing (BCHN)</td>
<td>$24.24</td>
<td>11.88</td>
<td>$531.22</td>
</tr>
<tr>
<td>Health Care Worker</td>
<td>$16.00</td>
<td>19.20</td>
<td>$308.00</td>
</tr>
<tr>
<td>HCW-Oversight (nurse)</td>
<td>$19.00</td>
<td>2.620</td>
<td>$46.720</td>
</tr>
<tr>
<td>Support Staff</td>
<td>$18.00</td>
<td>2.150</td>
<td>$35.040</td>
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<tr>
<td>Sub-Total</td>
<td>$27.010</td>
<td>$528.403</td>
<td>$2,485</td>
</tr>
</tbody>
</table>

| Add EI                    | 3.30%             | 1,053.00        | $3,554 |
| Add CPP                   | 3.20%             | 1,068.80        | $3,558 |
| Add WCB                   | 2.37%             | 1,139.99        | $4,839 |
| Add Other Benefits (BOGEMUHEU) | 3.13%       | 1,139.99        | $4,839 |
| Add Other Benefits (BCHN/HCNA/SHA) | 2.37%       | 1,139.99        | $4,839 |
| **Total Staffing**        | **$759.94**       | **10,554.00**   | **47,848** |

**FTE = 2085 hrs/year**

Relief:
- 12% for excluded manager
- 14.28% for BOGEMUHEU Health Care Workers/Ast Mgr
- 23% for BCHN/HCNA Paramedical/Nursing staff

#### Budget Summary:

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual $</th>
<th>Per Dcnm</th>
<th>Cost per km.</th>
<th># km's</th>
<th># doubles</th>
<th># single user</th>
<th>User Fee</th>
<th>$150.00</th>
</tr>
</thead>
<tbody>
<tr>
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<td>12.27</td>
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<td>12.27</td>
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<tr>
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<tr>
<td>Sub-Total</td>
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<td>$1,200.00</td>
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<tr>
<td>Less User Fee</td>
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<td>0.00</td>
<td>-</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
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<td>1,750</td>
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<td>0.00</td>
<td>0.00</td>
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#### Staffing Benefits:

<table>
<thead>
<tr>
<th>Category</th>
<th>Salary</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EI Calculation</td>
<td>627,749</td>
<td>23,854</td>
</tr>
<tr>
<td>CPP Calculation</td>
<td>528,403</td>
<td>16,013</td>
</tr>
<tr>
<td>WCB @ 2.23%</td>
<td>279,507</td>
<td>13,999</td>
</tr>
</tbody>
</table>

**TOTAL BENEFITS** 131,845

#### Reason for Update:

---

**FACILITY FACT SHEET**

**Short Stay Crisis Residence**

**Bed Capacity:**

10

Days - 1 FTE Nurse, 2 FTE HCI, 76 support staff

Evenings - 1 FTE Nurse, 2 FTE HCW

Shifts - 1 FTE Nurse, 1 FTE DCC/HDW

Facility Certified - (BOGEMUHEU/HCNA/SHA)

**Staffing Breakdown:**

<table>
<thead>
<tr>
<th>Position</th>
<th>Regular Staffing</th>
<th>Relief Staffing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regular</td>
<td>Relief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pay</td>
<td>Pay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FTE</td>
<td>Pay</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>Pay</td>
<td></td>
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<tr>
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</tr>
<tr>
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</tr>
</tbody>
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#### Staffing Benefits:

<table>
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<tr>
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</table>

**TOTAL BENEFITS** 131,845

#### Reason for Update:
GLOSSARY

accountability. The management team is responsible for defining expected outcomes and performance measures, a plan for monitoring service delivery of public funds.

accreditation. External, formal review of an agency’s performance and adherence to standards of delivering care services. Certification by a national organization whose business is the evaluation of compliance by service organizations, such as hospitals, with pre-set standards of care and/or service.

acute care (also referred to as secondary level care). Diagnostic and therapeutic health care (in medical disciplines, including psychiatry) provided by health care professionals, usually in a hospital setting and for a short duration.

acute psychiatry (inpatient). Assessment, diagnosis, treatment, stabilization and short-term rehabilitation of people with serious mental illnesses admitted voluntarily or involuntarily to a hospital psychiatric unit, which often entails emergency psychiatric care.

adult. Person 19 years of age or older.

advocacy. The act of informing and supporting people so they can make the best decisions possible for themselves or an act or acts undertaken on behalf of others when they are unable to act on their own.

ALOS. Average length of stay.

Assertive community treatment (ACT). An alternative to other forms of community care which, because of its comparative expense, should be targeted to the most appropriate clients (i.e., frequent users of the system, including inpatient care and forensic services). The 1998 mental health plan addresses the two per cent of the population with serious and persistent mental illness with accompanying functional disabilities. The plan supports intensive or assertive community treatment for only a portion of the most seriously mentally ill, up to 8,200 clients.

best practices in mental health. Descriptions of what can be done to facilitate change for the better in mental health policies, practices and initiatives. Factors that facilitate change include clearly articulated conceptual bases, wide stakeholder involvement, political vision and will, infrastructure supports, the reallocation of funds and personnel from institutions to community, partnerships beyond health, reduction in stigma, enthusiastic leaders, skilled staff and the Canadian Mental Health Association National Framework for Support.
biopsychosocial approach/model. Services that take into account the biological, psychological and social needs of an individual. Involves multidisciplinary care teams, including physicians, nurses, pharmacists, social workers, occupational therapists, dietitians and psychologists.

case management. The coordination of a consumer’s health care, housing, employment, training and/or rehabilitation services, usually by one person (the case manager) operating in a team environment who liaises with all others providing services to the consumer. Case management provides active outreach, coordination of personalized care plans and monitoring of mental health status.

clinical practices guidelines. Systematically developed statements to assist practitioners in decisions about appropriate health care for clients in specific clinical circumstances.

community resource base concept. This concept “assumes the perspective of the person in the centre: the consumer who is actually living and coping with a mental health problem. The majority of consumers now live most of their lives in the community and are influenced by a wide range of factors.” These factors include housing, education, work, income, mental health services, consumer groups and organizations, family and friends and generic community services and groups.

consumers. People who use mental health services.

crisis stabilization program. Provides community-based, short-term treatment and stabilization services for individuals in psychosocial and psychiatric crises as an alternative to hospitalization. During the client’s stay, a thorough assessment is completed, intensive brief crisis intervention services are provided and an immediate action plan for community re-integration is implemented.

decompensate. The psychotic symptoms return or the person’s ability to function is disrupted.

designated facility. A hospital or provincial mental health facility that may admit involuntary patients under the Mental Health Act.

determinants of health. Factors that influence and determine health status. These include social, economic and physical environments, health services, biological influences and health behaviors and skills.

DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. The American Psychiatric Association’s classification tool to assist care practitioners in classifying mental disorders based on symptoms.

dual diagnoses. Commonly used to describe the condition of people who have a mental illness and either a mental handicap or substance misuse issues.

ECT. Electroconvulsive therapy.
emergency accommodation. Facilities that offer short-term emergency accommodation in a supportive environment for people with marked behavioral and social problems associated with mental illness who have no other immediate housing options available to them, but who do not require care in a hospital or intensively-staffed facility.

effectiveness. The capacity of choice. Includes the ability to define, analyze and act on problems one experiences in relation to others and in one's environmental living conditions. As a process, describes the means through which internal feelings of powerlessness are transformed and group actions initiated to change the conditions that create or reinforce inequalities in power.

epidemiology. Prevalence of a disease in a particular community at a particular time.

etiology. Pertaining to the science of the causes of disease.

evidence-based decision making. A process that takes facts, data and evidence into account. It is an essential part of effective and accountable planning, action and evaluation.

family care home. Care provided in approved homes to one or two adults with a serious and persistent mental illness who are unable to live independently. This category of care is not subject to licensing under the provincial Community Care Facilities Act.

forensic. Forensic Psychiatric Services provides assessment, diagnosis, treatment, detention and supervision of people with mental illness who are involved with the criminal justice system.

FTE (full-time equivalent). FTE is the unit used to describe a full-time position. For example, two half-time positions equal one FTE.

functional impairment. An individual's reduced ability to perform usual daily activities. A number of measurements exist to gauge a person's level of functioning (and level of functional impairment). The global assessment of functioning (an aspect of assessment that is part of the ASP DSM-II) is one such tool.

governance. The authority to operate a health care program. Governing bodies, such as boards of directors or trustees, generally define the vision, mission and values of an organization and set goals, objectives and priorities for its operation.

guidelines. A suggestion or set of suggestions that guides or directs action. The purpose of a guideline is to provide additional information that assists service providers to comply with policy. Guidelines may be suggestions on how to carry out or implement policy. Whereas health authorities and services providers must comply with Ministry policy, they do not have to comply with guidelines.
health authorities. Public bodies mandated under the Health Authorities Act to govern, manage and deliver health services in a defined geographic area. Refers to either Regional Health Boards (RHBs) or Community Health Councils (CHCs). Community Health Service Societies (CHSSs) are included here, although they do not have status under the act and derive their authority from their constitution and bylaws, established pursuant to the Society Act.

RHBs govern the delivery of all health services within a designated region.

CHCs govern the delivery of acute and continuing care-based services, such as hospitals and intermediate-care facilities, in areas of the province where there are no RHBs.

CHSSs govern the delivery of services that are broadly regional in nature—public health, community health care nursing, community rehabilitation, case management, health services for community living and adult mental health services—in areas of the province where there are no RHBs. Collectively, the CHSSs and the CHCs within a region govern the delivery of all health services in the region.

health status. A group's or community's status of health, evaluated by means of universal epidemiological indicators, such as the rates of illness and death, life expectancy and potential years of life lost, and compared with other populations.

integration. Organization of service entities, along a continuum ranging from cooperation between agencies to full amalgamation of governance, management and service delivery structures, in order to ensure that the client's needs are met in a coherent, unified, holistic and efficient manner.

mandate. The scope of an organization's responsibility.

Mental Health Act. British Columbia's Mental Health Act was proclaimed in 1964. Its purpose is to ensure "...the treatment of the mentally disordered who need protection and care..." The main focus of the Mental Health Act is to provide authority, criteria and procedures for involuntary admission and treatment. The act also provides protection to ensure that these provisions are applied in an appropriate and lawful manner.

mental health crisis. An acute disturbance of thinking, mood, behavior or social relationship that requires an immediate intervention; which involves an element of unpredictability that is usually accompanied by a lack of response to social controls; and may be defined as such by the client, the family or other members of the community, including family physicians or police.
multiaxial assessment. An assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict the outcome. There are five axes included in DSM-IV:

- Axis I  Clinical Disorders
- Axis II  Personality Disorders
- Axis III  General Medical Conditions
- Axis IV  Psychosocial and Environmental Problems
- Axis V  Global Assessment of Functioning

operating budget. The amount of funding necessary to pay for the cost of running an organization.

organic brain syndrome. A psychological or behavioral abnormality associated with a temporary or permanent dysfunction of the brain caused by disease processes, strokes or accidents.

outreach. Services are taken to the consumer (e.g., at home, at work, in a facility), rather than requiring the consumer to attend a clinic or hospital.

partnership model in mental health. Services provided through individual care planning carried out in a partnership among the Ministry of Health, service providers, local governments, family members, other unpaid caregivers and consumers to meet the needs of consumers and in the context of all the roles and functions of all parts of the mental health system.

psychosocial rehabilitation. Psychiatric rehabilitation services designed to assist a person with a serious mental illness in effectively managing the illness and compensating for the functional deficits associated with the illness. People who receive psychosocial rehabilitation services are significantly more likely to be able to return to work or school or to resume a participating role in the community. The range of psychosocial services may include rehabilitation, case management, residential treatment and support, crisis services, social services, housing, vocational rehabilitation, substance misuse treatment, peer support and family support.

psychotropic drug. Any medication that has a primary effect on the central nervous system, with the intention of improving moods or thinking. The term "typical" psychotropic drug refers to relatively old products. The term "atypical" refers to psychotropic drugs that are relatively new and designed to treat a wider range of symptoms with fewer side effects.
primary care. Preventive, diagnostic and therapeutic health care provided by general practitioners and other health care professionals. The first level of care normally accessed by clients and patients. Primary care may include referral to more specialized levels of care—e.g., secondary (hospital or specialist care). Family doctors are often referred to as “primary care physicians.”

quality assurance (QA). An ongoing program to ensure that standards of service delivery are being met.

residential care. Provided in community-based, licensed facilities that are staffed to provide full-time care, supervision and psychosocial rehabilitation for people whose social and/or mental functioning prevents them from living more independently. These facilities average 13 residents and are regulated by the Community Care Facility Act and the Adult Care Regulations. The facilities are subject to program standards, guidelines, policies and procedures.

residential care for specialized needs. Augmented resources provided to community care settings, to respond to the complex care needs of people with severe neuro-psychiatric disorders and very challenging behaviors.

residential program/services. An organized program enabling clients to have the best possible quality of life, while remaining or becoming integrated into the community. Residential services may be provided in rural or urban areas, in houses, apartments, townhouses or other culturally appropriate settings.

respite. Temporary, short-term care, designed to give relief or support to a family caregiver who has responsibility for the ongoing care and supervision of a family member with a serious mental illness. Respite can be provided inside or outside the home.

secondary level care. (See acute care)

serious mental illness. Generally, illnesses such as schizophrenia, manic depression and bipolar disorder represent the most serious mental illness. It is acknowledged, however, that there are others for whom medical risk and level of impairment—regardless of diagnosis—defines their mental illness as “serious.”

stakeholders. Representatives of the British Columbia mental health care community of interest (e.g., consumers, families, professionals, unions, health authorities).

standard. An established, measurable, achievable and understandable statement that describes a desired level of performance against which actual performance can be compared. Used by service providers to attain and maintain quality of care or service delivery, they state what consumers and the public can expect from a service. While a policy tells service providers what to do, a standard is a tool that allows a service provider to measure, monitor and compare actual performance against a benchmark.
supported education. An effective means of helping individuals with psychiatric disabilities to achieve success in accessing and pursuing educational opportunities of their choice.

supported housing. A variety of living arrangements (usually self-contained living units) for people with a serious and persistent mental illness who are able to live independently with the assistance of a range of support services and the provision of a housing subsidy.

tertiary care. The care of people with serious, complex and/or rare mental disorders who, by reason of severe psychotic behavior or the need for specialized staff or facilities, cannot be managed by the resources available at the primary and secondary levels of care in the province. It also includes specialized services such as child and adolescent, psychogeriatric, alcohol/substance abuse and forensic mental health services.

Tertiary mental health care includes specialized intensive acute-care assessment and short-term treatment programs and both short-term (episodic) and long-term institutional care for severe chronic cases. It excludes long-term care that does not require daily access to the special clinical resources that are available only within the tertiary care programs.

utilization data. The information required to compare observed use of resources with recognized standards for use.

utilization management. Process by which agencies decide on the efficient use of care resources, comparing the observed use of resources with recognized standards of appropriate, timely and cost-effective utilization. The objective is to ensure that the right services are provided to the intended consumers, when they most need them, at the lowest cost consistent with high-quality care.

values. The beliefs of an organization that underlie its principles and actions and form the basis for planning and operating services.
BIBLIOGRAPHY


