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Preliminary Discussion and Research Paper for the: "Movement Towards the Levels of Assessment for Placement for Adults with Mental Health Illnesses"

Date: August 31, 2015

Presented by: The Ontario Homes for Special Needs Association

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Title: Movement Towards the Levels of Assessment for Placement for Adults with Mental Health Illnesses: Proposal and Discussion Paper

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At this time I am pleased on behalf of the Ontario Homes For Special Needs Association (OHSNA) to offer a strategy of moving towards level of assessments for clients in the Homes For Special Care Program and Housing with Related Supports Supportive facilities to determine the best placement possible. We continue to appreciate the consultation framework which has allowed stakeholders to provide input into important policy issues for the affordable housing strategies. However, this is one format that must be given serious consideration to move forward in our housing plan for individuals suffering from mental health illness to be able to provide "Best Practices". We sincerely hope the research and work our executive has put into bringing all of the following information to the forefront will result in timely movement of the Ontario provincial government and policy makers towards this direction .

Having the opportunity to meet with Dr. Robert Bell Deputy Minister of Health office, and his staff was invaluable in providing a vision and clear insight into our future role in the housing industry. This meeting and further meetings that took place with various policy makers were the driving force to what came to be the realization it would be not only beneficial but necessary to make a visit to Halifax, Nova Scotia. With assistance from the provincial government we could further analyze and measure the success of Nova Scotia's 5 level assessment system, which they currently utilize in their housing placement process.

Providing background of our organization will better help everyone understand our role. The OHSNA utilizes the collective leadership knowledge and expertise of its members to search for evidence and informed solutions for this sector's challenges and we work together to effect change and enhance quality of life for persons with mental health illnesses. We are accountable to the individuals we serve, their families, communities and our funding bodies. We also honour the inherent strength, skills, abilities, expertise and opinions of those with whom we collaborate in the government and respective communities. As a group we stand up for what we believe in, advocate on behalf of the people we serve and are prepared to take risks to enhance the system. All of the members within the Association provide supportive housing and create rehabilitative environments for approximately 100 homes and thousands of individuals with a complex array of chronic mental health diagnoses. As well, the Association includes in their membership all of the clients who reside within the homes. The members of the Association are a volunteer group that meets regularly to discuss emerging issues such as our place in housing. We support each other through alliance building and information sharing within our sector.

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This "Movement Towards the Levels of Assessment for Placement for Adults with Mental Health Illnesses" (See attached-Nova Scotia's "5 Levels of Assessment" version) is a vision that advocates for an accelerated pace to reach this type of delivery model. OHSNA supports all elements of the model, including the perceived rights and responsibilities, the concept of empowerment and the other principles upon which it is based. Thus, in order to provide an evidence-based analysis of this model, Joe Pollard, the Vice President of OHSNA, and the author of this paper, Connie Evans, President of OHSNA, offered to go to Halifax, Nova Scotia to undertake a thorough investigation of their sophisticated process of classifications that utilize a standard functional format for the population of adults with mental health diagnoses.

The reason we chose to research the progress in Nova Scotia was their impressive concentrated effort to develop a 5 level assessment tool (See attached) for individuals requiring services and placements. The differences and the factors determined in the level of needs assessment help to influence and have a direct impact on a home's operating costs. As such, every effort must be taken to ensure that a solid continuum of care is established. Our government and program must recognize the wide array of client needs in our homes and address each with the respective flexibility to maintain and enhance services we provide; we believe this particular tool and the overall model used in Nova Scotia can assist in establishing this goal.

It is evident that in order to create a process which builds and guides a true continuum of care and which will foster the development of an integrated structure at the community levels, both regionally and provincially, there needs to be an investment of significant funds into our program and housing for this vulnerable population. It is our position that the government is responsible for ensuring leadership and for providing adequate funding to create the essential supports. We appreciate that there are limited resources available and therefore we are requesting consideration of a more equitable and cost-effective re-distribution of funds, rather than entirely new funding allotments, which would be much harder to secure.

The philosophical and conceptual basis of this system is that of principles of normalization and empowerment. They have been the cornerstones of community-based service development. As noted by Saleeby(1992), "Empowerment cannot be returned to people but is something to be discovered within" (p. 62). It cannot be thrust upon people, nor be demanded of people non- standardized (Scleeby, 1992). Furthermore, Solomon in 1976 defined empowerment as "a process of developing a support system for and by people who have been blocked from achievement and actualization" (Wexler, 1995, p. 3). It becomes very clear empowerment addresses power, control and participation (Wexler, 1995). It can be encouragement returned by the structure of an environment and social aspect of a residential environment (Wexler, 1995). This is what our homes provide the clients that reside within them. Without using a complex assessment tool our system is inflexible, limited in scope and is relegated to self-perpetuating services in beds rather than clients. Progression is not possible with this type of system.

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A report entitled "The Institutions Case of the Insane, in the U.S.A and Canada", edited by Henry M. Hunt, M.D. published in 1917 stated "Dorthea Dix efforts at the site of Nova Scotia Hospital selected and established on January 21, 1850 a former American school teacher improved conditions for the mentally ill in USA, Canada and England" (Haley, 1986, p. 2). This was monumental in Nova Scotia legislation, for its impact and contributions to many countries in regards to housing people with mental health illness. It is astounding that Nova Scotia was the last of the provinces to make appropriate provisions for the population of people they termed as "insane" at that time. Today, even as an extremely impoverished province it has established a very detailed assessment and program to be proud of.

It was not until 1976 that the Nova Scotia HSC Act was created. This Act established regulations for residential care facilities with levels of care. The Act was to follow the trends of normalization. This concept meant normal conditions of life should be made available to all individuals affected by mental health illness. It means they put in a regular day filled with normal tasks and normal activities with a range of choices. Also to live freely in normal housing in a typical neighbourhood (Wolfensberger & Tullman, 1982 as cited in Haley, 1995). This caused the foundation of the homes to be redefined. However, more emphasis was placed on care provision and as such resulted in higher demands for staff. This also meant increased costs to maintain individuals. Unfortunately, these changes did create a custodial care orientation within the homes. Today we are giving our best efforts to move away from this type of care and the attached stigma. All home owners agree and want to be a part of a rehabilitation format. However, this is only possible with the right tools and appropriate funding from our government.

Our argument and stance is very clear; creating new programs to provide similar type of housing is very exciting and politically motivated. However, it makes so much more sense to be fiscally responsible to the tax payers of Ontario and focus on the programs that are already operating, moving these into best practices. Therefore, we are asking all individuals involved in housing and this government to respect and look after the housing programs that currently exist. Give stakeholders who have offered so much at very little compensation in comparison to all other programs a chance to change with the new philosophies. Provide direction and a fair and equal allocation of funding that other housing options currently receive. It is promised to the officials that this direction will most certainly give the desired best practices you are striving for. Dr. Bell has personally observed what has been done at Queenview Residential Home. These innovations were accomplished on a very challenging budget. Can you imagine what could be offered to and for the residents in the future if it would be finally recognized that our facilities are worthy of the per diem amount provided to other programs. All of the home owners within the OHSNA agree with this statement. We want to be proud of our homes and services, and the present funding format is the biggest barrier to accomplishing this outcome. If we are provided with a fair and equitable per diem we could offer our clients and funders, more qualified staff, a higher ratio of staff to clients, and significant renovations to our buildings including private rooms.

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Over a decade ago, Nova Scotia was very progressive in recognizing it was time to change from a model of care housing system to that of a model of support. This was done through an equitable re-distribution of funds within a program, similar to what we have continued to advocate for in Ontario. At this time they have over 300 residential settings and 90 service providers. They house all individuals with any form of intellectual disabilities including mental health (they do this in separate housing facilities). In the year 2000 adults over the age of 65 year came under the Ministry of Health for service provision instead of under the housing envelope. This was very important, especially for this province at this time, because in Canada 1 out of 5 persons had a disability, and in Nova Scotia that ratio was 1 in 4 (Purcell, J., Personal Communication, July 14, 2015). This presented a significant challenge, as they had to provide housing for a much higher percentage of their population of people with disabilities. The governing body declared it was essential to go forward with this initiative, while continuing to demonstrate trust and confidence in the home operators, whose role is very complex.

Nova Scotia displayed amazing forward thinking, while demonstrating true ethical accountability by assessing the functions of an individual, rather than focusing on their disabilities. By giving individuals the tools for life with supports they can make informative choices and they could move forward and navigate through a seamless system. This is the same goal our government has voiced a desire to implement. Our hope is that the Ontario government and policy makers will take the successful endeavour carried out in one province and go forward with an enhanced strategic plan that would not duplicate but resemble this initiative, and be even better, given the information we have been able to provide.

Our Visit to Nova Scotia

During our visit to Nova Scotia, the individuals involved in housing placements were very specific in all discussions that it is always first and foremost to support personal decision making of our clients. This thought process is very important in eliminating client resistance towards receiving care and assistance. However, for safety reasons, and financial and housing limitations, there are always parameters around choices, as there are for anyone making life decisions. Matching clients to community residences is a complex process and every effort needs to be taken to remove the use of "miss match". Compatibility is certainly a challenge to ascertain and can only be achieved through a careful matching.

To describe the Nova Scotia model, a knowledge-based analysis was done on policy directions that promote mental health and their impact on people with mental health illness and their families, and a plan was developed. It was an evidence-based decision making structure outlined below. This decision-making structure included;

1: Determine need for care

2: Assess level of care and support based on their functional capacity

3: Determine eligibility for financial assistance

4: Maintain or enhance functional capacity of client

GOALS:

1: To enhance ability of clients served to live as independently as possible

2: To prevent health and functional breakdowns of the client and or their support systems (i.e.: family, friends)

3: To assist the client is achieving a maximum level of functioning

4: To delay or prevent admission to long term care facilities

5: To prevent admission to an acute care hospital

HOW:

1: Personal support and integration into mainstream society to realize their potential

2: Set goals

3: Teach life skills

4: Assist in developing formal and informal social, personal skills

5: Helping to access medical care either ongoing or as needed

6: Monitoring changes in functional capacity

7: Assist with problem solving and crisis prevention

8: To have effective use of community based resources which are able to meet client's needs

(Flexibility and responsiveness to clients-essential to meet their needs-support principals-fragmentation and duplication of service)

Halifax does this process very effectively, as follows;

1: Identify client characteristics and care requirements through a functional assessment

2: Match characteristics for client. Provide with client needs and personality traits

3: Discuss possible match with client and family and advocate with potential care providers

4: Trial placements if necessary

5: Follow-up to obtain feedback of match

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6: On-going monitoring of placement

Once in a setting, a team approach is used wherein workers and home owners each have responsibility to ensure provision of quality services in the least restrictive environment. Personalized service plans are created for one-on-one care, and teaching and supportive care are provided based on unique needs of the clients. Development and holistic emphasis must be used in capitalizing on the clients' strengths and abilities and "assistance with care" or "providing care" based on assessed functional requirements. Accessibility will be discussed in more length but should be provided and be adaptable to meet clients' individualized requirements (Purcell, J. Personal Communication, July 15, 2015).

According to policy makers in the Halifax Disability Housing Program Assessments Office many clients require intensive support and supervision on a live-in basis due to both social and or mental health illness after long-term care (Rogers, J. Personal Communication, July 14, 2015). Clearly, the HSC program and the supportive housing programs are a viable cost-effective and humane alternative to institutional long-term care or hospital settings.

Our homes can meet diverse needs of clients, based on their ability to provide self-care and manage independently, while also being able to support them in medications, psycho social needs and assistance with activities of daily living (ADLs).The result is customized home situations that meet individual needs identified by the clients and their support systems. Shared decision making is an important element for success. Involving clients and family in planning and providing care must be facilitated wherever possible.

Similar to many Ontarians, vulnerable persons sometimes rely on the advice and assistance of others when making decisions. They may call upon their support networks i.e. their parents, other family members, friends and/or service providers chosen by the vulnerable person. It comprises of people who have a personal connection to the individuals making their own decisions. It is important that the support persons who are chosen to help with the planning process as follows;

*Support the person in making choices and decisions

*Help the person carry out functions that they may not be able to do alone

*Help person understand and communicate

*Help link person to community to strengthen support

This gives potential for self-determination, independence and dignity. When discussing housing, one must include the accessibility rights to live in an inclusive and barrier -free Ontario. We must replace all barriers in all facets of life and provide opportunities to build key milestones

and checkpoints to ensure priorities are identified and work progress is documented to produce a detailed timeline for the legislative process by laying out education and awareness plans to understand new policies and format and time allotted for homes to comply.

All Ontarians have the right to have and work to their potential and persons with mental health challenges should be able to participate freely in our society. Imposing requirements on homes without taking size and scale circumstances into account will result in unfairness and reduce economic ability. We must as home owners and government acknowledge client's rights to choice, embrace the individual and foster the community's practical mix of fairness and self-intent. This will provide a foundation leading to an Ontario that treats people in a fair manner. Ontarians with mental health challenges want to participate in work, education, family and community to be a vibrant part of the province they call home.

It is our responsibility to set the framework through regulations and standards and to develop policies with the goal of identifying, preventing and eliminating barriers to economic and social inclusion. This can be accomplished as follows;

*Extensive consultation with the stakeholders and vulnerable individuals

*Standards that turn promises into action

*Updated Standards that reflect changing needs which include a means for appeal

To establish a multi-level assessment approach, the government must play a crucial role in all aspects of housing. On moving forward the government should take the lead and serve to champion the development and implementation. Success will necessitate communication and collaboration between departments and all levels of governments while ensuring the inclusion of municipal governments. They must be creative in balancing and gathering measurable results to allocate already limited funds to achieve actual goals. They should also implement incentive programs or rewards to enhance compliance. An active system to publicize, acknowledge and celebrate homes displaying exceptional services and physical environments (i.e. private rooms) would result in service providers voluntarily improving homes. At the same time, an approach could be augmented with an appropriate penalty structure for those whose homes are not meeting standard requirements. Consider grants, tax reductions, interest free loans or incentives to diminish financial burden associated with adhering to new standards and levels. Success depends on support, commitment and participation of everyone.

An essential component for an individual's success for their future would be to establish a volunteer employment program including important skill-building and socialization opportunities for clients. At this time ambitious clients are frequently punished for their efforts to return to the work force, by reduction of their disability pensions and or benefits. Our government must broaden their scope for employment opportunities for vulnerable individuals in our homes. Without changing attitudes and financial structure it is basically setting clients up to fail or not

even to try in the first place. Financial incentives to employers for hiring individuals with mental health illness is a vital part of our system that to date has been neglected. This concept has been tremendously successful with individuals that are mentally challenged. It was reiterated numerous times throughout our visit to Nova Scotia, while researching their program, that the mentally challenged sector of society have a much larger purse and advocacy group. This seems very discriminatory to those individuals suffering from mental health illness. Both groups deserve equal treatment and support.

During our time in Halifax, we had the opportunity to meet with many policy people for the supportive housing program for individuals with disabilities. It was easy to understand why their program is so progressive and successful. These individuals have a unique passion and experience for their roles. We met with Jackie Purcell Co-ordinator of Residential Facilities, Disability Support Program, Jackie Rogers Co-ordinator of assessments, Anne Black Program Co-ordinator for Independent Living Supports and Alternate Family Support and Mary Anne Hannis Placement Co-ordinator. Each one of these individuals were forthright with information and extremely helpful. They provided us with the history of the program, the information and documentation of the five level assessments and what they include, and tours of both the for-profit and non-profit homes from all the various levels. Our focus was mainly residential care facilities (RCFs) or sites they call “group homes”. These homes are almost identical to our HSC homes in Ontario. They are regulated through the HSC Act and follow similar standards and core competencies.

The two RCF facilities we toured housed between 17 and 21 individuals suffering from mental health illness. The clients in these homes were assessed at a level 1. They do not mix the different levels of care in this province as they feel it is both unsafe and not the best practice. The facilities both provided shelter, food and assistance with ADLs. Unlike in the Ontario homes, house staff in these homes are not required to help clients co-ordinate structured job placements and social activities outside of the premises. They do not teach clients how to cook, do their laundry or learn how to use laptops and prepare resumes. They do not take their clients to Florida and on camping trips or arrange visits and trips with respective families, all of which we routinely do (This type of support was seen in level 2 housing settings in Nova Scotia). Further, they do not belong to hospital or community committees or committees associated with their HSC program to network and provide better lives for their clients. In Ontario, the author of this paper and other executive members have continued to participate in all of the above mentioned committees for 30 years and running.

We found that both homes were clean and well managed with a cook and someone on the premise 24 hours/per day (asleep at night). The homes are inspected annually for health and fire safety, but not inspected by the HSC department. The bedroom sizes were 100sq. feet for a private, with an additional 50sq. feet per each extra client in a particular room. i.e. 150sq. feet for two clients, 200sq. feet for three, etc. Most bedrooms were wards, consisting of 3-4 beds. They stated that the preference would be to move towards more single rooms, similar to the voiced

interest within our program to have private bedrooms. The clients are very healthy, friendly and appear happy, very stable and well groomed.

The single biggest difference we discovered is their per diem rate. Both of these facilities receive $96.00 per client each day. The policy individuals and home owners were shocked to find out that we receive a considerably lower per diem amount of $49.63 per client each day for the Homes for Special Care in Ontario and in some cases less in the Housing with Related Supports. The most remarkable feedback we received was, “It is not possible to do this job properly” on this amount. This is what we have consistently tried to emphasize and stress to our program leads and government officials. This explains why our clients have a food budget of $1.99 per day set by our program, which is funded by the Ministry of Health and Long-term Care. Whereas food budgets for jails in Ontario, which are also funded by the government, are set at $11.00 per inmate each day and in long-term residential care homes, additionally funded by the Ministry of Health and Long-term Care, the daily food budget is $7.80/resident. We recognize the inequalities that our clients face within the HSC program, as do the service providers, who operate on such a restrictive budget, but still maintain a level of standards consistent with best practice guidelines. Again with a proper per diem we could offer significantly better nutrition.

Also attached with this paper is a copy of the core competency levels that all staff in homes must have to be deemed qualified. To compare between jurisdictions, for a level one (1) home in Nova Scotia, staff must hold five out of the seven competencies; in our HSC homes staff also have these qualifications or in many cases more. The Nova Scotia homes are adequate and homey feeling, but they definitely are not inspected to the same degree as the Ontario homes. For example, we observed leaks on ceilings, tiles were missing and in some instances lifting in the floors. The furniture appeared old and worn and we saw no televisions in clients’ bedrooms, only in common areas. Additionally, the two Nova Scotia homes were not equipped with any form of air conditioning. In our Ontario homes we are mandated to adhere to regulations that encompass these structural features so that we do not have deficiencies of these sorts. In Nova Scotia the by-laws and guidelines are not as stringent. However, the clients and staff were both happy and staff provided great care. As noted, the above were observations made by my colleague and myself when we walked through, and are not in any way meant as a criticism, as the homes were very well operated. The relationship with operators and placement co-ordinators and the housing office is one of mutual respect and admiration. This is very evident in the way in which they communicate with each other and the trust that is clearly bestowed upon the operators. A final interesting point was that we discovered the owner of both homes that we toured also owns two for-profit homes in Ottawa.

During the second day of our trip we visited a non-profit home that consisted of level 2 clients. The home was very beautiful. It had hardwood floors, landscaped yard and individual bedrooms. The clients here were very high functioning; they went to work and did their own shopping and cooking. The level 2 clients were considered to require more attention, rather than

less, because they had higher levels of ability and as such a higher level of need. This was very confusing to us, but in retrospect it makes sense to put more resources in order to maintain a high level of functioning for successful potential of reintegration into the community. The clients' functional abilities in this home were similar to many clients in our homes, other than work placement abilities and opportunities, which currently is beyond the home owners' control. The per diem rate at this home was $266.00 per client each day, which is very similar to the New Generation House High Support housing program, information of which was provided to the Ministry of Health and Long-term Care at our last meeting with the Deputy Minister of Health. This home seems to be the rehabilitation environment all parties involved are striving to attain. Once more, it is being stressed that our Ontario homes are already providing a high percentage of these services. With proper funding it would be non-problematic to renovate and acquire services, which we are unable to secure at this time due to extremely restrictive funding allotments and lack of employment opportunities for our clients.

We acknowledge that not every client will reach this level of independence and be able to join our workforce. However, they deserve to have every support possible to provide such opportunities. Many individuals suffering with severe mental health illness will still need housing with 24 hour supervision and assistance. This fact, as echoed by The Disability Housing Program in Halifax, Nova Scotia, needs to be accepted, and then each individual must be treated in a positive and supportive manner so as to not feel stigmatized or feel as though they have failed if they cannot reach an independent living situation. Success is measured in one's ability to meet the highest attainable expectation, not what we wish they would accomplish (Nor what is more convenient for housing programs). As service providers we will continue to always give whatever supports are needed to improve our clients' lives. Over time, with stabilized housing, new medications, proper diagnosis, and community supports there is always the possibility of living a life of total independence. It is our job to keep instilling this belief into our clients as well, every day is a new day with new opportunities to achieve what **THEY** want. We are there to provide the support and assistance to attain these personal goals.

On the third day of our visit to Halifax we made a trip to the King's facility. This facility was very much like our old institution Penetanguishine. It houses over 100 clients from the very high needs ranging from the 3-5 levels of assessment. The clients need 24 hour 7 day per week care and there is a very low client to staff ratio. Many of the clients exhibit severe health problems as well as their mental health diagnoses. They have an Alzheimer's unit that was very intense. They also provide a very impressive program to help individuals use the skills they have to the best of their abilities. They have employed very exceptional individuals who can quickly identify limitations and create methods by which to overcome them. This facility is always full and there is a waiting list for admission. Although it was not within the scope of what we were researching it did provide a broader view of Halifax's entire housing format for clients from all levels of care. The Nova Scotia Housing Department has really come to understand that although many believe we should try to get away from this type of centralized setting, there is

still a need for it for individuals with extremely difficult and challenging dual diagnosis. The fact they have such a long waiting list and wonderful reputation amongst many experts and professionals in the field leads one to believe they are absolutely right.

After reviewing the 5 level assessment system (See attached), it is very evident that we typically have clients in our Ontario HSC homes and Homes with Related Supports from levels 1-3, at times also having clients from the levels 4-5 while they are waiting to be admitted into nursing home beds. Within the Halifax system, they have opportunity to request extra funding for higher need clients until they can find a more appropriate placement. We in Ontario have repeatedly been denied this request for extra interim funding. It is important to note Nova Scotia assessments are done at the time of admission to homes and then every two years thereafter, and it can be sooner if a client's needs change. The most apparent difference between the jurisdictions, aside from the per diem amounts, is that levels of care are not mixed in a setting in Nova Scotia. We are asking the government and our programs to respectfully acknowledge the different client needs and levels of care, and provide reflective and appropriate per diem rates.

When discussing per diem rates with Anne Black, Program Co-ordinator for Independent Living Support and Alternate Family Support, we discovered the per diem of each home varies. The service provider develops a business plan and meets with the housing department. This plan includes financial statements to indicate what is required to operate the home, similar to what the home operators provided in Ontario, along with the Grant Thornton report. At the meeting the service provider discusses the services, staffing, future plans, and housing structure they will provide. The housing department will also have input into staff salaries, which is accounted for in the per diem amount. The common salary for staff is $17.00 an hour, which is much higher than our per diem allows for staff salary allotment. The staff in the Halifax homes are very competent but they have comparable qualifications to the existing staff in the Ontario homes.

The Housing department also provides block funding for additional upgrades such as sprinklers or other renovations. Invoices must be provided for the completed work, which is a further item that Ontario home operators have requested repeatedly. We have asked for renovation grants or interest free loans and recognition to be given to home operators who do major work in order to provide a better structure and service provision to the clients. We were informed that the system which Nova Scotia has developed will be re-evaluated in September of this year. As can be expected, this type of system where everyone is paid differently can cause unrest and concerns regarding equality of contracts. They plan to simplify and establish more continuity in per diem amounts with basic dollars being provided for actual services and structure provisions. This was one area identified as a weakness with the need for further review to improve their housing system.

Nova Scotia also provides many supportive housing apartment units that offer up to 21 hours of care per week. This is exactly what our government has indicated they are striving for with future housing models. Some of our HSC homes here in Ontario already offer this type of

setting with no incentive or increased per diem for doing so. This is clearly another area our homes could offer assistance if we had adequate funding and supports. With all of the new funding allotments going towards this type of housing it appears that individuals who cannot reach this level of independence are being neglected and as such penalized. There are some members of society who will always require 24 hour care and supports, and to ignore this would be unsafe and negligent. As home owners we do our best to encourage, teach and provide opportunities for our clients to increase their abilities. We will continue to do so, however, sometimes a success story can be as simple as getting over a fear of leaving the house. To this client and their family members this accomplishment is a true triumph. It behooves the Ministry of Health and Long-term Care to not forget these individuals in the vision of future housing models. Our service providers live with and become family to our clients, and I would like to invite any member of the government or policy people from the housing programs to come and spend a week at our settings. Words on paper cannot provide a true picture of what we actually do and offer to our clients and for our government as funders. Then it will become clear why when we are referred to as a custodial model of housing it is so offensive because we are so much more than this. It is time we are recognized both fiscally and with respect for what we do. We care.

The individuals in the Halifax Housing department has offered our government a wonderful opportunity to build upon and enhance an already very sophisticated system by providing all of the assessment tools and policies they have developed. With having access to these documents our policy individuals can start with a concrete established structure, with knowledge from experience as to what worked and what changes were needed. This kind of co-operation is invaluable to provide Ontario with the confidence to move forward with this strategy.

Recommendations

Our association has offered time, funds and expertise to present all of the information and documentation necessary to work towards Best Practise for our entire housing system. At this time we are asking the accountable individuals to examine what we have provided and work with the people in our housing program to finally meet the housing needs of the individuals afflicted with mental health illness, a marginalized, vulnerable population that is so deserving of your attention.

Our government and the program policy makers must acknowledge the differing needs of individuals with mental health illness, many of whom require relatively limited help and services and others who require a long-term living structure. Uniform standards, along with inflexible attitudes that do not differentiate between varying client needs identified through an assessment system simply do not meet the unique needs of vulnerable individuals or housing providers. Factors such as location (urban or rural), the purchasing capital and operating costs directly influence the individuals served by facilities. These differences result in needs being

dramatically dissimilar from one facility to another. It is not only wrong but negligent to not assess and determine each individual's contextual needs. For a service provider to effectively meet the unique needs of each and every client in their home per diem amounts must be established by assessing appropriately. This of course will be very labour intensive as it has been in Nova Scotia. However, attempting to establish best practices, while also aiming for best outcomes for success, is the only practical way to ensure all client needs are met. It is time for policy makers and government officials to champion for the individuals in our HSC and supportive housing homes. A very quick and relatively simple start to show true intentions by our government would be acknowledge basic room structure and size i.e. private rooms vs quads by providing a higher per diem rate for single bedrooms.

The adoption of client-focused philosophy and client -focused services delivery models will create the necessary flexibility to meet diverse and changing client needs. Co-ordination among providers will be essential. The programs must allow current facilities to expand and change services with assistance in the form of block funding and varying per diems based on individual assessments and services each home may provide.

Outcome-based measurement tools for resource allocation should be based on client needs. As comprehensive assessment plans are not used to date in Ontario we do not have a consistent or co-ordinated system. Therefore, quite often we are incapable of providing effective placements. To achieve a better system we need a concentrated effort to develop new assessments and classification tools with the active participation of consumers and service providers. This should be a top priority. Attention must be paid to ensuring that a true continuum of care is established. A wide variety of care needs must be addressed and flexibility of these needs must be maintained and enhanced.

We need a process that can build and guide a true continuum of care, one which fosters the development of integrated structures at the community, regional and provincial levels. Today's system focuses primarily on housing issues and does not address needs, for example, transportation and vocational opportunities. It must also be recognized that rural areas will face different challenges, with added cost and other considerations for equitable access to both transportation and work placements. We believe government should be responsible to ensure leadership and funding to create these supports.

In conclusion, the OHSNA would like to reiterate our support for the general direction outlined above, and urge the government to move quickly in the direction to thoroughly review this type of system with eventual implementation of this process. OHSNA stands ready to actively participate and will make available a full range of expertise and skills to assist in this strategy. We discern a tacit message throughout this research that some clients will always require a structured environment. Therefore, if we are to provide a true continuum of care and provision of service to ensure appropriate cost-efficient and quality care, HSC and supportive housing facilities must be recognized for the work they do to reduce the fragmentation of

housing and be given the tools and chance to be a part of a rehabilitation type of setting that facilitates best practices. It is acknowledged that the implementation process will be time consuming, but it is imperative for the future of mental health housing. In the new affordable housing strategy there needs to be both the consideration of appropriate per diem amounts and the provision of the necessary tools so that home owners can be able to remain in the mental health housing industry. It behooves the Ontario government to recognize the value that the HSC and Housing with Related Supports program offers, and work with us in partnership moving into the future to deliver unprecedented services to individuals with mental health needs. This would be a perfect time for us to work collaboratively to establish our homes with todays "Best Practices". With a per diem and system that supports our clients and service providers we can absolutely provide better nutrition, private bedrooms, and an increase in our staffing and their credentials. As well operators would better be able to provide the supports needed to reach the maximum level of independence possible, keeping in mind "Personal Choice". With the new concept being defined today with "The affordable Housing strategy", this would be a good place to start.

I would like to take this opportunity to thank all of the individuals that were so helpful and important in creating this document and our opportunity to examine housing in Nova Scotia, Halifax. Without your time, knowledge and commitment to individuals suffering from mental health illness in Canada it would not have been possible. As well the help and support from the entire Ontario Homes For Special Needs executive, specifically Joe Pollard who took the time to visit Halifax along with myself. Your help and support has made a real impact on our revelations and recommendations for a brighter tomorrow for both the clients and Home Operators in Ontario.

Attached with this paper are the following documents;

1. The levels of service document
2. The Home for Special Care Act in Nova Scotia document
3. The Home for Special Care Regulations document
4. The Core Competencies document

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