

Supportive Housing for People with Dual Diagnosis

Documenting a System Level Collaboration

June 2015

PREPARED FOR

Waterloo Regional Homes for
Mental Health

and

The Waterloo Wellington Dual
Diagnosis Supportive Housing
Committee

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At TNC, our goal is to help organizations and communities generate the information, tools, and resources they need to improve their work and create strategic change. At TNC, we believe that:

-  Information should be useful and should inspire clear actions.
-  We share responsibility in the change process.
-  Complex social issues require collective action. Our projects build meaningful connections between individuals, organizations, and communities.

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Project Synopsis

In Waterloo-Wellington, recent local reviews have identified supportive housing for people with dual diagnosis as prominent service gap. Waterloo Regional Homes for Mental Health secured funding from the Waterloo Wellington Local Health Integration Network (WWLHIN) to promote the development of a cross-sectoral response to this need. Taylor Newberry Consulting developed and implemented an organizational engagement process to identify and scope out a collaborative framework that would help local organizations provide appropriate, timely, and responsive approaches to supportive housing. Through a series of organizational forums and key informant interviews, cross-sectoral and government representatives endorsed the creation of standing committee with a mandate to create and implement practical, action-oriented solutions. The Waterloo Wellington Dual Diagnosis Supportive Housing Committee has been established, representing a broad cross-section of mental health and addictions, developmental services, and government. This report documents the organizational engagement process, core issues identified by stakeholders, and the mandate and focus of the committee.

Part 1 – Introduction and Background

Supportive housing broadly describes a range of housing options and environments specifically designed to meet the needs of individuals who experience difficult life challenges. The rationale for supportive housing is similar across a broad spectrum of residents – without financial supports, physical accommodations, medical care, psychosocial supports, and a philosophy of community living and inclusion, individuals are put at risk of housing instability or homelessness alongside a host of other negative outcomes.

In Ontario, supportive housing has largely evolved along sectoral lines and boundaries. Municipal/regional anti-poverty initiatives focusing on affordable housing began developing more targeted supportive housing for disadvantaged citizens (e.g., the homeless, victims of violence, families). In addition, specific sectors developed a range of dedicated supportive housing options, typically funded by different federal and provincial ministries and program areas. Prominent sectors include mental health, addictions, developmental services, physical disabilities, violence against women, and seniors.

Because different sectors of supportive housing developed independently of one another, the associated policies, program models and characteristics, funding arrangements, housing options, and availability vary widely. This siloing according to different characteristics of need has led to complex, unintegrated systems of supportive housing. Although this appears to be changing, it is common for dedicated housing programs to exclude individuals based on other co-occurring characteristics. For example, housing for people with physical disabilities may exclude people who have addictions issues; or housing for people with mental health challenges may exclude people who have other specialized medical needs. Any matter of exclusionary criteria may come into play, depending on the sector and the provider. This tends to mean that people with more complex, co-occurring needs – and therefore the people who are most vulnerable – are more likely to have trouble acquiring decent, affordable, and safe housing with supports. An important backdrop to this context is the fact that the real estate (the “bricks and mortar”) is complex mixture of apartments, houses, and units variously owned by private individuals, corporations, governments, foundations, faith groups, and non-profit organizations. Organizations providing supportive housing must partner with private interests or become owners/managers themselves in order to enhance the availability of appropriate housing options.

The challenge of fragmented sectors is changing in relation to supportive housing and in relation to health and social services in general. In Ontario, provincial ministries are calling for greater integration. For example, in *Open Minds, Healthy Minds*, the Government of Ontario (2011) identifies four priority goals as follows:

1. Improve mental health and well-being for all Ontarians.
2. Create healthy, resilient, inclusive communities.
3. Identify mental health and addictions problems early and intervene.
4. Provide timely, high quality, integrated, person-centered health and other human services.

The last goal focuses on providing the “right mix of supports” when they are needed and calls for a seamless, coordinated, and integrated system of services and programs. Many Ontario communities are pursuing the goal of greater integration and are placing much greater emphasis on the confluent impact of multiple social determinants of health. In a social determinants of health framework, health care is coordinated with a range of social and community-based supports to address housing, income security, justice services, education, employment, family context, and many other important factors affecting health and well-being (World Health Organization,

2008). This requires much greater flexibility of the organizational and sectoral boundaries that have historically served to exclude certain segments of the population. Cross-sectoral partnerships are beginning to address the needs of many residents who have more complex needs.

This agenda is aligned with Minkoff and Kline (2004) who have asserted the need for agencies working in the mental health sector to develop as “complex and concurrent capable” organizations. In their model (Comprehensive Continuous Integrated System of Care – CCISC), organizations should expect that individuals will present with co-occurring needs and be prepared to find ways to address these complex needs – for e.g., by building staff competencies through training, expanding service teams to include additional members with complementary specialized expertise, or through collaborative service agreements with agencies who can provide complementary services in other areas of expertise. Co-occurring needs should be an expectation rather than an exception.

In Ontario, there are examples of cross-ministerial policies and initiatives that attempt to build collaborative cross-sectoral responses to meeting more complex needs. An example highly relevant to this current work is the *Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis* (MHLTC/MCSS, 2008). This policy directive was issued jointly by the Ministry of Health and Long-Term Care (MHLTC) and the Ministry of Community Social Services (MCSS). This document defines the roles of the Ministries, the Local Health Integration Networks (LHIN) and the Community Networks of Specialized Care (CNSC):

- **CNSCs** are mandated to streamline specialized services, enhance specialized service delivery, and train and build capacity in the community.
- **LHINs**: are to support/facilitate cross-sector planning and partnerships, identify resources to serve people with DD, facilitate case resolution linkages, plan/consult with CNSCs.
- **MCSS Regional offices**: are to work with Networks to develop cross-sector linkages, support a continuum of services, address unmet service needs, enable planning and coordination.

The Guideline is currently being updated to provide more concrete direction regarding implementation and will be reissued in the summer of 2015. The intent is to promote more integrated and responsive systems of care for people who are dually diagnosed.

Supportive Housing for People with Dual Diagnosis

An area where integrated sectors is sorely needed is supportive housing for people with dual diagnosis. In Ontario, supportive housing for people with mental health and addictions is funded through MHLTC and the LHINs. In parallel, supportive housing for people with development disabilities is primarily funded through MCSS. Housing dedicated to both populations have grown independently through their own histories and deinstitutionalization and mandates to support full community living. While there are pockets of cross-sector collaboration, it is generally rare, and organizations often struggle to support dually diagnosed people. Integrated approaches, as mentioned, are evolving through cross-sector training and capacity building of organizations to meet these needs. However, integration in regards to supportive housing specifically appears

to be lagging. There is a considerable body of literature focused on supportive housing for each population, but very little that concentrates on integrated approaches designed to meet the needs of those who struggle with both issues. The need, however, is well known – many policy and practice documents call for supportive housing that is able to meet the needs of people with dual diagnosis (e.g., Albanese, et. al, 2014; Housing Study Group, 2013). Other studies have shown how a dual diagnosis can lead to greater vulnerabilities and poorer outcomes. For example, Lunsy and Balogh (2010) demonstrated how rates of hospitalization for mental illness are higher and more frequent for people that also have a developmental disability. Community based supports, including supports within housing, require greater intensity and specialization for this group.

Sandor and Schmidt (2014) discuss the characteristics of intensive housing models for people with developmental disabilities and complex needs, which includes individuals with mental health difficulties. The authors found that housing/support organizations experienced success in meeting complex needs under the following conditions:

- There are continuums of service within the organizations.
- There are required clinical resources to meet needs
- There is staff training and expertise within residential settings.
- There is an ability to address risk and liability issues within the organization
- There are strong partnerships with other agencies with specialized resources (e.g., Behaviour Management, CCACs)
- There is access to a nurse within the organization.

These conditions tend to be lacking in supportive housing environments, at least to the degree that the needs of people with dual diagnosis can be met. These gaps can be traced to a general lack of partnership and collaboration between organizations that operate different sectors. Sandor and Schmidt (2014) offer the following recommendations to enhance supportive housing for this population:

1. **Build clinical capacity** in the system by developing a Mobile Specialized Clinical Support Team specifically related to housing.
2. **Increase specialized housing stock** by adding beds to existing programs that are currently serving individuals with very high support needs and experiencing success in doing so.
3. **Develop a Systems Lead for High Intensity or Complex Needs Housing** to assume the role of systems planner for housing for individuals with complex needs
4. **Develop an urban village housing concept** for individuals with developmental disabilities and complex needs.

Dual Diagnosis and the Context of Supportive Housing in Waterloo Wellington

In the past year, two major reviews have been conducted in Waterloo-Wellington that examine issues of supportive housing. The first review focuses on supportive housing for people with mental health and addictions (MHA) in the WWLHIN, and includes a discussion of definitions and concepts, a local inventory of supportive housing units and wait lists, a review of housing types, associated challenges and issues, and set of recommendations to enhance supportive housing for this population (Newberry & McMurtry, 2015). This review

also examines the supportive housing needs for people with MHA who may have other specialized needs or issues. The general finding was that MHA supportive housing is ill-equipped to meet the daily support needs of people who also have developmental disabilities; the reverse also true in that supportive housing programs for people with disabilities struggle to address co-occurring MHA issues. The report also emphasizes that the housing stock in both sectors is grossly insufficient to meet the current supportive housing need in Waterloo Wellington.

Other barriers speak to the sectoral divisions between MHA and developmental services. Support staff from both sectors need more training to meet these co-occurring needs and expressed frustration in accessing the supports that are required. One key informant from the developmental services sector estimated that the 50% of their recent referrals were from the mental health sector. A specific barrier experienced by MHA workers has been an inability to access services for individuals with developmental challenges but who do not have a formal diagnosis or do not meet the minimum assessment cut-off required to receive developmental services. Developmental service providers also expressed a need to pursue more independent housing options, rather than traditional congregate settings; in comparison, the majority of MHA supportive housing stock in WWLHIN is comprised of independent units.

The main recommendations pertaining to supportive housing for people with dual diagnosis were as follows (abridged from p. 69 of Newberry & McMurtry, 2014):

1. **Build cross-sectoral partnerships between disability and MHA supportive housing providers to co-deliver integrated supports and services.** Disability-focused housing providers need to develop support plans with the coordinated assistance of the MHA system. The reverse is also true. Individuals with co-occurring needs require a team-based approach that leverages the skills and expertise in the system so that supports can be holistically provided. Inter-ministerial cooperation is needed to ensure that integrated approaches are supported.

Develop cross-sectoral training opportunities so that support workers working in one area of support can gain the skills and knowledge necessary to better support their residents. Supportive housing staff in each sector could benefit from training opportunities that build their skills in areas where there have often been gaps. The system as a whole needs greater literacy in relation to multiple, co-occurring needs.

2. **Explore ways to create a more flexible threshold requirement in order to promote greater access to developmental services.** MHA support workers experience serious challenges in meeting the needs of people who land just above the cut off. Services are inaccessible, yet problems associated with cognitive capacity are preventing effective service delivery, which exacerbates mental health and addictions issues.

A second recent review examined supportive housing in Wellington County for people developmental disabilities (Lediett, 2014). Many of the conclusions reached are similar. There is an extraordinarily high need for housing for people with developmental disabilities and access to specialized and clinical care is challenging. The review highlights the acute need for interdisciplinary supports within housing for people with dual diagnosis. It is also

noted that the Joint Policy Guidelines, while highly relevant to the need, have not seen progress at the local level and need revisiting and cross-sector engagement.

It should be emphasized that there are a number of examples of successful cross-sectoral collaboration in Waterloo Wellington. In many instances, there is joint ad hoc problem-solving around meeting the needs of people with complex needs, including dual diagnosis. The development of service resolution mechanisms and wraparound care solutions in the WWLHIN demonstrate a commitment to flexible solutions to create appropriate supports (Newberry, 2014). There are examples of front-line and cross-sectoral relationships that form to build supportive solutions for people with dual diagnosis. There is a general appetite to move toward more systemic and formalized cross-sectoral partnerships so that ad hoc solutions become common mechanisms to meeting needs.

One important example of a more planful and systemic approach is the Extraordinary Needs Program (ENP). ENP is a cross-sectoral multi-organizational partnership of community housing providers and hospitals that seeks to house individuals who otherwise cannot be safely supported in other community settings. Program participants initially resided in hospital settings with an ALC designation. These are individuals with highly complex and co-occurring needs, typically with long histories of institutionalization. Through the creation of intensive, often 24/7 wraparound supports, successful community living became possible (Newberry & Love, 2013). In some examples, individuals experienced both MHA and developmental challenges. The program model utilizes a multidisciplinary, shared-care approach, drawing on the clinical expertise of multiple providers alongside intensive supportive housing.

Other creative partnerships are evidenced in WWLHIN. For example, Dunara Homes for Recovery (Dunara) and Community Living Guelph Wellington (CLGW) partnered around a supportive housing option for one individual with a developmental disability who experiences serious mental health difficulties and exhibits challenging and sometimes unsafe behaviours (Butella & Bowes, 2015). In order to properly support this individual in a community setting, Dunara housed the individual with shared staffing support from CLGW, the latter of whom have expertise in supporting people with developmental issues. Furthermore, MCSS initially provided the necessary funding to support the individual in a housing program. Support was then provided by ENP through funding by the WWLHIN. There was no service disruption for the person when funding arrangements changed, representing an example of flexible cross-ministerial actions.

Purpose of the Project

There is an appetite in Waterloo Wellington to capitalize on existing relationships that have been built across sectors to pursue collaborative actions to better meet the supportive housing needs of people with dual diagnosis. Prompted by the recent recommendations of the local supportive housing review (Newberry & McMurtry, 2014), Waterloo Regional Homes for Mental Health (WRHMH) took a leadership role and secured funding from the WWLHIN to explore the development of a collaborative service framework to meet the supportive housing needs of people with dual diagnosis. Taylor Newberry Consulting was contracted to lead the development of the framework. The overarching goal of the project were to engage with cross-sectoral representation of leaders from developmental services, mental health and addictions, and government in order gain consensus and commitment to pursue a

framework. A specific goal was to arrive at specific and concrete service agreements or memoranda of understanding between MHA and developmental services organizations to immediately begin pursuing actions around supportive housing for people with dual diagnosis.

In the remainder of this document we describe the design and implementation of the engagement and consensus building process, the main issues that emerged, the priorities agreed upon by stakeholders, progress to date, and next steps.

Summary of the Collaborative Engagement Process

The project unfolded in the following phases:

1. **Creation of an annotated bibliography** of references relevant to dual diagnosis and supportive housing, to inform the literature review.
2. **Hosting of an organizational forum** of local stakeholders representing MHA, developmental services, and government, with a focus on setting priorities for supportive housing and dual diagnosis.
3. **Key informant interviews** with a selection of forum attendees to clarify selected priorities.
4. **A second meeting of organizations** to present priorities and further develop the actions of the group.
5. **Development of a Terms of Reference** for a working committee focused on supportive housing and dual diagnosis.

In the sections that follow, we document each of these phases and conclude with next steps.

1. The Annotated Bibliography

The project was fortunate to secure the help of two practicum students from Wilfrid Laurier University¹. In addition to serving as note-takers at project meetings, they also developed an annotated bibliography of references relevant to dual diagnosis and supportive housing (see Appendix A). What was notable was the scarcity of references that specifically focus on supportive housing for people with dual diagnosis. However, the references did help set the context of need in this area.

2. The First Organizational Forum

Organizational stakeholders were invited to a forum on February 27th, 2015 held at the offices of K/W Habilitation. Over 20 individuals were in attendance representing developmental services (10 organizations) and mental health and addictions (4 organizations). Also in attendance were representatives from MCSS, the Region of Waterloo, the County of Wellington, service resolution (both MHA and developmental services), and Waterloo Wellington Addictions & Mental Health Network. Several other key organizations gave their regrets but joined the process in later phases. Organizational representation can be found in *Section 5. Terms of Reference*.

The forum began with a description of the overall goal and expectations of the project. Specifically, it was emphasized that actions of this project should be action-oriented, practical, creative, and collaborative. There was strong consensus among attendees to avoid “talking committees” that focused on problems and information gathering without also quickly advancing concrete solutions and actions. As a group, there was preliminary commitment to develop and actively pursue strategies to enhance supportive housing for people with dual diagnosis. Attendees also agreed that actions needed to be squarely focused on *supportive housing* for people dual diagnosis, rather than pursuing broader strategies of cross-sectoral integration of supports and services.

Following this opening dialogue, a brief review of the literature was provided, with a focus on the recent reviews covered in the introduction section of this report. The review was followed by two presentations that illustrated

¹ Amanda Sandichar and Jessica Nafziger.

collaborative, cross-sectoral solutions to supportive housing for this population. The first was a description of the ENP program and the successes it has achieved in providing intensive supports within housing for people with extraordinary needs. The second was a case study of supportive housing for a dually diagnosed individual that achieved success due to the collaborative efforts of Dunara and Community Living Guelph Wellington, supported by flexible funding from MCSS and subsequently WWLHIN (via the ENP program). The intent to was to demonstrate how collaborative efforts are already happening locally.

Breakout groups were then assembled to ask the following questions:

1. *In the context of supportive housing and your current organization’s role, what are the support needs of people with dual diagnosis in our communities that are currently challenging to meet and why?*
2. *What opportunities are there for cross-sector collaboration and coordination to meet these needs? Be specific and practical and think about who would be involved.*
3. *What could we do fairly quickly with low costs? What should we do longer term that will require some investment?*

A report back session compiled and synthesized a number of potential actions that could be taken locally to advance this supportive housing agenda. This was followed by a “dotmocracy” process, whereby individuals attached their names (and organizations) to the ideas they saw as most fruitful and that they would be interested in pursuing. These are listed in Table 1 along the with number of people who endorse each.

Table 1 – Generated ideas for advancing supportive housing agenda for people with dual diagnosis

Action Area	Group Endorsements
1. Establish a joint supportive housing table for operational planning	13
2. Develop and implement cross-sector training, orientation, awareness and job shadowing.	10
3. Establish a dual diagnosis system navigator for individuals, families, and providers.	8
4. Develop consistent community protocols re: dual diagnosis response and supports.	4
5. Create greater opportunities for engagement with the CW-CNCS.	3
6. Integrate the CCISC framework into the dual diagnosis system.	2
7. Develop standardized information and sharing protocols across sectors/system.	2
8. Develop greater capacity to bring relevant data into planning and problem solving.	2
9. Develop a shared understanding of success.	1
10. Expand, build capacity of existing services resolution type tables.	1

At the conclusion of the forum, next steps were discussed. The intended design was to:

1. Conduct key informant interviews with a subgroup of forum attendees to elaborate and clarify the priority areas.
2. Form 2 or 3 working groups, organized around the top priority areas, that will begin to meet to develop practical and collaborative actions.
3. Hold a large group meeting to review actions, progress, challenges, and next steps moving forward.

Before interviews were scheduled, a synopsis of the top 3 priority areas was sent out the forum attendees in order capture the discussions and issues of breakout groups and large group report back. This summary is provided below.

1. Establish a joint supportive housing table for operational system planning in relation to dual diagnosis

There was the most interest in this option, with 13 individuals across mental health addictions, developmental services, and government expressing interest. There were number of areas that such a table could focus on including:

- Pursuit of new funding envelopes and strategies to improve overall housing stock in the region that could be used to meet the needs of the dual diagnosis population.
- Interpretation and planning for local application of the new implementation guidelines that are being released in follow to the *Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis* (MCSS/MHLT, 2008).
- Identify areas where there are gaps in research and system data that is needed for planning functions, and strategies to acquire such data. This may include the issue of building standardized approaches to client information management and sharing.
- Developing shared understanding of outcomes and indicators of success within dual diagnosis and supportive housing.
- Provide oversight to the development of new community protocols regarding appropriate, high-quality support responses for people with dual diagnosis.
- Operational guidance and oversight of ongoing collaborative initiatives (e.g., oversight regarding priorities 2 and 3, below).

2. Develop and implement cross-sector awareness raising, training, and orientation

There was fairly high interest in cross-sector training, with 10 attendees expressing interest. This is a common recommendation in other systems and jurisdiction as a way to enhance cross-sector learning and collaboration. We noted in our discussions that training agendas, if they are to have systemic impact, need to be directed by a collective representing both sectors, rather than led by single organizations. Wide organizational endorsement and *expectation* of front-line participation in training across both the MHA and developmental service sectors is necessary.

Discussions also highlighted the need for more than training in dual diagnosis concepts and practices, but also on-the-job orientation and job shadowing opportunities so workers can attain a hands-on understanding of the context of supports in the other sector.

3. Establish a dual diagnosis system navigator for individuals, families, and providers

Among 8 attendees, there was support for idea of establishing dedicated a system navigator for individuals, families and providers. This is a position that would provide knowledge and expertise about dual diagnosis concepts, practices, policy, and the local service system. Such a position is most effective when the individual is well connected in multiple sectors from the front-lines up to management, and has the wide-endorsement of organizations in the system to do their work.

It should be noted that a navigator is not the same position as a service resolution facilitator; the latter is responsible for pulling together a system response to address complex cases. A navigator is tasked with helping to arrange support plan options that meet specific need. These could be plans developed at service resolution tables or could be on behalf of an agency, individual, or family (or all three) that has had trouble accessing other parts of the system. The actual day to day functions of a system navigator would need to be scoped out by a working group.

3. Key Informant Interviews

Interviews were conducted with 12 organizational representatives from the MHA sector, development service sector, and government. The purpose of the interviews was to further elaborate and clarify the top priority areas and to ensure that the initial endorsement of each area was widely supported and understood. This was worthwhile process as key informants a range of concerns and caveats regarding many of the list areas. In general there was a lack of consensus on what areas should be pursued and how. More specifically, it was felt by most key informants that additional discussion and oversight was needed in order to further develop each area, should they be pursued; and that a jump to smaller working committees to actively pursue specific actions was premature. The following summarizes the insights from the interviews.

1. There was wide support for the idea of assembling a standing operational committee focused on dual diagnosis and supportive housing.

There was a general perception that a standing committee needs to be providing the direction and oversight on any other priority areas and that the committee needs to be established first for this reason. This consensus position required an alteration to the proposed design of establishing multiple working groups that would move forward quickly on specific actions. Thus, scoping out the focus and mandate of the committee became the primary activity of the project. The following points emerged from the interviews in relation to development of a committee:

- The first step should not be to assemble the actual table, but to re-engage the stakeholders to scope out the tasks, roles, membership, and potential actions of the committee.
- Establishing the committee should not be the project deliverable. The project should seek to establish the mandate and focus of the committee, in a Terms of Reference. By project end, the committee should be able to move quickly toward mutual commitments and actions.

- Interviewees wanted to retain and emphasize the principle that the committee act quickly, concretely, and practically to improve cross-sectoral supportive housing options. There is little appetite for members to sit on a policy- and review-oriented committee.
 - The committee needs to interface effectively with other tables so that actions are:
 - specific to dual diagnosis and supportive housing
 - shared with other local planning tables.
 - The initial list of possible areas for the committee to focus on were generally endorsed as in scope and important. Some members emphasized not wanting to lose the agenda of creating and advocating for more housing stock and pursuing available funding envelopes.
 - The role of training and system navigation needs discussion by this committee (see below).
 - The committee should not take a system wide leadership role in interpreting and implementing the revised *Joint Policy Guideline* that will soon be reissued. Rather, the committee should take a leadership role in working with and piloting the new guidelines in relation to dual diagnosis and supportive housing. System leadership on the guidelines should fall to tables that are responsible for system development more broadly.
 - The membership of this committee must have a degree of authority to speak for and act on behalf their home organization. The membership must also be balanced between the developmental services and MHA sectors, and regional/provincial government.
2. **There was a lack of consensus on the need and scope for dual diagnosis training.** There was concern among some that dual diagnosis training was already available in the community. Specifically, the Central West Community Network of Specialized Care (CW-CNSC) has a mandate to deliver cross-sectoral training and has delivered a number of sessions to workers in both sectors. More thought was needed about what gaps exist in relation to training that already exists. Feedback from the interviews suggested that training will remain an important priority in the sectors, but that it need not be specifically developed and managed by this group. A standing committee may identify and endorse specific targeted training of some sort in the future, to be delivered by the CNSC. Additionally, some interviewees felt the sectors needed to go beyond “sit down” training and move toward models of job shadowing or “provider exchanges”, wherein workers to learn about support practices of their counterparts in the other sector.
 3. **There was little support for developing a system navigator position.** Most interviewees wanted greater clarity on what this role could and should be. There were some highlighted concerns about diverting money from existing services and supports to fund another position that was designed to help navigate through a system that is not functioning well (or, from a certain perspective, does not even exist for dual diagnosis). Alternatively, interviewees felt the system needed to be improved, rather than left to be navigated. There was also some concern that navigation, advocacy, and other related roles should be integral to existing front-line provider roles to begin with, rather than off-loaded to a single position.
 4. A few interviewees expressed **disappointment that the areas focus did not include an agenda to actually pilot some hands-on, cross-sectoral front-line actions around supports.** The priority ideas neglected the

need for establishing interdisciplinary team-based approaches to supporting people with dual diagnosis in the supportive housing context.

4. Second Meeting of Organizations

A second meeting of stakeholders was held on May 11th, 2015 at Waterloo Regional Homes for Mental Health. The meeting was once again well attended (over 20 attendees) with broad organizational representation from both sectors and from government (MCSS, WWLHIN, the County of Wellington). This level of engagement demonstrated an impressive and balanced degree of commitment to the objectives of the project.

The purpose of the second meeting was as follows:

1. To confirm the main priority areas of committee for dual diagnosis and supportive housing, and to discuss any divergences.
2. To discuss the intended structure of the committee and how it should operate.
3. To discuss the mandate and focus of the committee.

In the meeting the findings of the interviews were reviewed for consideration and discussion by attendee. An overall goal of the meeting was to gather information from attendees (following points 1 to 3 above) in order to develop a multi-organizational agreement. The group requested a Terms of Reference that would articulate the different element of committee structure, process, scope, and objectives. Large group discussion questions included the following:

- *What does the committee do?*
- *How does information come to the table?*
- *What kind of information does it need to act?*
- *Does the committee build new things or advise on things that are being built?*
- *How does the committee direct the actions of others? Which others?*
- *Where is the committee situated in relation to the rest of the system? What structures should it report to?*
- *What should be the lines and levels of accountability?*
- *What sorts of things does the committee approve? What lies outside its mandate?*

Group discussion was captured by note-takers. This information was in turn used to develop a Terms of Reference.

5. Draft Terms of Reference and First Committee Meeting

Based on the second meeting of organizations a Terms of Reference was drafted. Organizations were invited to attend the first meeting of the committee, with each organization deciding internally who should function as a representative. The Terms of Reference document was presented and feedback was collected from members. A number of changes and additions were requested. The subsequent version of the document is provided below. A finalized copy will be approved at the next meeting of committee (in July, 2015).

COMMITTEE NAME: Waterloo Wellington Dual Diagnosis Supportive Housing Committee (WW-DDSH)

GUIDING VISION: All adults with dual diagnosis have safe and secure housing within the community with responsive, person-centred, recovery-oriented, and integrated supports to meet their needs.

PRINCIPLES AND ASSUMPTIONS:

- The primary focus of the committee is on meeting the needs of adults with *dual diagnosis in relation to supportive housing*.
- The committee will be action-oriented with the ongoing intention of implementing to practical changes in the system as quickly and efficiently as possible.
- Members will pursue the work of the committee based on an organizational commitment of their home organizations to the guiding vision.
- Members will speak for their home organizations and will have the endorsement of their home organizations in pursuing and carrying out the activities of the committee.
- Participating members and their organizations will be prepared to be flexible and creative in their services and supports in order to implement the actions of the committee.
- The actions of the committee will be collaborative and cross-sectoral, leveraging the knowledge and resources of mental health and addictions and developmental services sectors.
- Actions of the committee will be consistent with a person-centred, recovery-focused approach and philosophy.
- The committee will explore additional guiding principles to inform the work, including those within the reissued *Joint Policy Guidelines*¹ and the *Comprehensive, Continuous, Integrated System of Care (CCISC) Model*²

OBJECTIVES: The overarching objective of the committee is:
“To enhance the cross-sectoral capacity of the system to meet the needs of people with dual diagnosis within the context of supportive housing”

- Sub-objectives will developed based on the input of the committee.

FUNCTIONS AND ACTIVITIES:

Collect and **synthesize** local and practice-based knowledge about the system from the membership in order to:

- Understand current state of the mental health addictions and developmental service systems as they relate to supportive housing.
- Identify specific service and support gaps in the systems.
- Identify groups whose needs are being met by the system; and groups whose needs are not currently being met.
- Showcase promising local practices in dual diagnosis and supportive housing for cross-sectoral sharing.
- Gain clarity on the current and potential supportive housing stock for people with dual diagnosis, and the resources available to enhance it.

FUNCTIONS AND ACTIVITIES:

Develop **creative actions to improve** the system:

- Identify what programs, practices, initiatives, and resources exist that can be leveraged to make immediate changes to practices.
- Identify places to bend or flex current practices.
- Identify partnerships that focus on cross-sector practices to support people with dual diagnosis and supportive housing
- Develop training and orientation opportunities for front-line staff to improve understanding of the system and build cross-sectoral connections.
- Develop opportunities to create new housing stock.
- Gain commitment from members agencies to implement committee actions.
- Evaluate and reflect on the efficacy of committee initiatives

The specific initiatives of the committee will be developed and articulated by the membership.

MEMBERSHIP:

Membership will be initially composed of management level representatives, as follows:

1. Developmental Services
2. Mental health and addictions services
3. Service resolution attached to 1 and 2
4. Waterloo Wellington Addictions and Mental Health Network
5. County of Wellington
6. Region of Waterloo
7. Ex-officio members representing:
 - a. Ministry of Community and Social Services
 - b. Waterloo Wellington Local Health Integration Network

- New standing or ad hoc members may be added based on the decisions of the committee.
- Originating membership is listed at end of Terms of Reference, by *organization*. Individual members will be appointed by their respective organizations.

COMMITTEE DURATION / MEETING TIMES:

- The committee will meet regularly over the course of one year (May, 2015 to April 2016). At one year, the status of the committee will be revisited.
- Meetings will be held monthly. Meeting frequency may be reduced at the discretion of the committee.

CHAIR:

Jason Newberry of Taylor Newberry Consulting will chair the first two meetings (and additional meetings if requested). Subsequently, the committee will appoint two co-chairs representing mental health and addictions, and developmental services sectors.

DECISION-MAKING

Decision-making will be by group consensus as determined by the chair. If clear consensus cannot be reached, the chair will call a vote. The committee may consider adopting a hybrid model in which votes are cast with accompanying statements of support (e.g., “strongly support”, “support with concerns”, etc.). This Terms of Reference

will be updated accordingly.

REPORTING:

It is expected that the activities of the committee will be routinely shared with other system tables, including:

- Wellington Developmental Services Planning Group
- Developmental Services Planning and Advisory Council (Waterloo)
- Integrated Mental Health and Addictions Program Council

It is also expected that individual members will share the activities and actions of the committee with their respective organizations.

RECORDING:

Waterloo Regional Homes for Mental Health will supply a recorder to summarize the minutes of the committee.

COMMITTEE ORGANIZATIONAL REPRESENTATION (DRAFT JUNE 25, 2015)¹

Mental Health and Addictions	Developmental Services
CMHA Waterloo Wellington Dufferin	Cambridge Community Living
Dunara Homes for Recovery	Central West Network of Specialized Care
Grand River Hospital	Community Living Guelph Wellington
Homewood Health Centre	Developmental Services Resource Centre
Waterloo Regional Homes for Mental Health	Developmental Services Ontario
Waterloo Wellington Addictions Services Group	Elmira District Community Living
Service Resolution Facilitator	Grand River Hospital
Waterloo Wellington Addictions & Mental Health Network	K-W Habilitation
Government	Service Resolution Facilitator
Ministry of Community and Social Services	
Waterloo Wellington Local Health Integration Network	
County of Wellington	
Region of Waterloo ²	

¹ This list subject to change as the committee develops. Individual membership to be determined.

² Membership to be confirmed.

6. Elaboration of Committee Function, Focus, and Next Steps

A number of issues and discussion points emerged during the second meeting of organizations and the subsequent first committee meeting. These issues provide additional context to the Terms of Reference and next steps of the committee.

Concept Clarification

Committee members requested clarification of certain concepts and definitions that are used throughout the two sectors of MHA and developmental services. Some terms used in one sector are not used and/or are poorly understood in the other. The creation of a glossary of terms and presentations from members on certain topics and areas will benefit the committee. The following terms and topics were identified as needing definitional clarification.

- **Developmental disability** and how it is formally assessed for the purposes of service provision.
- **Dual diagnosis** and how it is formally assessed.
- Distinctions between “**complex behavioural needs**” and **mental health diagnoses**.
- **Supportive housing**, especially distinctions based on different funding streams and programs (e.g., supportive housing as defined by the Region of Waterloo/County of Wellington versus supportive housing in relation to MHA and developmental services).
- Principles of “**Recovery**”, with explication of how it is used in the MHA sector and how it could be applied in relation to developmental services – and the potential pitfalls of using it in the developmental service sector.
- The **Complex Continuous Integrated System of Care (CCISC)** model.

Other Potential Members

While the current committee membership appears to be fairly comprehensive and balanced, additional organizations that were identified as potential contributors. The Welcome In (in Guelph) and The Working Centre (in Kitchener) were examples of organizations who routinely work with dually diagnosed individuals who experience housing instability and homelessness. Community Health Centres in Cambridge, Kitchener, and Guelph were also identified as useful partners. A next step will be to inquire about their interest in participating.

Information Needs to Promote Actions

Members noted that there are existing data sources that could help guide the committee’s actions and that it would be important to review what is already available. For example, committee actions could be informed by profiles of people with dual diagnosis who have been successfully supported in housing as compared to people who have been historically difficult to successfully support in community living.

In addition, there was agreement that the committee needs to develop evaluation indicators that can help demonstrate the impact of its actions, especially data that can show the extent to which the priority population gains access to supportive housing.

Members also felt that there are numerous situational and case examples of successes and challenges that can be brought to the table for analysis and reflection, to inform more systemic and consistent responses more generally. There was recognition that there many different pockets of conversations among providers and individual examples of innovation that are not broadly known or shared. An early action of the committee may be for members to bring forward these local examples for discussion and consideration.

Clarifying the Committee Mandate

With the Terms of Reference in place, committee members began to step back to begin to flesh out the focus of the committee. In broad terms, it was agreed that the focus is on supportive housing for people with dual diagnosis. This was followed by discussion of the most appropriate emphasis of the committee's work. Some questions that emerged included:

- Within this broad group, who should be prioritized? Is this committee seeking to prioritize people with dual diagnosis who also have particularly complex challenges and who are most difficult to support in community living? Should there be criteria for prioritization?
- Is the focus on building or acquiring new housing stock for this population? Is the focus on engaging with landlords in order to acquire more independent living options?
- Is the focus on ensuring that existing supports within housing are capable of meeting the needs of people with dual diagnosis? Should the focus be on developing the clinical capacity within the system for this purpose?

These are not mutually exclusive questions, but some may be preferred over others. Additional discussion is required.

Next Steps

A second committee meeting is scheduled for late July, 2015. The agenda for this meeting, tentatively, will focus on the first practical steps that committee can make in relation to the above discussion points. We recommend an initial focus on information sharing:

- To clarify selected key concepts.
- To identify existing data and information that exists that can help describe the profile of the priority population.
- To share examples of local innovative examples of successes and what can be learned from them.

We close this report with the observation that stakeholders from both sectors, as well as government representatives, have expressed great interest, energy, and commitment to improve supportive housing for people with dual diagnosis. There is clearly an exceptional need in this area. The commitment can in part be explained by a general frustration both sectors are experiencing in attempting to meet the needs of this group without the support and expertise of their counterparts. However, this is also in the context of system-wide dialogue regarding service integration and collaboration and on the ground examples on innovative cross-sector practices. The leadership in both sectors appears strong and committed. The balance and representativeness of organizations is particularly encouraging. While the effectiveness of the committee still needs to be tested, it seems to reflect a true system-level partnership, rather than the efforts of a small local partnership.

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- Newberry, J. (2014). Building Wraparound Supports for People with Complex Mental Health and Addictions Needs Evaluation report submitted to Homewood Health Centre and the Top 40 Steering Committee. Guelph, ON: Taylor Newberry Consulting.
- Newberry, J. & McMurtry, L. (2014). *Mental Health and Addictions Supportive Housing In WWLHIN: System Needs and Recommended Actions*. Report submitted to Waterloo Regional Homes for Mental Health and the Supportive Housing Working Group. Guelph, ON: Taylor Newberry Consulting.
- Sandor, G. & Schmidt, N. (2014). *Intensive Housing Model Review for Clients with Developmental Disabilities and Complex Needs*. Toronto, ON: HSC Vision.

World Health Organization (2008). *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Final Report of the Commission on the Social Determinants of Health. Geneva: Author.

Appendix A – Annotated Bibliography

Prepared by: Amanda Sanichar and Jessica Nafziger

Albanese, L., Elliott, C., Balkissoon, B., Dinovo, C., Hunter, M., Wong, S. (2014). Inclusion and Opportunity:

A new path for developmental services in Ontario.

This report highlights recommendations for the urgent need for a developmental services strategy to address the needs of adults, children, and youth in Ontario who are dually diagnosed with an intellectual disability and a mental illness, and coordinate the delivery of programs and services to the Ministry of Community and Social Services as well as many provincial ministries. When focusing on individuals with dual diagnosis, the committee heard that those with complex needs often fall through the cracks, as the developmental service sector is unable to accommodate all their mental health needs. The report highlights three recommendations for building capacity, which include: (1) the capacity for providing care be built on the specific needs of dually diagnosed individuals through professional training of primary care, dental care, direct service providers and through increased programs and services; (2) the use of mental health courts and other alternative diversion mechanisms be encouraged for individuals with a dual diagnosis in the justice system; and (3) the recommendations made in the Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis be implemented.

Ditchman, N., Kosyluk, K., Werner, S., Jones, N., Elg, B., & Corrigan, P. (2013). Stigma and intellectual disability: potential application of mental illness research. *Rehabilitation Psychology*, 58(2), 206-216.

Retrieved February 1, 2015, from ProQuest.

This study identifies the ways in which social stigmas affect individuals with an intellectual disability (ID) or mental illness (MI). Research findings suggest that those with an ID or MI face many health,

housing, and employment hardships, and are among the most socially excluded populations. This research would support Waterloo Region's dual diagnosis housing project because: it emphasizes the promotion of inclusive practices, it acknowledges possible instances of stigma discrimination, and it identifies several barriers that prevent the inclusion of individuals with an ID and MI in the community. An important implication for clinical practice and policy is that contact between group members and the public has been shown to positively impact the attitudes and social integration of people with an ID. As well, it is important that clinical professionals recognize the individual experience of clients with an ID, as the degree to which clients identify with an ID is associated with how they internalize social stigma. Understanding the challenges that individuals with an ID or MI face due to stigma is essential for developing a framework that will work to accommodate their housing needs.

Elliott, S., Taylor, S., & Kearns, R. (1990). Housing satisfaction, preference and need among the chronically mentally disabled in Hamilton, Ontario. *Social Science & Medicine*, 30(1), 95-102. Retrieved February 5, 2015, from ProQuest.

This study analyzed the factors affecting housing-satisfaction and coping among a sample of chronically mentally disabled (CMD) participants in Hamilton, Ontario, Canada. Using a socioecological model of health as a theoretical framework for research, this study identified which factors associated with the living situation were key determinants of the CMD's ability to remain out of hospital. This research contributes to Waterloo Region's dual diagnosis-housing project as it prescribes that a range of housing options, supporting total dependence to total independence, is necessary to effectively accommodate clients. By harmonizing housing accommodations with the personal and situational factors unique to each client, this is thought to reduce hospital re-entry. Failing to consider clients' individual differences could, in turn, foster feelings of isolation and dependence, due to institutional-like treatment.

Glasgow, T. (1998). A qualitative examination of best practices in the provision of specialized mental health services to individuals with a dual-diagnosis in London and Middlesex County. *Library and Archives Canada*, 1-172. Retrieved February 1, 2015, from ProQuest.

This thesis investigated the best practices for dual-diagnosis clients at the agency, community, and inter-organizational levels, in London and Middlesex County, Ontario. The prevalence of dual-diagnosis clients in caseloads, the extent of collaboration between community agencies in providing dual-diagnosis care, existing gaps in serving the dual-diagnosis population, service providers' perceptions of the best practices for dual-diagnosis clients, and current models of care, were particular areas of concern that were examined. Research findings support the design of the Waterloo Region dual diagnosis-housing project because they identify the best practices in service provision, which emphasizes person-centred strategies, specialized services, and community-based treatment. However, this study was limited in that several subsets of the dual-diagnosis population were not addressed: elderly parents transitioning to alternative care, violent offenders, and individuals with severe behavioural issues.

Hall, G., & Nelson, G. (1987). Housing for the chronically mentally disabled: part I—conceptual framework and social context. *Canadian Journal of Community Mental Health*, 6(2), 65-78. Retrieved February 4, 2015, from Scholars Commons.

This article reviewed an ecological framework for housing chronically mentally-disabled (CMD) individuals. Three dimensions for the social context of housing CMD individuals were examined within this framework: (1) housing in the geo-social environment; (2) responses of informal social systems to the location of housing; (3) and responses of the planning, policy, and service delivery system. This research suggests that acceptance by and interaction with neighbours and the general public is important for CMD clients' integration within their residence and the larger community. Thus, these findings support the Waterloo Region's dual diagnosis-housing project in developing and evaluating strategies for an effective

community-based system of care. The most successful programs have been ones that place the needs and rights of CMD individuals at the forefront of special-needs housing developments. The Metropolitan Toronto Supportive Housing Coalition, for example, was able to effectively coordinate the work of local housing programs, increase funding for these programs, change zoning bylaws to increase housing accessibility, and develop methods of promoting community acceptance. This program model could aid in special-needs housing development in other communities, as well.

Lediett, V. (2014, September). Supportive housing for dually diagnosed citizens: towards partnership solutions. *[PDF document]*.

This report discusses the goal of this project to locate interested parties, from both public and private sectors, who share a common interest in providing residential supports to clients with dual diagnosis disabilities, as well as initiate a process that will lead to more supportive housing for individuals who are dually diagnosed. This report discusses a written summary of residential housing models that could meet the needs of citizens, a list of potential partners, and a brief project report with recommendations on how to contend with supportive housing initiatives. In addition, the report discusses issues that are present such as advocacy, housing stock, service provider, and system level issues, as well as recommends how to overcome these issues. A recommendation to deal with housing stock issues would be the building of an 'ideal' model of housing to reduce social capital and operate expenses with a variety of measures such as (1) acquire existing public land through a purchase or leased agreement or (2) attract grant assistance for design and construction. This report is relevant to understand potential barriers to supportive housing initiatives that would be common, and recommendations on how to overcome these problems.

Lunsky, Y., & Balogh, R. (2010). Dual diagnosis: a national study of psychiatric hospitalization patterns of people with developmental disability. *Canadian Journal of Psychiatry*, 55(11), 721-728. Retrieved February 1, 2015, from ProQuest.

This peer-reviewed study examined the hospitalization patterns of young adults with a dual diagnosis, in Canada. Descriptive statistics were calculated to compare the frequency of patients with and without a developmental disability, in seeking psychiatric hospitalization. Resultant findings support the design of the Waterloo Region dual diagnosis housing project because they indicate that appropriate support services are lacking within communities to prevent subsequent psychiatric hospitalizations for dual-diagnosis patients, following their initial hospital-stay. As well, these findings suggest that more outpatient psychiatric services are urgently needed. Participants in this study did not include residents of Quebec. As well, developmental disability subgroups, such as individuals with autism spectrum disorders and fetal alcohol syndrome disorders, were not represented in this research. And, the reliability of this study is limited in that secondary data was drawn from the Discharge Abstract Database at the Canadian Institute for Health Information, which may be incomplete or have unconfirmed diagnoses.

Lunsky, Y., Garcin, N., Morin, D., Cobigo, V., & Bradley, E. (2005). Mental health services for individuals with intellectual disabilities in Canada: findings from a national survey. *Journal of Applied Research in Intellectual Disabilities*, 2007(20), 439-447. Retrieved February 1, 2015, from ProQuest.

This study examined the range of mental health services provided to individuals with an intellectual disability (ID) in Canada, and the perceived gaps in these services. Findings suggest that there is a need for more specialized services to meet the mental health needs of individuals with an ID, and further training for staff and professionals in identifying the needs of persons with an ID. This research strengthens Waterloo Region's dual diagnosis housing project because it identifies that there are possible barriers to overcome in ensuring that provided-services are appropriate and adequate.

Ministry of Health and Long-Term Care and Ministry of Community and Social Services. (2008, December).

Joint policy guideline for the provision of community mental health and developmental services for adults

with dual diagnosis. Retrieved from

http://www.health.gov.on.ca/english/providers/pub/mental/joint_policy_guideline.pdf

This guideline, provided by the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services outlines a framework for the planning, coordination, and delivery of community mental health and developmental services that will promote increased access to both sectors for individuals over 18 years old with a dual diagnosis. A major focus of this paper that is useful for the Waterloo-Wellington region would be the local roles and functions guidelines which include local health integration networks (LHINs), community networks of specialized care (CSC), and the involvement of MCSS regional offices. The report states the responsibilities of the LHINs, the leadership roles of the CNSC, and how the MCSS regional offices will work with the network develop cross-sector linkages for the planning and coordination of people with dual diagnosis. This information is important to understand the various roles different sectors will take in the achievement of developing community mental health and developmental services.

Nelson, G. (2010). Housing for people with serious mental illness: approaches, evidence, and transformative change. *Journal of Sociology and Social Welfare*, 37(4), 123-123. Retrieved February 4, 2015, from ProQuest.

This study examined the historical evolution of deinstitutionalization. Specifically, the research followed housing and support services provided to patients with mental illness, following their institutional-discharge. The evolution of housing approaches, published evidence supporting housing approaches, and a theoretical analysis for the improvement of housing approaches in current use, were particular areas of inquiry. This research adds to the Waterloo Region's dual diagnosis-housing project because it supports the social inclusion of people with mental health struggles in the community, and it provides evidence that suggests there is a need for social justice and more equitable allocation of resources. A weakness of

this study is that an evaluation of the differential outcomes between the supportive and supported housing approaches is lacking.

Nelson, G., Hall, G., & Forchuk, C. (2003). Current and preferred housing of psychiatric consumers/survivors. *Canadian Journal of Community Mental Health, 22*(1), 5-19. Retrieved February 17, 2015, from Scholars Commons.

This study explored the housing preferences and satisfaction among psychiatric consumers/survivors in southwestern Ontario. This report summarizes the steps that have been taken since the era of deinstitutionalization began in the 1960s, and the problems that have occurred in supportive housing over the decades. Participants were interviewed mainly in London, Ontario about demographic variables, psychiatric history and diagnosis, housing preferences, housing history, and quality of life. It was found that 79% of consumers stated they prefer to live in their own home, with the most important qualities preferred in their living situation being privacy, freedom, independence and ownership. Although many people prefer independent living, 76% of individuals were living in another type of setting such as a temporary shelter, supportive housing or sheltered care. This information is important for stakeholder groups to understand the preferential housing situation for those with dual diagnosis so that individuals with dual diagnosis will have housing that intends to increase their quality of life, as it suggests a particular preference for independent living.

Nelson, G., Hall, G., & Walsh-Bowers, R. (1998). The relationship between housing characteristics, emotional well-being and the personal empowerment of psychiatric consumer/survivors. *Community Mental Health Journal, 34*(1), 57-69. Retrieved February 4, 2015, from ProQuest.

This study explores the relationship between housing features and the community adaptation of psychiatric consumer/survivors. More specifically, researchers reviewed how two dimensions of housing, the physical-architectural environment and the social environment, is related to two dimensions

of psychiatric consumer/survivor adaptation: emotional well-being and personal empowerment. Findings showed that the number of living companions, housing concerns, and level of privacy affected the community adaptation of psychiatric consumer/survivors. Waterloo Region's dual-diagnosis housing project will benefit from this research because knowledge about the effects of housing features on adaptation will help program planners, practitioners, and consumer/survivors to create housing environments that are more effective. However, these research findings are limited in that issues of control and decision-making in residences for psychiatric consumer/survivors are inconsistent with other studies, and they therefore require further elaboration and study.

Nelson, G., Ochocka, J., Janzen, R., Trainor, J., & Lauzon, S. (2004). A comprehensive evaluation framework for mental health consumer/survivor organizations: values, conceptualization, design, and action. *The Canadian Journal of Program Evaluation*, 19(3), 29-53. Retrieved February 17, 2015, from Scholars Commons.

The report discusses the best approach for a framework for evaluation of mental health consumer organizations. The evaluation framework has four primary components: participatory processes, conceptualization of the activities and outcomes at the individuals and systems level of the organizations, the combination of qualitative and quantitative methods for examining outcomes, and dissemination and action. This paper also outlines how the framework can be put into practice by describing an evaluation of four consumer/survivor initiatives in Southern Ontario. This evaluation was an important step forward for the consumer/survivor community in Ontario because consumers were the active participants in a provincial mental health evaluation initiative. This information is important because it helped solidify the inclusion of consumers as important stakeholders and may also inform evaluation approaches for the dual diagnosis project.

Nelson, G., & Smith-Fowler, H. (1987). Housing for the chronically mentally disabled: part II—process and outcome. *Canadian Journal of Community Mental Health*, 6(2), 79-91. Retrieved February 17, 2015, from Scholars Commons.

This paper reviews the process and outcome research on community housing programs for people who are chronically mentally disabled (CMD). The first part of this review on housing for people who are CMD focused on the framework and social context of housing programs. The second part focuses more specifically on the nature of housing programs including the impact and outcome of housing programs on the adaptation of individuals and the micro-level characteristics of housing programs. This information can formulate an image of the most desirable type of residence based on the findings. The image can be explained as a family-like living situation with an atmosphere with mutual support and responsible behaviour expectations. The residence is a home that would provide dignity, privacy, and autonomy that clients need and the clients themselves would be responsible for the care of the setting. The literature shows superior adaptation for clients who live in apartments, group homes, and halfway houses as opposed to nursing facilities or other supervised institutions. The end of this paper discusses that future experimental evaluation research should focus not only if community-housing programs are beneficial, but also why they are beneficial for people who are CMD. The information from this study is important for what is needed for supportive housing for people who are CMD.

Sandor, G., & Schmidt, N. (2014, March 19). Intensive housing model review for clients with developmental disabilities and complex needs. HSC Vision Group. [PDF Document]

This report is a review of the need for an intensive housing model for clients with developmental disabilities and complex needs in Toronto. The review began in November 2013 and a presentation of the findings was given to the Toronto Network of Specialized Care (TNSC) in March 2014. The TNSC concluded there is no residential capacity for patients with developmental disabilities and complex needs.

The report summarizes areas needing for improvement in the system, which include a lack of adequate funding for housing options for people with complex needs, lack of continuum of supports, inadequate staffing levels, services required across multiple sectors, and savings accrued by moving people from hospital to community settings. There are four recommendations outlined to provide a strategy for the creation of housing capacity for individuals with developmental disabilities and complex needs in Toronto. The four recommendations include: build clinical capacity, increase specialized housing stock, develop a systems lead for high intensity or complex needs housing, and spearhead the development of an urban village housing concept for individuals with complex needs and developmental disabilities. This report is important to recognize the needs and recommendations of people who are dually diagnosed in Toronto to apply them to the Waterloo-Wellington region.

Sylvestre, J., George, L., Aubry, T., Durbin, J., & Nelson, G. (2007). Strengthening Ontario's system of housing for people with serious mental illness. *Canadian Journal of Community Mental Health, 26*(1), 79-95. Retrieved February 4, 2015, from Scholars Commons.

With funding from the Ministry of Health and Long-Term Care, a study was conducted to make recommendations for system improvements in housing people with serious mental illnesses in Ontario. Improvement recommendations were based on: values that underlie housing programs, evidence of effective housing practices, the current status of the system, and international practices for monitoring community mental health systems. However, the Local Health Integration Networks (LHINs) has 14 regional bodies that must be convinced to act, making any proposed recommendations more difficult to implement. This research supports Waterloo Region's dual diagnosis project, as it provides background information about the Ontario housing policy and system context, and it also suggests areas of improvement for shaping a more comprehensive housing framework going forward.

Sylvestre, J., Nelson, G., Durbin, J., George, L., Aubry, T., & Ollenber, M. (2006). Housing for people with serious mental illness: challenges for system-level community development. *Community Development*, 37(3), 35-45. Retrieved February 17, 2015, from ProQuest.

This paper discusses the developing partnerships and collaboratives among stakeholders in a system of housing and support services for people with mental illness in Ontario. This work has involved helping to develop networks for the creation of housing for people with mental illness in four large, urban Ontario communities. This paper in particular informed stakeholders to engage in discussions about how to strengthen the province's housing system. This work is designed to reflect the challenges that arise in efforts directed at supporting discussion on stakeholders including those who use and provide services. It was concluded from this paper that a successful housing system is built on a flexible, strong, and dynamic network of partnerships and service relationships. This paper also suggests that developing a successful system requires multi-stakeholders involvement. This paper is beneficial for Waterloo-Wellington region to realize the importance of multi-stakeholder investment in support services for people with dual diagnosis.

The Housing Study Group. (2013, September). An action agenda to address the housing crisis confronting Ontario adults with developmental disabilities. Retrieved from [http://www.autismontario.com/Client/ASO/AO.nsf/object/Sep13ENews/\\$file/Ending+the+Wait+final+sep6.pdf](http://www.autismontario.com/Client/ASO/AO.nsf/object/Sep13ENews/$file/Ending+the+Wait+final+sep6.pdf)

This report discusses the issues and consequences of adults with dual diagnosis, as well as identify ways of moving towards solutions to the crisis that exists for adults with developmental disabilities. The Housing Study Group designed and administered a survey through the networks of the Partnership Table members to identify the key barriers, models, and goals. The Housing Study group identified the components of an "action agenda" and from this acknowledged a number of key principles and

assumptions that need to be taken in the immediate future and long-term for individuals with dual diagnosis. This report also outlined a three-year action agenda that combines immediate and long-range intentions to impact the lives of adults with developmental disabilities.

Tsai, J., Bond, G., & Davis, K. (2010). Housing preferences among adults with dual diagnoses in different stages of treatment and housing types. *American Journal of Psychiatric Rehabilitation, 13*, 258-275. Retrieved February 17, 2015, from ProQuest.

This study explores whether housing preferences are different between the stages of treatment for substance abuse, consumers who prefer certain housing types have preference for certain characteristics, and consumers living in different types of housing report difference in choice, social support, and housing satisfaction. No other study found has examined housing preferences of dual diagnosis clients by their stage of treatment. Self-questionnaires were distributed to consumers by a psychosocial rehabilitation agency in Chicago. All participants had a history of dual diagnosis and homelessness. It was found that most dual diagnosis consumers prefer living in their own apartment or house, regardless of their stage of treatment. It was also found that clients prefer on-site staff and peer support for preference for supervised housing and consumers in single-room occupancies reported the least choice and lowest satisfaction. These findings are important because they contribute to the understand of consumers' housing preferences and housing types with dual diagnosis. This information is useful to determine what type of housing support should be given preference in the Waterloo-Wellington region.

Wark, S., Hussain, R., & Edwards, H. (2014). Impediments to community-based care for people ageing with intellectual disability in rural New South Wales. *Health and Social Care in the Community, 22*(6), 623–633. Retrieved February 1, 2015, from ProQuest.

This Australian study investigated possible impediments that community workers face in trying to support individuals with an intellectual disability. The top three impediments were found to be funding,

training, and access to services. These findings help to identify ways to improve services and assistance, as well as how to improve clients' quality of life and maintain their community-based placement. This research would support Waterloo Region's dual diagnosis housing project because it provides an understanding for the ways in which clients can be better accommodated as they age.

Werner, S., & Stawski, M. (2012). Mental health: knowledge, attitudes and training of professionals on dual diagnosis of intellectual disability and psychiatric disorder. *Journal of Intellectual Disability Research*, 56(3), 291-304. Retrieved February 7, 2015, from ProQuest.

This review examined the knowledge, attitudes, and training of professional caregivers in serving dual diagnosis clients. Findings in this review revealed that ignorance about the special needs of the dual diagnosis population with respect to their mental health, and the need for specialist knowledge concerning psychiatric diagnostics and treatment, are obstacles to overcome. It has been suggested that a lack of training and experience among mental health workers may be responsible for their low level of knowledge in serving dual diagnosis clients. Thus, the Waterloo Region dual diagnosis housing project may benefit from ensuring comprehensive training among mental health workers, to reduce negative attitudes and develop knowledge for more effective dual diagnosis treatment. Possible limitations of this review are that it may not have addressed all relevant literature, and it was based on English publications only.