Canadian Population Health Initiative

MENTAL HEALTH AND HOMELESSNESS IN CANADA

WORKSHOP PROCEEDINGS REPORT

May 27, 2008

SHERATON GATEWAY HOTEL
TORONTO, ONTARIO

Table of Contents

Section 1: Background and Information

On May 27th, 2008, the Canadian Population Health Initiative (CPHI), a part of the Canadian Institute for Health Information (CIHI) hosted a one-day workshop in Toronto, ON, on mental health and homelessness in Canada. This workshop was a collaborative initiative between CPHI and the Homelessness Partnering Secretariat at Human Resources and Social Development Canada (HRSDC).

The objectives of the workshop were to:

- Share some of the current research focused on mental health and homelessness, including CPHI's *Improving the Health of Canadians: Mental Health and Homelessness* report;
- Share best practices and experiences with grass-roots initiatives; and
- Provide a new networking opportunity for people working in the area of mental health and homelessness.

There were approximately 45 participants representing a diverse group of academics; researchers; representatives from emergency-housing services and community health organizations; representatives from various national, provincial and non-government health associations; clinical practitioners; and federal-level government representatives. Various provincial and municipal government representatives were invited, but were unable to attend. Participants were invited to share their expectations for the workshop. A list of participants and their key expectations are available in Appendices A and B, respectively.

About This Document

This document summarizes the discussions that took place at the workshop held May 27, 2008 in Toronto, Ontario at the Sheraton Gateway Hotel. It is divided into five sections.

- **Section 1** – **Background and Introduction**
- **Section 2** – **Setting the Context for the Workshop** summarizes two presentations that were used to set the context for the day.
- **Section 3** – **Research and Practice in Action** summarizes four presentations that were used to highlight examples of current research and practice across Canada and their place in understanding and addressing homelessness and the mental health needs of those experiencing homelessness.
- **Section 4** – **From Words to Action** highlights key messages that emerged from the presentations as identified by the participants, as well as examples of policies, programs and other initiatives of which participants were aware or with which they had experience. This session also highlights the ideas that were suggested for organizations to move forward on addressing mental health and homelessness in Canada and the potential roles CPHI might play to support them.

Welcome and Opening Remarks

Jean Harvey, Director, Canadian Population Health Initiative (CPHI)

Jean Harvey, CPHI Director, began the workshop by welcoming participants and explaining that as part of its Knowledge Exchange strategic function, CPHI brings various stakeholders together following the release of its *Improving the Health of Canadians* reports to share ideas and knowledge from interested parties living across the country on moving knowledge into policy and action.

Section 2: Setting the Context for the Workshop

Objective of Session:

- To provide participants with some background to the workshop and the work that national level partners are conducting in this area

Presentation #1:

- **Dr. Elizabeth (Lisa) Votta,** Program Lead, CPHI

To set the context of the workshop, Dr. Lisa Votta provided an overview of CPHI's *Improving the Health of Canadians* three-report series on mental health and resilience. She briefly introduced CPHI's *Improving the Health of Canadians: Mental Health and Homelessness* report (presented in more detail in Section 3 of this document). Dr. Votta emphasized that the main purpose of this workshop was to foster dialogue and partnerships relevant to work on mental health and homelessness.

Presentation #2:

- **Mr. Ashique Biswas,** Director, Policy, Research and Government Relations, Human Resources and Social Development Canada (HRSDC)

Mr. Ashique Biswas of HRSDC presented an overview of the Homelessness Partnering Strategy (HPS) and began by providing an overview of the current state of homelessness in Canada. He noted that those with mental illness are among the most visible and vulnerable of the homeless population. Frequent involvement with the criminal justice system is more likely to occur with homeless individuals with mental illness. Statistics presented showed that Canada's Aboriginal population is over-represented in the homeless population, revealing double or higher proportions of Aboriginal Canadians in some cases.

A number of contributing factors to homelessness were identified by Mr. Biswas including poverty, stigma, abuse and lack of adequate medical services, etc. However, causality is considered bi-directional – that is, mental illness may predispose some people to be homeless versus negative impacts of homelessness may cause mental illness.

Two different types of homelessness were defined: chronic (typically need longer term attention, housing and healthcare) and situational (closer to self-sufficiency, may be easier to work with to bring closer to self-sufficiency). Given the different types of homelessness and the varying needs of those experiencing homelessness, Mr. Biswas indicated that providing shelter and support is not sufficient to help solve the problem of homelessness and that supportive housing, affordable housing, etc. offers more long-term support to individuals.

Mr. Biswas introduced the Homelessness Partnering Strategy (HPS) as one strategy that helps build partnerships and structures, including longer-term supports to assist homeless individuals and families move towards self-sufficiency through a housing-first approach. This strategy was established in 2007 to replace the National Homelessness Initiative and includes community-based projects, research projects and Federal horizontal projects. A key component is the bilateral approach to partner with provinces and territories for a community-based strategy to find local solutions to local problems. Lessons learned so far from HPS show that successful health outcomes can result from stable housing and that an 'integrated services' approach to homelessness is very effective with more long-term support and solutions properly targeted (for example, help situational homeless individuals to become more self-sufficient). When asked if there were any lessons learned based on the challenge of sustainability to support housing in the strategy, Mr. Biswas explained that the role of the HPS is to support a continuum by showing initiative and leadership for others to follow.

Moving forward, Mr. Biswas explained that $110 million will be going to the Mental Health Commission of Canada for five pilot projects across Canada to test how best to provide services to mentally ill patients that are homeless. These projects will take place in Vancouver, Winnipeg, Toronto, Montreal and Moncton and each will target a distinct group of homeless people with mental illness. Mr. Biswas concluded that homelessness is a complex challenge that may be compounded by drug addiction and mental illness and that a lack of data creates benchmarking challenges. Adopting a housing first approach allows the HPS to help the homeless by providing basic housing needs for some and self-sufficiency for others.

Section 3: Research and Practice in Action

Objective of Session:

- To highlight examples of current research and practice across Canada and their place in understanding and addressing homelessness and the mental health needs of those experiencing homelessness.

Presentation #1
IMPROVING THE HEALTH OF CANADIANS: MENTAL HEALTH AND HOMELESSNESS
Dr. Elizabeth (Lisa) Votta, Canadian Population Health Initiative

Objective of Presentation #1:

- To present highlights from CPHI's report, *Improving the Health of Canadians: Mental Health and Homelessness*

CPHI's report, *Improving the Health of Canadians: Mental Health and Homelessness*, is the first in a series of three reports on mental health that CPHI will be releasing over an 18-month period. The report, which was released on August 30, 2007, examines the links between mental health, mental illness and homelessness. Dr. Votta explained that one of the biggest challenges with writing the report was the ability to report the number of homeless people in Canada. It was found that there are no clear means to accurately count the homeless population due to lack of consistent reporting etc., but the message showed that an approximate can be achieved and gaps highlighted. Dr. Votta was pleased to point out that this report highlighted new data opportunities from two key CIHI databases: Discharge Abstract Database (DAD); and National Ambulatory Care Reporting System (NACRS).

Two key findings emerged from the report. Homeless individuals tend to endure compromised mental health, in terms of higher levels of stress, less effective coping strategies, lower self-esteem and lower levels of social support, relative to non-homeless comparison groups. Similarly, the homeless population shows a higher prevalence of mental illness, substance abuse and suicidal behaviours compared to the general population.

As outlined in the report, there are a number of pathways to homelessness including housing challenges, income, employment, mental health, mental illness and addictions, most of which are inter-related. Further, it was found that there were a wide variety of related policies and programs, however very few were evaluated mainly due to lack of funding. For a focused approach, the report covered two types of initiatives: housing and community mental health programs.

The second report in the series, *Improving the Health of Canadians: Mental Health, Delinquency and Criminal Activity*, was released on April 29, 2008. The third and final report in the series on positive mental health will be released in February 2009. CPHI has also commissioned a collection of authors to contribute writings on what they thinks make for a mentally healthy community. The collection of papers was release on CPHI's website

in September 2008. CPHI's reports can be downloaded free of charge from its website: www.cihi.ca/cphi.

Presentation #2
ADDRESSING MENTAL HEALTH AND HOMELESSNESS: THE IMPORTANCE OF COMMUNITY-ACADEMIC PARTNERSHIPS
Dr. Stephen Hwang, St. Michael's Hospital and University of Toronto

Objective of Presentation #2:
- To look at the role of community-academic partnerships in understanding mental health and homelessness in Canada

Dr. Hwang provided an overview of the Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital and his experiences developing the team over the past five years. The CRICH is dedicated to reducing health inequalities through research innovation that impacts social change. It is Canada's sole interdisciplinary and hospital-based research center created to improve the health of socially and economically disadvantaged urban populations.

At the beginning of his work with the CRICH, Dr. Hwang explained that they were not collaborating outside of the Toronto area, despite dealing with an issue that faces all of Canada. As a result, opportunities were sought to collaborate with existing researchers across Canada with an interest in housing and health and in cities where it was feasible to conduct large-scale studies. Top academic investigators were identified as well as community based organizations in the cities that could partner with these investigators. These collaborations began to take place in 2005, called Research Alliance for Canadian Homelessness, Housing, and Health (REACH^3) and they now meet on an annual basis. These meetings allow for time to get to know each other, learn the priorities and objectives of all partners, and move forward while being policy-relevant. Currently there is collaboration across the provinces of British Columbia, Alberta, Ontario and Quebec.

In addition to collaboration across provinces, another key factor is the broad array of academic disciplines, e.g. epidemiology, health economics, psychology, public health, urban studies, etc. Dr. Hwang stressed that psychology is not the only discipline involved when dealing with mental illness and related issues. It is important to look across disciplines and collaborate.

A third key factor is the collaboration across the broad areas of concern, e.g. homeless adults, street youth, etc. Dr. Hwang stressed that communication is key in order for all of those involved to know what each other is working on to help develop synergies and become more than the sum of our parts. For example, Dr. Hwang's work focuses on adult homelessness but as part of REACH^3 all areas are covered.

Dr. Hwang explained that the strength of the community-academic collaborative approach was to start slowly and learn each others' priorities, strengths and interests. It was not simply based on timing and funding as is the tendency of other initiatives. With a mandate to conduct academic research, this approach establishes a need to ask the right research

questions from an academic research perspective while also considering what can be done on the front-line. This approach facilitates the ability to respond to a broad range of opportunities and challenges given the breadth of the group. Academic and community credibility is also achieved through this approach. The academic perspective applies research to validate the problem and provide effective approaches while the community side has practical use of the knowledge and research. Further, this approach supports effective knowledge translation whereby research findings are translated into policy and practice.

Presentation #3:
INTEGRATING RESEARCH INTO COMMUNITY-BASED CLINICAL TEAMS
Dr. Susan Farrell, Royal Ottawa Health Care Group

Objective of Presentation #3:

- To look at the role of research in community-based programming specific to mental health and homelessness

Dr. Farrell presented an overview of the service models of two key teams operating within the Royal Ottawa Health Care Group (ROHCG) as well as how to develop a research culture and lessons learned. With a mandate to provide specialized mental health services for those most vulnerable or hard to serve (for example, homeless mentally ill individuals), ROHCG includes the Assertive Community Treatment (ACT) and Psychiatric Outreach Teams.

As explained by Dr. Farrell, there are 80 ACT teams in Ontario and they are defined as multi-disciplinary teams providing 24-hour, long-term support to individuals with severe mental illness. Housing support is included in their role with approximately half of the patients being homeless. The Psychiatric Outreach Team is also multi-disciplinary and it provides initial contact, assessment and treatment to those with serious mental illness and are homeless. Dr. Farrell indicated that this team works with a 'dual client', meaning they work with both homeless individuals as well as agencies such as shelters to deal with treatment and intervention. Over the past year, the Outreach Team provided direct consultation, assessment and treatment to approximately 546 patients of all ages, and provided indirect consultation or education to approximately 7944 persons. Further, the Team worked with 33 partner agencies and provided formal presentations and education to share information for those working with the homeless.

Dr. Farrell highlighted the challenges for these teams, particularly given that a community-based approach was introduced within a strong biologically-based research culture of the hospital. For instance, research and evaluation was lacking within the Psychiatric Outreach Team and there was a tendency for the value-added of this program to be questioned. There was a perceived lack of application to clinical practice and the concept of using collaborators was not clear. As result, Dr. Farrell explained that scope and validity of measurement are key to overcoming such challenges.

Despite these challenges, it is both possible and rewarding to conduct mental health research in the context of community teams, using a collaborative approach. Both teams

have done this successfully as measured by the delivery of local, provincial, national and international presentations, publications and receipt of peer-reviewed funding. It is possible, and rewarding, to engage team members to be both critical consumers of research and collaborators on the work itself.

Dr. Farrell also discussed the concept of 'research culture' where everyone is *engaged* in the research and not just simply using the results. It involves looking at what the research is telling us and how to plan services accordingly. Dr. Farrell continued that development within the team and acting as a catalyst to support the team are also important and it is not effective to just look to external consultants for support. However, Dr. Farrell warns that there can be danger in leading change from within a team and there is a need to continue to show people the relevance in obtaining the information. Despite these challenges, Dr. Farrell stressed that it is important to actually start creating a team/initiative since some initiatives never move passed the initial discussion stage. Starting involves assessing readiness in terms of timing and balancing priorities – enthusiasm isn't enough. Dr. Farrell outlined four key lessons learned:

1. **Highlight the familiar.** Have people read relevant research papers to resonate with your work and look for teams that wrote their own story or write about yourselves (publish own model of lesson learned etc.)
2. **Collaboration is key.** It is important to involve all team members and partner with other researchers to help ensure all real research questions are asked and answered. Develop mentors (as an individual or as a team) and get a sense of what they are working on. Dr. Farrell noted that you can get the most insight and ideas when least expected and she urged the group to use collaboration whenever possible.
3. **Start by measuring what you do.** When providing a service it is important to find a way to measure its success. Evaluation is used to make a case for what you do and explain it to others. Measurement should not stop with statistics, the overall outcome produced needs to be evaluated.
4. **Don't keep it to yourself.** Seek opportunities for early dissemination and in a variety of ways. Aim to include all team members in sharing the message. Dr. Farrell suggested writing a brief overview of what your organization or team does and sharing it with a relevant hub as one approach to slowly developing partnerships.

Dr. Farrell's analysis to date regarding her experiences with developing and working on the ACT and Psychiatric Outreach teams included:

1. **Strengths:** the value of clinical wisdom and observation on the team to help guide work, continual grounding in practicality, access to a range of clients and providers/agencies, and the excitement and enthusiasm associated with the research, consumers and collaborators; and
2. **Challenges:** balancing service demands with time for this type of team work, selecting relevant partners, and empowering others to play smaller roles and not just partnering with academics.

In response to a comment from a workshop participant regarding the lack of research and attention of community-based or service-based programs in Canada, compared to UK, Australia and New Zealand etc., both Dr. Farrell and Dr. Hwang agreed that there are gaps. In particular, service user-lead research or consumer-based research seems to be lacking.

Dr. Hwang added that community-based groups should be leading the research and researchers should be involved to collaborate.

Presentation #4
FOSTERING HOPE AND PROMOTING HEALTH – CONSIDERATIONS FROM THE FIELD
Mr. Timothy Crooks, Phoenix Youth Programs

Objective of Presentation #4:
- To present highlights from a successful program that is being delivered at the local level

Mr. Crooks introduced the Phoenix Youth Programs, which includes a broad base of health protection and promotion services, parenting support program and special initiatives, e.g. drop-in centers, emergency health shelter, etc. for youth. Described as 'staggering' by Mr. Crooks, he revealed that the percentage of children living in poverty has remained exactly the same since 1989. In fact, approximately 1 in 6 children live in poverty. Mr. Crooks linked this, in part, to the absence of a national housing initiative.

Mr. Crooks explained that the educational trend tends to focus on training youth, such as those served by Phoenix, for working in the trades industry. He conceded that this training has merit, but the current job market has shown significant changes. Specifically, the workforce is more focused on the knowledge economy and there is high turnover (e.g. today's learner will have 10-14 jobs by the age of 38). Furthermore, it has been predicted that the top 10 jobs in 2010 will not have even existed in 2004. These changes have implications that impact youth and how best to equip them for the future.

Mr. Crooks instructed the workshop participants to take a moment and think about the important things in their life that comfort them. Family, health, community, meaningful employment, volunteering, friends, money were examples of these important things revealed by participants. Participants were then asked to think about how they would feel if they lost those important things. Responses included anxiety, fear, sadness, depression, anger and hopelessness. In both cases, Mr. Crooks indicated that in his experience these are the common responses regardless of who answers these questions. He went further to explain that being homeless leads to a greater striping of those important things. Experiencing loss of the important things in life tends to arise from different factors at play. Once an individual is experiencing difficulty and has no sense of opportunities or support to find a way out of their problems, it becomes even more difficult for the situation to improve. However, as presented by Mr. Crooks, there is a fundamental truth that *increased hope equals increased health and well being* and this is significant with respect to the stages of intervention with troubled youth. Mr. Crooks presented the stages of intervention as investment opportunities as outlined below.

- **Stage one: Prevention and Early Intervention** (school based prevention program) - involves building of skills and protective factors and therapeutic support of individuals and families
- **Stage two: Reactive Responses to Identified Need** (emergency shelters) – includes involvement in the child welfare system and hospital and emergency room visits

- **Stage three: Supports and Services with Long-term Intent** (community based network of support) – includes affordable housing and educations and skills development training

Mr. Crooks explained that the majority of focus and funding is spent at stage two in order to manage or contain a crisis, while stage one (where there is an opportunity to intervene or prevent an impending crisis) and stage three (involving community and school based programs that are more successful than shelters and other homeless programs) receive less attention and support. Given this situation, Mr. Crooks indicated that there is a disconnect between hope and the experience of loss, and the various related policies and programs. As a result, Mr. Crooks believes that youth need to experience a sense of empowerment and believe that they have an influence on the world around them. There is a need to create opportunities for youth to share moments where they are especially proud of themselves. In other words, there is a need for substantial investment in stages one and three of the stages of intervention.

One solution presented by Mr. Crooks was for professionals to work with youth to help them re-write and unfold their own story. Translating a narrative practice from a clinical setting to front-line settings focuses on problems, but also helps to look for hope and opportunities for youth. Phoenix Programming Special Initiatives referred to as SPIN by Mr. Crooks are key to developing youths' strengths through programs that not only keep youth busy but position youth to experience pride in themselves and let researchers understand the experience while helping to build support systems.

When presented with a comment that poverty is the main issue to address with the troubled youth, Mr. Crooks responded that despair and victimizations are saturated messages that people are generally not willing to listen or respond to from a marketing perspective. In order to gain support and attention, Mr. Crooks explained that Phoenix uses messages of change, support and hope related to basic necessities and rights not being met for some individuals.

Mr. Crooks concluded that there is a need to push for more community-based work right from the beginning of a program or initiative and make it 'marketable'.

Presentation #5
HOMELESSNESS IN CANADA: PULLING IT ALL TOGETHER
Dr. Marie-Carmen Plante, University of Montreal

Objective of Presentation #5:
- To learn some lessons from the past, and hear about the challenges and possible opportunities that lie ahead with respect to mental health and homelessness

Dr. Plante provided a snapshot of her various experiences over the years working with the mentally ill and homeless population. This included the international year of homelessness in Montreal in 1987 (before homeless shelters) with a trial centre that would become a

place that homeless people would go to for food and support and in the winter it would provide shelter for those in need; this was closed after three years in operation.

1990 saw the inception of the homeless team, of which Dr. Plante is now a member, and included one social worker, one community worker and one nurse. Work involved some outreach and working directly with homeless people in Montreal. Eventually the team grew to about ten members including three nurses, three social workers, one psychiatrist and one part-time medical doctor. Dr. Plante worked with the homeless and this team for twelve years. Liaison between the US and Canada was part of the program's activities, given that the US tended to have more research on the homeless.

Working through the department of Sociology at the University of Québec at Montréal, a number of events, including symposiums and conferences, were conducted; partnerships with other organizations also arose. Dr. Plante explained that it was a challenge to transition from working in a psychiatric setting to working in the field, directly with the homeless population. Learning to respect the dignity of every person was crucial. Working out in the field included outreach to shelters or responding to phone calls about persons seen in parks or on the side of a road, etc.

Dr. Plante and her team's work involved regular discussions of work, including current approaches, what is being done, are there better options, etc. Respect for individuality of each person was required and Dr. Plante's approach was to treat everyone equally and as special. Openness and flexibility was also required to work in this environment. Dr. Plante explained that this type of work was not based on a regular schedule and that personal compassion beyond clinical work was needed to deal with patient's needs beyond healing (for example, providing extra clothing if the weather was cold). Involvement in work programs, as well as preparation and support for housing needs were also part of this work. Dr. Plante added that consumer participation (for example, homeless persons) and involvement, as well as advocacy, teaching and research were important elements of effectiveness.

In presenting the current situation on homelessness, Dr. Plante considered both the good and bad news. Beginning with the bad news, Dr. Plante stated that poverty is continuing to increase and that there are more and more homeless people. More immigrants are homeless as are young people; hospitalization and follow-up are still difficult in treating the homeless and more people are in prison with mental illness. Dr. Plante indicated that there is a lack of follow-up care and treatment for the homeless and there is a need for long-term re-insertion services. There is also a lack of training in social and medical facilities to provide care for the homeless population and there is a need for new ways to administer finances and medication (for example, access to and receipt of) to help those individuals re-integrate into society.

Dr. Plante also presented good news to the current homeless situation. Dr. Plante began by stressing that there is hope. There is more known about the homeless than ever before; there are new structures to homeless shelters, including more supervision and housing. Improvements in dealing with discrimination are being shown with programs that offer shared care and serve the mentally ill even if they are homeless. Working together through

partnerships, evaluation programs to evaluate criminals' mental status before sending them to prison, more sensitization on homelessness in the media, as well as more work and research with the homeless are all current positive impacts.

Moving forward Dr. Plante identified advocacy and working for the rights of the homeless as important steps. Care for the well-being of the homeless and for those who care for them is also crucial. Dr. Plante pointed out that burnout and depression are common for those working with the homeless and there may be a need for more support and care for these workers. Increased levels of support, structure and housing, as well as need for partnerships and engagement at every level of government are all connected to dealing with the issue of homelessness.

Dr. Plante concluded that a lot of work has already been done regarding the homeless mentally ill population, but there is still a lot of work yet to do. Research to action is important and must be done to implement the right solution.

In response to a participant's question to further explain the idea of advocacy, Dr. Plante provided the example of welfare. She explained that advocacy is needed on behalf of those who are transitioning from welfare to the workforce because determining readiness for the workforce requires assessment and training. Dr. Plante indicated that approximately three months are needed to properly assess an individual's situation and help them re-organize their life. During this time, individuals experiencing homelessness often cannot work and thus require welfare. Without welfare support and proper assessment individuals may be forced into homelessness.

Section 4: From Words to Action

Telling Our Stories

Before participants were separated into working groups to facilitate discussions, participants were shown a short video by Ken Robinson. The key message of this video was to allow for innovation and support creativity and diversity among today's youth. Following the video, participants were separated into working groups and asked to identify the key themes that emerged from the workshop presentations. Themes that emerged from this discussion were as follows:

- Knowledge exchange, utilization and translation
- More coordination and collaboration across programs
- Importance of research – particularly in obtaining and sharing information
- The need to continue to speak about hope; collaboration; need for creative solutions
- Money
- Importance of using political process to see change and social political theory
- Willingness to take risks and be wrong
- Value of narrative storytelling
- The need to look after staff that are looking after homeless clients

World Café-style Discussion

Participants took part in a world café-style discussion involving three rounds of discussion.

- In round 1, a question was posed to all participants and then in groups, participants were instructed to take notes and discuss this question.
- In round 2, the group compositions changed and participants were asked to share the notes from round 1 with their new group and all were to record ideas that appealed to them. Participants were instructed not to discuss the ideas except to ask questions for clarification.
- For round 3, participants re-convened with their initial groups from round 1 to discuss what was shared and then, as a group, identify the top three ideas to share amongst all groups.

The question posed to participants for this world café-style discussion was:

> *"What are the practical and realistic things that we, our organizations and our communities can do that would have a significant and positive impact on the services that we provide to those experiencing – or at risk of experiencing – mental health issues and homelessness?"*

Following the three rounds of the world café-style discussion, participants shared with the entire workshop group their top ideas related to the question posed (see above). The ideas were shared and then categorized into seven themes as listed below. Refer to Appendix C for the complete list of ideas by theme.

1. Collaboration and partnership
2. Education, learning and knowledge exchange
3. Social inclusion, full and equitable participation
4. Costs of inaction
5. Getting the message out
6. Providing a voice for the homeless/consumers
7. Holistic Care

Once the ideas were categorized, participants were asked to place dots on the category titles to denote where they feel attention should primarily be focused to achieve the strongest return on investment. The results of this task showed that the top two priority areas were: 1) collaboration and partnership; and 2) providing a voice for the homeless.

Closing Remarks

In closing the workshop, participants were asked to discuss what can be done collectively to address the issues related to the workshop.

One participant noted that the Mental Health Commission is a good starting point and suggested that people can proactively find out what the Commission is doing, get involved and provide input.

In the spirit of collaboration and partnership, webcasts were identified as an approach to staying connected beyond meeting at workshops. Webcasts were considered an effective way to highlight success stories of what is happening across the country and how they work.

Interest was expressed amongst workshop participants for means to reconnect after the workshop, such as sending participants the report and reminding participants to recall with which workshop participants they planned to connect and why. It was generally agreed that it would be useful for CPHI to send out a follow-up email approximately six months after the workshop session to facilitate this. CPHI representatives were receptive to this suggestion and indicated that they will follow-up with participants.

Dr. Farrell of the Royal Ottawa Health Care Group informed the participants that they could contact her for information needs based on geography and/or like-minded space.

A representative of the Homeless Hub informed participants that the Hub can be an effective resource for looking up people in a specific area as well for interconnections.

All participants agreed to be added to a shared contact list related to the workshop.

Information regarding a conference coordinated by Raising the Roof that was currently in the planning stages for November 19-21, 2008 in Toronto would be passed on to Dr. Votta of CPHI for sharing with the workshop participants.

The facilitator urged participants to take the following question away from the workshop: 'What can I do?'

Jean Harvey of CPHI concluded by thanking participants for joining and encouraging them to stay involved.

Appendix A: Workshop Participants

LIST OF PARTICIPANTS

THE CANADIAN POPULATION HEALTH INITIATIVE (CPHI) WORKSHOP:
MENTAL HEALTH AND HOMELESSNESS IN CANADA

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TORONTO, ON

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Pam Leahy
Canadian Mental Health Association

Sarah Liberman
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Appendix B: Participants' Expectations

At the beginning of the workshop, participants were asked to share their expectations for the day. The following expectations were shared:

- Learn about knowledge translation
- Share a lot about work done over the years – find out what each does and recommendations and solutions that affect all of Canada
- Funding possibilities – sources of funds
- Learn from what is presented today to share with contacts and organizations
- Need more financial support (for programs, etc.)
- Learning about service supports available and community research
- Best practices and program delivery models for homelessness – including culturally sensitive ones
- Inclusion despite geographic location
- More programs to implement – less reports
- Consistent statistical reporting
- How to identify in simple terms who can do what and how they can do it
- What is being done in the area of advocacy

Appendix C: Highlights from World Café-style Discussion

As part of the world café-style discussion, participants were asked to answer the following question in groups:

> *"What are the practical and realistic things that we, our organizations and our communities can do that would have a significant and positive impact on the services that we provide to those experiencing – or at risk of experiencing – mental health issues and homelessness?"*

The top ideas shared among the groups were categorized by themes and are outlined below.

1. **Collaboration and partnership**
   - Working together
   - Breaching professional silos and collaborating as peers
   - Commit to better partnerships – all with the purpose of better services for people (via understanding outcomes, integrating services, building credentials, better knowledge, strengthen advocacy voice, etc.)
   - Community-based service providers and researchers need to come together
   - Active inclusive partnerships with capacity and relationship building, power shifts and valuing of many diverse voices

2. **Education, learning and knowledge exchange**
   - Savvy early education and upstream integration: communication strategies that bridge sectors/stakeholders; targeted social justice education throughout public school, university and college. Sense of collective responsibility to inform public/political will. Integrated training/education/practice.
   - Knowledge exchange for front line workers
   - Education and training:
     - Training health providers/students to understand issues facing the homeless
     - Good discharge planning
     - Best practices
     - Staff exchange programs across Canada
     - Balance of education that is theory-based and applied

3. **Social inclusion, full and equitable participation**
   - Organize and empower people experiencing homelessness to share their personal story
   - "The homeless" are people – humanize homelessness
     - Deliver services with respect and dignity
     - Use the media proactively to destroy stigma and change perceptions – mental health is an issue for all; promote success stories
     - Create venues for consumers to educate the general public
   - De-stigmatization:
     - Sensitize the public about issues facing the homeless and who they are – emphasis on the positive aspects of them as individuals

    - Track if having impact on reducing stigma

4. **Costs of inaction**
    - Provide information on the costs of not addressing these problems
    - Lack of evaluation of programs – risk re-allocating resources to programs that may not work from those that may

5. **Getting the message out**
    - Strive to use positive language and messaging at all levels – front line, media, community, political
    - Client-centered, strength-based services, evaluation tools, research and community development
    - Foster awareness about the commitment of front line workers
    - Promote the asset-based aspects of work, programs, research, public education, policies, stories

6. **Providing a voice for the homeless/consumers**
    - Give consumers voice
        - Engage homeless individuals in listening/talking with policy makers
        - Research methods – qualitative, narrative methods
        - Media – pass on positive stories
    - Educate public regarding the process of making policy decisions

7. **Holistic Care**
    - Ensuring health care services are accessible and accountable for health outcomes across the life span
    - Change clinical practice lens
        - Offer more services and the right services rather than just emergency beds
        - Change approach to address multiple issues concurrently
        - Increase accessibility to services