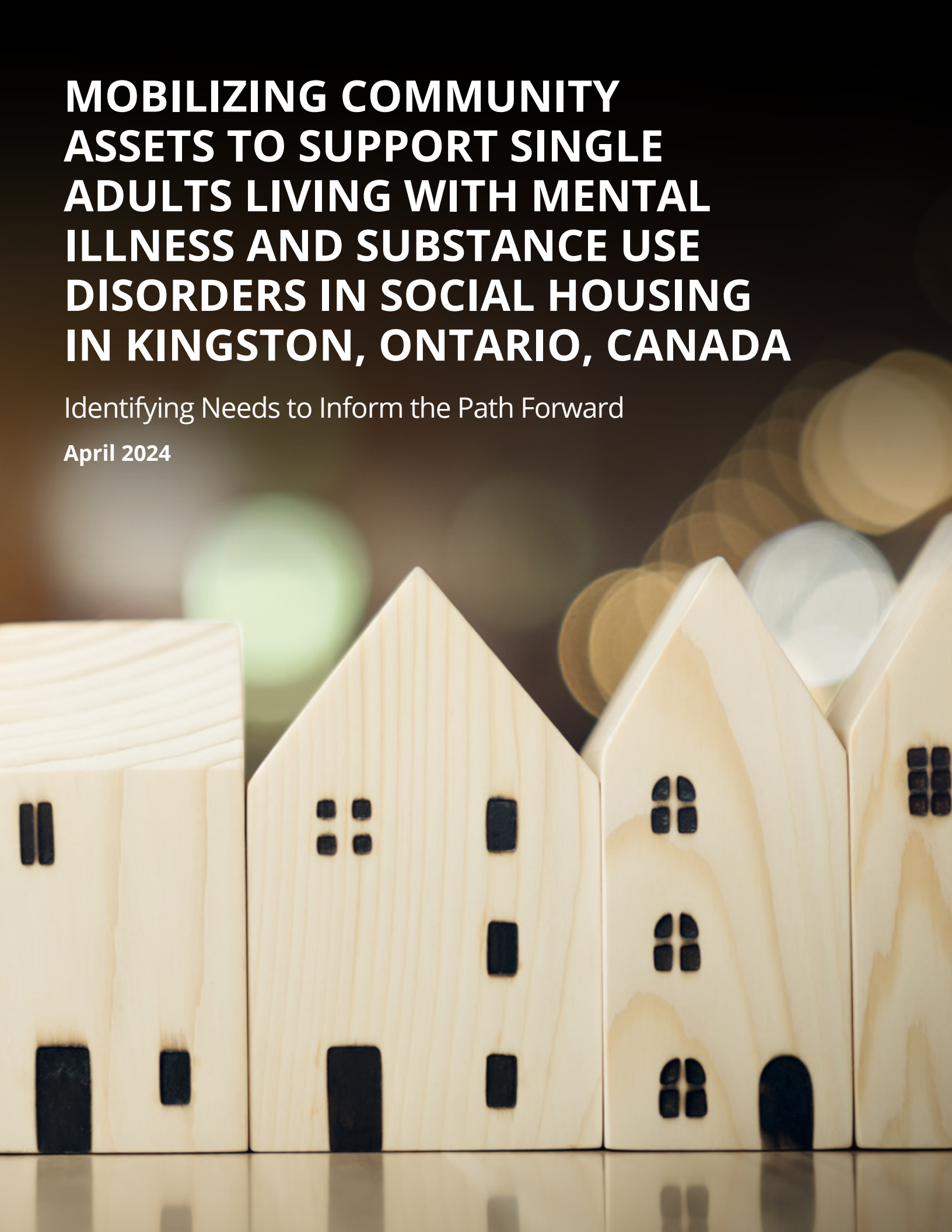
MOBILIZING COMMUNITY ASSETS TO SUPPORT SINGLE ADULTS LIVING WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS IN SOCIAL HOUSING IN KINGSTON, ONTARIO, CANADA

Identifying Needs to Inform the Path Forward

April 2024



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1. EXECUTIVE SUMMARY

Social housing is housing that is owned and/or operated by governments or non-profit groups for the purpose of providing deeply affordable housing for individuals living in low income. It is an essential social service, and one that is needed more than ever before in the context of a growing housing affordability and homelessness crisis that continues to persist across Canada and beyond [1]. In recent decades, approaches to supporting individuals living with mental illness have shifted from institutional approaches to community-care models where individuals live in and receive services in their homes and the community. These shifts, which have been important for promoting the recovery of Canadians living with mental illness, have changed the landscape of social housing. Because individuals living with mental illness experience poverty at a disproportionate rate, access to social housing is essential for meeting their housing needs. Social housing providers have noticed these changes, and report that they are supporting a tenant group that has become increasingly complex over time [2]. Social housing providers are considered landlords, however, and as such, are allotted little to no funding to provide services to tenants. Instead, they are intended to rely on community services to meet the needs of their tenants in the community. In recent years, however, social housing providers have reported that community services are not meeting their tenants' needs, and consistent with these reports, tenants living with mental illness report a range of unmet needs [2, 3]. This has likely worsened since the onset of the COVID-19 pandemic, which has exposed serious health inequities among individuals living in poverty [4, 5].

This report represents the findings of a stakeholder consultation with tenants living with mental illness in social housing, social housing staff and leaders, and community service providers in Kingston, Ontario, Canada. In this consultation, we focused on identifying the strengths and unmet psychosocial needs of single adult tenants living with mental illness in social housing. We collaborated with one social housing provider, Kingston-Frontenac Housing Corporation (KFHC), located in Kingston, Ontario, Canada. In conducting this consultation, we have interviewed tenants, KFHC staff and leadership, and community service providers who support tenants in social

housing. We conducted: 1) mixed interviews (qualitative and qualitative) with 85 tenants; 2) qualitative interviews with 10 KFHC staff and leaders; and 3) qualitative interviews with 13 community service providers in the Kingston, Ontario community.

Our report begins with a rationale for this project, followed by a summary of the stakeholder consultation methods used. This is followed by a detailed summary of our consultation findings with all three stakeholder groups. We end our report by making several recommendations for future research, policy and practice aimed at more effectively addressing the psychosocial needs of tenants living with mental illness in social housing in the Kingston community. Our recommendations, while based on interviews conducted in the Kingston, Ontario community, may be relevant to researchers, policymakers, and practitioners in a range of communities. The findings of our consultation will be used as a foundation for co-designing strategies in collaboration with tenants, social housing staff and leaders and community service providers aimed at improving the psychosocial well-being of social housing tenants.

2. INTRODUCTION

Social housing constitutes government subsidized apartments for tenants living on low incomes who would otherwise struggle to pay market rent [6]. It is distinguished from other forms of affordable housing by being owned directly or indirectly by federal, provincial, municipal, or Indigenous governments, and by providing deeply affordable units that are accessible to individuals living on some of the lowest incomes in Canada [7]. This form of affordable housing is a critical part of any strategy aimed at mitigating the effects of poverty, and has been named as an important part of Canada's Poverty Reduction Strategy [8]. In recent years, social housing providers have been reporting that the prevalence of mental illness and substance use disorders are increasing among tenants, that the social needs of this tenant population are growing, and that they are struggling to provide housing in the context of these high support needs [2]. This is in part a systemic outcome whereby social housing is often rent geared-to-income and therefore the most deeply affordable solution for individuals living in low income in Canada, which disproportionately includes individuals living with mental illness (including substance use disorders) [9]. Social housing providers are allotted little to no funding or resources for the provision of psychosocial supports, and instead they are encouraged to rely on supports available in the broader community to meet their tenants' complex needs. At the same time, the demand for mental health and social services is greater than ever before, and organizations who support persons living with mental illness are struggling to meet the needs of the community overall. In a 2018 Statistics Canada community health survey, 5.3 million people identified the need for mental health support in the last year [10]. Nearly half indicated that their needs were fully unmet (1.1 million), or partially met (1.2 million) [10]. Evidence suggests that prior to the COVID-19 pandemic, tenants living with mental illness in social housing may not have had equitable access to mental health and social services, and consequently lived with a range of unmet basic needs [3]. These inequities have likely deepened further since the onset of the COVID-19 pandemic, as has been the experience of individuals living in poverty more generally [5, 11, 12]. To address these health inequities, there is a need to understand the mental health profiles and social needs of tenants living with mental illness in social housing to direct the development of targeted solutions.

Rationale and Goals of the Project

We conducted this study to identify solutions for more effectively supporting the needs of tenants living with mental illness in social housing in Kingston, Ontario, Canada. The specific goals of this project were to: 1) identify the specific strengths and psychosocial challenges of tenants living with mental illness and substance use disorders; and 2) collaborate with tenants, social housing and community service providers to identify a strategy for more effectively addressing tenants' unmet needs. This report summarizes the findings of a consultation conducted with: 1) tenants living in social housing; 2) social housing providers; and 3) health and social care providers in the broad community. The findings presented here will be used as a foundation for co-designing solutions that will follow the release of this report in the Kingston, ON community.

Project Setting

Kingston-Frontenac Housing Corporation (KFHC) is a social housing provider in Kingston, Ontario, Canada. Funded by the City of Kingston, KFHC has been providing social housing since 2000. KFHC manages 2152 rent geared-to-income, rent supplemented, and affordable housing units in Kingston and Frontenac County. Like many social housing providers in Ontario, supports are minimally integrated within social housing complexes, and tenants are expected to access supports, if needed, from agencies in the broader community. Prior to the COVID-19 pandemic, only one person was employed to provide support to all tenants with a 0.8 full time equivalent (FTE) position. During the pandemic, it was recognized that there was an increased need for support, and funding was provided by the City of Kingston to increase this complement to two FTE positions including one full-time Manager of Support Services, and a full-time Housing Support Worker. Although social housing is designed with the intention that community services will provide needed supports with any on-site supports filling in gaps, previous research indicates that prior to the COVID-19 pandemic, these services were not always reaching tenants [3]. This lack of access to supports has likely been compounded by the fact that service restrictions imposed during the pandemic may not have been fully restored to pre-pandemic levels, placing tenants living with mental illness at increased risk.

3. METHODOLOGY

This report represents one component of a community-based participatory research (CBPR) project aimed at identifying strategies for more effectively supporting tenants living with mental illness and substance use disorders in social housing. This research began with establishing a community advisory board consisting of tenants living in social housing, social housing staff and leadership, community (health and social care) providers in the Kingston, ON community, and researchers from Western and McMaster Universities. The findings presented in this report summarize our analysis of stakeholder interviews conducted with three key groups: 1) single adult tenants living in social housing; 2) social housing staff and leadership; and 3) community (health and social care) providers working in organizations throughout the City of Kingston. Prior to approaching participants for interviews, our study was approved by the Non-Medical Research Ethics Board at Western University in London, ON, with whom the principal researcher is affiliated.

It is important to note that we have decided to focus our project activities on understanding the strengths and needs of single adults living in social housing. As such, members of our community advisory board have been selected for their expertise regarding this tenant sub-population, and our recruitment strategies have focused on including only tenants living in social housing buildings designed for single adults.

3.1 Data collection

3.1.1 Tenant interviews

Tenant interviews consisted of demographic components (age, gender, race, sexual orientation, years in social housing, income source, health status) and a series of standardized measures, which are presented in Table 1. The purpose of these interviews was to gain insight into the health characteristics and both met and unmet needs of tenants living with mental illness and substance use disorders in social housing.

Table 1. Description of Standardized Scales

Scale	Description
Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) [13]	22-item inventory exploring basic psychosocial needs on a categorical scale. Scale categories include: 1) "no problem," meaning that a participant has never had a problem in this area of their life; 2) "met need," meaning that a participant has experienced difficulty in this area of their life in the past, but not at present due to help given; and 3) "unmet need," meaning that a participant continues to experience difficulty in this area of their lives despite any help provided.
Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) [14]	7-item inventory of mental well-being using a 5-point Likert scale ranging from 'none of the time' to 'all of the time.' A high score indicates a higher degree of mental well-being.
Alcohol Use Disorders Identification Test-10 (AUDIT-10) [15]	10-item inventory using a 3-5 point nominal scale corresponding to an established score related to severity of alcohol use. A high score indicates greater use of alcohol.
Drug Abuse Screening Test-10 (DAST-10) [16]	10-item dichotomous scale (YES/NO) that assesses the extent of a person's substance use. A high score indicates greater degree of drug misuse.
World Health Organization Disability Assessment Schedule 2.0 (12-item) (WHODAS-12) [17]	12-item inventory that measures the impact of a health condition on function and participation in daily life on a 5-point Likert scale ranging from "none" to "extreme or cannot do." A high score indicates a greater degree of disability associated with the presence of one or more health condition(s).
Engagement in Meaningful Activities Survey (EMAS) [18]	12-item inventory of one's engagement in meaningful activity using a 5-point Likert scale ranging from 'never' to 'always.' A high score indicates a greater degree of engagement in meaningful activities.
Post-Traumatic Stress Disorder Checklist for the Diagnostic and Statistical Manual of Mental Disorders-5 (PCL-5) [19]	20-item checklist measuring the extent to which experiences of past trauma are affecting an individual in their daily lives using a 5-point Likert scale ranging from "not at all" to "extremely." A high score indicates a greater degree of trauma affecting a person in their daily life.
UCLA Loneliness Scale (UCLA-LS) [20]	20-item scale measuring loneliness on a 4-point Likert scale ranging from 'I often feel this way' to 'I never feel this way.' A high score indicates a higher degree of loneliness.

A sub-group of tenants who self-identified as living with mental illness in quantitative interviews was approached to participate in qualitative interviews. Qualitative interview questions posed to tenants living with mental illness focused on identifying strategies for meeting the needs of this tenant group. These interviews were recorded on a digital recording device and transcribed verbatim to facilitate analysis. Participants were asked to select a pseudonym to assign to their quotes to protect their confidentiality. A sample of questions posed to tenants in qualitative interviews is presented in Table 2.

Table 2. Sample qualitative interview questions posed to tenants

1	Tell me about where you live. What is it like for you to live in your building? How is it the same or different from other apartments or homes you've lived in?
2	In what ways does living in social housing support or detract from your mental well-being?
3	What can you say about the sense of community in the building? How does this support or retract from your mental well-being?
4	How does living with mental illness and/or substance use challenges affect your ability to do things that you want to do or need to do in your daily life if at all?
5	How are you managing right now to take care of yourself and your apartment?
6	What workers both within social housing and in community services like mental health, social services, doctors or police are most helpful to you and other tenants who are living with mental illness and/or substance use challenges in your building?
7	In what ways have such services changed since the COVID-19 pandemic began, if at all?
8	How could workers both within social housing and in community services like mental health, social services, doctors or police do to better support your mental well-being, and the mental well-being of other tenants living with mental illness and substance use difficulties in your building, if anything?
9	What could workers both within social housing and in community services like mental health, social services, doctors or police do differently to help support your ability to manage in your daily life (e.g. maintain your apartment, cook, care for yourself, do things with your time that is meaningful) more effectively, if anything?

3.1.2 Social housing staff and leader interviews

Interviews with KFHC staff and leaders consisted of brief demographic components (gender, role, education) followed by semi-structured qualitative interviews. These interviews focused on understanding the strengths and needs of tenants living with mental illness in social housing from the perspectives of social housing providers. These interviews were recorded on a digital recording device and transcribed verbatim to facilitate analysis. Participants were asked to select a pseudonym to assign to their quotes to protect their confidentiality. A sample of questions posed to social housing staff and leadership is presented in Table 3.

Table 3. Sample qualitative interview questions posed to social housing staff and leaders

1	Tell me about what it's like to work in social housing as you support tenants who are living with mental illness and/or substance use challenges.
2	In your view, how does living in social housing support or detract from the well-being of tenants? In what ways?
3	Tell me about the sense of community in social housing, and the ways in which you think it supports or retracts from tenant mental well-being.
4	In what ways does living with mental illness and/or substance use challenges affect the ability of tenants to function in their daily lives, and sustain their tenancies from your perspective?
5	What are the most common reasons for tenancy loss (i.e. eviction or notice of eviction) among individuals living with mental illness and/or substance use difficulties in social housing?
6	What do you think tenants living with mental illness and/or substance use disorders need to avoid eviction or a threatened tenancy?
7	What workers both within social housing and in community services like mental health, social services, doctors or police are *most helpful to tenants who are living with mental illness and/or substance use challenges* in social housing from your perspective?
8	What could social housing support and community services do to better *support the mental well-being of tenants* living with mental illness and substance use difficulties in social housing, if anything?
9	What could social housing support and community services do differently to help support tenants' *ability to manage in their daily lives* (e.g. maintain their apartment, cook, care for themselves, do things with their time that is meaningful) more effectively, if anything?

3.1.3 Community service provider interviews

Interviews with community service providers consisted of brief demographic components (gender, role, education) followed by semi-structured qualitative interviews. Community service providers included mental health and social care professionals working in organizations that support individuals living with mental illness and who experience poverty in the Kingston, ON community. These interviews focused on understanding the strengths and needs of tenants living with mental illness in social housing from the perspective of community services (i.e. mental health services, social services, emergency services). These interviews were recorded on a digital recording device and transcribed verbatim to facilitate analysis. Participants were asked to select a pseudonym to assign to their quotes to protect their confidentiality. A sample of questions posed to community service providers is provided in Table 4.

Table 4. Sample qualitative interview questions posed to community service providers

1	Tell me what you know about social housing, and your experience of supporting tenants who are living in social housing buildings.
2	What kinds of support do you provide to tenants who are living in social housing within your role?
3	From your experience in social housing, how does living in social housing support or detract from the well-being of tenants? In what ways?
4	Tell me about the sense of community in social housing that you've observed, and the ways in which you think it supports or retracts from tenant mental well-being.
5	In what ways does living with mental illness and/or substance use challenges affect the ability of tenants to function in their daily lives, and sustain their tenancies in social housing from your perspective?
6	In what situations have you provided support to a tenant living with mental illness in social housing who is facing a threatened tenancy (i.e. either eviction or notice of eviction)?
7	What supports that you provide seem to be most helpful to tenants who are living with mental illness and/or substance use challenges in social housing?
8	What could community services do to better support the mental well-being of tenants living with mental illness and substance use difficulties in social housing, if anything?
9	What could community services do differently to help support tenants' ability to manage in their daily lives (e.g. maintain their apartment, cook, care for themselves, do things with their time that is meaningful) more effectively, if anything?

3.2 Analytic strategies

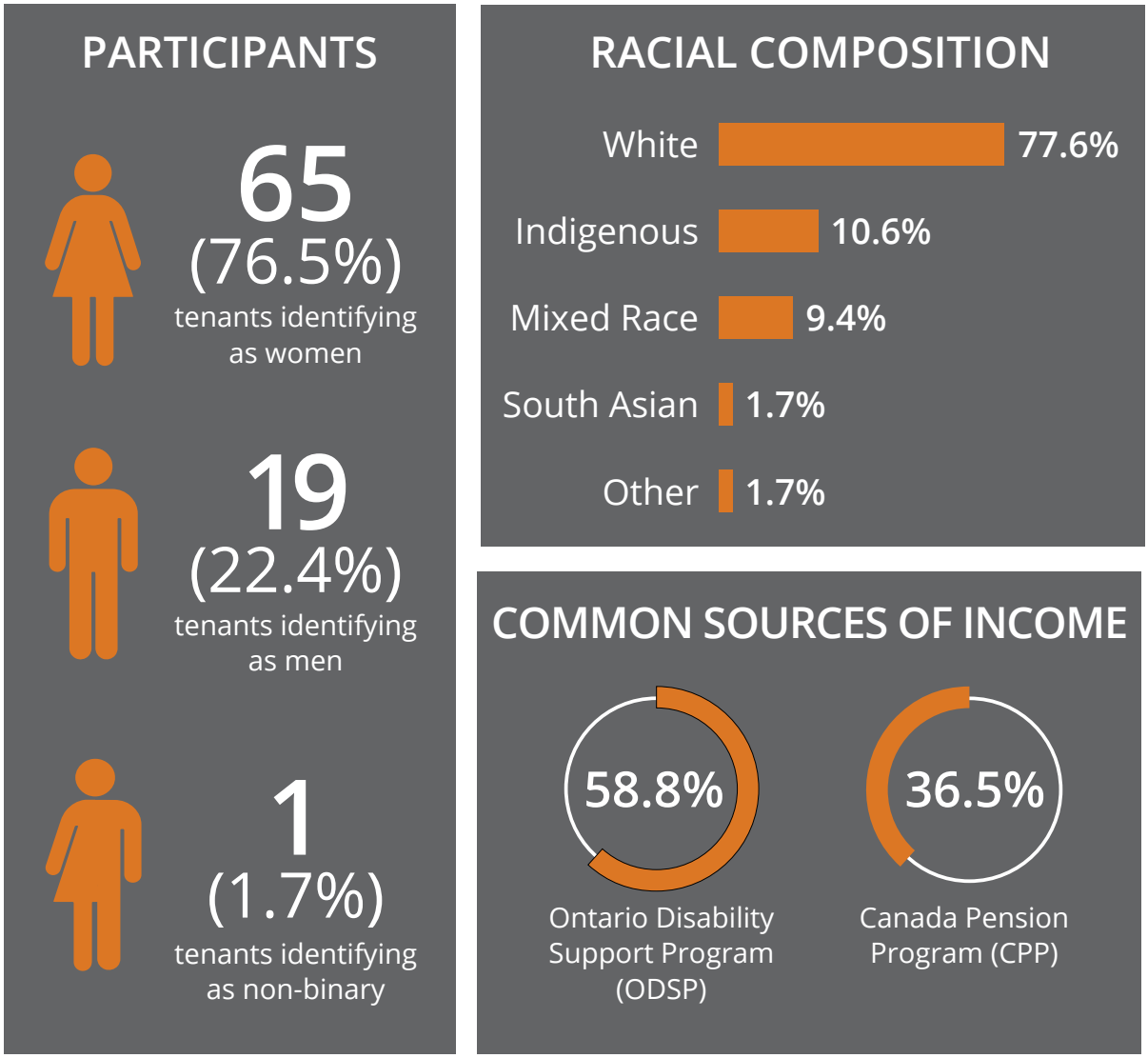
Descriptive statistics were calculated to represent the demographic characteristics of each stakeholder group including tenants, KFHC staff and leadership, and community service providers. Quantitative data from tenant interviews were analyzed by conducting: 1) descriptive statistics with demographic information (means, medians, ranges); 2) Pearson correlations aimed at identifying associations between trauma, unmet needs, and the number of years of residence in social housing; and 3) one-sample t-tests to determine any significant differences between participant scores on standardized measures of psychosocial well-being and norms and threshold scores published in the broad literature. We analyzed qualitative interviews using thematic analysis [21] by coding statements in participant transcripts to identify themes and categories that would characterize the narratives of participants in each stakeholder group.

4. QUANTITATIVE FINDINGS:

TENANT INTERVIEWS

We interviewed 85 tenants living in four social housing buildings operated by Kingston-Frontenac Housing Corporation (KFHC).

4.1 Tenant demographic characteristics



A detailed summary of the demographic and income characteristics of tenants interviewed in our consultation is provided in Table 5.

Table 5.

Tenant demographic characteristics (n=85)

Demographic Characteristics			
	n (%)		n (%)
Age	Mdn=59; IQR=15; 20-89	**Primary source of income[3]**	
Gender		ODSP	50 (58.8)
Woman	65 (76.5)	OW	6 (7.1)
Man	19 (22.4)	CPP	31 (36.5)
Non-binary	1 (1.7)	OAS	18 (21.2)
2SLGBTQ+ status		GIS	10 (11.8)
Yes[1]	13 (15.3)	Long Term Disability (employer-paid)	3 (3.5)
No	72 (84.7)	Worker's Compensation	1 (1.2)
Race/Ethnicity		Employer	6 (7.1)
White	66 (77.6)	Self-Employment	3 (3.5)
Indigenous[2]	9 (10.6)	Non-traditional employment (i.e. sex work, bottle collecting, panhandling)	3 (3.5)
Mixed Race	8 (9.4)	Other	11 (12.9)
South Asian	1 (1.7)	Years of tenure in social housing	Mdn=10 years; IQR=12.7 years; 1-42 years
Unknown	1 (1.7)		

Note: Not all percentages add to 100 due to rounding

Note: ODSP=Ontario Disability Support Program; OW=Ontario Works; CPP=Canada Pension Plan; OAS=Old Age Security; GIS=Guaranteed Income Supplement

1 Bi-sexual (n=9); Pansexual (n=2); Lesbian (n=1); Queer (n=1)

2 Iroquois (n=2); Algonquin/Inuit (n=1); Cherokee (n=1); Cree (n=1); Metis (n=1); Metis/Ojibwa (n=1); Mohawk (n=1); Unknown (n=1)

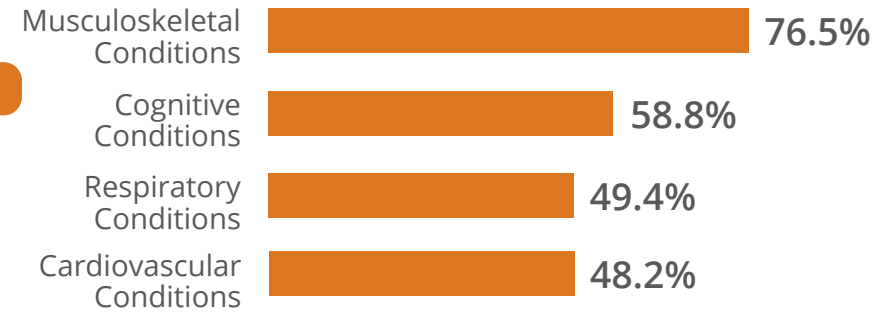
3 Several participants had more than one source of income resulting in frequencies in this domain which exceed the total number of participants in the sample

4.2 Tenant health characteristics

Tenants identified a median of seven health conditions (IQR=4; 2-14), with a median of three mental health conditions (IQR=3; 0-8), and four physical health conditions (IQR=2; 0-7).

MOST COMMON MENTAL HEALTH CONDITIONS

MOST COMMON PHYSICAL HEALTH CONDITIONS



A detailed summary of the health characteristics of tenants interviewed in this study is provided in Table 6.

Table 6.

Tenant health characteristics (n=85)

Characteristic	n (%)
Mental health conditions	
Anxiety disorder	69 (81.2)
Mood disorder	63 (74.1)
Stress and trauma related disorder (e.g. acute stress, post-traumatic stress)	60 (70.6)
Substance use disorder	34 (40.0)
Obsessive-compulsive disorder	23 (27.1)
Personality disorder	16 (18.8)
Eating disorder	13 (15.3)
Psychotic disorder	9 (10.1)
Other	6 (7.1)
No mental health condition	4 (4.7)

Note: Percentages do not all equal 100 due to rounding and comorbidity

Note: ADHD = Attention Deficit Hyperactivity Disorder

	n (%)
Physical and cognitive health conditions	
Musculoskeletal condition	65 (76.5)
Cognitive condition (e.g. brain injury, learning disability, ADHD)	50 (58.8)
Respiratory condition	42 (49.4)
Cardiovascular condition	41 (48.2)
Gastrointestinal issues	33 (38.8)
Immune condition	25 (29.4)
Skin condition	23 (27.1)
Infectious disease	3 (3.5)
No physical health condition	3 (3.5)
Frequency of health conditions	
Mental health conditions reported	Mdn=3; IQR=3; 0-8
Physical health conditions reported	Mdn=4; IQR=2; 0-7
Total number of health conditions reported	Mdn=7; IQR=4; 2-14

4.3 Strengths and psychosocial challenges of tenants

To identify the strengths and psychosocial challenges of tenants living in KFHC social housing, we conducted a range of quantitative analyses to address the following questions: 1) what are the met and unmet psychosocial needs of tenants?; 2) what is the self-reported psychosocial well-being of tenants; 3) how does the psychosocial well-being reported by tenants compare with the general population and other groups?; and 4) how are the number of unmet needs and time in social housing associated with indices of psychosocial well-being?

4.3.1 What are the met and unmet psychosocial needs of tenants?

Using the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), tenants reported a median of six unmet psychosocial needs (IQR=5; 1-16). A summary of the needs and unmet needs reported in all domains of the CANSAS is presented in Table 7.

COMMON AREAS THAT WERE **"NO PROBLEM"**[1]

Childcare	98.8%	Safety to others	94.1%
Using the telephone	95.3%	Alcohol	90.6%

COMMON NEEDS THAT HAVE BEEN A PROBLEM IN THE PAST BUT ARE **MET BY EXISTING SUPPORTS**[2]

Food	41.2%	Psychological distress	22.4%
Safety to self	28.2%	Daytime activities	21.2%
		Physical health	21.2%

COMMONLY REPORTED **UNMET NEEDS**[3]

Accommodations	69.4%	Physical health	61.2%
Having sufficient "company"	62.4%	Sexual expression	52.9%

[1]To contextualize these findings, it should be noted that the buildings in which we interviewed were for single adults, which is the likely reason for a lack of need for childcare.

[2]These needs were being met by local food security services, tenant informal supports, and mental health services in the Kingston community.

[3]In qualitative interviews, participants discussed experiencing difficulties in their current housing, which is the likely reason for identifying accommodation as an unmet need, as well as having poorer quality relationships, leading to identifying "company" as an unmet need.

Table 7.

Tenant met and unmet needs reported on the CANSAS (n=85)

CANSAS domains	Need rating n (%)			
	No problem	Met need	Unmet need	Don't know
Accommodation	9 (10.6)	17 (20.0)	59 (69.4)	-
Food	27 (31.8)	35 (41.2)	23 (27.1)	-
Looking after the home	35 (41.2)	17 (20.0)	33 (38.8)	-
Self-care	59 (69.4)	12 (14.1)	14 (16.5)	-
Daytime activities	25 (29.4)	18 (21.2)	39 (45.9)	1 (1.2)
Physical health	13 (15.3)	18 (21.2)	52 (61.2)	2 (2.4)
Psychotic symptoms	69 (81.2)	9 (10.6)	7 (8.2)	-
Information on condition and treatment	56 (65.9)	7 (8.2)	21 (24.7)	1 (1.2)
Psychological distress	22 (25.9)	19 (22.4)	44 (51.8)	-
Safety to self	55 (64.7)	24 (28.2)	5 (5.9)	1 (1.2)
Safety to others	80 (94.1)	1 (1.2)	4 (4.7)	-
Alcohol	77 (90.6)	3 (3.5)	5 (5.9)	-
Drugs	68 (80.0)	8 (9.4)	9 (10.6)	-
Company	21 (24.7)	9 (10.6)	53 (62.4)	2 (2.4)
Intimate relationships	42 (49.4)	5 (5.9)	37 (43.5)	1 (1.2)
Sexual expression	37 (43.5)	3 (3.5)	45 (52.9)	-
Childcare	84 (98.8)	-	1 (1.2)	-
Basic education	69 (81.2)	4 (4.7)	12 (14.1)	-
Telephone	81 (95.3)	3 (3.5)	1 (1.2)	-
Transportation	47 (55.3)	13 (15.3)	25 (29.4)	-
Money	28 (32.9)	16 (18.8)	40 (47.1)	1 (1.2)
Benefits	38 (44.7)	1 (1.2)	28 (32.9)	18 (21.2)

† Median number of unmet needs per participant = 6; IQR = 5; 1-16

4.3.2 What is the reported psychosocial well-being of tenants in social housing, and how do these compare with the general population or other groups?

We asked tenants about various aspects of their psychosocial well-being (disabilities that they experienced in relation to a health condition; engagement in meaningful activity; mental well-being; substance use; trauma affecting them in their daily lives; and loneliness). We then compared participants' ratings with the mean rating of participants in other studies that used the same measure with the general population. For some measures, we compared the mean rating of tenants with a threshold score (i.e. a score indicating that a person might have a problem in a particular area of their life) established by the authors of the standardized measures that we used. We have summarized these findings in Table 8.

DISABILITY was significantly higher among tenants in social housing than other groups in the general population.

MEANINGFUL ACTIVITY engagement among tenants was slightly lower than in older individuals in the general population.

MENTAL WELL-BEING among tenants was similar to individuals in the general population.

SUBSTANCE USE including alcohol and other substances was significantly lower among tenants than what would be considered “hazardous”.

TRAUMA that affected tenants in their daily lives was reported to be at a level where mental health treatment would be beneficial.

LONELINESS was reported by tenants to be low, and not a problem.

Table 8.

One-sample t-tests comparing tenant scores on indices of psychosocial well-being with norms and threshold scores in existing literature

Measure	*n*	Mean	sd	Range	Comparison Value	t	*df*	*p* (2-tailed)	Effect Size (d)
WHODAS	83	19.14	9.08	0-39	1.4[1]	17.8	82	<.001***	1.95[13]
					6.3[2]	12.9	82	<.001***	1.41[13]
					4.3[3]	14.9	82	<.001***	1.63[13]
EMAS	84	45.86	9.45	22-60	48.2[4]	-2.272	83	.026*	0.31[11]
SWEMWBS	85	22.44	4.83	12-35	23.2[5]	-1.461	84	.148	-
AUDIT-10	85	4.55	6.72	0-39	8.0[6]	-4.728	84	<.001***	-0.51[12]
DAST-10	85	1.21	2.40	0-10	6.0[7]	-18.425	84	<.001***	-2.00[13]
PCL-5	79	34.01	19.41	0-76	31.0[8]	-3.604	78	<.001***	0.16[10]
UCLA-LS	83	29.47	16.68	0-60	35.0[9]	-3.021	82	.003**	-0.33[11]

*p<.05; **p<.01; ***p<.001

Note. WHODAS = World Health Organization Disability Assessment Schedule; EMAS = Engagement in Meaningful Activities Survey; SWEMWBS = Short Warwick-Edinburgh Mental Well-Being Scale; AUDIT-10 = Alcohol Use Disorders Identification Test – 10-item version; DAST-10 = Drug Abuse Screening Test – 10-item version; PCL-5 = Post-Traumatic Stress Disorder Checklist for the Diagnostic and Statistical Manual of Mental Disorders – 5; UCLA-LS = University of California Los Angeles Loneliness Scale

1 Normative mean score of participants living with no health conditions in existing literature [22]
2 Normative mean score of participants living with mental disorders in existing literature [22]
3 Normative mean score of participants living with physical health conditions in existing literature [22]
4 Mean derived from a psychometric study evaluating the EMAS with n=154 older adults [23]
5 Mean derived from a large population sample of the general population in the UK, 2011 [24]
6 Threshold score derived from Reinert & Allen [25] identifying a score of 8 or higher as 'hazardous drinking'
7 Threshold score derived from Cocco & Carey [26] identifying scores of lower than 6 'low-moderate' drug use
8 Threshold score derived from PCL-5 user manual indicating that a score of 31-33 or higher indicating that the person may benefit from clinical treatment for post-traumatic stress disorder [27]
9 A score of 35 or more represents moderate to high levels of loneliness [28]
10 Represents a 'very small' effect size according to Cohen [29]
11 Represents a 'small' effect size according to Cohen [29]
12 Represents a 'moderate' effect size according to Cohen [29]
13 Represents a 'large' effect size according to Cohen [29]

DISABILITY: On the WHODAS-12, tenants' mean score was 19.14. When we compared this mean with a group of participants who did not live with a health condition, not surprisingly, tenants in our interviews reported a significantly higher level of disability. The same was true when the scores of tenants were compared with individuals living with a mental health or physical health condition in other studies. This indicates that tenants living in social housing are experiencing a very high level of disability associated with their mental and physical health conditions and would benefit from support such as environmental modification or services that can help them to function more effectively in their daily lives.

ENGAGEMENT IN MEANINGFUL ACTIVITY: On the EMAS, tenants' mean score was 45.86, which was significantly lower than a sample of older adults in other research. The choice to compare participants in the current consultation with a sample of older adults in other research was informed by the age distribution of interviewees in this report, which was generally older (Mdn=59). While there was a statistical difference, the effect size was small, indicating that this difference from a practical perspective is rather small. This finding indicates that overall, tenants may benefit from support with identifying and engaging in meaningful activity, but that little support may be needed to help tenants to identify and engage in activities at the same level or higher than individuals in the general population. Goals related to meaningful activity, however, should be responsively developed in collaboration with tenants based on their individual needs.

SUBSTANCE USE: Tenants living in KFHC housing reported lower levels of alcohol use on the AUDIT-10 (m=4.55) and lower levels of other forms of substance use on the DAST-10 (m=1.21) than the scores established by the test authors to be considered hazardous or high levels of substance use [15, 16]. Alcohol use was significantly lower than what would be considered to be a 'hazardous' level of drinking. Statistically, this difference was only moderately lower. Use of substances other than alcohol was significantly lower than what would be considered a low-moderate level of use. The difference here was large, indicating that tenants are using substances other than alcohol to a degree that is far lower than the level of substance use considered to be 'low to moderate use'. This means that tenants' use of substances overall is non problematic. Individual tenants, however, may experience difficulties with substance use, and support for managing problematic use should be offered and tailored to their individual needs.

TRAUMA: On the PCL-5, tenants' mean score was 34.01. The test authors indicate that a mean score that is higher than 31 means that a person will benefit from treatment for post-traumatic stress disorder [30]. The mean score reported by participants was statistically higher than the score used to indicate that a person may benefit from treatment for PTSD. While there was a statistically significant difference, the magnitude of this difference was small. It should be noted that several tenants reported very high levels of trauma on this measure that exceeded the threshold score of 31, suggesting that there is a need for mental health support for these tenants to address the symptoms of trauma that they experience. Further, these findings indicate that there is a need to expand on existing trauma and violence-informed approaches within the social housing buildings in which we interviewed.

LONELINESS: Regarding loneliness, which was measured using the UCLA-LS, tenants' mean score was 29.47, which was not statistically higher or lower than 35, the threshold score established by the test authors where higher scores indicate moderate to high levels of loneliness. This finding suggests that while tenants reported "company" as an unmet need on the CANSAS, that they do not experience moderate or high degrees of loneliness. This finding is further contextualized in our qualitative findings, which suggest that a high level of interpersonal conflict within social housing environments may lead to poor quality relationships. This would explain why tenants may describe low levels of loneliness, yet rate "company" as an unmet need. This finding suggests that tenants living in KFHC social housing would benefit from support to improve the quality of their relationships.

4.3.3 How are unmet psychosocial needs and time in social housing related to psychosocial well-being?

To understand how unmet needs and years in social housing might be related to psychosocial well-being, we conducted a correlational analysis, the findings of which are presented in Table 9. While the number of overall unmet needs were associated with a range of areas of psychosocial well-being, time in social housing had no positive or negative correlation with any of these areas. A higher number of unmet needs (CANSAS) was associated with greater levels of disability (WHODAS-12), lower mental well-being (SWEMWBS), lower engagement in meaningful activity (EMAS), increased drug use (DAST-10), and increased trauma (PCL-5). There were no statistically significant correlations between number of unmet needs and time in social housing, or alcohol use (AUDIT-10). These findings indicate that time in social housing has no positive or negative association with psychosocial well-being, but that the number of unmet needs reported by tenants is associated with a range of indices of psychosocial well-being. It is important to note that these are simply associations, rather than a demonstration of cause and effect. Studies using analyses and research designs that demonstrate cause and effect are needed to determine the nature of these associations.

THE GREATER THE NUMBER OF UNMET NEEDS THAT TENANTS REPORTED:

The higher they reported **disability**

The lower they reported **mental well-being**

The lower they reported engagement in **meaningful activity**

The higher they reported **loneliness**

The higher they reported **drug use**

The higher they reported **trauma** affecting them in their daily lives

There was **NO RELATIONSHIP** between the time that tenants lived in social housing, and **DISABILITY, MENTAL WELL-BEING, ENGAGEMENT IN MEANINGFUL ACTIVITY, LONELINESS, SUBSTANCE USE OR TRAUMA**.

Table 9

Correlations (r) between trauma, unmet needs, time in social housing and measures of psychosocial well-being (n=85)

Scale	TSH	WHODAS-12	SWEMWBS	EMAS	UCLA-LS	AUDIT-10	DAST-10	PCL-5
Number of Unmet Needs (CANSAS)	-.114	.623**	-.534**	-.573**	.486**	-.023	.356**	.517**
Time in Social Housing (TSH)	-	-.015	.183	.123	-.137	-.030	-.086	-.147

*p<.05 (two-tailed); **p<.01 (two-tailed)

Note. WHODAS = World Health Organization Disability Assessment Schedule; EMAS = Engagement in Meaningful Activities Survey; SWEMWBS = Short Warwick-Edinburgh Mental Well-Being Scale; AUDIT-10 = Alcohol Use Disorders Identification Test – 10-item version; DAST-10 = Drug Abuse Screening Test – 10-item version; PCL-5 = Post-Traumatic Stress Disorder Checklist for the Diagnostic and Statistical Manual of Mental Disorders – 5; UCLA-LS = University of California Los Angeles Loneliness Scale

5: QUALITATIVE FINDINGS:

TENANT, COMMUNITY SERVICE PROVIDER & SOCIAL HOUSING STAFF/LEADER INTERVIEWS

5.1 Essence: "We're in [between] a rock and a hard place"

The overall essence of our analysis of qualitative interviews with tenants, KFHC staff and leaders, and community service providers was derived from a quote from a tenant interview: "*We're in [between] a rock and a hard place down here…that's why people are dealing with it on our own*" [Sara, Tenant]. Tenants described feeling abandoned, and forced to live with many of their needs unmet largely due to structural issues such as ongoing poverty, a finding consistent with previous research conducted by our team [3]. Not only did tenants describe having their own needs unmet, but they also expressed concern for other tenants in their building who they thought needed far more support than they were provided: "*abandoned. They're just abandoned…they give them an apartment they think they're fine….give them an apartment and forget about them, you know?... It's ridiculous*" [Arnold, tenant]. Social housing staff and leaders, and community service providers expressed similar sentiments as they acknowledged many of the challenges faced by tenants resulted from structural issues, including ongoing poverty after moving into social housing. The relationship between this essence and themes from qualitative interviews with tenants, social housing staff and leaders, and community service providers is represented in Figure 1.

Figure 1. Summary of themes from qualitative analysis with all participant groups

5.2 Tenant qualitative interviews

A total of 20 tenants participated in qualitative interviews including 13 (65%) women and 7 (35%) men with a median age of 57 (IQR=18; 32-77). We generated three themes to describe tenant perspectives: 1) being chronically deprived; 2) surrounded by chaos; and 3) the critical importance of the relationship between social housing providers and tenants.

5.2.1 Theme 1: Being chronically deprived

Tenants discussed at length the difficulties they experienced with ongoing financial difficulties even though they had been provided with rent geared to income housing. While tenants were appreciative of the opportunities afforded by having their housing costs subsidized, the rising cost of food and other basic needs coupled with inadequate social assistance payments made it impossible to meet their basic needs: "*I find the only thing that's really missing is…the money they give you is disgusting…ODSP should do something about that*" [Cash, tenant]. Tenants struggled to pay for food and relied on local services including food banks and meal programs to supplement their diet and meet their basic needs. Despite the presence of these services, they sometimes still could not sustain sufficient access to food throughout the month. This was particularly pronounced during COVID restrictions. They coped by sharing food with one another in their buildings using a variety of strategies including the independent creation of a food sharing box in their hallways: "*I'm putting it in the hallway by the elevator there…or downstairs because that's where most people are coming in… there's a lot of us who just drop the food right there…you can just take what you need and go*" [Sara, tenant].

> "they're bringing in their business…they're having to sell their drugs and make extra money because…they don't make enough. We never make enough"
> [JANE, TENANT]

Tenants discussed that there was an active illicit substance use trade occurring within their buildings. While they expressed concerns about this, they acknowledged that some tenants were engaged in selling illicit substances as a way of supplementing their incomes when social assistance payments were critically low: "*they're bringing in their business…they're having to sell their drugs and make extra money because…they don't make enough. We never make enough*" [Jane, tenant]. They recognized that social assistance rarely has kept up with inflation, leading to a feeling that there was little help on the horizon in the face of growing inequities: "*What are they going to do? Give us a 1.5% increase this year? Another twenty dollars when everything has gone up a hundred dollars*?" [Angry Gramps, tenant]. They described how living in poverty and occupying social positions that were stigmatized afforded them little power in society to change this situation, leading to an overall feeling of helplessness and hopelessness: "*But who am I, right? I'm just an ex-junkie...that doesn't know better*" [Monkey, tenant].

5.2.2 Theme 2: Surrounded by chaos

Tenants described their housing environments as chaotic, which had a negative impact on their mental well-being. They described experiences of witnessing overdoses, neighbours being victimized by visitors and other tenants in the building, theft and constant involvement of emergency services including police, fire and ambulance: "*there's a person that dies here every month or…more than that. They take them out in a bag 'cause*

they've OD'd on that fentanyl stuff and…I mean somebody's gonna get shot or knifed or something" [Ralph, tenant]. This unrelenting chaos led to the overall feeling that they were unsafe in their housing:

> "*I'm…afraid to leave my apartment because now I'm afraid that …it's gonna get broken into, but I'm also afraid it's gonna get broken into if I am there, and then something happens to me…I'm just sick of being scared, I'm sick of constantly going through the same thing over and over, like I have my own mental battles… and then kind of put all the, the housing stuff on top of that.*"
> [Lola, tenant]

Tenants described how frequent acts of victimization and health crises in their building activated symptoms related to their own past traumatic experiences:

> "*Trust me, it happens all above me cause I'm on the sixth floor so I hear the seventh floor at nighttime just going nuts and I can hear girls screaming please let me go, I want my daddy, so you know they're doing things that ain't fucking right, you know what I mean?...[referring to activated trauma] Well when I start hearing that shit man, my fear goes right up and when my fear goes up, I'm prepared…I'm doing nothing but watching my door and I'm listening for every little freaking sound, and it makes me sound like I'm a junkie and I'm on a paro[noid] trip but I'm straight as a board, just marijuana…I feel unsafe.*"
> [Monkey, tenant]

Tenants emphasized that much of this chaos was elicited not by tenants, but by visitors to the building who were often uninvited and emphasized the need for security in their building: "*all they would have to do is get a security guard and get rid of these goofs*" [Cash, tenant]. They also identified additional benefits with having a security guard in the building, such as being a liaison between tenants and the police: "*it's easier for a security officer to give an officer files than it is for a tenant*" [Monkey, tenant].

> "Well when I start hearing that shit man, my fear goes right up and when my fear goes up, I'm prepared…I'm doing nothing but watching my door and I'm listening for every little freaking sound"
> [MONKEY, TENANT]

5.2.3 Theme 3: The critical importance of the relationship between social housing providers and tenants

Tenants emphasized the importance of cultivating and maintaining a healthy working relationship with their social housing provider. At times, however, they felt that when they advocated for themselves, that they didn't feel heard when their concerns were expressed. One tenant described that she wanted to transfer to another unit out of her current building, however, this had not yet occurred. Little response from social housing staff led her to believe that she was "*in a silent battle with housing*" [Sara, tenant]. Tenants expressed the importance of opening lines of communication with social housing staff and leadership, and identified the need for an open forum or regularly scheduled meetings where tenants and staff could discuss their concerns. Some tenants described that they had concerns about how this was facilitated in the past, however, as they did not feel heard: "*every meeting that I went to that they had, I felt that no matter what I said was shut down*" [Artie, tenant].

"I was drinking pretty hard...and I just got into arrears...man that lady did me a favour...cause I had been in arrears a few times and it was just piling up so [name of social housing staff] was just like 'nope we gotta do something.' You know she helped me in the long run. So, it worked out for me...I paid my arrears, I have been sitting debt free with this building for about four or five years now"

[SARA, TENANT]

While tenants expressed frustration with social housing staff and leadership, they also recognized that social housing is absolutely needed, and acknowledged the support of staff to help when they reached out. One tenant described periods when her rent was in arrears, and social housing staff supported her by making arrangements to prevent the loss of her tenancy:

> "*I was drinking pretty hard…and I just got into arrears…man that lady did me a favour…cause I had been in arrears a few times and it was just piling up so [name of social housing staff] was just like 'nope we gotta do something.' You know she helped me in the long run. So, it worked out for me…I paid my arrears, I have been sitting debt free with this building for about four or five years now…My rent goes direct pay to them. I don't even touch it…we think that they're being jerks…when you're in the middle of [it and] somebody's calling you on your bullshit being like 'hey you're not paying your rent. We don't wanna kick you out. I like you [Sara]…we don't want you to go but this is becoming a problem.'*"
> [Sara, tenant]

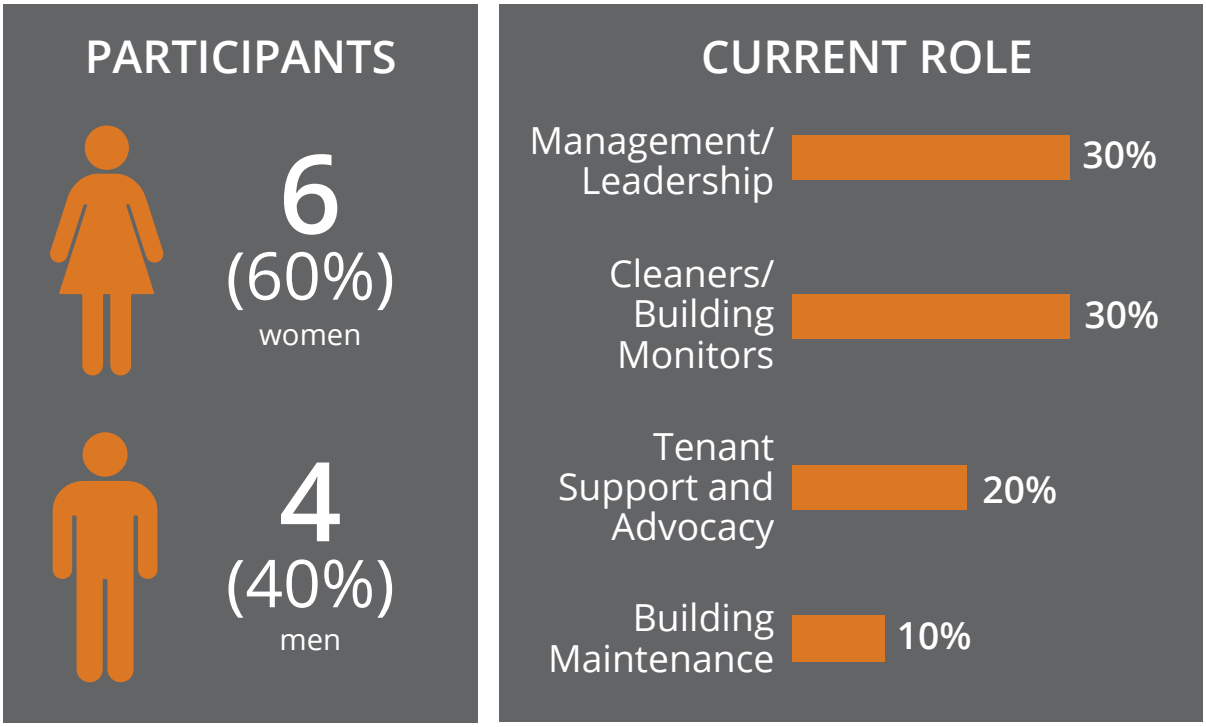
While tenants were simultaneously frustrated and also appreciated the support that social housing staff offered, they recognized that KFHC was tasked with renting to an incredibly complex tenant group that many agencies in the community are struggling to support. They also recognized that community members who did not live in the building frequently came to the building and were responsible for social and maintenance issues that affected both tenants and social housing providers alike. One tenant described, for example, how the attempts of social housing providers to maintain the building were thwarted by the behaviour of community members who were let into the building but didn't live there: "*Housing painted the staircases and stuff and they just come in and wrote everywhere and destroyed that paint job and…meanwhile it cost housing thousands and thousands of dollars and then you know what I mean? Who's gonna pay for that in the end?*" [Monkey, tenant].

Tenants recalled strategies used by their social housing provider to help them to address the problems with their current housing situation and to address their unmet needs. While these strategies have all had limited success, they were hopeful that new strategies could work, and thought it was important that they keep trying to develop them: "*who knows what's gonna work but like if we don't try, we don't know*" [Matilda, tenant].

5.3 Social housing staff and leader qualitative interviews

A total of 10 KFHC staff and leadership participated in qualitative interviews. Participants in these interviews included six (60%) women and four (40%) men. Of these, three participants (30%) represented management/leadership, three (30%) occupied roles as cleaners/building monitors, two (20%) provided tenant support and advocacy, and one (10%) provided building maintenance. Participants had been in their current role for a median of 4.25 years (IQR=6.8; 1.1-16 years) and had supported tenants in social housing across their careers for a median of 5.25 years (IQR=6.6; 3.16-19 years). A full summary of the characteristics of social housing staff and leadership who participated in qualitative interviews is provided in Table 10.

In our analysis of interviews with KFHC staff and leadership, we generated three themes: 1) "*it's like well okay you're landlords…but you still have…to take care of your tenants*"; 2) we need services to be present with the person to provide effective support; and 3) "*don't put a Band-Aid on it. Let's deal with it.*"



Participants had been in their current role for a median of **4.25 YEARS** (IQR=6.8; 1.1-16 years)

Participants had supported tenants in social housing across their careers for a median of **5.25 YEARS** (IQR=6.6; 3.16-19 years)

Table 10.

Social housing staff and leadership demographic characteristics (n=10)

Demographic Characteristics			
	n (%)		n (%)
Gender		**What is your current role?**	
Woman	6 (60.0)	Management/Leadership	3 (30.0)
Man	4 (40.0)	Cleaner/Building Monitor	3 (30.0)
What is your professional background?		Tenant Support/Advocacy	2 (20.0)
Behavioural Psychology/Psychology	3 (30.0)	Building Maintenance	1 (10.0)
Legal/Paralegal/Human Resources	2 (20.0)		
Accounting/Management	1 (10.0)		
Mechanic	1 (10.0)		
No formal education/profession	3 (30.0)		
For how long have you been working in your current role?		Mdn=4.25years; IQR=6.8 years; 13months–16 years	
For how long have you supported tenants in social housing in your career?		Mdn=5.25 years; IQR=6.6 years; 3.16years–19 years	

Note: Not all percentages equal 100 due to rounding

5.3.1 Theme 1: *"It's like well okay you're landlords … but you still have … to take care of your tenants"*

KFHC staff and leaders explained how their relationship with tenants is that of a landlord, and as such, they are provided with few resources with which to support tenants beyond this role. Instead, they rely on collaborations with key organizations in the city to meet their tenants' needs. They identified that this is not commonly understood among tenants and organizations throughout the city:

> *"so I really think in terms of social housing, I think that the problem is… the name social housing almost implies, gives the impression that it's supportive housing…but it's really not. We're just a landlord like any other landlord except the difference, the big difference is the population that we house and, and that we're funded, right?"*
> [Essar, KFHC staff/leader]

In the view of KFHC staff and leadership, confusion about the nature of social housing led community agencies to erroneously believe that supports were integrated within social housing, and that fewer supports from their agencies were needed when tenants were living in this form of housing. Social housing staff and leadership identified that when community services retracted due to this erroneous belief, it left them in the difficult position to find a way to provide needed support when they saw a tenant struggling. They wished that the nature of social housing was understood from the very

beginning of a tenancy, and that community organizations would be engaged at that time and throughout the tenancy:

> "*if you have a client that you know that is going to be living in social housing, come to the lease signing…Go with them when they pick up their keys. Look at the apartment to see how it looks before they move in and then go and see them in a month and see if the apartment still looks the same, you know?...how are they doing? Are they accessing food, you know?...Are they settled in? What's going on with the neighbours? Are they getting along?...it's not the landlord's responsibility to do that and I feel that it is left to us to do that…It has to be ongoing support.*"
> [Charlie, KFHC staff/leader]

Social housing staff and leadership emphasized how critically important community services are, particularly because they explicitly acknowledged that the social environments of some buildings are not conducive to fostering tenant mental well-being. When describing how living in some social housing buildings may influence the well-being of tenants, one participant indicated that:

> "*it detracts…I often feel quite badly…. they've been housed. They're special priority. They're victims of violence. They know nothing about social housing. They're fleeing this abusive relationship… then suddenly they're living in [street on which a social housing building is located]…and there are these…people… yelling and swearing and fighting and… there are people that are unwell in our buildings and we need to support them but so often their behaviour… cause[s] issues for other people in the building and you sorta mix these people all together…and we get requests all the time like you gotta move me cause there's noise…like just you're somebody who's trying to live with the aftermath of being in a violent relationship and you're, you're in an apartment and the neighbours next door are fighting and beating each other up…it's not a healthy environment so I absolutely a hundred percent say it detracts.*"
> [Daphne, KFHC staff/leader]

> "I think that the problem is… the name social housing almost implies, gives the impression that it's supportive housing…but it's really not. We're just a landlord like any other landlord"
> [ESSAR, KFHC STAFF/LEADER]

5.3.2 Theme 2: We need services to be present with the person to provide effective support

KFHC staff and leaders discussed how they needed community services to be present in their buildings more often to meet the needs of tenants more effectively. Unfortunately, they found that this did not happen often enough, with community agencies more often meeting their tenants in community locations rather than in their housing units. Social housing staff and leaders felt that it was critical that community service providers visit tenants in their homes. In so doing, they emphasized that community service providers would have a better understanding of the environments in which tenants were situated, and their overall daily functioning. As such, they would be in a better position to provide effective support:

> "*First and foremost number one priority needs to be meeting tenants in their units. There is no better way to assess*

their wellness and to assess their ability in terms of ADLs and to see the environment that they spend the most of their time in…[it's the] best indicator of wellness, best indicator of challenges that they may face and actually I find people are more comfortable in their home environment and are often more likely to open up and kind of share information with you and it gives you an opportunity to show respect by being respectful to their environment and their home…first and foremost being on site. Meeting tenants in their unit. Not only does that remove barriers to accessing services because many of our tenants don't drive, right? Or sometimes services aren't located near all of our buildings. So not only does it remove barriers in terms of accessing services, but it increases I think the accuracy of the assessment." (Essar, KFHC staff/leader)

KFHC staff and leaders emphasized the need for improving collaboration between social housing providers and community services, recognizing that by working more closely together, they could more effectively support the needs of tenants. One interviewee discussed how such collaborations are improving, and how it translated into a more effective and dignified approach with tenants:

"*I have to give props to the police force… Policing is changing because I saw a real human side to the way they approach people especially with mental illness…they go above and beyond and I think that's what's needed in all services really…A human side…I just know years ago police were a little bit more, you know… to the point…back in the 80s, right? But now, because [when] I'm helping them [tenants], in some cases I have to phone them [police] and when they show up, they take a really good approach to the homeless and the mental health and drug addiction…treat them like anybody would want to be treated, right?*"
[James, social housing staff/leader]

Interviewees expressed the need for on-site supports for tenants so that they could be accessed at any time, which didn't currently exist in their buildings. In their view, the increasing complexity of tenants in social housing requires that on-site supports are needed now more than ever before. They specifically identified the need for intensive on-site supports that have knowledge of the functional implications of mental illness to help tenants to learn skills needed to be well, sustain their tenancies, and live independently:

"First and foremost number one priority needs to be meeting tenants in their units. There is no better way to assess their wellness and to assess their ability in terms of ADLs and to see the environment that they spend the most of their time in…[it's the] best indicator of wellness, best indicator of challenges that they may face and actually I find people are more comfortable in their home environment and are often more likely to open up and kind of share information with you and it gives you an opportunity to show respect by being respectful to their environment and their home"
[ESSAR, KFHC STAFF/LEADER]

"*someone who is suffering from mental health or addiction, they can't keep a clean unit. They may not have…the life skills beforehand and now they don't have the resources…we want them to keep a clean unit because a cleaner unit means that we are going to see bigger problems. If your unit is a mess, you have brought in a lot of furniture or items off the street we can't see a plumbing issue because you won't notice a plumbing issue until it's far too late…Once a year every building gets a talk about safety, security and the fire department is there and they're explaining why you need to have access to both of the doors going into your apartment, and the fire department needs access to your bedroom to get you safely out if there was a fire and that sort of thing… the tenants who are facing mental health issues and addiction, they're not going to show up to that talk. They're not going to change their behaviour…they're bringing in materials off the street. They're doing that for some other need or goal and they either can't tell us about it or don't want to tell us about it, so it's very interesting… So someone who already had a difficult day, they now have pest issues, they have mold…it can blow up very quickly like just four to six months of someone going through a dark depression.*"
[Christie, KFHC staff/leader]

5.3.3 Theme 3: *"Don't put a Band-Aid on it. Let's deal with it."*

Social housing staff and leaders discussed how many of the community supports and resources available to tenants living in social housing were focused on addressing immediate challenges that tenants faced, rather than using solutions that would help tenants living with mental illness in the long term: "*All we're doing is putting a Band-Aid on stuff, and it's not helping at all*" [Ryan, KFHC staff/leader]. KFHC staff and leaders expressed concern that as a society, we have come to a state of acceptance that needed supports would simply be unavailable to tenants living with mental illness and poverty. One interviewee discussed the dire lack of accessible substance use treatment programs in the community, despite a pressing need for such supports for tenants and others in the community:

"*Where are all the substance abuse treatment programs?...we should be tripping over those…they should be as common as Tim Horton's but they're not and we all sort of talk about 'like well, you know they're not ready', and I'm like…'what if everybody tomorrow is ready?' then what would we do, right? ...I think we're kind of comfortable in not really having solutions.*"
[Daphne, KFHC staff/leader]

Interviewees expressed, however, their belief in social housing, and that it is needed more than ever before given the current rising cost of market housing in their community. While this was the case, they expressed how chronic

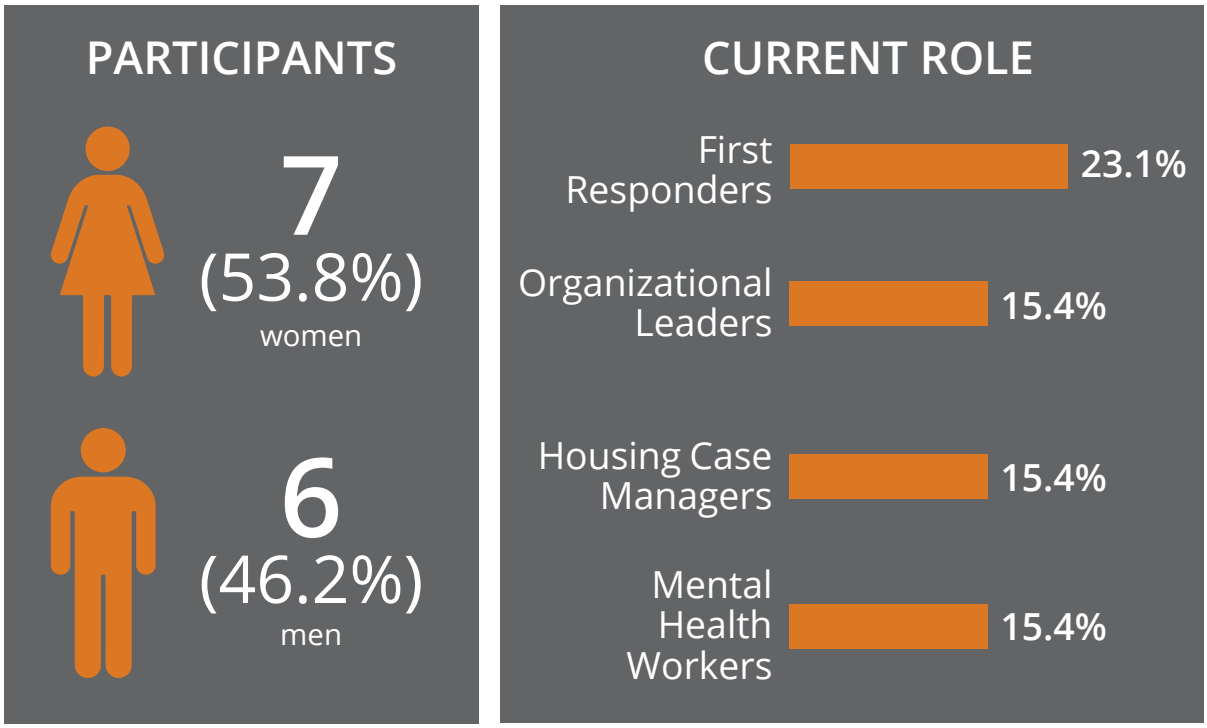
"Where are all the substance abuse treatment programs?…we should be tripping over those… they should be as common as Tim Horton's but they're not and we all sort of talk about 'like well, you know they're not ready', and I'm like…'what if everybody tomorrow is ready?' then what would we do, right?…I think we're kind of comfortable in not really having solutions."
[DAPHNE, KFHC STAFF/LEADER]

underfunding of social housing and community services led to the inability to focus on the long-term well-being of tenants:

> "*Social housing is a necessary program that needs more funding. It's necessary… because market rent is absolutely ridiculous…if you're struggling with mental illness or substance abuse, good luck making market rent, especially in Kingston…Folks in their forties with mental health concerns who are on OW and not even qualifying for ODSP…they're struggling, and you can't hit that. Living in social housing on the other hand it detracts, it makes their mental health absolutely worse because there aren't supports here…There's not someone coming by even once every two weeks or even monthly necessarily to handle a simple conversation and say hey, are you okay, is everything going alright? I can do my best and go to a hundred and some odd units but I'm not going to get everywhere with my job duties and putting out the fires…that crop up.*"
>
> [Mark, KFHC staff/leader]

5.4 Community service provider qualitative interviews

In total, we interviewed 13 service providers with experiences of supporting tenants living in social housing and who were working in health and social care organizations throughout the city of Kingston. Of these, we interviewed seven service providers who identified as women (53.8%) and six as men (46.2%). Three service providers were first responders (i.e. police, fire, ambulance) (23.1%), two were organizational leaders in health and social care organizations (15.4%), two were housing case managers (15.4%), two were community mental health workers (15.4%), one was a program coordinator (7.7%) and three occupied other roles (23.1%). Participants had been in their current role for a median of 2 years (IQR=11.9; 18 months - 19 years) and had supported tenants in their careers for a median of 10 years (IQR=8.25; 4 months - 19 years). A full summary of the characteristics of community service providers who participated in qualitative interviews is provided in Table 11.



Participants had been in their current role for a median of **2 YEARS** (IQR=11.9; 18 months - 19 years)

Participants had supported tenants in their careers for a median of **10 YEARS** (IQR=8.25; 4 months - 19 years)

Table 11

Community service provider demographic characteristics (n=13

Demographic Characteristics			
	n (%)		n (%)
Gender		**What is your current role?**	
Woman	7 (53.8)	First Responder	3 (23.1)
Man	6 (46.2)	Organizational Leadership	2 (15.4)
What is your professional background?		Housing Case Management	2 (15.4)
Occupational Therapist	3 (23.1)	Community Mental Health Workers	2 (15.4)
Police Officer	2 (15.4)	Program Coordinator	1 (7.7)
Addictions Worker	2 (15.4)	Other	3 (23.1)
Behavioural Science Technologist	1 (7.7)		
Child and Youth Worker	1 (7.7)		
Other	4 (30.8)		
For how long have you been working in your current role?		Mdn=2 years; IQR=11.9 years; 18 months–19 years	
For how long have you supported tenants in social housing in your career?		Mdn=10 years; IQR=8.25 years; 4 months–19 years	

Note: Not all percentages equal 100 due to rounding

In our analysis of interviews with community service providers, we generated three themes: 1) social housing is more important than ever, and we need to know how to support tenants as a community; 2) "*we need to be sewing up the wound instead of just putting on a small Band-Aid that's going to fall off in five days*"; and 3) COVID has exacerbated inequities for tenants living in social housing.

5.4.1 Theme 1: Social housing is more important than ever, and we need to know how to support tenants as a community

Consistent with interviews with KFHC staff and leaders, community service providers emphasized the importance of social housing in their community, particularly for persons living with mental illness and in poverty, who often experience exclusion from market housing: "*I do know how beneficial social housing is for many of the clients that I work with, otherwise I don't know necessarily where they would be*" [Michelle, community service provider]. Community service providers discussed how they were unclear on the differences between social housing and permanent supportive housing, and that they recognized this confusion throughout community services. They indicated that this confusion translated into a lack of appropriate services for tenants, and that gaining clarity to better support

tenants' needs is an important goal that could be addressed through collaboration between community services and social housing providers:

> "*So social housing will sometimes have roles of people who…I guess kind of superintendent roles. Sometimes they'll have like service-oriented roles. But I think a lot of the time, the services that people need exist outside of the scope of social housing so I think…this can be kind of suboptimal and I think this can cause a lot of the problems…how do we understand social housing nomenclature and language that they use and trying to create a knowledge exchange, a knowledge translation perhaps? For me anyways, so that we understand the terms that we're working with when we think about people with serious mental illness…and people with addictions issues and have a better understanding…[of] what each other does so that we can figure out those care pathways that are necessary*." [Jonathan, community service provider]

5.4.2 Theme 2: *"We need to be sewing up the wound instead of just putting on a small Band-Aid that's going to fall off in five days"*

Similar to interviews with social housing providers, the metaphor of a Band-Aid was used in community service provider interviews to represent the same concern that the current system emphasizes short-term, superficial solutions over those that address long-term outcomes aimed at addressing systemic issues: "I *do believe there's always more we can be doing…I just know like we're confined…* [there are] *a lot of systemic barriers that are out there…where is our funding coming from? What models do we have to follow?*" [Steve, community service provider]. Systemic issues identified by community service providers included inadequate social assistance funding resulting in long-term poverty for many individuals living with mental illness, the stigma of mental illness that existed in the community, and a lack of access to needed mental health and social supports. Because social housing, policy and services are structured in a way that focuses on short-term approaches from the perspectives of community service providers, this translated into tenants living in a constant state of survival: "*they're just surviving, it's…all survival mode all the time*" [Tess, community service provider].

"how do we understand social housing nomenclature and language that they use and trying to create a knowledge exchange, a knowledge translation perhaps? For me anyways, so that we understand the terms that we're working with when we think about people with serious mental illness…and people with addictions issues and have a better understanding…[of] what each other does so that we can figure out those care pathways that are necessary."

[JONATHAN, COMMUNITY SERVICE PROVIDER]

Community service providers emphasized the need for longer-term solutions to supporting social housing tenants living with mental illness. They recognized that the level of involvement of community services in social housing has increased in recent years, and

> "they're just surviving, it's…all survival mode all the time"
> [TESS, COMMUNITY SERVICE PROVIDER]

that this increased involvement requires some reflection as a community to find better ways of meeting tenant needs:

> "*I think we're getting to that point now where we're starting to look at, like looking at the baseline. Why are we getting more involved? How many calls for service in the last week or month are we having with this individual where we have never had before?...you know, what is the root problem? But I think we need to look…at more reasons of how we just can't put a Band-Aid on a situation…we need to be sewing up the wound instead of just putting on a small Band-Aid that's gonna fall off in five days.*" [Dawn, community service provider]

5.4.3 Theme 3: COVID has exacerbated inequities for tenants living in social housing

Community service providers described how the COVID-19 pandemic has entrenched inequities that were already experienced prior to the pandemic, and that this has had a serious impact on demand for services in the Kingston community: "*life has changed dramatically for a lot of us. But for them, they've lost a lot when they didn't have much to even begin with*" [Ruth, community service provider]. In their view, the pandemic exacerbated the symptoms of mental illness for many individuals, and this was particularly the case in social housing. These inequities were made worse by the fact that in-person services were limited during the pandemic, and still hadn't returned during the time of conducting interviews:

> "*I remember at the beginning there was some agencies who were just simply not doing face to face interactions…a lot of people were neglected during that time and mental health just simply exacerbated… and like the deterioration of apartments as well. You know, further isolation for a lot of these clients is super detrimental to their overall wellbeing and COVID simply did a lot of that… [on the] crisis [team]…you get a lot of phone calls from individuals you know whose mental health has just deteriorated because they've been stuck in their apartment for months and months on end, they're not engaging with the traditional services that they're used to…and it really kind of concentrated the issues that were already happening in these housing environments because…there was nowhere else to go. So all the issues just kind of devolved and devolved more further and further*

> "it really kind of concentrated the issues that were already happening in these housing environments because…there was nowhere else to go. So all the issues just kind of devolved and devolved more further and further and whether that was the deterioration of their apartments or their abilities to take care of themselves or their general overall like mental health. So I think when services retracted then uh, a lot of individuals suffered because of it."
> [EDWARD, COMMUNITY SERVICE PROVIDER]

and whether that was the deterioration of their apartments or their abilities to take care of themselves or their general overall like mental health. So I think when services retracted then uh, a lot of individuals suffered because of it." [Edward, community service provider]

Since the pandemic began, community service providers have felt overwhelmed by the increasing demand for support by individuals living with mental illness in Kingston overall. With services at capacity, it has been challenging to meet the needs of the community, including tenants living in social housing. Community service providers emphasized the need for increased resources to address their growing waitlists. Without these additional resources, they felt that they could no longer refer tenants to needed services. Regarding one service with a long waitlist, one provider remarked: "*lately…I haven't given any referrals. I think the last referral I gave was probably six months ago because like I've said, they've been at capacity*" [Mike, community service provider].

6. RECOMMENDATIONS

The findings of our stakeholder consultation have highlighted several needed changes to practice and policy that have the potential to lead to improvements in the lives of tenants living with mental illness in social housing and to and relieve pressure on social housing providers and community services. These include:

1. **Identifying effective strategies for improving the social context of social housing to support tenant well-being:** Such strategies need to be developed collaboratively among tenants, social housing providers, and community service providers.

2. **Enhancing or implementing a trauma and violence-informed care approach within social housing and community services for individuals living with mental illness:** The high rates of trauma among social housing tenants necessitates the use of trauma and violence-informed approaches within all health and social care contexts.

3. **Designing on-site models of support to more effectively meet the needs of tenants living with mental illness in social housing:** These models need to be co-designed with tenants, social housing providers, and community service providers. Once designed, the effectiveness of these supports need to be evaluated. Models known to be effective for improving the psychosocial well-being of tenants need to be properly funded in operational dollars to promote sustainability.

4. **Designing solutions for improving collaboration between social housing providers and community services to more effectively address the needs of persons living with mental illness in social housing:** Such solutions can be developed at the local level with opportunities for collaboration among community agencies and social housing providers.

5 Building healthier forms of community in social housing to increase the resilience of individuals living with mental illness: On-site supports and/or community agencies can collaborate with tenants to build community that supports well-being.

6 Providing education to community service providers and tenants regarding the nature of social housing and the limited supports that are available in current social housing models: Social housing providers may consider providing information to community service providers and tenants on what resources they may have at their disposal for supporting tenants. Such education can be provided in written materials, presentations, and in daily conversations with community service providers and tenants. This information can be used as a foundation for collaborating on supporting tenants.

7 Improving security in social housing buildings by using approaches that are not based on punishment and surveillance: While tenants in our consultation identified the need for increasing the presence of security guards in their buildings, we encourage social housing providers to be cautious about security-focused approaches which may unintentionally increase unnecessary evictions and criminalization, rather than provide needed support to tenants at risk.

8 Improving income support programs to more effectively enable tenants living with mental illness in social housing to meet their basic needs: Individuals living with mental illness in Canada have been disproportionately living in poverty for far too long. While there is hope that change is on the horizon with the passing of Bill C-22, a law that will introduce the Canada Disability Benefit (CDB), a federal benefit that will increase income support payments for qualifying individuals, this benefit has not been implemented [31]. As a community, it is imperative that we continue to advocate for structural changes that address ongoing poverty among individuals living with mental illness in social housing.

9 Increasing funding to enable social housing providers to repair existing social housing: In future refinements to the National Housing Strategy, policymakers may consider increasing community housing renewal funding to enable social housing providers to more adequately address delayed repairs to their buildings due to historical and current limitations imposed on capital funding for addressing these issues

7. LIMITATIONS

Firstly, when considering the findings of this report, readers should recognize that we conducted this research in four social housing buildings for single adults in one city in Ontario, Canada. As such, the findings of this research should be used to inform policy and practice related to social housing in this context and should be transferred to social housing in other communities or for families and other tenant sub-groups with caution. Further, the reader may consider that we conducted interviews while the COVID-19 pandemic was unfolding, and physical distancing restrictions were still in effect to some degree in the Kingston, Ontario community. As such, our findings reflect this context and may have changed since interviews were conducted. While this is the case, the reader may also consider that the findings of our pilot research with women living in social housing, conducted prior to the COVID-19 pandemic, identified similar realities [3]. Finally, readers may consider that tenants participating in our research were mostly women, white, and cis-gendered, and our findings reflect the demographic composition of our sample. As such, individuals wishing to transfer our findings to inform initiatives in their own communities may consider this sample composition in their interpretation of the findings presented in this report.


WELCOME

8. CONCLUSION AND NEXT STEPS

This report summarizes the findings of research conducted in collaboration with one social housing provider in Kingston, Ontario, Canada aimed at identifying the strengths and psychosocial needs of tenants living with mental illness in social housing. Our findings emphasize that tenants living with mental illness in social housing have a range of unmet needs including ongoing poverty, living in environments that negatively impact on psychosocial well-being, and limited access to services. These realities are acknowledged by social housing providers and community services. Our analysis of qualitative interviews revealed confusion regarding the nature of social housing and that education with tenants and community services is needed to clarify what supports are available within social housing buildings for single adults, while identifying opportunities for increasing the availability of existing support as a community. The findings of this report will be used as a foundation for co-designing approaches that can be used to more effectively support tenants living with mental illness in social housing. This process will unfold following the release of this report. Further, our findings will be used to raise consciousness in the Kingston, Ontario community and beyond regarding the plight of tenants, social housing providers, and community services as they provide support to an increasingly complex tenant population. In so doing, we hope to contribute to improvements in social housing practice and policy and thereby improve the lives of tenants living with mental illness and poverty in our communities.

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