Court File No. CV-10-403688

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

JENNIFER TANUDJAJA, JANICE ARSENAULT, ANSAR MAHMOOD, BRIAN DUBOURDIEU, CENTRE FOR EQUALITY RIGHTS IN ACCOMMODATION

Applicants

- and -

HER MAJESTY THE QUEEN IN RIGHT OF CANADA, HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, ATTORNEYGENERAL OF CANADA and ATTORNEY GENERAL OF ONTARIO

Respondents

APPLICATION UNDER Rule 14.05(3)(g.1) of the *Rules of Civil Procedure*, R.R.O. 1990, O. Reg. 194 and under the *Canadian Charter of Rights and Freedoms*

AFFIDAVIT OF PAULA NINA GOERING
(Affirmed August 24, 2011)

I, Paula Nina Goering, of the City of Toronto in the Province of Ontario, SOLEMNLY AFFIRM:

1. I have taught as an Instructor, Lecturer, and Research Supervisor with an emphasis on psychiatry since 1966.

2. I am a Full Professor at the Department of Psychiatry and Faculty of Nursing, University of Toronto as well as an Affiliate Scientist at the Centre for Addiction and

Mental Health. I have taught at the Department of Psychiatry and Faculty of Nursing since 1998.

3. Prior to becoming a Full Professor, I was: an Associate Professor at the University of Toronto's Department of Psychiatry and Faculty of Nursing (1991-1998); an Assistant Professor at the University of Toronto's Faculty of Nursing (1986); an Assistant Professor with the University of Toronto's Department of Psychiatry (1985); and Lecturer at the same Department of Psychiatry (1982-1985).

4. I currently hold other positions at the University of Toronto, including being a: Full Member of the Limited Term Graduate Department of Health Policy, Management & Education (since 2000); Full Member – Continuing of the Institute of Medical Science (since 1995); Professor at the Department of Health Policy, Management & Evaluation (since 2000); and a Full Member – Continuing of the Graduate Faculty of Nursing (since 1988).

5. From 1991-2010, I was Director of the Health Systems Research and Consulting Unit at the Centre for Addiction and Mental Health (CAMH) where I supervised a team of scientists who conducted applied health services research and consulting. Our interdisciplinary research sought to identify best practices and to inform policies related to mental health. I also held a CIHR/CHSRF Chair in Health Services Research for ten years. I therefore have extensive experience in the relevance of empirical evidence to developing policy.

6. I am currently the Research Lead for At Home/Chez Soi, a four-year pragmatic trial of Housing First in five Canadian cities that builds on existing evidence about the impact of secure housing on mental health. The At Home/Chez Soi project seeks to learn what service and system interventions can best help homeless people living with mental. "Housing First" involves providing homeless people with immediate access to subsidized housing, together with supports. No pre-conditions, such as bringing substance abuse under control or being stabilized on medications, are imposed. It draws upon an evidence based practice that originated in the 1980s. The Pathways to Housing in New York City program introduced a consumer-choice-oriented variant of Housing First, in which clients were offered a choice of subsidized scattered-site apartments (as opposed to one-size-fits-all congregate-housing). Clients, who have severe mental illness in addition to being homeless, were also offered the support of a multidisciplinary team, following a well-defined program model called assertive community treatment (ACT). At this time, the At Home/Chez Soi project has recruited the study's participants, who will be followed for two years. I anticipate that an interim report will be released in the Fall 2012.

7. Over the course of my career, I have conducted health services research and published numerous articles that address mental health and homelessness. Some of the previous research projects I have undertaken on mental health and homelessness have included: the housing preferences of homeless women, the Hostel Outreach Program evaluation, the Pathways into Homelessness Project that explored the causes of homelessness; healthcare in Toronto's shelters; the interplay between mental illness and involvement with the criminal justice system; and a multi-city feasibility study of

supportive housing. As such, I have personal knowledge of the matters deposed. A copy of my *curriculum vitae* is attached and marked as **Exhibit "A".**

8. I have been retained by the Applicants to provide expert opinion evidence on the disproportionate incidence of homelessness among people with mental disabilities, on the factors that contribute to the disproportionate incidence of homelessness among people with mental disabilities, and on the effect of homelessness on people with mental illness and addictions. A copy of my Acknowledgement of Expert's Duty Form is attached and marked as **Exhibit "B"**.

9. My opinions are that homelessness exacerbates mental illness and addictions; and that, while personal characteristics play an undeniable role in homelessness among people with mental disabilities, macro-level factors that generate and sustain poverty, such as poor incomes, high housing costs and limited economic opportunities, are a more significant contributor to homelessness.

10. My opinion on the role of macro-level factors in causing and sustaining homelessness is based in part on empirical research I have conducted, including the 1996-1997 Pathways Into Homelessness Project (the "Pathways Project") of the Health Systems Research Unit of the Clarke Division, Centre for Addition and Mental Health. The Pathways Project interviewed 300 adult users of homeless shelters in Toronto to identify characteristics of individuals who are homeless. The sample reflected the total population of homeless shelter users in terms of age, sex, level of shelter use, and type of

shelter. A copy of a report based on the Pathways Project, entitled, "Mental Illness and Pathways Into Homelessness: Proceedings and Recommendations" is attached and marked as **Exhibit "C"**. I have also attached a copy of a 1998 report entitled "Pathways Into Homelessness: Broadening the Perspective", marked as **Exhibit "D".**

11. The results of the Pathways Project support the conclusion that, while mental illness and addiction are common and disproportionately prevalent among people who have either faced homelessness or who currently are homeless, psychopathology alone is not the primary cause of homelessness. Rather, poverty appears to be a leading cause of homelessness. People with serious mental illness and addictions, however, may experience more numerous and prolonged periods of homelessness compared to the general population, as these individuals are more vulnerable to housing instability during periods of high unemployment, combined with a shrinking stock of affordable housing.[1]

HOMELESSNESS AMONG PEOPLE WITH MENTAL ILLNESS AND ADDICTIONS – AN OVERVIEW

12. People who are homeless have a disproportionately high prevalence mental illness and addictions. For example, while a 1% rate for schizophrenia is generally accepted as the best estimate of its prevalence among Canadians[2], research has shown that homeless people experience schizophrenia several times that rate. A study of Vancouver's

[1] See, for example: T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation" (2000) Issues in Mental Health Nursing 21, 581-604; and G.S. Tolomiczenko & P.N. Goering, "Pathways Into Homelessness: Broadening the Perspective" (1998) 2 Psychiatry Rounds 8.

[2] Public Health Agency of Canada, *The Human Face of Mental Health and Mental Illness in Canada 2006* (Ottawa: Minister of Public Works and Government Services Canada, 2006), at 72.

homeless population, for example, revealed that 7 of 124 shelter users (5.6%) reported a diagnosis of schizophrenia.[3] My own research in the Pathways Project similarly showed that 5.7% of the homeless population had a psychotic disorder.[4] The Public Health Agency of Canada reported in 2006 that "individuals with schizophrenia are greatly over-represented in … homeless populations."[5]

13. In 2003, the Canadian Mental Health Association (the "CMHA") reported that one-third of all homeless people live with mental illness.[6] A copy of the CMHA's report, "Housing and Homelessness", is attached and marked as **Exhibit "E"**.

14. Individual studies from various Canadian cities have also confirmed the high prevalence of mental illness and addiction among the homeless. In a 2005 study on homeless people in Vancouver, 23% of 1,719 people living in shelters and on the streets reported having a mental illness and 49% reported having an addiction.[7] In Calgary, 60% of respondents in a 2000 study on homelessness reported having a mental illness.[8] In Halifax, a 2004 study showed that 20% of 266 homeless individuals self-identified as mentally ill.[9]

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[3] S. Acorn, "Mental and Physical Health of Homeless Persons Who Use Emergency Shelters in Vancouver," (1993) *44 Hospital & Community Psychiatry 9*, 854-857.
[4] S. Tolomiczenko & P.N. Goering, "Pathways Into Homelessness: Broadening the Perspective", *supra*, at 3.
[5] Public Health Agency of Canada, *The Human Face of Mental Health and Mental Illness in Canada 2006*, *supra*, at 73.
[6] Canadian Mental Health Association, "Housing and Homelessness" (2003) Citizens for Mental Health Backgrounder, at 1. Available at http://www.cmha.ca/citizens/housingENG.pdf.
[7] Canadian Institute for Health Information: *Improving the Health of Canadians 2007-2008: Mental Health and Homelessness* (Ottawa: Canadian Institute for Health Information, 2007), at 19.
[8] *Ibid.*
[9] Canadian Institute for Health Information: *Improving the Health of Canadians 2007-2008: Mental Health and Homelessness*, *supra*, at 19.

15. People with addictions are over-represented among the homeless population.[10, 11] Of the 300 participants interviewed during the Pathways Project, 68% reported a history of substance abuse or dependence.[12] These findings are similar to other Canadian studies that showed a higher prevalence of drug use, when compared to the general population.

16. Statistics Canada's 2002 Mental Health and Well-being Survey notes that, among females respondents from the general population, 1.3% reported alcohol dependence and 0.4% reported illicit drug dependence; both within the previous 12 months. Among males, 3.8% reported alcohol dependence, and 1.0% reported illicit drug dependence within the previous 12 months.[13]

17. A 1993 study in Vancouver, however, showed that 44% of the city's homeless population reported using non-prescription drugs, such as marijuana and cocaine.[14] In 1999 in Edmonton, 40% of homeless youth reported drinking alcohol at least two or three times a week, and 55% reported consuming marijuana two or three times a week.[15] Fifty-five percent of Edmonton street youth also reported using cocaine, heroin, amphetamines

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[10] See, for example: D.P. Culhane, J.M. Avery & T.R. Hadley, "Prevalence of Treated Behavioral Disorders Among Adult Shelter Users: A Longitudinal Study" (1998) 68 American Journal of Orthopsychiatry 1, 63-72.

[11] G.S. Tolomiczenko & P.N. Goering, "Pathways Into Homelessness: Broadening the Perspective", *supra*, at 1.

[12] P.N. Goering *et al*, "Characteristics of Persons Who Are Homeless for the First Time", (2002) 53 Psychiatric Services 11, at 1473.

[13] Statistics Canada, "Canadian Community Health Survey: Mental health and Well-being", online: The Daily Wednesday September 3, 2002 <http://www.statcan.gc.ca/daily-quotidien/030903/dq030903a-eng.htm>

[14] Canadian Institute for Health Information: *Improving the Health of Canadians 2007-2008: Mental Health and Homelessness*, *supra*, at 16.

[15] *Ibid.*

or tranquilizers within the last year.[16] In Montreal, a five-year study of 415 street youth showed an incidence rate of drug injection use of 8.2 per 100 person-years.[17]

18. Beyond Canada, international studies have also found that the prevalence of mental illness and addiction are high among homeless people. In 2008, a report entitled "The Prevalence of Mental Disorders Among the Homeless in Western Countries: Systemic Review and Meta-Regression Analysis" reviewed 29 international studies of the prevalence of mental illness among the homeless population of seven western countries. The study found a pooled prevalence rate for psychotic disorders of 12.7% and a pooled prevalence rate for major depression of 11.4%. A copy of the report is attached and marked as **Exhibit "F"**.

19. According to the CMHA, "Safe and affordable housing is pivotal to a person's recovery [from mental illness]. It provides the stability required to pursue activities, such as employment."[18] The CMHA also notes that, "For persons who are poor and predisposed to mental illness, losing stabilizing resources, such as income, employment, and housing, for an extended period of time can increase the risk factors for mental illness or relapse,"[19] and "The inability to access affordable housing increases a person's risk of homelessness. Being homeless, in turn, increases a person's risk of developing mental illness. More affordable housing is part of the solution to alleviate poverty among

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[16] Canadian Institute for Health Information: *Improving the Health of Canadians 2007-2008: Mental Health and Homelessness*, *supra*, at 16.
[17] *Ibid.*
[18] Canadian Mental Health Association Backgrounder, "Poverty and Mental Illness" (November 2007), at 3. Available online at http://www.ontario.cmha.ca/admin_ver2/maps/cmha_poverty_backgrounder.pdf
[19] *Ibid.*

Ontario's poorest citizens."[20] A copy of the CMHA's 2007 Backgrounder paper, "Poverty and Mental Illness", is attached and marked as **Exhibit "G"**.

20. In a separate 2004 publication entitled "Housing, Health & Mental Health", attached and marked as **Exhibit "H"**, the CMHA observes that "adequate housing is an obvious prerequisite for health, including mental health"[21]. The CMHA concludes that "People with serious mental illness may require additional supports in order to stay well in their own homes and live as independently as possible."[22]

21. The Canada Mortgage and Housing Corporation (the "CMHC") similarly notes that "Safe, secure and affordable housing is recognized as one of the vital factors for recovery from mental health issues."[23] A copy of the CMHC's 2010 "Research Highlight: A Longitudinal Study of Housing for Mental Health Consumer-Survivors" is attached and marked as **Exhibit "I"**.

22. My opinion is that these statements from the CMHA and the CMHC accurately describe the interplay among poverty, homelessness or inadequate housing, and mental illness.

THE PATHWAYS INTO HOMELESSNESS PROJECT

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[20]Canadian Mental Health Association Backgrounder, "Poverty and Mental Illness", *supra*, at 4.
[21] Canadian Mental Health Association, "Housing, Health & Mental Health" (2004), at 4. Available online at: http://www.cmha.ca/data/1/rec_docs/549_CMHA_Housing_EN.pdf.
[22] *Ibid*, at 5. Available online at: http://www.cmha.ca/data/1/rec_docs/549_CMHA_Housing_EN.pdf.
[23] Canada Mortgage and Housing Corporation, "Research Highlight: A Longitudinal Study of Housing for Mental Health Consumer-Survivors" (Socio-Economic Series 10-002) (Canada: Canada Mortgage and Housing Corporation, 2010), at 1.

23. In 1996-1997, I led the Pathways Into Homelessness Project of the Health Systems Research Unit of the Clarke Institute of Psychiatry (now merged into the Centre for Addiction and Mental Health). Researchers from the Clarke Institute of Psychiatry, Wellesley Hospital and the Queen Street Mental Health Centre conducted a study of homeless people in the City of Toronto over 18 months. The project's objectives were: (1) to estimate the prevalence of mental illness among people who are homeless; (2) to describe pathways into homelessness; and (3) to identify policy areas for reform.

24. We interviewed 300 adults from 16 homeless shelters in Toronto to identify characteristics of individuals who are homeless. The sample reflected the total population of homeless shelter users in terms of age, sex, level of use and type of shelter.

25. The results of the project showed that, while mental illness and addiction are common among people who have either faced homelessness or who currently are homeless, psychopathology alone is not a primary cause of homelessness.

26. Rather, the influence of mental illness and addiction result in greater housing insecurity compared to the rest of the population during periods of high unemployment in combination with a shrinking stock of affordable housing.[24]

[24] See, for example: T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation" (2000) Issues in Mental Health Nursing 21, 581-604; and G.S. Tolomiczenko & P.N. Goering, "Pathways Into Homelessness: Broadening the Perspective", (1998) 2 Psychiatry Rounds 8.

27. The Pathways Project highlighted poverty, and not mental illness, as a leading cause of homelessness. We observed, however, that mental illness and addictions may predispose a person to episodes of homelessness, and may also prolong a period of homelessness, exacerbating the person's symptoms. We concluded that this interplay may account for the disproportionately high incidence of mental illness and addiction among people who are homeless.

BECOMING HOMELESS

Poverty is a Leading Cause of Homelessness and Other Poor Social Outcomes

28. Studies reveal that poverty is a leading cause of disadvantageous social outcomes among people with mental illness and addictions, including homelessness and involvement with the criminal justice system.[25] Although a common characteristic of many homeless people is mental illness and/or addiction, psychopathology alone does not explain the incidence of homelessness. Rather, poverty, whether associated with a lack of education, a lack of employable skills, physical or mental disabilities, or the absence of financial and social support, is the one factor that is common among all homeless people.[26] The 2007 Final Report of the "Panel Study on Persons Who Are Homeless in Ottawa: Phase 2 Results", for example, noted that "economic difficulties were a central

[25] See for the example: the "Pathways Project"; and C.T. Sheldon, T.D. Aubry, J. Arboleda-Florez, P.N. Goering & D. Wasylenky, "Social Disadvantage, Mental Illness and Predictors of Legal Involvement" (2006) International Journal of Law and Psychiatry 29, 249-256.
[26] T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*, at 582.

reason behind the homelessness" of the study's participants.[27] A copy of the Final Report is attached and marked as **Exhibit "J"**.

29. Importantly, research shows that deinstitutionalizing patients from mental health hospitals is not a significant contributor to homelessness today.[28] Deinstitutionalization began in the mid-1950s and peaked in the early-1970s. By 1980, the number of deinstitutionalized patients had stabilized. Nevertheless, homelessness continued to rise. Studies have concluded that economic factors account for the recent rising prevalence of homelessness.[29]

30. Human Resources and Social Development Canada explains that poverty "involves more than just income deprivation. It can also extend to (or result from) exclusion from essential goods and services, meaningful employment and decent earnings, adequate and affordable housing, safe neighbourhoods with public amenities, health and well-being, social networks and basic human rights."[30]

31. Unfortunately, people with mental illness and addictions are more susceptible to living in poverty primarily because of poor economic opportunities and the shrinking

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[27] Tim Aubry *et al*, "Panel Study on Persons Who are Homeless in Ottawa: Phase 2 Results" (Ottawa: Faculty of Social Sciences, University of Ottawa, March 2007), at 47

[28] T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*, at 583.

[29] See for example: T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*; and C.A. Kiesler, "Homelessness and Public Policy Priorities" (2001) 46 American Psychologist 11, 1245-1252.

[30] Human Resources and Social Development Canada Policy Research Initiative, "New Approaches for Addressing Poverty and Exclusion". Available online at <http://www.policyresearch.gc.ca/page.asp?pagenm=rp_ep_index>

pool of public and subsidized housing.[31] Studies suggest that a physical health, mental health or substance abuse problem (or a combination of all three) interferes with a person's ability to successfully navigate the housing and labour markets, or access government income supports, *et cetera*.[32] Mental illness and addiction can therefore precipitate and perpetuate cycles of housing instability. These cycles affect more people more persistently during periods of high unemployment.[33]

32. In 2000, I was one of a team of researchers that produced a report from our Pathways Project, entitled, "Becoming and Remaining Homeless: A Qualitative Investigation". A copy is attached and marked as **Exhibit "K"**. Common themes that emerged from the study's participants with respect to individual-level factors that led to homelessness, included histories of childhood abuse, neglect and poverty.

33. Our findings showed that 23.3% of the respondents reported childhood sexual abuse (inside or outside of the family), and 41% reported childhood physical abuse within the family.[34]

34. In addition to negative childhood experiences, individual level factors included experiences of abuse in adulthood, interpersonal problems, and substance abuse and

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[31] Human Resources and Social Development Canada Policy Research Initiative, "New Approaches for Addressing Poverty and Exclusion". Available online at <http://www.policyresearch.gc.ca/page.asp?pagenm=rp_ep_index>

[32] See, for example, D.A. Snow, L. Anderson, *Down on Their Luck: A Study of Homeless Street People* (Los Angeles: University of California Press, 1993).

[33] G.S. Tolomiczenko & P.N. Goering, "Pathways Into Homelessness: Broadening the Perspective", *supra*, at 5.

[34] T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*, at 589-590.

mental health problems. Depression, for example, was common among the study's participants: 46.7% reported at least one major depressive episode in their lifetime, and 28.2% met criteria for an ongoing depressive episode.[35]

35. Interestingly, there was only a lifetime prevalence of 10.7% for severe mental illness (*i.e.*, psychotic disorders).[36] We previously had reported that 6% of the participants in the Pathways Project had been hospitalized for severe psychiatric symptoms within the previous 12 months[37]. These findings reinforce the conclusion that individual factors alone, including severe mental illness, cannot explain the prevalence of homelessness. Still, it should be noted that although deinstitutionalization does not contribute greatly to the number of homeless persons, individuals with serious mental illness who are denied admission to a psychiatric hospital or incorrectly placed in a mainstream homeless shelter because of healthcare policy will suffer harm.

36. In a later study investigating the connection among social disadvantage, mental illness and involvement with the criminal legal system, "Social Disadvantage, Mental Illness and Predictors of Legal Involvement",[38] my fellow researchers and I concluded that legal involvement was attributable to factors other than mental illness. The study revealed that the role of social disadvantage, particularly as it relates to living in poverty, had the highest influence on the likelihood of legal involvement. We specifically

[35] T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*, at 590.
[36] *Ibid*.
[37] P.N. Goering *et al*, "Characteristics of Persons Who Are Homeless for the First Time", *supra*, at 1473.
[38] C.T. Sheldon, T.D. Aubry, J. Arboleda-Florez, P.N. Goering & D. Wasylenky, "Social Disadvantage, Mental Illness and Predictors of Legal Involvement" (2006) International Journal of Law and Psychiatry 29, 249-256.

concluded that “Unstable housing and the receipt of social assistance were predictive of legal involvement.”[39] A copy of the study is attached and marked as **Exhibit “L”**.

Discrimination in the Rental Market

37. The CMHA explains that people with serious mental illness face many barriers over their lifetime, including discrimination, which may prevent them from securing adequate education and employment.[40] The CMHA notes: “Experiencing a mental illness can seriously interrupt a person’s education or career path and result in diminished opportunities for employment. A lack of secure employment, in turn, affects one’s ability to earn an adequate income. As a result, people may eventually drift into poverty.”[41]

38. Unfortunately, for persons who are poor and predisposed to mental illness, the loss of income, employment or housing, and the stability that these represent, may heighten the risk factors for mental illness, or result in a relapse.[42] That is, poverty and poor mental health appear to feed each other in a vicious circle.

39. A 2009 Canadian Parliamentary report, entitled “Risk Factors for Homelessness”, explains that, “On the one hand, mental illness and substance abuse can contribute to homelessness, often by influencing other determinants such as an individual’s ability to secure employment or housing. On the other hand, homelessness itself can contribute to

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[39] C.T. Sheldon, T.D. Aubry, J. Arboleda-Florez, P.N. Goering & D. Wasylenky, “Social Disadvantage, Mental Illness and Predictors of Legal Involvement”, *supra*, at 254.
[40] Canadian Mental Health Association Backgrounder, “Poverty and Mental Illness”, *supra*, at 1.
[41] *Ibid*.
[42] *Ibid*, at 3.

problems such as mental illness and addiction, and can exacerbate existing health conditions."[43] Safe and affordable housing, therefore, is a pivotal determinant of a person's overall mental health. A copy of the report is attached and marked as **Exhibit "M".**

40. The Ontario Human Rights Commission (the "Commission") has observed that "For people with mental health and addiction disabilities, access to affordable housing is a major human rights concern."[44] The Commission has further stated that:

> People may face challenges in the rental housing market due to negative attitudes and stereotypes. In a Canadian survey of people with mental illness, half the respondents said the area of their life most affected by discrimination was housing. They said that their experience as a psychiatric patient meant they were less likely to get an apartment lease.[45]

A copy of the Commission's January 2011 report, "Human Rights and Mental Health Research and Policy Consultation Paper", is attached and marked as **Exhibit "N"**.

41. The Mental Health Commission of Canada's 2006 Senate Report on mental health, entitled "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada", explored the effects of discrimination against people

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[43] H. Echenberg, H. Jensen, "Risk Factors for Homelessness" (2 February 2009), Parliamentary Information and Research Service, Library of Parliament Document Number PRB 08-51E, at 2.
[44] Ontario Human Rights Commission, "Human Rights and Mental Health Research and Policy Consultation Paper" (January 2011), at 8.
[45] *Ibid.*

with mental illness and addictions in the housing market. The report quotes a participant to the study named Katherine, who succinctly says: "Good luck finding adequate housing when they find out you have a mental illness."[46] A copy of Chapter One of the report, which quotes from people with mental illness, is attached and marked as **Exhibit "O"**.

REMAINING HOMELESS

42. As with becoming homeless, remaining homeless appears to be a consequence of an interaction of both macro level and individual level factors. Our findings[47] show that remaining homeless is not a choice, but rather is a result of a complex array of issues, including, for example, a lack of adequate support and counseling services, livable wages, affordable housing and incentives for individuals to change their situation.[48] Because these factors that tend to lead to homelessness are typically beyond the control of an individual, a person who becomes homeless once is likely to become homeless again.[49] Many of those who experienced multiple episodes of homelessness shared certain childhood factors, such as childhood poverty, childhood homelessness and out-of-

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[46] Canada, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, (Ottawa: The Standing Senate Committee on Social Affairs, Science and Technology, 2006), at 8.
[47] See, for example: T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*; P.N. Goering *et al*, "Characteristics of Persons Who Are Homeless for the First Time", (2002) 53 Psychiatric Services 11, 1472-1474; and G.S. Tolomiczenko & P.N. Goering, "Pathways Into Homelessness: Broadening the Perspective", *supra*.
[48] T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*, at 594.
[49] P.N. Goering *et al*, "Characteristics of Persons Who Are Homeless for the First Time", *supra*, at 1472.

home placement. Early experiences of not having a secure and stable place to live predispose adults to experience homelessness later in life.[50]

43. In our 2002 paper,“Characteristics of Persons Who Are Homeless for the First Time”, we considered the characteristics of persons who are homeless for the first time and defined “Homelessness” as a lack of housing for at least seven nights in the previous month and no prospect of housing in the next month. To qualify for the study, episodes of homelessness had to be more than one month apart to be counted as separate incidences of homelessness. By requiring the one-month separation, our study ensured that contextual factors, such as limits on the duration of shelter stays, did not artificially increase the number of reported episodes of homelessness.[51] A copy of the paper is attached and marked as **Exhibit “P”**

44. First-time homeless persons were defined as people who had not been homeless since the age of 18 years.[52] Of the study’s sample population of 300 people, 126 people were homeless for the first time, and 174 people had experienced multiple episodes of homelessness.

45. Both groups were predominantly male and had impoverished socioeconomic backgrounds with high rates of family histories of mental illness and substance abuse. Lifetime substance abuse or dependency and rates of psychiatric hospitalization within the previous 12 months were also similar between the two groups.

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[50] P.N. Goering *et al*, “Characteristics of Persons Who Are Homeless for the First Time”, *supra*, at 1474.
[51] *Ibid*, at 1472.
[52] *Ibid*, at 1473.

46. The principal difference in the experiences of participants to the study who were homeless for the first time and of those participants who experience multiple episodes of homelessness was of childhood events related to housing history.

47. Among those who experienced multiple episodes of homelessness, all had, to some extent at least, lost hope of changing their circumstances and had become habituated to life on the streets.[53]

48. Our research showed that, when people first become homeless, they are motivated to find work, to find decent housing, and to seek counseling and other treatment for mental illnesses that contributed to their homelessness.[54] Over time, however, as these individuals encounter barriers to accessing good employment, housing and supportive counseling, they gradually lose hope that they are able to improve their circumstances, including homelessness. Such hopelessness may contribute to the development or escalation of a substance abuse problem, which can then perpetuate homelessness.[55]

49. When untreated, psychotic and other mental health symptoms may also perpetuate homelessness.

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[53] T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*, at 600.
[54] *Ibid.*
[55] *Ibid.*

50. Since the 1990s, both the Federal and Provincial Governments have retreated from providing housing. In the City of Toronto, in or about 1998, the municipal government implemented a provincial moratorium on non-profit housing, which translated into the cancellation of funding for 385 housing programs with 16,732 rental units at a time when the vacancy rate was only 1%.[56] Furthermore, there was an almost contemporaneous reduction in both the basic needs and shelter allowance components of Ontario Works benefits. At the time, the City of Toronto Housing Department estimated that 175,000 jobs were lost between 1980 and 1995.[57] The result was the lack of affordable housing, coupled with the additional lack of opportunity to lift oneself out of poverty through employment or government income supports. We concluded that government funding for nonprofit housing must be restored. Additionally, funding must also be made available for retraining, improving access to supportive counseling, and adequate social assistance benefits.[58]

51. In addition to addressing the macro-level factors that contribute to persistent homelessness, individual characteristics, such as childhood poverty and homelessness, must also be considered. Efforts to address these individual-level factors should be both preventive and restorative. A 2007 study on the evolving policy areas of mental health, housing and income support in Ontario, entitled "Housing, Income Support and Mental Health: Points of Disconnection", concluded that these three policy areas lacked a rational connection to ensure an appropriate level of service. The study noted:

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[56] T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*, at 601.
[57] *Ibid*.
[58] *Ibid.* at 600.

> The move to shift the focus of care of psychiatric survivors to community-based centres away from the hospital and institutional setting occurred while the availability of affordable housing was experiencing a decrease. The increased restrictions placed on income support further reduced the availability of housing that could be considered affordable to this population. The disconnection existing between these policy areas has created a situation which has increased an already vulnerable population's risk of being reducing [*sic!*] to a state of homelessness. Since these policy changes have occurred simultaneously throughout multiple policy sectors, the resulting areas of disconnect are often poorly understood even by service providers within each policy sector. Solutions to the problems resulting from the existing areas of disconnect can only arise by re-establishing and strengthening the connections existing between these diverse policy arenas.[59]

A copy of the report is attached and marked as **Exhibit "Q"**.

52. A full, holistic approach that recognizes the interaction among mental health, income support and good housing is therefore necessary to address homelessness and, indeed, the larger issue of persistent poverty. Improving the circumstances of children by addressing childhood poverty, neglect and abuse should be a high priority, since negative individual factors in childhood can lead to persistent homelessness and it accompanying risks, including the heightened risk of suicidality.

<u>HOMELESSNESS AND HEALTH – A FOCUS ON THE PREVALENCE OF SUICIDE AMONG HOMELESS PEOPLE</u>

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[59] C. Forchuk *et al*, "Housing, Income Support and Mental Health: Points of Disconnection" (2007) 5 Health Research and Policy Systems 14, at 6.

53. A November 2010, cross-Canada research report on health and housing concluded that good, secure housing is a necessary condition for good health, including mental health.[60] The study tracked the health and housing status of 1,200 vulnerably-housed and homeless, single adults in Toronto, Vancouver and Ottawa over a two-year period. The report, entitled, "Housing Vulnerability and Health: Canada's Hidden Emergency", observed that more than half (*i.e.*, 52%) of the people throughout Canada who participated in the study reported a past diagnosis of mental illness, and that 61% had suffered a traumatic brain injury at some point in their lives.[61] Among the highest reported mental health problems were depression (31%), anxiety (14%), bipolar disorder (13%), schizophrenia (6%) and post-traumatic stress disorder (5%).[62] The report concluded that "People who don't have a healthy place to live are at high risk of serious mental health problems."[63]

54. In 2002, I was a co-author of "The Association between Homelessness and Suicidal Ideation and Behaviours: Results of a Cross-sectional Survey", an article that reported the association between homelessness and suicidal ideation and behaviour, attached and marked as **Exhibit "R"**.[64] This study used data taken from the 1998 Pathways Project. We concluded that homelessness was a risk factor in suicidality, and that government intervention to decrease the structural causes of homelessness (*e.g.*,

[60] E. Holton, E. Gogosis, S. Hwang, "Housing Vulnerability and Health: Canada's Hidden Emergency" (Toronto: Research Alliance for Canadian Homelessness, Housing, and Health, 2010).
[61] E. Holton, E. Gogosis, S. Hwang, "Housing Vulnerability and Health: Canada's Hidden Emergency", *supra*, at 2.
[62] *Ibid*.
[63] *Ibid*.
[64] R. Eynan, P. Goering *et al*., "The Association between Homelessness and Suicidal Ideation and Behaviours: Results of a Cross-sectional Survey", (2002) 34 Suicide and Life-Threatening Behavior 4, 418-427.

increasing the availability of subsidized housing and other social programs) could reduce suicidality.[65]

55. The data from the Pathways Into Homelessness Project showed that 61.3% of the study's participants reported suicidal ideation, and that 34.1% had attempted suicide in their lifetime.[66] When disaggregated according to gender, a higher proportion of women reported both suicidal ideation (78.4% compared to 56.3%) and suicide attempts (56.8% compared to 27.6%).[67] To put these figures into perspective, several Canadian and US population-based studies[68] have shown that the overall rate of lifetime suicidal ideation ranges between 2.6% and 14.6% of the population, and that suicide attempts range between 1.5% and 4.2% of the population.[69]

56. The prevalence of suicidality was particularly high among people who had experienced homelessness during childhood. Forty-four percent of the Pathways Into Homelessness' study group had experienced homelessness on their own before the age of

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[65] R. Eynan, P. Goering *et al*., "The Association between Homelessness and Suicidal Ideation and Behaviours: Results of a Cross-sectional Survey", *supra*, at 425.
[66] *Ibid*, at 421.
[67] *Ibid*.
[68] See for example: R. Boyer, D. St-Laurent & M Preville, "Epidemiology of Suicide, Parasuicide, and Suicidal Ideation in Quebec" in A.A. Leenars *et al*., eds., *Suicide in Canada* (Toronto: University of Toronto Press, 1998) at 67-84; R.J. Dyck *et al*., "The Relationship Between Adolescent Suicidal Behavior and Life Events in Childhood and Adolescence" (1992) 149 American Journal of Psychiatry, 45-51; E.K. Moscicki *et al*., "Suicide Attempts in the Epidemiologic Catchment Area Study" (1988) 61 Yale Journal of Psychological Medicine, 259-168; and R. Ramsay & C. Bagley, "The Prevalence of Suicidal Behaviours, Attitudes and Associated Social Experiences in an Urban Population" (1985) 15 Suicide and Life-Threatening Behaviour, 151-167.
[69] R. Eynan, P. Goering *et al*., "The Association between Homelessness and Suicidal Ideation and Behaviours: Results of a Cross-sectional Survey", *supra*, at 419.

18 years.[70] Among this group, 71% reported suicidal ideation, compared to 58% of the study's participants who had not experienced childhood homelessness.[71]

57. The highest proportion of lifetime suicidal ideation was found among those participants who had been diagnosed with psychotic disorders. Indeed, all (100%) of the study's participants with a DSM-IV diagnosis of a psychotic disorder had reported suicidal ideation, compared to 75% of those with a mood disorder and 64% of those with post-traumatic stress disorder.[72] Participants who reported both drug and alcohol dependencies reported lifetime suicidal ideation of 51.7%, and those with a drug use diagnosis only reported suicidal ideation at a rate of 40%.[73] Participants with no psychiatric diagnosis reported a lifetime suicidal ideation of 20.5%, the lowest rate among the study's participants.[74]

58. The pattern of suicide attempts reflected that of suicidal ideation among people with mental illness or drug and alcohol dependency. Psychiatric diagnosis was significantly associated with suicide attempts. Nearly three-quarters (72.2%) of the study's participants diagnosed with psychotic disorders had attempted suicide, compared to 42.5% of those with mood disorders, 40% of drug users and 33% of those diagnosed with post-traumatic stress disorder.[75] Interestingly, alcohol users with no concurrent Axis

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[70] R. Eynan, P. Goering *et al*., "The Association between Homelessness and Suicidal Ideation and Behaviours: Results of a Cross-sectional Survey", *supra*, at 421.
[71] *Ibid*.
[72] *Ibid*, at 422.
[73] *Ibid*.
[74] *Ibid.*
[75] *Ibid*, at 424.

I diagnosis reported the lowest prevalence of suicide attempts at 6.5%, compared with non-alcohol users who also had no Axis I diagnosis at 11%.[76]

REDUCING HOMELESSNESS AND REDUCING HARM

59. Research in mental health and housing supports the conclusion that poor economic conditions, including low wages, limited access to employment and high housing costs are leading causes of homelessness. Mental illness and addictions may interfere with a person's ability to secure and maintain employment. Prejudice and discrimination in labour and housing markets against people with mental illness and addictions may also limit the availability of stable housing and increase harm on particularly vulnerable people. The result is a continuum of housing instability to homelessness that exacerbates the effects of mental illness and addictions.

60. Studies have shown the connection between affordable housing and housing stability, especially in the context of housing subsidies.[77] In a 2007 report entitled "Housing, Income Support and Mental Health: Points of Disconnection", the authors identify the significance of affordable housing for people with mental illness and addictions: "early literature suggested that… increased rates of homelessness and unstable housing were due to the presence of a mental illness. More recent literature has

[76] R. Eynan, P. Goering *et al*., "The Association between Homelessness and Suicidal Ideation and Behaviours: Results of a Cross-sectional Survey", *supra*, at 424.
[77] See, for example, Aubry T. *et al*, "Panel Study on Persons Who Are Homeless in Ottawa: Phase 2 Results", *supra*, at 47.

suggested that these increased rates are more likely the result of an overall lack of affordable housing."[78]

61. The Panel Study on homeless people in Ottawa noted that almost all (*i.e.*, 97%) participating homeless families were housed within approximately two years after initial contact for the study.[79] Three-quarters of these families were housed in subsidized housing.[80] The authors attributed the high rate of re-housing to the success of Ottawa's housing program, which targeted families. By contrast, less than half of the single male participants in the study were re-housed within the same period.[81] Single women were housed at rates higher than the single men.[82] The authors concluded that, "In light of the research findings showing the relationship between living in subsidized housing and housing stability… the need for assisting single men to access subsidized housing is an important policy implication indicated by our findings."[83]

62. Although more direct research on the impact of affordable and stable housing on mental health outcomes is necessary, my observations as the Research Lead in the At Home/Chez Soi project suggest that securing and maintaining good housing is a necessary condition for improved mental health. Government programs to increase the availability of affordable housing through rent subsidies should therefore be an important element of any housing strategy

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[78] Forchuk, C. *et al*, "Housing, Income Support and Mental Health: Points of Disconnection" (2007) 5 Health Research Policy and Systems 14, at 1.
[79] *Ibid*, at 6, 47.
[80] *Ibid*, at 47.
[81] *Ibid.*
[82] *Ibid*.
[83] *Ibid.*

CONCLUSION

63. Research has shown that, while people with mental illness and addictions are over-represented among the homeless population, psychopathology and the deinstitutionalization of patients cannot be seen as the primary contributors to homelessness. Individual factors related to a history of mental illness and addiction may precipitate and perpetuate periods of housing instability, but one cannot ignore the role of social disadvantage, caused by poverty. Indeed, as we concluded in our 2000 research report, "Becoming and Remaining Homeless: A Qualitative Investigation": "The consensus that appears to have emerged… is that there is value in identifying individual vulnerabilities but that the dissemination of such findings should always include an acknowledgment of the contribution of macro level factors including poverty and the lack of affordable housing."[84]

64. Research has also linked the importance of good, stable housing to recovery from mental illness and addictions. As we observed in our research: "homelessness is perpetuated by a loss of hope that it is possible to change one's situation that appears to be connected to the inability, due to limited resources, of shelters to provide services beyond those that meet the survival needs of the homeless."[85]

65. Because recovering from mental illness requires good, affordable and stable housing, our findings support the conclusion that government funding for non-profit

[84] T. Morrell-Bellai, P.N. Goering & K.M. Boydell, "Becoming and Remaining Homeless: A Qualitative Investigation", *supra*, at 583.
[85] *Ibid*, at 601.

housing is essential. The senior levels of government's retreat from social housing since the 1990s must be recognized as a contributing factor to persistent homelessness. The shrinking stock of affordable housing may be likened to a game of "musical chairs", where as chairs become scarce, those left standing show greater rates of personal, medical and social handicaps.[86] As we stated in one of our articles, "To reduce levels of homelessness, policy must reverse trends both in terms of the number of chairs available and the issues that make competition unfair to disadvantaged players."[87]

Affirmed before me at the City of Toronto, on this 24th day of August, 2011	)))	
	))	____________________________ Paula Nina Goering
____________________________ Harry Yeon Cho A Commissioner, *etc.*	)))	

[86] G.S. Tolomiczenko & P.N. Goering, "Pathways Into Homelessness: Broadening the Perspective", *supra*, at 5.
[87] *Ibid*.