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Evidence for a healthy city

Informing healthy municipal policy: a resource
from the Centre for Research on Inner City Health

CRICH

CENTRE FOR RESEARCH ON INNER CITY HEALTH

Prepared September 2014

About the Centre for Research on Inner City Health

The Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital was established in 1998 with the explicit mandate of improving the health of urban populations through research with direct relevance to policy and practice. CRICH also works with two specialized units: **Well Living House** is an action research centre for Indigenous infant, child and family health and wellbeing, and the **CRICH Survey Research Unit** provides research and evaluation services to the health and social science community using a range of techniques.

Acknowledgements

This resource was produced by the Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital in Toronto in September, 2014. People who collaborated on this resource include: Amy Katz, Alix Freiler, Dr. Stephen Hwang and Dr. Patricia O'Campo. This resource is available for download at: www.crich.ca. For more information about this resource, or to find out more about CRICH, please email crichlist@smh.ca. You can also find us at www.crich.ca or [@crich_stmikes](https://twitter.com/crich_stmikes)

About this report

In this report, we share evidence with relevance to policy and programs intended to improve health and wellbeing in Toronto. Please ask candidates running for Mayor and City Council where they stand based on the evidence included here. Please note: this is not a comprehensive municipal platform, and is not meant to address all issues related to community health. Rather, it is a survey of recent research from the Centre for Research on Inner City Health with direct application to municipal policy and related ideas and resources.

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1. Inter-related factors like racism, discrimination* and the historical and contemporary effects of colonization deeply impact the health and wellbeing of Toronto residents.

These factors have created and contributed to barriers to meeting basic needs such as housing, food security and stable, livable income^{1,2} and impeded access to health and social services.^{1,2,3,4,5} Further, a growing body of research evidence points to the negative health impacts of discrimination and intergenerational, historic and community-level trauma.^{1,2,6} Structural and interpersonal racism and discrimination are embedded in our society, including the social institutions of education, health care, criminal justice and social services. These issues are of key concern in the city of Toronto as one of the most diverse cities in the world and a city in which grave health and economic inequities persist along racialized lines. Responses to address issues of racism and discrimination include but are not limited to:

- Actively, accountably, and authentically engaging the knowledge of communities in the design and implementation of services.⁷
- Anti-racism/anti-oppression training, trauma-informed and cultural safety training (see text box) for all staff including frontline staff and policy-makers.^{2,6,7}
- Frontline, management staff and decision-makers who reflect people accessing services.⁷
- Formal discrimination complaint mechanisms for staff and people using services,⁷ which are clearly communicated (e.g. posted signs with complaints hotlines).
- Building time and safe space for reflection into the workplace (e.g. team meetings, clinical supervision, etc.).

PROMISING PRACTICE:

Partnering with Indigenous organizations to provide ongoing cultural safety training.²

The concept of cultural safety has been developed in the health care context, but has application to a range of services. The concept of cultural safety goes beyond that of ‘cultural competence,’ requiring decision-makers and providers to reflect on their own positions in the society, and relationships of power. Cultural safety also requires decision-makers and providers to:

- Ground their understandings of service provision in the socio-political context, including colonial processes past and present.
- Recognize that the way the person receiving service conceptualizes health and wellbeing is valid.
- Recognize that it’s up to the person receiving service to decide whether or not they have received culturally safe care.

* This includes but is not limited to discrimination on the basis of class, neighbourhood, housing status, receipt of social assistance, immigration status, perceived ability, gender, gender identity, sexual orientation, age, ethnicity, religion, physical health status and/or mental health status.

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2. Access to quality, stable housing for every resident would dramatically improve population health in Toronto.

Over the past 15 years, no matter what we're researching, participants consistently bring up clean, stable, safe, quality housing as fundamental to health. While our research has identified a range of necessary services and infrastructure, housing comes up as a key need, underlying or linked to so many other concerns. For example:

- Women list lack of quality affordable housing as a barrier to leaving violent situations.¹
- Youth, family members and community workers in a west-end Toronto neighbourhood, when asked about gaps in services and supports, spoke to a range of issues, including the need for housing.²
- Community residents, frontline workers and managers in downtown east Toronto identified lack of access to housing as major barrier to community health.³

Toronto residents are clear that dramatic increases to housing access are needed to improve community and individual health. Scientific evidence also demonstrates clear links between quality, stable housing and health,^{4,5} as well as the relationship between precarious housing and homelessness and increased health care use.^{5,6} The need is vast, and includes:

- Ensuring there is a robust city-administered housing stabilization fund that is easily accessible at different points throughout the health and social services system and that allocates sufficient funds to individual recipients to prevent people from having to live in poor conditions and/or becoming homeless;
- Bringing current social housing and private market rental stock up to standard;
- Providing new affordable units and access to market rental stock through rental supplements;
- Ensuring and/or facilitating the availability of appropriate, multi-disciplinary supports for people living with addictions and mental health problems.

Our evidence demonstrates that one of the most impactful things the City of Toronto could do to improve population health on a large scale would be to ensure that every Toronto resident has access to stable, safe, quality and appropriate housing.

PROMISING PRACTICE:

Housing with stable, ongoing multi-disciplinary supports.

The right supports can help some people maintain independent housing. This support can be provided through multi-disciplinary teams that are not tied to a particular housing situation but that follow the person. This approach – rent supplements sufficient to secure quality independent housing coupled with a multi-disciplinary team – is called 'Housing First,' and has been recently explored through a randomized controlled trial in Vancouver, Winnipeg, Toronto, Montreal and Moncton. Researchers found that a rigorous adherence to the Housing First model dramatically improved housing stability for people with histories of both chronic homelessness and mental health problems.⁷

Housing First includes two different levels of support – Assertive Community Treatment (ACT), and Intensive Case Management (ICM). ACT teams are generally appropriate for people facing serious mental health problems and/or addictions. Key components include:

- A program team that delivers direct, integrated services in settings that work for clients and assumes a ‘we will do whatever it takes’ attitude towards service delivery.
- 1-10 staff to client ratio.
- Supports available 24 hours a day, seven days a week.
- Skilled team members, including peers with lived experience, team coordinators, psychiatrists and primary health care providers who address health issues along with:
 - Household concerns like shopping, paying bills and negotiating with landlords.
 - Life issues like employment, daily living skills, social skills and connecting with family and friends.
 - Connecting people to community resources, group activities, cultural resources, exercise and group activities.

ICM can be appropriate for people whose mental health and/or addictions problems are less severe, and features a case-manager who connects people to external services.⁸

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3. Toronto residents are looking for services that are stably-resourced, welcoming, responsive and barrier-free.

Toronto residents have expressed clearly that they are looking for community services that have stable and sustainable resources, and that meet the needs of communities.¹ People also want services and spaces that are welcoming, and where they feel they are treated with dignity and respect. Evidence indicates that Toronto's service system (including but not limited to city services) should:

- Offer services that are flexible and individualized, with a balance of supports.^{2,3,4}
- Respond to people's realities and remove barriers to service, which includes offering:
 - Evening/night hours or 24/7 hours; ⁴
 - Transportation supports;
 - Child care as needed;
 - Multi-lingual services; ^{4,7}
 - Mobile services; ⁴
 - Outreach, including to people who are isolated; ^{3,4}
 - Services and approaches that respond to the realities of people with different abilities.³
 - Services that are free, do not have waiting lists and do not require ID.⁴
- Be delivered by providers who are given the time and supported to relate to people as human beings and to be compassionate, genuine and accepting.^{2,3} Evidence also suggests that, in some cases, people prefer to engage with a worker who 'really gets it' due to personal experience with mental health problems, homelessness and/or 'interlocking oppressions: such as those of race, class, gender, sexual, national and/or cultural identity.'²
- Ensure that services and housing are available for people who are using drugs or alcohol- ie. a harm reduction approach.^{3,5,6}
- Ensure access to ongoing supports. As a research participant put it during a qualitative interview: "I wish that group was still there because then, you don't have to be like: Oh - I should be over this by now."²

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4. Healthy cities don't work in silos.

Both people accessing services and people delivering them have spoken extensively to us about the need for funding structures that incentivize collaboration and integration between and within organizations, government Ministries, City Departments and across orders of government, and this is reflected in many of the studies cited in this document. Both people accessing services and people delivering them have also spoken to the need for help navigating within systems (eg. mental health and health care) and between systems (eg. health care and housing). Some have also expressed the need for time and resources to be allocated so that management and frontline staff from various agencies, Departments and Ministries can share information and develop relationships in order to make better and more seamless referrals.

We note, however, that calls for 'collaboration' or 'integration' are sometimes used in an attempt to generate savings in the context of systems already straining, or simply failing, to meet need. While we see strong evidence for the need to break down silos in both funding and system structures – and while this may indeed generate savings in some cases – we caution against the use of concepts like collaboration and integration as Trojan horses for funding cuts.

More generally, we have found that when we ask about a specific service or program, we will inevitably hear, not only about additional services or programs, but also about the social context.

PROMISING PRACTICE:

A Health in All Policies approach.

Jurisdictions around the world are putting into place a 'Health in All Policies' (HiAP) approach at different levels of geography. HiAP allows sectors to work together (eg. health, housing, transportation, recreation) to improve population health. Key facets of HiAP include:

- Joint budgets – as seen in Norway – can act as catalysts by facilitating the pooling of resources across sectors/Ministries/Departments and providing fiscal incentives for collaboration.¹
- Health impact assessments or health equity impact assessments can be powerful tools when considering policy options that impact population health.²
- Dedicated structural support helps see the implementation of healthy public policies – for example, in South Australia, there is a Health in All Policies Unit that provide expertise on the impact of new, potential projects or policies.³
- When considering population health, policy and program priorities should be established by all sectors, rather than being dictated by the health sector alone.

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5. Healthy cities require flourishing, independent grassroots groups and movements.

While municipalities and large organizations often hold consultations and maintain advisory groups, they are generally not bound to apply input provided through these mechanisms. As a result, it is important that independent, grassroots groups are able to:

- Develop and maintain capacity to monitor City processes, including the establishment and effectiveness of advisory processes;
- Engage in long-term work to see the development, implementation and evaluation of progressive policies;
- Suggest and advocate for alternative policies and planning practices.^{1,2}

More broadly, case studies and input from civil society groups around the world demonstrate that the implementation of genuinely equitable decision-making practices with the capacity to redistribute resources and improve health equity generally emerge as the result of pressure from grassroots groups working in collaboration and/or social movements.³ In Toronto, work to define and push for ‘equitable decision making’ must also take into account the right of diverse Indigenous communities to self-determination,⁴ and what this means for the pursuit of justice in urban governance.

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