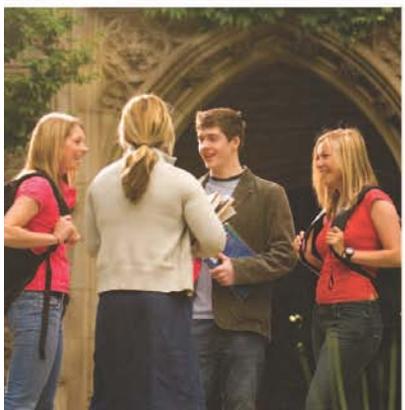




DIALOGUE  
SUMMARY

ADDRESSING HOUSING  
CHALLENGES FACED BY PEOPLE  
WITH HIV IN ONTARIO



1 JUNE 2010

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:  
Addressing Housing Challenges Faced by People with HIV in Ontario**

1 June 2010

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

Author

John N. Lavis, MD PhD, Director, McMaster Health Forum, and Professor and Canada Research Chair in Knowledge Transfer and Exchange, McMaster University

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## **SUMMARY OF THE DIALOGUE**

Dialogue participants were generally persuaded, either by their own experiences or by the available research evidence, that many Ontarians with HIV struggle to find and maintain appropriate, stable housing. They also agreed that housing challenges affect the health and well-being of people with HIV, as well as their access to healthcare services. Differences of opinion tended to be about the uniqueness of the housing challenges faced by people with HIV, compared to, for example, people with hepatitis C, addictions and select other conditions. Some of the potentially unique housing issues confronting people with HIV are: 1) the stigma associated with HIV and its implications for disclosure of HIV status to those who can provide healthcare, housing and other forms of care and support; 2) the access to healthcare and adherence to treatment that can be enabled by stable housing and their implications for living well with HIV; and 3) the realities and uncertainties associated with living with HIV and being treated with powerful medications that cause or could cause significant side-effects, and their implications for fluctuations in the factors that influence housing stability.

Dialogue participants tended to like aspects of all three options: 1) build on what's in place now; 2) build new programs, particularly ones that foster integration of programs and services to better meet the needs of clients; and 3) tackle the tough jurisdictional issues. However, many dialogue participants felt that a three-pronged strategy had the potential to yield the greatest impacts:

- 1) collaboratively identify or develop the guiding principles, promising practices and outcome indicators that would guide how these three options were pursued;
- 2) push for these principles, practices and indicators to be incorporated into credible accountability agreements, such as funding agreements with Local Health Integration Networks (LHINs) and memoranda of understanding between housing providers and AIDS service organizations; and
- 3) push for a dramatic increase in the affordable housing stock available in Ontario and in the support services available in Ontario (e.g., LHINs).

While most dialogue participants felt that forming alliances with other groups facing similar challenges would be the most fruitful way forward, one dialogue participant wondered whether the uniqueness of the housing challenges faced by people with HIV would mean that these individuals would be better served by 'going it alone' with dedicated housing and support services for people with HIV.

Dialogue participants drawn from the HIV community agreed that there would be value in the community clarifying the arguments about the unique housing issues confronting people with HIV, identifying other groups confronting similar housing issues, and mobilizing the numbers that back-up the stories about these issues. Most dialogue participants saw great value in HIV housing providers and key partners collaboratively identifying or developing the guiding principles, promising practices and outcome indicators that would guide further work in this area, both within the HIV sector and potentially well beyond it. They also agreed that the HIV community and its key allies should consider pushing for corresponding changes to accountability agreements and for a dramatic increase in the affordable housing stock and support services. Several dialogue participants noted the importance of being attentive to 'windows of opportunity,' such as upcoming municipal, provincial and federal elections, the launch of new strategies (e.g., housing, mental health), and the periodic re-negotiation of service agreements with housing and support service providers.

## SUMMARIES OF THE FOUR DELIBERATIONS

### DELIBERATION ABOUT THE PROBLEM

Dialogue participants were generally persuaded, either by their own experiences or by the available research evidence (much of which came from the Canadian Institutes of Health Research-funded *Positive Spaces Healthy Places* study), that many Ontarians with HIV struggle to find and maintain appropriate, stable housing. They also agreed that housing challenges affect the health and well-being of people with HIV, as well as their access to healthcare services. Dialogue participants typically agreed that: 1) existing housing and housing-related services often do not meet the needs of people with HIV; 2) the way housing and HIV services are currently delivered often complicates access to these services; 3) funding arrangements and jurisdictional issues make it more difficult to provide services that meet the housing and health needs of people with HIV; and 4) communities trying to develop housing programs for people with HIV face other barriers, such as the small number of people with HIV in some communities (i.e., lack of critical mass to support a program) and the lack of information about housing and support models.

Dialogue participants also agreed that there is, more generally, a significant shortfall in the affordable housing stock (and related support services) available in Ontario, which affects many Ontarians, not just those with HIV. One dialogue participant considered the lack of housing stock a supply-side issue, the lack of affordability a demand-side issue, and the lack of a layering in of support services an integration issue.

With respect to supply considerations, this dialogue participant argued that there was: 1) in absolute terms, “too little housing – period,” so that in some communities there was simply “no place to go except to homeless shelters, hospitals or long-term care facilities;” and 2) in relative terms, too much purpose-built housing and not enough all-purpose housing that can be re-prioritized and re-designed in a flexible manner as needs change (e.g., for women suffering from abuse or for woman living with HIV and bringing up children). The participant noted that the “Where’s Home?” report estimated that 10,000 rental properties will need to be built each year for the next 10 years to address the current and expected future supply

#### **Box 1: Background to the stakeholder dialogue**

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Ontario;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three options (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated issue brief that mobilized both global and local research evidence about the problem, three options for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

shortfall. Another dialogue participant asked why Ontario does not provide the same type of housing tax credit to corporations building housing for low-income Ontarians that appears to have worked so well in the United States (at least when coupled with zoning requirements, in the view of another dialogue participant). A third dialogue participant noted that there also needed to be firm commitments to maintain the existing housing stock so that it provides homes that people will want to go to. This same dialogue participant also argued that supply-side issues would remain for the foreseeable future, and that service providers needed to “think about where people are as their home... and work to provide the right basket of services to them in that setting, whatever it is.”

Turning to integration, and initially to integration across departments within government, one dialogue participant noted that the money saved in the healthcare sector never accrues to the housing or social services sectors that made possible the savings. This participant also noted that a more integrated perspective is also needed across levels of government, and that this need not mean that local communities should not have flexibility within the overall parameters set by a provincial housing strategy (should one be released), or by a national aboriginal housing strategy (should the federal government re-engage with aboriginal housing as a key area of responsibility). Another dialogue participant noted that Saskatchewan’s Human Services Integration Forum had opened up lines of communication, and enabled collaborative action, both within government and across levels of government.

Other dialogue participants noted that integration could also mean that people with HIV are housed in all-purpose housing and provided support by all-purpose service providers or by a mix of all-purpose service providers (e.g., Community Care Access Centres) and HIV-specific service providers. Several dialogue participants strongly endorsed the idea of integration across service providers, noting that the Mental Health Commission of Canada was also promoting a similar approach, and that a recent pilot project of this type in Toronto had proven remarkably successful.

As an off-shoot of the discussion about integration, but also as a substantive area of focus in its own right, dialogue participants discussed the absence of (and need for) performance measurement using “indicators that matter,” and for accountability by the housing and support service providers whose performance is being measured. One dialogue participant argued that the focus for performance measurement with housing providers has been on the indicator of “housed” (or not), whereas the focus should be on “tenure horizon” or “tenure stability.” Another dialogue participant noted that the focus with support service providers has been on outputs, not outcomes. One dialogue participant complemented this observation about the lack of routine performance measurement with an observation about the lack of one-off, in-depth assessments. This participant noted the importance of empirically documenting housing challenges among other groups, not just among people with HIV (as the *Positive Spaces Healthy Spaces* study had done), in order to ‘back up’ the stories that are so often told, and to provide a basis for finding shared ground with other groups experiencing housing challenges.

Dialogue participants occasionally disagreed about the uniqueness of the housing challenges faced by people with HIV compared to, for example, people with hepatitis C and other blood-borne diseases, addictions, select other conditions, and long-term health-related disability. Some of the potentially unique housing issues confronting people with HIV are: 1) the stigma associated with HIV and its implications for disclosure of HIV status to those who can provide healthcare, housing and other forms of care and support (and to sexual partners, which can have significant legal implications); 2) the stigma associated with homosexuality and substance use for many people with HIV (as one participant said: “HIV often makes you marginalized within a marginalized community”); 3) the access to healthcare and adherence to treatment that can be enabled by stable housing and their implications for living well with HIV; and 4) the realities and uncertainties associated with living with HIV over many years and being treated with powerful medications that cause or could cause significant side-effects, and their implications for fluctuations in the factors that influence housing stability (including disability pension eligibility). One dialogue participant suggested that it’s the “multiplicity of complexity” that makes HIV so unique. Another dialogue participant reminded others that the *Positive Spaces Healthy Places* study had found that many, but not all people with HIV experience housing-related

discrimination, and that those that did often have many other vulnerabilities as well (e.g., they may be gay, of low socio-economic status, and suffer from several addictions). This participant also noted that the challenge was to “identify those most in need and what they need most.”

Several dialogue participants noted that the HIV community would need to work through whether these differences mean that people with HIV will be better served by purpose-built housing (as opposed to all-purpose housing) and by local flexibility (as opposed to centralized planning). One dialogue participant noted that disclosure affects the visibility of the problem. Another dialogue participant observed that the holistic needs of aboriginal people with HIV may be better served through housing and support services designed by and for aboriginal people, than through housing and support services designed by and for people with HIV.

While dialogue participants tended to agree on the HIV epidemic’s “deep roots,” they differed in the relative priority that they accorded to addressing the root causes of HIV (and deteriorations in the health status of those with HIV), and to focusing on housing as a strategic intervention point that had the potential to address at least some of these causes (and hence to support both primary and secondary prevention efforts). However, most dialogue participants strongly endorsed a focus on housing as a strategic intervention point.

A number of dialogue participants worried about making generalizations about people with HIV and about defined sub-groups of people with HIV. They argued that one solution won’t work for all people with HIV, or even, as just one example, all people with HIV and a substance use problem. Moreover, another dialogue participant noted that stigma-related disclosure concerns can mean that groups identified as “substance users” and “substance users who are HIV positive” may be the same people. Several dialogue participants noted some of the particular challenges faced by aboriginal people with HIV. At the individual level, one dialogue participant noted the “lack of cultural wholeness” as an overarching challenge, while another noted the problems that many aboriginal men have with forming attachments to people, places and jobs, and the problems that many aboriginal women have with teenage pregnancy, substance use (and multi-generational fetal alcohol syndrome) and marital breakdown. At the societal level, one dialogue participant noted the lack of federal government engagement in housing since “the downloading of supportive housing to provincial and territorial governments” and, when it does engage, a lack of federal government effort to work in a holistic manner and within aboriginal people’s cultural heritage.

## **DELIBERATION ABOUT POLICY AND PROGRAM OPTIONS**

Dialogue participants tended to like aspects of all three options that had been “worked up” as concrete examples of what could be done differently.

### **Option 1 – Build on what’s in place now**

A number of dialogue participants saw advantages to the three elements of this option: 1) policymakers and organizations responsible for services for people with HIV would use a combination of education and advocacy with housing and housing-related service providers to change current eligibility criteria, thereby making existing housing and support programs more easily available for people with HIV and people at risk; 2) organizations and care providers serving people with HIV would familiarize themselves with the housing and support services available in their communities and make appropriate referrals; and 3) organizations providing services for people with HIV would work with housing organizations and programs to ensure they understand the complex needs of different populations affected by HIV and provide culturally competent services. A current example of the third element of this option is the Ontario HIV & Substance Use Training Program, which is based at Fife House.

Dialogue participants identified the main advantages of this option as being that it provided a chance to: 1) “get our house in order” in terms of understanding and addressing complexity, building new relationships with service providers, planners, policymakers and researchers, and demonstrating success in functional integration; 2) pilot test more integrated housing and support service indicators that “tell the stories of our clients,” help us to understand what we’re doing well and what needs to be improved, and demonstrate accountability to funders; 3) make progress while Local Health Integration Networks (LHINs) are reviewing their assisted living policies at a community level and “refreshing the basket” of services they fund, the provincial government is developing both a provincial housing strategy and a 10-year mental health and addictions strategic plan, and provincial and federal governments are beginning early preparations for an election; and 4) develop some experience with options 2 and 3 before “taking them on in a systematic way.”

As one dialogue participant said, “there’s no better time. The issue is under the radar and there are no barriers up yet.” Another dialogue participant noted that “we’ve already started with the pilot in Toronto,” and “we need to keep being entrepreneurial as we were in that case.” While another dialogue participant suggested calling these efforts “pilots,” several dialogue participants worried that these short-term pilots would not be translated into sustainable long-term programs without proactive and coordinated efforts. One dialogue participant asked “what are the ‘hot spots’ where we should direct our attention?” Another dialogue participant recommended focusing on affordable housing, rent supplements (for housing providers)/portable housing allowances (for clients), and supporting housing as priority areas, and noted that the provision of support services (if delivered in a timely and reliable way) could help to engage at least some private sector housing providers. A few dialogue participants worried about the implementation challenges that would arise and need to be managed, including directing people into “recovery” models instead of harm reduction models, and directing people with low needs into supportive housing. One dialogue participant said, “I’m always surprised how little support can be provided to many people and yet they are still successful.”

Several dialogue participants expressed concern that this option only addressed the “tip of the iceberg” given current shortfalls in housing stock and support services. One dialogue participant cautioned that this option was an “underachiever” as a solution, and that it failed to address the need for timely access to housing that was so critical for populations such as those released from prison (who will have lost their subsidized housing when they were incarcerated and who, if they are aboriginal, may be flown back to remote communities after they are released). This participant noted that prison is often the housing solution when the system fails.

## **Option 2 – Build new programs**

A number of dialogue participants saw advantages to developing comprehensive, one-stop HIV-specific programs, based on a “housing first” model, which would involve community-based HIV organizations shifting their primary focus to first helping clients – both people with HIV and people at risk – find and maintain stable, appropriate housing and then, once they are housed, focusing on helping people access a range of services as they become available, with the ideal being ‘wrap-around’ services based on each client’s needs, which can include counselling, social support, buddy programs, peer programs, case management, harm reduction and access to healthcare. Dialogue participants noted that there are examples of success with this option in both Hamilton and (north) Toronto, and expressed regret that a key civil servant in Toronto’s municipal government had been unable to attend the dialogue to describe that city’s approach and the lessons learned. One dialogue participant also noted that there are lessons to be learned from the application of the “housing first” model in the mental health and addictions sector.

Dialogue participants identified the main advantages of this option as being that it: 1) created opportunities for new partnerships with a range of housing and support service providers (given that there are so few HIV-specific housing providers and that there are so many support services that people with HIV could need to access); and 2) created opportunities for a brokerage function that linked housing and support service providers in creative ways to meet the unique needs of each client. One individual noted that in the U.S. the

“housing first” model has been implemented in a population-specific manner in major cities so that the housing and support services are typically HIV-specific. Many dialogue participants noted that this wouldn’t be possible in most Ontario communities.

One dialogue participant argued that there was a need for investing in data collection in order to be able to provide a more accurate and timely picture of the availability of and gaps in support services for all Ontarians, not just those with HIV, and that the Ontario government should help to pay for this to ensure that it is “invested” in the process of data collection and in the resulting data.

As with option 1, several dialogue participants expressed concern that this option only addressed the “tip of the iceberg” given current shortfalls in housing stock and support services. With regard to the current shortfalls in support services, one dialogue participant suggested finding ways to leverage new resources coming into communities. For example, the province’s LHINs now have to direct significant resources into avoiding hospitalization, among other priorities, and this presents an opportunity for re-allocating resources to promising innovations. One dialogue participant noted that in the U.S., a large hospital paid a local housing provider in order to avoid repeat admissions by individuals for whom housing was their primary challenge.

One dialogue participant worried that such a “one-size-fits-all” model would restrict clients’ choices about what they most need at a given moment in time. This participant noted that a “housing first” model would mean that every client had to focus on housing first, even if it were primarily those “on the cusp” that would benefit the most. Another dialogue participant worried that this option would have a significant negative impact on people for whom housing isn’t the biggest concern. This participant noted that front-line staff in community-based HIV organizations, who are already over-stretched in terms of their capacity to meet client needs, would have to stop doing many things while developing this additional expertise and following this new model. A third dialogue participant noted that in Alberta, where this model is being used, community-based HIV organizations have found it difficult to retain their funding, while at the same time the organizations find that they are continually being called in by housing providers to provide HIV-related support services. This participant wondered what elements of the model elicited this type of response.

One dialogue participant suggested that one way to address these concerns with the “housing first” model would be to focus less on the model and more on identifying guiding principles and promising practices for the Ontario context. Another dialogue participant embraced this suggestion, and gave examples of guiding principles that could be the basis for starting a conversation: 1) avoid the ideology that comes with statements like “only a private housing market” or “only rent supplements;” 2) address the affordability challenge; 3) build support services around the needs of clients and “where they are at a given time;” and 4) establish workable memorandums of understanding so that housing providers will take in vulnerable populations (knowing that there is a credible commitment to providing these populations with the support services they need), and support service providers know what is expected of them. Another dialogue participant added an additional principle to this list: “those most in need should always get first shot at housing and at support services,” and this individual noted that many types of needs should be taken into consideration, not just income, and that acts of discrimination against those with the greatest need should be documented and those persons responsible held accountable.

### **Option 3 – Tackle the tough jurisdictional issues**

Many dialogue participants saw significant advantages in brokering and supporting the implementation of a cross-payer, cross-discipline model of client-centred housing, health care and supportive services for all people with health conditions that put their housing at risk. One dialogue participant said, “this is the future.... And governments are recognizing this.” This participant also noted that the economic downturn and steady increase in healthcare’s share of the provincial government have accelerated the government’s focus on this option.

Several dialogue participants provided examples of where such integration has happened or is happening. In Ontario, Community Health Centres have long provided an example of a “one-stop shopping” model that is driven by the voice of its clients and community, which are typically disadvantaged and marginalized. In the same province, the AIDS Bureau has supported ethnocultural-specific and client-centred HIV-related prevention programs and support services, Peel region has supported the integration of healthcare services, and two levels of government have sponsored the Provincial-Municipal Fiscal and Service Delivery Review. In Saskatchewan, Human Services Integration coordinates government initiatives to provide more integrated human services, and the Horizontal Pilot Project coordinates a variety of government and community initiatives to meet the needs of people with or at risk of HIV. These dialogue participants noted that the partnerships underpinning these efforts had often taken years to build. Other dialogue participants noted that many years of partnership building may also be needed with key players like the Ministry of Municipal Affairs and Housing, a representative of which had been unable to participate in the dialogue.

A number of dialogue participants reflected on what supports the dynamism and persistence that contributes to success in tackling tough jurisdictional issues. One dialogue participant suggested that the keys to success were picking the right “outcome indicators,” aligning funding with outcomes, having a neutral convenor (like a LHIN) that can pull people together and instill a culture of collaboration, and celebrating successes. Another dialogue participant noted that the big question is “how do you convene a table with all key groups but with clients at the heart of the discussion?”

Several dialogue participants expressed concern that the deliberation about this option moved back and forth between a general discussion about integration and a specific discussion about what form integration could best take for people with HIV. The participants who were particularly focused on the latter were struggling with whether, for example, they should be pushing “for more Fife Houses,” meaning more HIV-specific housing and support service providers, or for something else. These participants felt that the HIV community needed to first clarify the arguments about the unique housing issues confronting people with HIV, and decide whether they warranted a community-specific planning exercise, which could include a review of success stories in integration, a review of innovations like client navigators who help people to find and choose among a variety of housing and support service options, and a review of approaches to developing memorandums of understanding and ways of operating that both acknowledged the funders, hosts and providers of each program and service being delivered in a “one-stop shop,” and established appropriate accountabilities among them. Other dialogue participants argued that pushing for people with HIV to be identified as a priority housing population (as women who have been the victims of domestic violence are currently identified) will only create “a list within a list” and hence more challenges in a system with such severe limitations in housing stock.

One dialogue participant noted that aboriginal people are not well served by an approach that fails to acknowledge the federal government’s commitment to them. This dialogue participant noted that roughly half of First Nations people and nearly all Métis people live in urban areas, not on reserves, and governments have to be prepared to meet the needs of clients wherever they are. That said, this participant worried that the federal government’s accountability to aboriginal people would be lost if it is not given significant attention in all steps of the process of tackling tough jurisdictional issues.

### **Considering the full array of options**

While dialogue participants tended to like aspects of all three options – building on what’s in place now, building new programs, particularly ones that foster integration of programs and services to better meet the needs of clients, and tackling the tough jurisdictional issues – many dialogue participants felt that a three-pronged strategy had the potential to yield the greatest impacts:

- 1) collaboratively identify or develop the guiding principles, promising practices, indicators of complexity/need, and outcome indicators that would guide how these three options were pursued;

- 2) push for these principles, practices and indicators to be incorporated into credible accountability agreements, such as funding agreements with LHINs and memoranda of understanding between housing providers and AIDS service organizations; and
- 3) push for a dramatic increase in the affordable housing stock available in Ontario and in the support services available in Ontario (e.g., LHINs).

Dialogue participants also discussed whether and how to engage in the development of a provincial housing strategy. As outlined earlier, some felt that the uniqueness of the housing challenges faced by people with HIV may mean that people with HIV will be better served by a housing strategy specifically for people with HIV, by purpose-built housing and HIV-specific support services (as opposed to the all-purpose housing and all-purpose support service providers that may be endorsed in a provincial housing strategy), and by local flexibility (as opposed to the centralized planning that may be initiated through a provincial housing strategy). Other dialogue participants argued strongly for engagement in the six to nine months remaining before election planning begins, particularly if there is interest in supporting more of a “systems thinking” approach and in promoting particular innovations like portable housing allowances. Still others argued that, while a provincial housing strategy might be an enabler for their work, significant attention would still need to be focused on local efforts to identify new partners (such as LHINs) and ways to leverage opportunities with these partners. As one dialogue participant said: “Do it when you can, and ask for forgiveness later.”

### **DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS**

Most dialogue participants felt that forming alliances with other groups facing similar challenges would be the most fruitful way forward. One dialogue participant said: “we’re stronger if we work together.” A second dialogue participant returned to an early suggestion to empirically document housing challenges among other groups, not just among people with HIV (as the *Positive Spaces Healthy Spaces* study had done), in order to provide a basis for finding shared ground with other groups experiencing housing challenges. A third dialogue participant reminded others that it had been an alliance among diverse groups that had led to the establishment of the Trillium Drug Program. The HIV community realized that it would not succeed in creating a catastrophic drug plan, or it would fail to ensure its sustainability, if the community failed to work in partnership with other groups facing catastrophic drug costs. However, another dialogue participant wondered whether the uniqueness of the housing challenges faced by people with HIV would mean that these individuals would be better served by ‘going it alone’ with dedicated housing and support services for people with HIV.

A few dialogue participants argued that a greater degree of engagement with LHINs was necessary in order to support the push for greater integration of support services. One of these dialogue participants noted that HIV-specific service providers “have not been playing in the LHIN field,” but perhaps should. As had been brought up in earlier deliberations, this would mean identifying their priorities (e.g., avoiding hospital admissions) and building the case for how addressing housing challenges for people with HIV would help them to deliver on their priorities.

Several dialogue participants noted the importance of “getting on agendas” in different parts of government. As with LHINs, this would require identifying their priorities (e.g., reducing healthcare costs, recidivism, child protection case loads, and employment program usage) and how the HIV community can help them to achieve these priorities. One dialogue participant noted that the limited successes with purpose-built housing and support services for people with HIV had come about because of the direct involvement of particularly engaged Ministers of Health. This dialogue participant suggested that this was not a sustainable strategy and that a broader effort to influence government agendas was needed (while also taking advantage of the opportunities created by the personal interests of Ministers when they arose).

**DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES**

Dialogue participants drawn from the HIV community agreed that there would be value in the community clarifying the arguments about the unique housing issues confronting people with HIV (which could be done by the housing sub-committee of the Toronto HIV/AIDS Network or by a broader group convened by the Ontario HIV Treatment Network), identifying other groups confronting similar housing issues, and mobilizing the numbers that back up the stories about these issues. Most dialogue participants saw great value in HIV housing providers and key partners collaboratively identifying or developing the guiding principles, promising practices and indicators that would guide further work in this area, both within the HIV sector and potentially well beyond it. This work could include any and all of building on what's in place now, building new programs, particularly ones that foster integration of programs and services to better meet the needs of clients, and tackling the tough jurisdictional issues. They also agreed that the HIV community and its key allies should consider pushing for these principles, practices and indicators to be incorporated into credible accountability agreements (e.g., funding agreements with LHINs, memoranda of understanding between housing providers and AIDS service organizations), and pushing for a dramatic increase in the affordable housing stock available in Ontario and in the support services available in Ontario (e.g., through LHINs).

Several dialogue participants noted two other key considerations. First, the HIV community and key allies should consider supporting the National Aboriginal Housing Association's efforts to ensure that the housing challenges faced by aboriginal populations (with or without HIV) is addressed appropriately at the federal level. For one dialogue participant, this meant (in the short term) supporting the federal bill C-304, which calls for a conference aimed at supporting the development of a national housing strategy and for ensuring that aboriginal people are "at the table," and (in the long term) pushing the federal government directly (and indirectly through the Ontario provincial government) to take action. Second, all groups should be attentive to "windows of opportunity" such as upcoming municipal, provincial and federal elections, the launch of new strategies (e.g., housing, mental health), the periodic re-negotiation of service agreements with housing and support service providers (e.g., by LHINs), and the emergence of crises (e.g., healthcare costs, judicial system failures).