



Addictions &  
Mental Health  
Ontario



Canadian Mental  
Health Association  
Ontario

# Promising Practices

12 Case Studies in Supportive Housing for People  
with Mental Health and Addiction Issues

April 2018



# About This Resource Guide

This resource guide was produced by Addictions and Mental Health Ontario (AMHO), Canadian Mental Health Association (CMHA) Ontario, and the Wellesley Institute.

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# Introduction



## Overview

This resource guide documents 12 examples of promising practices in supportive housing for people with mental health and addiction issues from across Ontario.

Each case study has a distinct approach, but common themes were identified across these twelve specific examples – regarding supports, housing and partnerships. In addition to those themes, the challenges and successes demonstrated through the case studies pointed to system level implications and opportunities for improvements across the sector including more affordable housing, further standardization in some areas, and enhanced system coordination.

The case studies documented in this guide are examples of the high quality work that is being done across the supportive housing sector. They serve as replicable or adaptable examples of promising practices in supportive housing along with shared resources that can be borrowed and modified for use in other supportive housing programs.

This resource guide is intended firstly for providers and secondly for policy and program staff in provincial ministries, municipalities,<sup>1</sup> and Local Health Integration Networks (LHINs).

This guide is part of a project that also includes an online forum where people can connect with case study participants and project staff to share knowledge and resources, and identify areas for further investigation.

## Context

Supportive housing provides many Ontarians who live with mental health and addiction issues with long term, permanent housing that is both affordable and supported. The supports help residents to develop skills, maintain their housing and manage their health. Supportive housing is an important part of our health care system, reducing hospitalizations and helping people avoid the negative health impacts associated with unaffordable, low-quality, or no housing.

Community-based supportive housing providers have been delivering this key piece of our health care system for decades. Historically, resources for these programs have come from a complicated system that crosses Ministries and local entities such as Service Managers and LHINs. Providers have responded in creative and thoughtful ways to situations in their communities; many examples of such innovation are found in these case studies. Supportive housing is a policy priority in Ontario, and this guide, along with other complementary resources, demonstrates that with greater investments in supportive housing, delivered in a coordinated way, the community sector is well situated for the expansion needed to serve Ontarians with mental health issues and addictions.

This guide has been prepared in a policy environment that is favourable to adding more supportive housing. The National Housing Strategy is providing federal funding for affordable housing, including supportive housing. It involves cost-matching from the provinces, and a reconstituted federal homelessness program. Ontario has added significant resources, including Home for Good (Ministry of Housing) as well as added mental health and addictions supportive housing units: 1,150 being delivered in 2017 and 2018 and an additional 2,475 announced in 2018. Significant further investments have been recommended by the Mental Health and Addictions Leadership Advisory Council.

This guide is one step in a process of building up more documentation of supportive housing models and practice. More research and more rigorous evaluations that can lead, over time, to identifying and establishing best practices. The case studies capture a range of approaches that serve the diverse population of Ontario, including organizations that serve racialized clients or Indigenous clients. The sponsors of this report recognize the need to better document supportive housing that serve diverse communities, including racialized communities, Francophone Ontarians, and Indigenous communities.

<sup>1</sup> Municipalities refers to the 47 designated municipalities and district social services administration boards that are local/regional system managers for affordable housing and homeless-related services.

## Complementary Resources on Supportive Housing

- *LHIN Guide to Lessons Learned and Local Practices in Implementing Supportive Housing for Individuals with Mental Health and Addictions Conditions (not yet released).*<sup>1</sup> A resource guide to support LHINs in planning and implementing supportive housing and programs.
- *Ontario Government - Supportive Housing Policy Framework<sup>2</sup> and accompanying Best Practices Guide.*<sup>3</sup> The Policy Framework outlines a definition of supportive housing, as well as a common vision, principles and outcomes to guide program improvements and coordination. The *Best Practices Guide* identifies best practices related to support, housing and coordination of housing and supports.
- *Mental Health and Addictions Leadership Advisory Council Final Report<sup>4</sup> and Supportive Housing Working Group: A Supportive Housing Strategy for Mental Health and Addictions in Ontario.*<sup>5</sup> A strategy addressing four main challenges in supportive housing: supply, flexible support services, a range of housing options, and coordination and cooperation.
- *Addictions and Mental Health Ontario – Supportive Housing: Recommendations for the Provision of Support Services.*<sup>6</sup> A guide for implementation of models for the provision of support within housing.

In addition, this resource guide builds on many of the key works on supportive housing including the *Mental Health Commission of Canada's At Home/Chez Soi*<sup>7</sup> and *Turning the Key*<sup>8i</sup> reports, the Wellesley Institute's *Coming Together on Supported Housing*,<sup>9</sup> and ONPHA's *Innovations in Housing Stability*.<sup>10</sup> (See Endnotes, page 56)

## Key Terms

### Supportive Housing:

Combination of housing, services, and programs for people with mental health and addiction issues that supports people to maintain their housing and manage their health.

### People who are served by the organization:

Each of the providers have their own language to describe the people that are served/housed by the organizations. Throughout the document we use the language used by each of the case studies.

### Supports:

Our case studies represent a range of supports including: tenancy support, independent life skills training, social supports, health and wellness, personal support, community linkages, crisis intervention, eviction prevention, clinical support & peer support. Some service providers clearly separate the roles of housing supports and health supports, others integrate these services through one staff role. (AMHO - Supportive Housing: Recommendations for the Provision of Support Services, 2017).

## Themes

The Promising Practices in Supportive Housing case studies are examples of the extraordinary work being done across the sector to support tenants with mental health and addiction issues to develop skills to maintain their housing, and manage their health. Although each case study has a unique approach, they all face similar challenges that they have responded to in innovative ways. Below are some of the common challenges and ways providers have responded.

Through review of our case study practices, implications for system reform were identified.

The need for...

1. More Affordable Housing
2. Greater Standardization
3. Better System Coordination

### 1. More Affordable Housing

Challenge	Provider Responses
<p><b>Acquiring Housing Stock</b></p> <p>This was a challenge across nearly all of the case studies and housing models. Even with rent supplements and funding available, finding units is difficult. Our case studies demonstrate strategies for managing this challenge, but until there is a greater amount of affordable housing available generally, this problem will persist.</p>	<ul style="list-style-type: none"> <li>▪ Have a landlord engagement strategy</li> <li>▪ Dedicated housing staff who work closely with landlords</li> <li>▪ Agency owned and operated buildings</li> </ul>
<p><b>Growing Waitlists (bottleneck issue)</b></p> <p>Housing stability is a key element of supportive housing, but the lack of other affordable housing options means that tenants who could transition to less intensive supports and wish to move elsewhere have nowhere to go. This lack of movement results in a bottleneck issue with waitlists growing faster than available units. Our case studies demonstrate ways to manage this bottleneck issue by either moving tenants or moving supports. Both approaches are innovative, but require greater affordable housing availability.</p>	<ul style="list-style-type: none"> <li>▪ Partner with other supportive housing service providers to identify potential tenants who require less supports and would like to move into lower support housing</li> <li>▪ Work with partners to provide information to tenants, coordinate moves, and create service plans</li> <li>▪ Provide flexible levels of support that can move between residents when they need them; this approach is similar to a case management approach, but with support workers who are also able to provide housing and tenancy support</li> </ul>
<p><b>Providing Quality Housing</b></p> <p>Tenants need housing that is safe, secure and well maintained. This can be a particular challenge for service providers working in partnerships with private landlords. With low vacancy rates in most regions across the province, it is challenging to find landlords that work with budgets in housing that is suitable.</p>	<ul style="list-style-type: none"> <li>▪ Conduct quality checks (bylaw and fire-code)</li> <li>▪ Follow tenant choice (as long as quality standards are met)</li> <li>▪ Communicate with landlords ahead of time about partnership and expectations</li> </ul>

## 2. Greater Standardization

Challenge	Provider Responses
<p><b>Alignment of Supports</b></p> <p>The service providers in our case study offer a wide range of support services with much variance between them. Although the providers noted that flexibility is important in their work in order to respond to the particular needs of the communities that they serve, this inconsistency can be a challenge for people navigating the supportive housing system.</p>	<ul style="list-style-type: none"> <li>■ Clear roles and job descriptions for support providers</li> <li>■ Utilize support work plans, models, and guidebooks to facilitate staff and resident service planning</li> </ul>
<p><b>Standard Assessments</b></p> <p>Each of our case studies have commendable outcomes in housing stability, and resident health and wellness. However, there is lack of consistency in how support needs and health outcomes are monitored. Without consistency between providers it is difficult to match clients to the specific services they need and to match the necessary resources.</p>	<ul style="list-style-type: none"> <li>■ Use of standardized assessment tools</li> <li>■ Conduct needs assessment to determine what supports residents need and what services they are already receiving</li> <li>■ Track outcomes related to housing stability, health and use of public services</li> </ul>

## 3. Better System Coordination

Challenge	Provider Responses
<p><b>Balancing Act Between Health and Housing</b></p> <p>Our case studies demonstrate the unique position of supportive housing to be both a health service and a housing program. It can be a challenge to deliver services housed in different ministries with different priorities (eg. stability vs flow).</p>	<ul style="list-style-type: none"> <li>■ Form partnerships between health and housing service providers to each work within their expertise</li> <li>■ Bring health services onsite to dedicated supportive housing sites</li> <li>■ Clearly define staffing roles whether for multiple positions, or support workers who do both support and housing</li> <li>■ Using a coordinated access system to simplify entry points for clients into services</li> </ul>
<p><b>Navigating Complicated Funding Streams</b></p> <p>Many of the supportive housing organizations in our case studies are supported through a patchwork of multiple, complicated funding streams. Many of the participants detailed complex funding arrangements such as having different units tied to different funding streams, each with different priority populations and reporting requirements. Creating consistency between funder requirements can result in inefficiencies.</p> <p>With greater system coordination and planning at a regional level, a more efficient supportive housing sector could exist.</p>	<ul style="list-style-type: none"> <li>■ Plan at a regional level to coordinate multiple funding streams to deliver funding as one cohesive system</li> <li>■ Many providers were able to synthesize the requirements of these funding streams to appear as one cohesive organization to the residents</li> </ul>

# Cambridge STEP Home Collaborative

Case Study # 1

## Promising Practice

- Using a three phase approach to transition homeless individuals into housing.
- Supporting tenants to maintain their housing following a five stage work plan to recover from homelessness.
- Partnership between the Region and four organizations with experience in outreach, housing and support.

## Background

The Region of Waterloo in collaboration with service providers have been taking a systematic approach to eliminating chronic homelessness. In 2007 the Region developed its All Roads Lead to Home homelessness and housing stability strategy that set the ground work for policy and action frameworks to reduce homelessness across Waterloo Region. Out of this strategy the first STEP Home (Support to End Persistent Homelessness) program was initiated that consisted of a group of services specifically to support people experiencing persistent homelessness. Most recently, the Region joined the 20 thousand homes campaign, a movement dedicating to ending homelessness in 20 communities across Canada. At this time, the Region conducted a point-in-time count of people experiencing homelessness across the region and used the SPDAT (Service Prioritization Decision Assistance Tool) to measure each person's chronicity of homelessness and the complexity of issues that may be affecting their housing

stability. This list formed the region's PATHS list (Priority Access to Housing Services). To house people from this list, expanding on the STEP Home program, the Region of Waterloo funded four organizations to collaborate and run a two-year pilot, with the goal of housing 50 individuals from that list who have the highest chronicity and acuity. The pilot design was strategic. It involved a systematic approach, to engage participants from the by-name list and transition them into housing. The plan also included a work plan for supporting tenants to recover from homelessness once they have moved in.

## Population Served

Anyone from the PATHS (Priority Access to Housing Services) list, a by-name list of people experiencing homelessness in Waterloo Region. Cambridge Pilot serves people from that list who have experienced chronic homelessness and who have the most complex co-occurring issues that impact housing stability often including mental health and addictions issues.



**Funding Model:**

- Funding is administered through the Region of Waterloo.
- The Region receives federal funding through the Homelessness Partnering Strategy (HPS) and from the province through the Community Homelessness Prevention Initiative (CHPI) and the Investment in Affordable Housing (IAH) Program.

**Cambridge Step Home Collaborative:**

- Argus Residence for Young People
- Cambridge Self Help Foodbank
- Cambridge Shelter Corporation
- Lutherwood (lead agency)



## Housing

### ***Using a 3 phase approach to transition homeless individuals into housing.***

Cambridge Step Home uses portable rent supplements to house people in units of their choice. Most of the units are with private landlords, although some are in non-profit housing. Tenants sign a lease directly with their landlord. Cambridge Step Home follows a three-phase approach to engage people experiencing homelessness, find them housing, and support them upon move in.

Below are the 3 phases to their housing first approach along with key learnings:

- **Phase 1 - eligibility, invite to service and document readiness.** Eligibility is first determined by identifying individuals with highest acuity and chronicity from the PATHS list. An outreach worker will contact that person, inform them about the program, and offer them housing and support services. If a person agrees to engage services, they sign a consent form and a service agreement. The outreach worker will then work with the participant to get “document ready” to find housing. Documents that are gathered include proof of income (outreach workers will assist participants in securing financial assistance if needed), identification, and ensuring that program documents are completed (full SPDAT, service agreement, consent forms). The participant and worker will also discuss the participant’s housing needs and preferences.
- Staff have not had difficulty finding participants who are named on the list and attribute this to the existing linkages many of the people on the list already had with local services. When individuals are added to the list, they are asked to provide their contact information including any services/workers that they are involved with.
- **Phase 2 - housing search, lease signing, move in.** Housing liaison workers connect with landlords in order to find housing for the tenants, balancing tenants’ needs and preferences with unit availability and landlords who are willing to participate in the program. When a unit becomes available, the housing liaison worker will take the participant for a viewing and to meet the landlord or property manager. If the participant accepts the unit and is approved by the landlord, they sign their lease and the housing liaison worker assists them through move in.
- With low vacancy rates across the region, finding landlords has been a challenge. To combat this, Cambridge Step Home utilized a landlord marketing strategy that included distributing posters and business cards in community spaces across the region (churches, businesses, community centres, etc). They also met with their regional apartment managers association, giving a presentation with information about the Step Home program and surveying landlords to ask what they would need to agree to participate in the program.
- Housing liaison workers complete a bylaw and fire code check of each unit and will not move someone in if there are infractions.
- For efficiency, when scheduling viewings they will bring two to three participants to view the unit at the same time.
- **Phase 3 - move in.** When a person physically moves into the unit, they transition to receive supports from a support coordinator who implements the 5 stages to recovery from homelessness work.

## Support

### ***Supporting tenants to maintain their housing following a 5 stage work plan to recover from homelessness.***

Once participants are moved into their housing unit they are connected with a support coordinator and a peer support worker. Support coordinators work with each participant to work through a guidebook consisting of 5 steps to recover from homelessness. The guide was developed by the Region of Waterloo in consultation with a housing-based case management consulting company. Peer support workers (PSWs) are available to help people become a part of the community, and accompany them to appointments. PSWs are also available to support other activities that come up while the participant is going through the workbook. Although tenants’ journey through these 5 stages vary, tenants typically take about 18 months to work through each of the stages and complete the associated activities.



Below are the 5 Stages of Recovery from Homelessness:

- 1. Housing** - In this stage support is focused around move in and basic needs. Support coordinators meet with tenants in their new homes, talk about what their role as support coordinators will be, and what responsibilities the participant has as a tenant. During this stage, the support coordinator will go over the lease agreement, complete a crisis plan, talk about budget, and complete a full SPDAT assessment.
- 2. Individualized Housing Support Coordinator Plan** - Once tenants are stable in their housing, the support coordinator and tenant will take an in-depth look at the SPDAT assessment and determine what areas to work on to support greater housing stability. Examples of areas to consider include self-care, mental health, social relationships, addictions, money management, legal issues, abuse and trauma etc.
- 3. Promoting Self Awareness** - In this stage, tenants and support coordinators work to implement the support plan by focusing on areas identified by the tenant as affecting their housing stability.
- 4. Recognizing Self-Management** - Tenants in this stage continue to work through their housing support coordination plans. This stage focuses on changing behaviours that may affect maintaining housing including self-control, accountability, and outlook about the future. In this stage, tenants complete a quality of life survey and make plans for their future.

**5. Reframing/Rebuilding** - This is the phase where participants have completed the activities in the workbook and focus on transition planning. Tenants in this stage may still be connected to ongoing supports such as a mental health nurse, ongoing case manager or other support person but will disconnect the housing stability services from the support coordinator.

## Partnerships

***Partnership between the Region and four organizations with experience in outreach, housing and support.***

The Cambridge Step Home pilot is a collaborative of four different organizations supervised by the administrative committee members of each organization in collaboration with the Region of Waterloo and the team lead of the project. The agencies came together as a collaborative in order to systematically bring together all of the organizations who were previously providing housing supplements individually. In this model, the four organizations each have staff who come together and work under one roof. Although overall this model has worked well some challenges have included inconsistencies with human resource matters such as vacation time, sick time, and performance appraisals as each organization came to the program with different policies in place. Upon evaluation of the one-year pilot and through a series of community consultations, the Region of Waterloo

decided to fund two separate frameworks across Waterloo Region to provide a continuation of the permanent program, with a clear division of responsibilities. One framework will provide the housing based outreach workers and housing liaison workers for phases 1 and 2 of the housing approach; the other framework will handle the phase 3 component, supporting the tenants to complete the 5 stages of recovery from homelessness to after move in.

The collaborative also works closely in partnership with the regional housing service manager who participates on planning tables for the project. The service manager and staff from each of the organizations involved in the collaborative come together to do knowledge sharing and guide direction of the project. These planning tables also provide opportunities to ensure that the work fits within larger housing planning frameworks from the region.

### Outcomes:

- 62 Individuals housed
- 11 People went back to homelessness. Of these 11, 8 were re-housed through the program.



## Replication and Advice

- The tools developed to engage tenants and transition them into housing, in addition to the 5 stages of recovery from homelessness workbook could be utilized by many other supportive housing service providers.
- Strong leadership is essential. Need to have someone to oversee the work who believes in its usefulness and its benefits for the entire system.
- Staff need to receive a housing first orientation to understand the underlying principles.
- Need a strong outreach team that understands how to work with a housing focus.
- Understand that this program has three key stakeholders: participants, landlords and the community. It is impossible to operate in a silo. The needs of the participants are the main priority but you must also consider the needs of landlords and the needs of the wider community.
- The program's role is to support participants to be responsible tenants and sometimes it also requires support for landlords to be responsible landlords.
- Have a repair fund if possible. Damages do happen and being able to fund the necessary repairs is key to maintaining positive relationships with landlords.
- Consider a landlord marketing strategy.

## Shared Resources

- Housing Support Coordination Document Check-List
- Housing Support Coordinator Guide (5 Stages of Recovery)

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# CMHA Lambton-Kent

## Case Study # 2

### Promising Practice

- Supporting tenants to transition from living in group homes to self-contained supportive housing units.
- Housing tenants with private landlords under a housing first model.

### Background

CMHA Lambton-Kent provides a range of mental health supports from crisis intervention, to ongoing case management, clinical services and mental health promotion activities. Their supportive housing program began in 2002 and adopted a housing first approach in 2013. As part of this change, CMHA Lambton-Kent transitioned 20 tenants from 3 group homes into self-contained private rental units. Today, CMHA Lambton-Kent houses over 200 residents in their permanent supportive housing program.

### Population Served

People who need affordable housing and supports to maintain their housing, particularly people with mental health and addiction issues.

### Housing

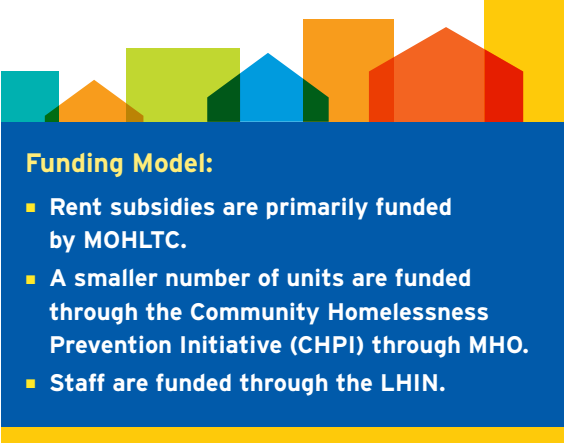
#### ***Housing tenants with private landlords under a housing first approach.***

CMHA Lambton-Kent's supportive housing program consists of portable rent supplements largely with private landlords. When a person enters the program they work with a Housing

Case Manager to find housing of their choice and are provided a rental subsidy and any supports that are needed to help that person maintain their housing. CMHA Lambton-Kent receives most of the funding for the housing portion of their program from the Ministry of Health & Long Term Care (MOHLTC). In addition, they receive some rent supplement funding through the Community Homelessness Prevention Initiative (CHPI) program. In both approaches, CMHA has a referral agreement with private landlords and the tenant holds the lease directly with the landlord. Through this approach, tenants are able to pick housing of their choice and are able to move the rent supplements with them across their life span as their housing needs change.

Below are key features from the housing model at CMHA Lambton-Kent:

- **Separate landlord and support function.** CMHA Lambton-Kent has found it to be beneficial to de-link support services from the landlord function. In their experience, having the roles separated removes power dynamics that may arise with one's case manager also being the landlord. In order to support positive



**Funding Model:**

- Rent subsidies are primarily funded by MOHLTC.
- A smaller number of units are funded through the Community Homelessness Prevention Initiative (CHPI) through MHO.
- Staff are funded through the LHIN.

tenant-landlord relationships, landlords have ongoing communication with the organization and are provided with a direct contact person within the organization.

- **View the landlord as a service partner.** Although the Housing Case Manager's ultimate role is to support the tenant, staff spend a considerable amount of their time working with landlords. In order to build relationships with landlords and continue to build a partnership to acquire more units in the future, CMHA Lambton-Kent staff make a point to respond to landlord concerns immediately and if possible in person.

■ **Identify clients from the waitlist with priority.**

CMHA Lambton-Kent manages an internal waitlist for their housing program. Priority is given to tenants with the highest housing need whose housing costs are in line with the amount of subsidy available. CMHA is piloting the SPDAT (Service Prioritization Decision Assistance Tool) in one of their programs to determine the complexity of presenting needs. CMHA Lambton-Kent also administers an intake form of their own design that asks clients about their housing and support needs. The organization found that administering their own form as a part of a longer process of building rapport gave a clearer indication of the types of supports a person needed after move in. (see shared resources).

■ **Determine Housing Quality Standards.**

Housing Case Managers work with tenants to find housing units of their choice but require the units to meet a baseline of standards determined by the organization. The tenant and worker use an apartment checklist when visiting a potential unit to identify any areas of concern. The checklist includes checking that the appliances work, that the unit is in good repair, that fire safety measures are in place, and that the utilities are affordable. (see shared resources).

■ **Over Housing Challenge.** Typically tenant subsidies cannot be applied to a unit with more bedrooms than are needed to house a tenant, even if that unit is within budget, because it is considered “over housing” by the Ministry. However, CMHA Lambton-Kent has been successful in getting permission to

apply subsidies to units with extra bedrooms if a tenant requires the additional space to accommodate a disability (eg. need a larger space to accommodate a wheelchair/scooter), and in smaller rural communities when a larger unit is all that is available.

## Support

### *Supporting tenants to transition from living in group homes to self-contained supportive housing units.*

In 2013 when CMHA Lambton-Kent adopted a housing first approach for their supportive housing, they decided to close the three group homes they were operating and transition twenty tenants into self-contained, supported independent units. It was determined that many of the residents in these group homes would be able to successfully live independently with the proper supports in place. Many of the tenants had been living in group homes for extended periods of time - some for as long as 30 years - and transitioning them into self-contained units was a long but ultimately successful process.

Below are key learnings from this process:

- **Get staff on board with the change.** Many staff had been working in the group homes with the same tenants for a long time. Some of the staff were skeptical of the change and did not believe that the tenants would be able to live independently. As an exercise, staff would meet and come up with a list of reasons they thought the tenant would not be able to live independently and then problem solve how that barrier could be remedied with supports.

For instance, if a person is unable to cook they could be set up with meal delivery; if a person is unable to manage their money, staff could work with them to plan their finances or if necessary, they could be set them up on public trustee. Through this exercise staff were able to problem solve and shift their thinking around tenants being able to live independently.

- **Have a clear consistent message from all staff.** It is important to communicate the changes to tenants as a positive change. Emphasizing new benefits that tenants can get from independent living, like more privacy and freedom can help ease transition.
- **Consider nuances of tenant personalities and feelings when approaching them with the change.** Each tenant will have concerns and reactions that are unique to them. It is important to meet with each tenant and address the concerns they have, and explain to them in a personal way how the change may benefit them. Many of the tenants were excited that they would have more control over their finances, instead of paying room and board with a small personal needs allowance, and would now have more discretion on how to spend their finances after paying rent. CMHA staff found that talking to people about their specific interests helped get buy-in from the tenants. For example, if a tenant is interested in painting you can explain that they will have more choice on how much to spend on art supplies; if someone is into physical activity they can now budget to buy a pass to the YMCA.

- **Work with each tenant to find housing of their choice.** Staff spoke to each tenant about their housing needs and tried to find housing that met each person's individual preferences. Most of the tenants had lived in the group homes for a long period of time and viewed their co-tenants as family and wanted to remain in close proximity. CMHA Lambton-Kent were able to find a landlord that had multiple units in the same building and were able to move tenants who wanted to remain close into self-contained units in the same apartment complex.
- **Need flexibility from regular funding policies.** In order to ease the transition, it is important to have some wiggle room with budgets. This could be spending a bit more on a rent supplement to get the person into an ideal unit, or covering moving costs.
- **Start with intensive supports and scale back when appropriate.** When tenants first moved into self-contained units housing case managers met with them very regularly. The first tasks were to link them with a primary care doctor, a psychiatrist, public trustee (if needed), social activities, and turning their apartment into a home with furnishings. Each tenant is connected to a housing case manager. These workers do case management, housing advocacy, assistance with activities of daily living, and apartment checks. Over time, it was found that in most cases, the levels of supports needed became less and less.

- **Monitor outcomes.** After transitioning the tenants, CMHA Lambton-Kent monitored how each tenant was doing and found that there were many positive outcomes. Many of the tenants had reunited with family members, and were seeking out activities that they had never engaged in before.

## Partnerships

The Supportive Housing program at CMHA Lambton-Kent functions with a variety of partners. The main partnership is with the private landlords. The local communities in Lambton-Kent are small enough that landlords often speak to each other. It is important to maintain a positive reputation in order to keep housing options for your tenants. One way CMHA Lambton-Kent builds this reputation is by making it a point to respond to landlords very quickly when there is an issue. If a landlord calls with an issue, staff make sure to respond to that landlord immediately and, if possible, attend to the matter in person the same day.

CMHA Lambton-Kent also has partnerships with the local homelessness shelter. Staff go to the shelter twice a week and talk to the people living in the shelter about their housing needs and assist them to find housing where possible, or add them to the waitlist for the supportive housing program. Similarly, CMHA has a partnership with the local hospital to participate in discharge planning on the psychiatric unit, including working with people on their housing needs.

## Outcomes

CMHA Lambton-Kent describes their success as being with each individual client. When someone is able to maintain their housing and have supports in place to support them with their mental health that is a success. Incremental successes include things like hearing from tenants that they are now a member of the YMCA, that they got a job, or that they are in school and that they attribute this to having housing and supports or that they feel safe and happy in their home. In addition to hearing from tenants about their successes, the organization does track data outcomes including length of tenancy, and use of emergency services. In the CHPI funded program, the first reporting cycle of 8 months, there was an 80% reduction in ER visits across their entire supportive housing program.

## Replication and Advice

- All staff from leadership to frontline case managers have to be on board with the changes of transitioning tenants out of group homes into self-contained units.
- The housing first approach is very adaptive but it is important to keep key elements such as tenant choice with portable rent supplements, scattered units, and delinking support from housing.
- When transitioning tenants you must be able to work creatively and have flexibility with the budget to do so.
- Respond to individual tenants concerns and try to match each tenant to the best possible housing for their particular needs.

## Shared Resources

- CMHA Housing Intake
- Apartment checklist
- Role of Housing Case Manager

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# Family Services Windsor-Essex - Housing First Program

Case Study # 3

## Promising Practice

- Working through a by-name list of homeless individuals using a housing first approach, conducting outreach to initiate contact with services.
- Using a trauma informed approach to providing support.
- Partnership between experienced support agencies, housing outreach services and the municipal housing corporation.

## Background

Family Services are multi service organizations in Ontario communities, whose core service is counselling. Each local Family Services agency provides programming geared to needs in their community. In addition to counselling, Family Services Windsor-Essex (FSWE) provides a number of clinical and practical programs for low income people with mental health and addiction issues. Because of the array of services available and their clinical expertise, FSWE was selected to be a community lead agency for a program to address local homelessness through a housing first approach. The City of Windsor administers federal and provincial funds aimed specifically at reducing homelessness. When initiating the Housing First program 3 years ago, the City approached FSWE to lead a program, along with 3 other community organization partners.

They work through a by-name list of people experiencing homelessness in Windsor-Essex to engage those individuals, move them into housing and provide necessary supports to keep them housed. The goal of the program was to house 50 unique individuals off of this list; to date FSWE and their partners have exceeded this goal and have successfully housed over 200 individuals in 3 years.

## Population Served

To be eligible for this program, a person must be on the by-name list of people experiencing homelessness, must have experienced a chronic period of homelessness (at least 6 months of the past 12 months) and have mental health and addiction concerns. The by-name list was developed by the City of Windsor during a point in time count and can be continuously updated as new people are engaged.



**Funding Model:**

- Supports are funded through the Community Homelessness Prevention Initiative (CHPI) from the Ministry of Housing and the City.
- Landlord Developers are funded by the Homelessness Partnering Strategy (HPS) Federal Funding.
- Rent Supplements are funded through the Investments in Affordable Housing (IAH) Program.

## Housing

*Working through a by-name list of homeless individuals using a housing first approach, conducting outreach to initiate contact with services.*

The housing first program at FSWE operates through a portable rent supplement model, with the rent supplements paid wherever the tenant



chooses to live. In order to find the housing, the program staff includes 2 “landlord developers” who look for available units with landlords willing to work with the program. Landlord developers look for buildings that fit with criteria given to them by intensive support team staff to match units with the specific needs of the future tenant. In order to appeal to landlords, landlord developers let them know that support workers will meet with tenants at least once a week and they guarantee that rent will be paid on time (tenants are often on pay direct or voluntary trusteeship and the rent subsidy portion comes directly from program partner Housing Information Services). The program also has a landlord repair fund that can cover any potential damages that are the fault of the tenant.

FSWE recognized that it takes a highly motivated individual to walk through the doors of support organizations to get the help that they need. In order to engage with the most vulnerable population experiencing homelessness in Windsor, FSWE developed an extensive outreach program to add people to the by-name list, and engage tenants to participate in services including the housing first program.

Below are key learnings from the outreach program:

- **Determine where to look.** In Windsor, like many small to mid-sized cities, the homeless population is not large and visible. In order to engage with homeless individuals who may not be as visible in public spaces, the outreach

worker actively seeks out homeless people by exploring areas where people may sleep outside. It is also useful to visit organizations serving homeless individuals such as shelters and food programs. The outreach worker at FSWE found it useful to connect with tenants at the local mission during their community kitchen program.

- **Carry supplies to distribute.** Some basic items for outreach workers to carry with them include food, water, gift cards and a naloxone kit. Get to know individuals you are approaching and ask them what their needs are and bring those items with you for future interactions.
- **Repeatedly approach.** Developing a relationship with someone who has been disconnected from services for an extended period of time can be a long process. Expect engagement to take time and continuously approach individuals to build a rapport. At FSWE, there were people they had to approach over 10 times before engaging them in services.
- **Coordinate with other outreach services.** Many times there are other outreach services working the same path attempting to engage people for different services. To make outreach across the region more efficient, FSWE has organized an outreach table for outreach workers to come together with the goal of covering the city and connecting individuals to the services they need in a coordinated way. For instance, at this table, the addictions outreach workers who are distributing harm

reduction kits said that the number one service need they hear from the people they connect with is housing. This provided an opportunity for housing and addictions workers to discuss ways to coordinate their activities and more readily connect people with services.

## Support

### *Using a trauma informed approach to providing support.*

Family Services Windsor-Essex recognizes the prevalence of trauma amongst the people they serve throughout their organization and practice within a trauma informed approach. FSWE also uses Maslow’s hierarchy of needs to determine what supports someone may need urgently before engaging in mental health services. When a person comes to FSWE for counselling or any other services they are first assessed to ensure that their basic needs are being met - including housing. Although it isn’t often that someone will walk into the Family Services office and not have somewhere to live, many present with substandard housing, precarious housing, in rent arrears, or lacking basic utilities. FSWE implemented a housing first approach throughout all services and will first work with the tenants to make sure their basic needs are being met before attempting mental health interventions. Once in housing, each tenant is assigned an Intensive Support Team (IST) staff who visits with them at least weekly. ISTs are hired by Family Services Windsor-Essex and work with 15 people at a time.

### Trauma Informed Care:

- Recognize the prevalence of trauma people have experienced.
- Ensure emotional and physical safety. Provide a safe and welcoming space. Use screening tools to assess basic needs.
- Foster trust. Have clear and consistent policies. When you make a promise to do something - do it.
- Choice. Ask the person receiving service about their needs, goals and wishes and make them a priority when providing a service or finding them housing.

Below are some key features of providing trauma informed support services to housing first tenants:

- **Once in housing - focus on housing.** At the beginning of a tenancy, focus first on furnishing the unit, working on practical skills such as cleaning and educating the resident about responsibilities of being a good tenant.
  - Furnishing the unit - During their first year, FSWE would provide furnishings for each tenant but found that many of the items were getting very damaged or were being traded/sold. They soon realized that this was happening because the tenants did not feel ownership for these items. ISTs began shopping for furnishings with the tenant for these items and found that damages and loss was drastically reduced. ISTs and tenants will shop together working within a set budget and with a basic household items check list.

- **Improve tenant income.** Individuals who have been disconnected from services are often not receiving all of the benefits they are entitled to. Many of the tenants can have a quick improvement to their income by being connected to social assistance programs or navigated to appropriate supports such as moving to ODSP from OW.
- **Connect tenants to their neighbourhood.** Once tenants are becoming settled into their units, begin to introduce tenants to amenities in their neighbourhood. ISTs will walk around with the tenants showing them where the grocery store is, library, and any other community program they may be interested in.
- **Start goal setting.** Tenant choice needs to be a key feature of any housing first program from the beginning when finding a housing unit through to support services. ISTs at FSWE work with service users to establish their own goals which are adapted over time. At the beginning these goals may be small and practical - related to upkeep of the unit, self-care etc. - and adapt over time.
- **Primary care and mental health care.** After the first year or so in which the focus is on practical skills, ISTs will work with tenants to connect them to primary health care and mental health care. FSWE has found primary care doctors to be a valuable tool as a first step to mental health and addictions services. Primary care doctors may build a rapport with their patient and then identify areas that are outside of their scope and refer them to psychiatrists and addictions services.

- **Understand that changes take time.** Service providers need to recognize that change takes time. At the beginning of the program, ISTs would sometimes experience frustration that their scope of support with the person had been focused on practical skills and harm reduction and not seeing concrete change related to mental health or addictions issues. It wasn't until after the first year of the program that one of the residents approached a worker saying they would like to work towards getting a handle on their addiction.

### Partnerships

***Partnership between experienced support agencies, housing outreach services and the municipal housing corporation.***

The housing first program at Family Services is a partnership between 4 organizations with FSWE as the lead. The other three organizations are Housing Information Services (HIS) - a non-profit who helps people look for housing, Access County Community Support Services (ACCESS) - a multi service organization who works in the smaller communities in Essex County, and Can-Am Indian Friendship Centre (CAIFC) - a multi-service organization serving Aboriginal peoples within the areas of Windsor Essex County. FSWE oversees the housing first program and employs the ISTs, outreach worker, social worker and manager. Outside of this main partnership, FSWE has other partnerships including the outreach table consisting of outreach workers from across the region and case conferences every two weeks with CMHA to profile support issues back and forth without using people's names. FSWE also does quite a bit of direct work with municipal staff administering housing and homelessness

programs, who visit the office regularly, coordinate their homelessness point in time count, and sit on the homelessness coalition table. The latter is a coalition of community organizations working together to end homelessness in Essex county.

## Outcomes

- Main outcome is that people stay housed. This is the program’s primary determinant of success.
- ISTs take case notes that are then synthesized by a data analyst to demonstrate outcomes.
- Use a HERIN workbook.
  - When search began, when person was placed, 6 month, 12 month, 24 month milestones
  - Reasons for exiting the program: returned to homeless, successful exit, other exit

**Outcomes:**  
**203 individuals housed**

- 38 had a positive change in income (22 OW, 16 ODSP)
- 100 positive change in social well-being (can be counted in multiple categories below)
  - Employment 35
  - Training and education 36
  - Volunteer work 21
  - Social participation 64
  - Recreational or cultural activities 47



## Replication and Advice

- Create a healthy tension between landlord developers and support workers. Landlord developers work closely with landlords and are able to view issues from their perspective, while ISTs work closely with participants and are well positioned to advocate for their needs. Having staff able to speak from both perspectives has been invaluable for the collaborative when problem solving.
- Municipal housing providers can be quite receptive to housing tenants through such a program, but you must work within the waitlists they are managing.
- Need to establish buy-in from the community that housing is a basic right, harm reduction is a valuable approach that saves lives, and services need to be delivered in a trauma informed way.
- Be prepared for successes and setbacks along the way. Successfully housing and supporting peoples does not happen in a linear process.
- Focus on main outcome goal of keeping people housed.
- Foster trust with the tenant. Use clear and consistent policies and follow through on tasks that you have committed to.

## Shared Resources

- HERIN Workbook
- Unit Viewing Protocol
- Outreach Protocol
- Move in Protocol

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# Homes First Society - Strachan House

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## Case Study # 4

### Promising Practice

- Creating a community within a community in a changing neighbourhood.
- Practicing “assertive tolerance” to accommodate and support individuals with complex needs.

### Background

Homes First was a 1980s pioneer of permanent housing for people experiencing chronic homelessness in Toronto. It provides supportive housing and emergency shelter across the city of Toronto. Strachan Housing opened in 1998, replacing the former StreetCity project. It provides transitional and supportive housing, using a low-barrier approach and “assertive tolerance” principles, for people who have experienced chronic homelessness. Strachan House provides supportive housing to those with mental health and addictions issues but is distinct in the way the supports provided are municipally funded.

### Population Served

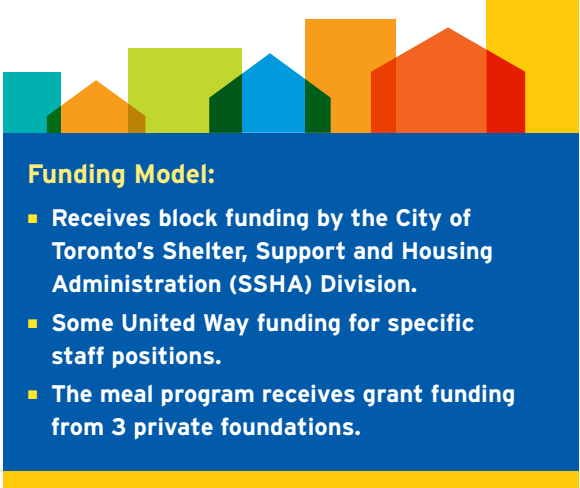
Single men and women 21 years and older who are chronically homeless and are considered “hardest to house” with severe mental health

issues, addictions, behavioural and cognitive issues, cognitive disabilities, physical disabilities and people are experiencing issues related to aging. The population has histories of chronic homelessness and has always had difficulty securing and maintaining housing.

### Housing

***Creating a community within a community in a changing neighbourhood.***

Strachan House is a 3 level former textile warehouse owned by the City of Toronto and operated by Homes First. It has 83 housing units for long term tenants and 5 emergency shelter beds. Strachan House has maintained many of the design elements from the original StreetCity program to function very similarly as a community/neighbourhood within a dedicated building.



**Funding Model:**

- Receives block funding by the City of Toronto’s Shelter, Support and Housing Administration (SSHA) Division.
- Some United Way funding for specific staff positions.
- The meal program receives grant funding from 3 private foundations.

Below are key features of the Strachan House building that allow it to function as a community within a community:

- **Building is broken up into smaller ‘neighbourhoods’.** Strachan House consists of 11 areas each named after a letter (A through L). Each area or neighbourhood consist of 5-8 units, a shared kitchen area and a shared washroom. This design allows space for micro communities within a large residential building.



- **Individual units are private spaces.** Tenants are protected by the Residential Tenancies Act (RTA) and are able to do what they choose in their individual units, including keeping pets and having guests. Staff must also follow legal procedures to enter the unit including giving proper notice, providing tenants with greater privacy despite sharing other elements of their housing.
- **Common space use Guidelines.** Although the common areas located outside of the units they are considered shelter space. Residents participate in decision making on how that space functions including how to decorate the common areas. There are also guidelines that residents helped to develop against substance-use in common spaces. Having residents participate in these types of processes allows for a feeling of ownership and feels less top-down.

In addition to being a community within the dedicated building site, Strachan House is also part of the external community of Liberty

Village. The neighbourhood around Strachan House is rapidly changing with the development of condominiums thus bringing an increase in middle-class young adults. Strachan House views themselves as an important part of the neighbourhood, serving the most marginalized people who are a part of the community. Strachan House decided to be proactive in responding to the community changes and built relationships with their new neighbours and businesses while providing information and education about their services.

Below are key ways to get community buy-in in a neighbourhood that is rapidly changing:

- **Attend neighbourhood meetings.** When a new condominium opened up directly across the street from Strachan House, some of the new residents responded to Strachan House tenants with fear. Staff at Strachan House asked to attend their condo meetings including their condo board meeting to introduce themselves and provide education on the tenants they are serving and what types of services they provide. Strachan House explained that the tenants they serve are already members of their community, and that Strachan House is there to support them with their range of complex issues. The majority of neighbours who participated in these discussions became supporters after learning about the program.
- **Speak with nearby businesses.** Similar to the condo meetings, Strachan House staff introduced themselves to businesses opening up in the area and explained who their tenants are and the work that they do. Many of the businesses support the program and have

utilized the supports of Strachan House staff to intervene if they are having a challenge with any tenant in the community. In situations where potential conflicts arise, local businesses are able to connect with a support worker from Strachan House to de-escalate the situation rather than involving police. This has led to fewer conflicts while also helping to reduce the stigma tenants face and create bonds and working relationships with the local community.

## Support

***Practicing “assertive tolerance” to accommodate and support individuals with complex needs.***

Strachan House provides 24/7 on site supports from Community Support Workers. Supports available for tenants include a life skills program that assists tenants with activities of daily living, improving financial literacy, and educating tenants about tenant obligations. They also have a hoarding and housekeeping specialist position that engages intensive case management with tenants around pest control, hoarding and hygiene. Strachan House considers themselves to be “no barrier housing” because residents are able to choose how much or little they want to engage with supports available and tenants are able to maintain their housing so long as they are not causing harm to themselves or others. Strachan House refers to this as “assertive tolerance”, where they do whatever it takes to accommodate and support individuals with complex needs with very minimal requirements for service engagement or change in behaviour.



Below are some key features of their “assertive tolerance” support approach:

- **Follow a harm reduction approach.** Strachan House received funding from the Toronto Urban Health fund to establish their own internal harm reduction-within-housing framework. In this framework, harm reduction principles are applied to all aspects of a person’s health and behaviours. When following up on a problematic behaviour associated with substance-use, staff focus on the harms associated with that behaviour and how they can be reduced instead of focusing on how to get that tenant to stop using.
- **Use staff meetings as a place to debrief around troubling behaviour.** Staff at Strachan House frequently engage with residents who have problematic behaviour. In staff interviews, it is explained to potential candidates that it is not unusual for staff at Strachan House to experience occasional verbal abuse and high conflict situations. Staff regularly discuss residents’ behaviour in their team meetings as a way to problem solve discerning behaviour. When a tenant has prolonged problematic behavior and the issue of possible eviction arises, staff will talk through where that tenant would go if they were to be evicted and remind themselves that they are often the last stable housing option for people with complex needs. Having the opportunity to debrief with colleagues and discuss client behaviors and needs brings perspective to front-line staff about the importance of the work that they do.
- **Use landlord function as a strategy to engage with tenants when necessary.** If a tenant’s behaviour is disruptive to other residents or

staff and they will not engage with support services, Strachan House staff will work to demonstrate to tenants from a ‘landlord’ perspective what harms are being done by their behaviour and what real consequences may follow if it continues. Drawing up agreements helps tenants to actualize the severity of the situation. If problematic behaviour still continues to exist, Strachan House staff will submit a mediated agreement through the Landlord and Tenant Board, which will detail steps the tenant agrees to take to change the problematic behaviour.

## Partnerships

Strachan House directly partners with the Parkdale Queen West Community Health Centre to provide on-site medical supports. Parkdale Queen West Community Health Centre serves low income individuals and communities who are at risk and/or face barriers accessing health services. Physicians from this health centre work on a rotating schedule to provide medical services on site to the tenants at Strachan House. This service has been a necessary component to the success of the Strachan House program as many of the tenants face barriers accessing health services and will not go to appointments off site.

Strachan House also works closely with other service providers, particularly with referring organizations who continue providing services to tenants after they move in. The majority of referrals to Strachan House come from CAMH, St Joseph’s Health Centre - Mental Health and Addictions Division, City of Toronto Streets to Homes and ACT teams. Formal partnerships

have been formed with CAMH and the Streets to Homes Program.

- CAMH: Under an MOU, CAMH can provide direct referrals to Strachan House, and remain connected to these individuals to provide additional supports they may need. 14 clients are currently supported in this partnership.
- Streets to Homes: *Streets to Homes and Hostels to Homes* are City-run programs (with federal, provincial and City funding) that help move chronic homeless people into shelters and into permanent housing. Through the Hostels to Homes project, City staff identify clients who bring the most challenges to service provision and connect them to housing through Strachan House. In this partnership, staff help tenants move from this program into the emergency shelter portion of Strachan House, with the goal of transitioning them eventually into a permanent housing unit. To date, 9 people have come through this program and been placed in permanent housing.



*Many of these individuals have had bad experiences dealing with outside institutions, doctors, hospitals... they just won’t go. So even minor issues become major issues. So now they have been able to build relationships with doctors that come on site, get bloodwork, wound care, managing diabetes things like that.”*

Homes First Housing and Shelters Manager

## Replication and Advice

- Provide as many supports on site as you can. This population faces barriers to accessing programs off site.
- Use a harm reduction model to guide work with tenants beyond substance use.
- Be proactive and engage with the external community.
- Need to have staff who are capable of dealing with residents with complex issues. Need to hire intensive case managers. If possible, bring in a medical component including Personal Support Workers and Nurses.
- If designing a new build - use strong materials. The building may take a lot of abuse and need to withstand high traffic.
- Have a community space where everyone can get together. Particularly a communal dining area.
- If possible, give each tenant their own washroom and kitchen.

## Outcomes

For Strachan House, the most important outcome is that tenants remain stably housed, and in this goal, the project has been successful. Homes First has recently started increasing documentation of staff interactions with clients in upgraded case management software. This will yield more specific information on performance and impact of services so that they may work continually to improve the program.



*Sometimes people want this conveyer belt of success - this person is really bad then they're going to go through the program and be really good. Our successes are measured really differently here. It is more this person is really struggling and may not have had a home in 10, 15, 20 years...may have been in hospital for 2 years...may be jail for 4 years... may be living under a bridge...and now they have a home, they feel safe, they have good, they have access to primary care, those are our successes."*

Homes First Housing and Shelters Manager

### Outcomes 2016:

- 96% of tenants remained stably housed at Strachan House.
- 96,360 nutritious meals were served.
- 9 people from City of Toronto Streets to Homes partnership were successfully transitioned to permanent housing at Strachan House.



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# Hong Fook Mental Health Association

## Case Study #5

### Promising Practice

- Providing culturally competent services to East and Southeast Asian communities across the GTA.
- Assisting clients to find housing of their choice in their communities of choice by building partnerships with non-profit housing providers and private landlords.
- Providing culturally responsive ongoing support.

### Background

Hong Fook is a multi-service mental health organization serving East and Southeast Asian communities in Greater Toronto, through clinical mental health services, self-help, family initiatives, prevention and promotion, youth services and training. Hong Fook started their supportive housing program in 2001 and today houses 60 families, with 103 people.

Today Hong Fook serves a variety of different ethnic communities including Chinese (Mandarin and Cantonese speaking), Vietnamese, Cambodian and Korean communities.


### Population Served

People aged 16 and over who have mental health issues and linguistic and cultural barriers in accessing other mental health services. To qualify for the supportive housing program you must also be homeless or at risk of homelessness.

### Housing

*Assisting clients to find housing of their choice in their communities of choice.*

Hong Fook adopts different models in its Housing Program. One of the models used is a head lease model, where Hong Fook partners with private landlords to run 60 units. In this model, Hong Fook is the lease holder and pays rent directly to the landlord and the tenants pay their portion of the rent to Hong Fook. The head lease model with scattered units across the city works well for Hong Fook and their tenants because it gives flexibility for tenants to find apartments of their choice in neighbourhoods of their choice, an important feature for Hong Fook's culture specific services. Hong Fook shared some of the challenges and successes from this housing model as well as key features related to providing culturally specific supportive housing.



**Funding Model:**

- RMOHLTC provides funding for the housing subsidy. Hong Fook can apply the subsidies to units as they see fit - as long as they house a minimum number of tenants set by the Ministry.
- Case management is funded through the Central East LHIN.
- Recently awarded funding for an additional 8 units from the City of Toronto through the Housing Allowances to Maintain Successful Tenancies program.

Below are key learnings from their housing model:

- **Build a relationship with landlords.** At the beginning, Hong Fook experienced discrimination from private landlords when they told them they were a mental health agency.

Hong Fook provided detailed information and explained the kind of supports provided to their clients when they approached the private landlords. Many landlords, who were previously in an agreement to rent a unit, would suddenly say the unit became unavailable. Hong Fook addressed their stigmas by providing education on mental health. They provided information about what is involved and what benefits there are to the landlord. Although they make a point to say that they cannot promise behaviour of the tenant, they do promise rent and that tenants will receive ongoing supports. Hong Fook also encourages tenants to build their own relationship with their landlord, by working with them as partners to address housing issues. One way that Hong Fook has facilitated this is through the creation of their *Communication Booklet for Tenant and Superintendent/Landlord* – a resource with pictures and phrases in 5 languages to assist tenants to communicate with landlords who do not speak the same language about maintenance concerns (see shared resources).

- **Prioritize tenant choice and autonomy.** Housing workers are assigned to clients based on their ability to speak the same language and their understanding of the culture. When assisting a tenant to find a rental unit, housing workers discuss what their needs are in terms of location and community amenities. Through their familiarity with the tenants' cultures and culturally specific neighbourhoods across the city, housing

workers and tenants are able to find suitable rentals that meet their needs- including proximity to family, grocery stores, places of worship and other community resources.

- **Be creative and evaluate risk when using rent subsidies.** Rather than being assigned a maximum subsidy per tenant, Hong Fook is given a total dollar amount from the MOHLTC and a minimum number of tenants that it must house. Under this model, Hong Fook is able to work creatively to apply different subsidy amounts responding to each situation. In this way Hong Fook has been able to house a greater number of tenants than the minimum set by the Ministry.

- **Successes:**

- 35% of Hong Fook's clients are families which is much higher than other supportive housing agencies. By housing families together, overall housing costs are cheaper than people living on their own in separate units.
- Moving tenants into non-profit municipal housing when possible. If a tenant moves into RGI housing, Hong Fook will continue to provide the supports to that client and transfer the rent supplement to a new tenant requiring culturally specific supportive housing.

- **Challenges:**

- Market rents go up every year. It is especially challenging when landlords are approved to raise rent above the

Rent Increase Guideline when they have done repairs or renovations. Hong Fook mitigates this risk by budgeting for rent increases beyond the standard amount each year.

- Tenants who have needed a lower subsidy for a unit may have to work with less if they wish to move in the future. Whether there is additional subsidy available for tenants to move may change from year to year. If a tenant wants to move Hong Fook will let the tenant know what their rent subsidy budget is and try to work with the tenant to find a new unit, however the portability of the rent supplement is a challenge when working with the reduced amount.

- **Use head lease model to maintain lease terms.** Hong Fook signs the lease agreement with each landlord, and each tenant signs a separate sublease with Hong Fook. Although the headlease involves some financial liability for the agency, the benefit is that they can hold onto the lease with the same rent and same terms when tenants move in and out. The challenge in this model is that it gives tenants somewhat less choice of rental units, and the agency has to move quickly to find a new tenant for a vacant unit. Hong Fook has managed to avoid such issues, in part because units where they hold leases are often in desirable neighbourhoods for the communities they serve.

## Support

### *Providing culturally responsive ongoing support.*

Each tenant at Hong Fook is connected to a case manager. Case managers are assigned to tenants who share the same culture and speak the same language. Hong Fook specializes in culturally specific support from their case managers, community events and mutual support building.

Below are some of the key learnings from Hong Fook on providing culturally responsive support:

- **Assign clients to case managers from outside of the housing program.** In cultural specific supportive housing programs there are a lot of factors to consider when assigning clients to staff. Matching staff to clients who share the same culture and speak the same language is the top priority at Hong Fook. Other factors to consider include geographic distance between clients and allowing room for change in who is working together. With all of these factors at play, Hong Fook has found success in assigning case managers 1-2 tenants from the supportive housing program and the rest from their general case management services. This approach allows Hong Fook to match clients to workers from the same culture, limits travel time for home visits and allows flexibility for who staff are working with and for how long.
- **Family reunification.** For many of the clients at Hong Fook, family relationships are an important part of their well-being and recovery. Hong Fook understands this

and assists tenants to connect with family members where relationships may have broken down. Some of the tenants have left the supportive housing program after they have reconnected with their families.

- **Facilitate mutual supports between clients.** Hong Fook lays the groundwork for clients to connect with one another through events and informally introducing tenants to each other. One way they do this is through neighbourhood support groups. Tenants who live in the same neighbourhood come together for facilitated group sessions where many of them also make personal connections with neighbours from the same cultural background who are also clients of Hong Fook.
- **Tenants remain connected to a case manager throughout their tenancy.** Hong Fook tenants are always connected to a case manager. Although intensity of supports may change over time, each tenant will always have a point person who they are connected to. This works for Hong Fook because they are able to provide flexible supports but tenants always know who to contact within the organization and Hong Fook is able to quickly respond.

## Partnerships

Hong Fook functions with a variety of partnerships including with landlords, primary care and other service providers. A distinctive partnership that they have is with family members of their tenants. Hong Fook

understands the importance of family in many Asian cultures and to many of the clients that they serve. Upon intake, if clients identify that they would like Hong Fook to include their family members in the services they receive, they sign a consent form allowing Hong Fook staff to be in contact with their family. The work Hong Fook does with families includes case management, education about mental illness and mental health promotion, as well as informal dispute resolution and family reunification.

## Replication and Advice

- Assess risk when deciding how many units to take on. Costs change year to year.
- When working under a head lease model, find landlords who are compatible with the organization's approach to housing. Some landlords have refused to communicate with the tenants because the lease agreement is with the organization, not the client. Hong Fook will avoid entering into agreements with landlords who do not share the same value of tenant autonomy.
- Use head lease agreements to hold on to lease terms for multiple years.
- Provide supports at the right time and place. For those who are not suitable for the housing program, provide case management and assist them to find the appropriate referral.
- Provide flexible support - always connected but pull back and step in as needed.

## Outcomes

Hong Fook uses a variety of methods for tracking the outcomes of their supportive housing program including tenant satisfaction, whether clients are reaching their desired goals and through data indicators provided to the LHINs annually.

In order to track tenant satisfaction, Hong Fook uses the Ontario Perception of Care (OPOC) tool which examines the client's experiences related to their expectations of service. OCANs (Ontario Common Assessment of Need) are used to service plan with the clients and track progress overtime. Hong Fook also has a list of data indicators that they provide to the LHINs related to housing stability, such as the use of hospital beds, emergency room visits and development of Coordinated Care Plan.

## Shared Resources

- Communication Booklet

### Contact:

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### Outcomes from OPOC:

- 85% of tenants agreed with the statement "The services I have received have helped me deal more effectively with my life's challenges"
- 86% of tenants agreed with "I think the services provided here are of high quality"



# Houselink Steps to Support

Case Study #

# 6

## Promising Practice

- Determining resident needs and getting the right services for the people you support.
- Supporting tenants with mental health and addictions issues in municipal housing using a supportive housing model and a partnership.

## Background

Houselink is a supportive housing provider with a 40 year history of providing permanent, affordable and supportive housing to people with mental health and addiction issues. In 2013 they partnered with Toronto Community Housing (TCH) to provide on-site supports to tenants in 2 TCH buildings that were identified as having many tenants with complex health problems including mental health and addictions issues. The context included rising needs in several TCH buildings, and more TCH-LHIN collaboration to help meet such needs. This particular partnership formed the “Steps to Support” program.

## Population Served

Steps to Support offers voluntary supports to tenants in two TCH buildings who self-identify as having mental health and addiction issues.

## Housing

Toronto Community Housing (TCH) is the landlord and responsible for the safety and maintenance of the building. The buildings house tenants in rent geared to income units who have come through the general Housing Connections waitlist and are protected by the Residential Tenancies Act. Rising numbers of applicants and tenants have significant support needs, often undiagnosed. As TCH carries out its normal property management and tenant services functions, its staff are able to identify tenants who may need further support. They can connect them to the Steps staff, who can in turn provide supports to those tenants around issues that may affect their housing. For example, if a tenant is having issues with clutter/hoarding or rent arrears, TCH can encourage the tenant to connect with Steps staff to work with them on these issues.

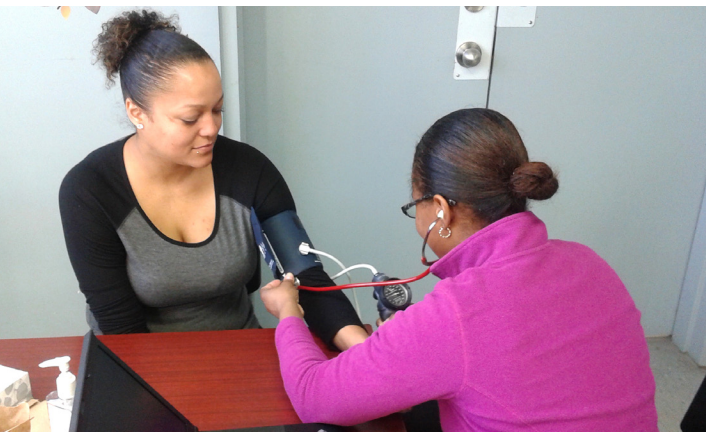


## Support

***Determining resident needs and getting the right services for the people you support.***

The Steps program consists of 5 Mental Health Supported Housing Workers, 1 Recovery Worker and 1 Coordinator, with capacity to support about 100 people. The main purpose of this program is to support TCH tenants to maintain successful tenancies despite all of the limitations and barriers they may experience. The main supports provided are eviction prevention services, informal counseling, referral services, recreation and community development.





In order to determine support needs of tenants in the two buildings Houselink conducted a needs assessment in partnership with Fred Victor, a non-profit also providing supports in the buildings, and the Centre for Urban Health Solutions a research centre with a focus on improving health in cities, particularly for those experiencing marginalization. Conducting needs assessments identifies what services your tenants are already utilizing and where the service gaps are. In addition, the process of administering the needs assessment works as a community engagement tool.

Below are some key learnings from the Steps needs assessment:

- Assess roles needed to complete and project and whether partnerships are necessary.** Houselink was working with Fred Victor (another support provider) to support tenants in partnership with TCH. They utilized in house staff to coordinate the project, hired peer interviewers, and partnered with the Centre for Urban Health Solutions to collaborate on designing the research instrument, data analysis and final write up.

#### Steps to Conducting a Needs Assessment:

- Determine work roles and develop partnerships if needed
- Design a research instrument
- Recruit participants
- Interview service users
- Analyze data
- Write up findings
- Use findings for service planning

- Design the research instrument.** Determine what areas of service your tenants may require or may be already accessing. For Steps, the partners collaborated to develop a tenant questionnaire with 8 domains of service needs. The questionnaire was based on the Ontario Common Assessment of Need (OCAN) tool, so that findings could be related back to other agency data, but was modified to include questions about tenant capacity, service needs, services already utilized, to further guide development of the Steps program.

- Recruiting participants.** Create realistic targets for the number of service users you interview. If the program serves a large number of tenants - aim to interview at least 30%. Research recruitment can often be challenging, particularly when potential participants have unmet health challenges. The Steps team was proactive in sharing information about the project with tenants in the front lobby of the buildings, and had interviewers available to conduct on the spot interviews (tenants were taken to a private office). Tenants were also provided with gift cards to a nearby grocery store as a thank you for their time.
- Building connections in interviews.** Hiring peer interviewers who identified as having a mental health issue was a critical success factor. They were able to establish a quicker rapport with residents and had knowledge and lived experience in the subject area that helped them explore people's issues more deeply.
- Plan response to support needs raised in interview.** Be prepared that when engaging tenants about their support needs that some tenants may raise issues for which they need immediate support. Each participant was also provided with background information about the project including a FAQ sheet and a consent form. They were also provided with a resource guide of services available in their community. If a serious issue was raised during the interview, interviewers were trained to bring this to the attention of the project coordinator who had a background as a supportive housing worker.

### Advice from Steps on conducting a Needs Assessment:

- Consider whether ethics approval is needed (particularly when partnering with an academic institution) and the additional time and training that may be necessary.
  - Plan who the data and findings will be shared with at the onset
  - Ideally analyze the data collaboratively with people familiar with the community.
- 
- **Analyze the data.** Have a framework for reviewing the data once the interviews are completed. Having a team available to review the data to look for common themes helped spread the workload and gather different perspectives on the same information.
  - **Write up findings.** Document the project and findings in one place in order to share information between partners and to reference when service planning.
  - **Use findings for service planning.** Once the needs assessment is complete you can identify what services are already in the building and coordinate efficiently. You can also identify where the high service needs are, where the gaps in services are and strategize how to fill those gaps. (See shared resources for needs assessment tool and accompanying documents.)

## Partnerships

### **Supporting tenants with mental health and addictions issues in municipal housing using a supportive housing model and a partnership.**

Both Toronto Community Housing and Houselink Community Homes have long histories of providing non-profit housing to low income tenants across the city. Partnering with Houselink allows TCH to focus on being a landlord while Houselink focuses on responding to the service needs of the tenants. Leveraging each partners' strengths has improved the overall safety and security of the building and has improved the health and well-being of many of the tenants.

Below are key factors to leveraging strengths in similar partnerships:

- **Voluntary supports.** A main difference between this partnership and a typical supportive housing program is that participation is voluntary because tenants did not initially choose to move into a supportive housing arrangement. At Steps, tenants are able to opt in and out of supports, providing flexibility for tenants should they want support to address a short-term need or if they have more ongoing issues that they would require greater support with.
- **Tenant engagement.** In order to engage with tenants, staff have found it most effective to have an open community space with drop in hours and programming such as a community meal, staff onsite with regular office hours available for walk in meetings, and participating in already standing events including building meetings.

- **Coordination with housing staff.** TCH has Community Service Coordinators and Tenancy Service Coordinators who work with tenants on issues related to housing (arrear, safety and maintenance etc.). Steps staff have built a relationship with them through face to face contacts and inviting them to participate in their team meetings. Through this direct contact TCH staff are able to alert Steps staff to issues related to mental health, addictions or other issues where the tenant may benefit from contact with support staff.



*The program started off by talking about stabilizing buildings but buildings are composed of individuals. The more you work with the individual the better understanding you have of the demographics. You get to know the particular issues, and what their struggles are and a lot of them are complex."*

Support Services Manager



## Replication and Advice

- Establish clear partner roles and expected outcomes from the beginning
- Need to have external resources available to refer tenants to. Not all support needs will be in the scope of the support program.
- Need to have high rises or a cluster of buildings with enough tenants that would access the program. Because supports are voluntary and tenants are able to opt in and out of supports, having a density of service users in the area ensures levels of participation in the program that will regularly be high enough to warrant having support staff on site.

## Outcomes

The buildings involved in the Steps program have seen an increase in safety and security and decreased use of emergency services.

The tenants of the building have seen improved health outcomes. With deliberate planning, Steps staff are able to coordinate services effectively knowing which service providers were already in the buildings, bringing in services where there were gaps and improving tenancy outcomes through arrears follow up and other eviction prevention activities.

## Needs Assessment Tools

- Needs Assessment Tools:
  - interview guide
  - flyer
  - consent form
  - FAQ sheet
  - resource list
  - honourarium and consent tracker

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# John Howard Society - Rita Thompson Building



## Promising Practice

- Combining housing with onsite clinical health services to support and house men who experienced long term homelessness.
- Reducing tenant involvement in the criminal justice system and hospital through diversion.

## Background

John Howard Society (JHS) started providing housing in Ottawa 30 years ago with halfway houses, before expanding into Supportive Housing 15 years later. In 2015, they opened the Rita Thompson building. Supports are provided on site 24/7 including case workers from JHS and medical services provided by Ottawa Inner City Health (OICH) - a non-profit organization that provides health care to homeless and street involved people.

## Population Served

Men who have experienced chronic homelessness and complex, co-occurring issues that impact overall housing stability.

## Housing

In line with the City of Ottawa's 10 year Housing and Homeless Plan implemented in 2014, the Rita Thompson building was built comprised of 34 independent bachelor apartments with full kitchens and bathrooms. The building is owned and operated by the John Howard Society. Building safety and maintenance as well as tenancy support is done by JHS. Referrals to the program are through the city's coordinated access system, using Service Prioritization Decision Assistance Tool (SPDAT) scores to prioritize individuals with the highest acuity. Support workers provide both case management support as well as a role in housing and will follow up with arrears and behaviours that may affect tenancy. Harm reduction as a philosophy and practice cornerstone carries through to the housing supports. As an example, tenants may be written warning letters about their behaviours but not about their drug use (see shared resources).



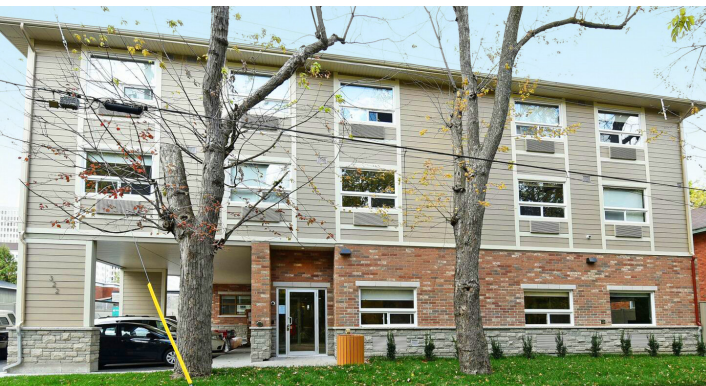
**Funding Model:**

- Operational funding is provided by the City of Ottawa.
- Housing operating subsidies are funded by the city of Ottawa on a per unit basis & rental income from tenants.
- Medical component is funded through the Champlain LHIN.
- John Howard Society bought the property for \$1.3 million. The City of Ottawa invested \$5 million.



*Having a role in both support and housing can be a weird line to walk but at John Howard Society we have been walking that line forever. Being supportive but also having people be accountable."*

Residential Coordinator



*We give them needles, we're not going to write warning letters about them using them."*

Residential Coordinator

## Support

**Combining housing with onsite clinical health services to support and house men who experienced long term homelessness.**

The tenants at Rita Thompson Residence have all experienced chronic homelessness, most with long term shelter stays. Many of the men have complex health needs including acquired brain injury (ABI), Hepatitis C, HIV and mobility issues. In order to support these tenants in permanent housing, the John Howard Society have

developed a support program that combines onsite case management and medical services.

Below are some key learnings from the support model:

- **Determine tenant support needs:** JHS uses a combination of needs assessment tools through the SPDAT scores, staff assessment and tenant self-determination. Staff frequently engage with the tenants including visiting tenants in their units. JHS staff point out that what is often most effective is asking the tenants what their needs are.
- **Use harm reduction as an overall support practice and philosophy:** Staff at Rita Thompson take a holistic approach to harm reduction services to improve the health and housing retention of their clients with high needs. Their harm reduction program includes providing safer inhalation and injection supplies and alcohol management and dosing, along with a money management program. The money management program tailors a regular schedule of money disbursements that permits the participating residents to plan around use of substances, maintain food as a priority, and diminish behaviours due to food scarcity and withdrawal.
- **Engage tenants in education about health care:** At Rita Thompson, tenants are invited to attend a health literacy program where they learn about diseases, addictions and health care. Tenants are paid \$5 to participate and become equipped to share this knowledge between tenants.
- **Utilize peer support:** Peer support workers are hired by OICH. The main role of the peer support worker is medical accompaniment but

in practice their role runs the gamut including helping with taxes to facilitating a meeting on safer drug use. Peer support staff sit in on case conferences so they have the same knowledge as the professional staff.

- **Bring supports onsite:** In order to engage tenants in support services, JHS found it essential to bring as many supports on site as possible. Many of the tenants will not access supports offsite due to a multitude of reasons ranging from negative past experiences, long term stays in institutions to symptoms of mental health conditions. Onsite services at Rita Thompson include: primary health care, medication management, assistance with personal hygiene, activities of daily living, safety checks and case management. In addition to the support provided by JHS and OICH there are also supports provided by partners including a visiting psychiatrist, ABI specialist, and ACTT teams.
- **Delink tenancy and supports:** Following a housing first philosophy, use of or compliance with supports or medical services at the building is not tied to tenancy. Tenants are welcome to use supports or disengage from supports as they see fit.

## Partnerships

**Reducing tenant involvement in the criminal justice system and hospitals through diversion.**

The success of the supportive housing program at John Howard Society relies on partnerships. The core partnership to this program is with Ottawa Inner City Health providing medical services onsite to the tenants, as well as a psychiatrist, ABI specialist, and ACTT teams

that visit on site regularly. JHS utilizes their partnership with OICH through their diversion program where OICH provides off site clinical services at an emergency shelter for men who are in serious risk of harm to themselves. This partnership between OICH, Shepherds of Good Hope (the shelter operator), Ottawa Police, and Ottawa EMS forms their Diversion Program. Through this program, if a tenant's behaviour is putting themselves or others at risk and staff are not able to safely monitor that person, they are able to phone the police (911) and ask them to take the tenant to the nearby shelter rather than into custody or hospital. The nearby shelter is familiar with the tenants from Rita Thompson and are able to provide clinical monitoring while removing the tenant from their home building.

Below are key learnings from the Diversion Program:

- Assess whether a diversion program is needed:** Consider how often emergency services are called to respond to tenant behaviour and whether the behaviour surrounding the call actually requires police or emergency medical response. At JHS, there were tenants who had disruptive behaviour in the common areas of the building posing potential risk to themselves or others. In order to intervene, JHS staff would call 911 and the tenant would either be taken into custody with hours of police involvement or into hospital which often resulted in hospital security calling the police as well. JHS staff knew that in reality, the tenant needed time away from the building with medical monitoring to prevent harms which could be provided through their partnerships.

- Ensure staff understand the diversion program and know when to use it:** JHS has created a Diversion Flow Chart (see shared resources) which runs through decision making of when to utilize this program starting with whether staff are able to safely monitor the tenant at Rita Thompson, whether there is potential risk, and whether to use the diversion program.
- Work with tenants to prevent situations where diversion is needed:** Although some situations where emergency services need to be involved is inevitable, the amount of occurrences can be greatly reduced through prevention. JHS staff are familiar with their tenants and work closely to know what types of supports are needed. Because of this, staff can sense an escalating situation and intervene with the tenant before it reaches the point of emergency service involvement.



*If Joe\* is downstairs drinking frequently we know that we can give him some of his p.r.n. (take as needed) medication, some food, and get him to go upstairs to his unit."*

Residential Coordinator

\*Name changed to protect privacy.

## Outcomes

John Howard Society administers a survey annually that tracks tenant goals including employment and increase in finances, as well as administering the SPDAT (Service Prioritization Decision Assistance Tool) to track housing acuity over time. However, staff from the Rita Thompson residence point out that for many of their tenants, the seemingly simple or small changes are hugely impactful and transformative. Many of the tenants have a limited capacity and high mental medical and mental health needs that many of the outcomes that occur are noticed by program staff and are not necessarily captured in formal measurements.

### Outcomes from OPOC:

- Improvement in overall health
- Employment - including some men being hired by the local Business Improvement Area
- Family Reunification
- Reduction in negative behaviours associated with substance use



## Replication and Advice

- The medical services partnership is essential. Need to have the LHIN funded health service.
- Need to have an operating subsidy for sustainability.
- It is important to operate under a harm reduction and housing first philosophy. Service engagement and behavioural changes cannot be linked to housing or be necessary for participation in this program.
- Money management and food security continue to be one of the most challenging areas of this program. Having access to an on-site and individualized voluntary trusteeship and food security program is key to improving the health outcomes and housing retention of the residents.
- Engage with local police or community police officers to create a strong relationship
- Be involved in local community with residents and businesses. Attend community association meetings, respond to neighbour calls/ complaints and hold consultations.
- Dedicated site is necessary. These tenants do not go out or seek services so you must bring them in house.
- Have a staffing model that allows for 24/7 supports including case workers, nurses, and community developers.

## Shared Resources

- Diversion Flow Chart
- Hospital Diversion Consent Form
- Ottawa Inner City Health Consent Form
- Tenant Warning Letter Template

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# Regeneration Community Services - Step Up Program

## Case Study # 8

### Promising Practice

- Partnering with high support housing providers to transition tenants into lower support housing.
- Facilitating tenant-directed moves by supporting tenants to make an informed choice and providing the necessary supports needed for the transition.

### Background

Regeneration Community Services is a mental health and addictions agency in Toronto that provides supportive housing, case management services and peer support. They have a wide range of supportive housing programs across the housing continuum. The Step Up program consists of 20 supportive housing units located in a large high rise building for tenants transitioning out of High Support Housing. The program began as a response to the need to create “flow” in high support housing in order to move ALC (alternate level of care) patients from the Centre for Addiction and Mental Health (CAMH) into the community. In other words, tenants in high-support housing could be helped to move to other supportive housing and thereby free up high-support units for people in need. At the same time, this enables tenants to live more independently. Through the ‘High Support Consortium,’ a group of 14 supportive housing and service providers in Toronto come together

along with CAMH. They worked to match ALC patients into the best suited high support housing program, and identify current tenants in that program to invite into the Step Up program.

### Population Served

People with mental health and addictions issues. For Step Up - it is specifically for people who have relatively high support needs but no longer require the levels of support provided from agencies within the high support consortium and are interested in moving.

#### High Support Housing Partners:

- Cota
- Good Shepherd (Toronto)
- House of Compassion
- LOFT Community Services
- Madison Community Services
- Margaret’s Housing and Community Support Services
- Pilot Place
- Regeneration Community Services



### Housing

The Step Up Program consists of 20 self-contained units in a high rise building owned and operated by a private landlord. Regeneration has a headlease with the landlord and sublets units to their clients. Strengths of the headlease model includes giving Regeneration staff more ability to enter units when needed, greater flexibility when tenants are late with their rent, and providing the agency more leverage to mediate between the tenant and the landlord if there are maintenance concerns.

When designing the program, it was recognized that the housing must be equal to or better than the units in the High Support Programs where the tenants are moving from. Each unit has a



self-contained kitchen, large bedroom, ample storage and a balcony. Units are completely furnished including household items, and an air conditioning unit.

A benefit of the 20 units being clustered in the same building is that Regeneration is able to have an office and a community room on site. Tenants are able to drop in and use the common space and meet with staff, and staff are able to more easily run group programming.

## Support

***Facilitating tenant-directed moves by supporting tenants to make an informed choice and providing necessary supports needed for the transition.***

Regeneration provides an extensive support program to facilitate tenants' transitions from high support housing to living independently and maintaining their own housing. Because moving into the Step Up program is a choice of

each tenant, the first step for the support staff is engaging with potential tenants in the high support program and providing information and education about the housing and supports available.

Below are the key steps to inviting tenants to move into the Step Up program:

- **Give presentations about the program to tenants and staff at the High Support buildings.** Staff from the Step Up program give formal presentations to potential tenants (and to staff) to provide information about the Step Up program. The presentation includes a description and pictures of the building, and the apartment units. It also lists what is included in the furnishings and the types of supports and programs that are available.
- **Give tours of the building, units and community space.** Tenants who are interested in the program are invited to visit the building and are given a tour. On this tour they see the common areas of the building, the Regeneration office and community space, any vacant units, and get to meet staff and potentially tenants of the program.

Once tenants move into the Step Up program, supports are in place to help the tenant with whatever they need to live independently and maintain their housing. Supports are flexible and individualized to each tenant.

Below are key learnings from supporting tenants transitioning from high support housing:

- **Residential Support Workers on site.** RSWs are onsite 7 days a week from 8am to 9pm. RSWs can assist tenants with activities of daily living with the goal of gradually increasing living skills and independence. RSWs are often the first line of support for the tenants and

can assist tenants navigating other services. Each tenant is connected to a specific RSW but staff will work with any tenant and are available for drop in meetings.

- **Peer support.** Peer Support Workers (PSWs) are available for one-on-one and group supports. Group sessions that PSWs have run at Step Up include: WRAP (Wellness Recovery Action Plan), Pathways to Recovery, art groups and guided meditations.
- **Medication offering program.** Tenants are able to participate in a voluntary medication offering program through Step Up. In this program, a pharmacy delivers participating tenants' medications to the office where it is stored and distributed. Clients can come to the office for their medication where staff provide their medication to them and track it on a sign out sheet. There is a separate count sheet for narcotic medication. Tenants may take their medication in the office, or they may take it with them to take elsewhere. If tenants do not come down to the office for their medication at their usual time, staff will go to the person's unit to check in with them. If the tenant misses their medications staff will work with them to find out why and troubleshoot concerns that they have. Staff may also bring this up with the tenants' case manager or other supports. Staff only offer medications and do not administer.
- **Maintained connection with CAMH.** Tenants in the Step Up program may maintain their connection to CAMH through an Interdisciplinary Transition Team (ITT). This is a community based ACT team that includes nurses, a behavioural therapist, a social worker, an occupational therapist and psychiatrist(s).





*With the right supports in place people can often move to independent living. You can make adjustments for what each person needs. Maybe they don't have the best cooking skills, or they're afraid of the stove then you get creative and organize meals on wheels. There are always ways to make it work."*

Program Manager

## Partnerships

### **Partnering with high support housing providers to transition tenants into lower support housing.**

The Step Up program was born from partnerships between high support service providers and CAMH. The High-Support Housing Consortium was in existence before the Step-Up housing program and unites representatives from the supportive housing, hospital, and community case management sectors within the TC-LHIN for the purpose of promoting and examining the need for high-support housing for individuals with complex mental health issues and co-occurring needs. From the High Support Housing Consortium a smaller group of agencies came together to develop a system response to ALC at CAMH. The ALC High Support Housing Initiative was funded by the TC-LHIN in 2013 and included four elements: the Step-Up Housing program, new high support

housing, the Interdisciplinary Transition Team and the Flex Fund. Through collaboration and successful partnerships, several innovative system practices have evolved, including but not limited to, matching meetings, community support planning meetings, Steering Committee for the implementation of the ALC Initiative, and the Step-Up Housing program. The Step-Up housing program was to create "flow" within the supportive housing sector for those tenants in high support housing who were wanting and able to move to the newly funded program. To date, over 80 complex ALC clients, who have been in hospital on average for 4 years, have moved into the community.

Below are key learnings from the partnerships involved in the Step Up program:

- **Matching meetings.** When a client is ready to transition out of hospital into a high support program, the matching table (representatives from each agency and CAMH staff) reviews the tenants support needs and determines which of the high support programs would be most suitable. Key factors in the decision-making process include what types of supports are needed, vacancies and/or current tenants that may be able to move into the Step Up program. If vacancies are needed in a particular building, staff from the Step Up program will begin engaging with the tenants and providing them with information about the program.
- **Developing support plans.** All supports involved discusses case planning for tenants transitioning into the Step Up program.

Through this coordinated effort, Step Up can start facilitating the specific supports needed based on the tenants needs and strengths. Support plans are regularly reviewed and updated if needed.

- **Coordination with Central Access.** The matching table has an agreement with The Access Point (coordinated access to supportive housing in Toronto) to consider transfers from the high support agencies involved in the partnership to Step Up as internal. This way, the selected tenants have priority regardless of others on the waiting list; the matching table advises the Access Point but tenants do not need to apply there.
- **Ongoing connections to services.** Step Up tenants may remain connected to CAMH through their transition to high support housing and through their transition to the Step Up program if that level of support continues to be needed.
- **Flex Fund.** As part of their funding agreement, the consortium receives \$40,000 annually that acts as an available flex fund. Regeneration administers the funds, but any of the providers in the partnership can apply to use the funds for extra costs associated with transitioning and supporting tenants in their housing. 3 members from the consortium review requests and make a decision on whether to administer the funds.

## Outcomes

Overall, the Step Up program has been successful at transitioning tenants out of High Support Housing, enabling other clients to move from the hospital into high support housing in the community. It has created “flow”, with benefits to the entire system. Since its inception, 26 individuals have moved into the Step Up program. Staff from Step Up check in regularly with each other and have regular supervision meetings where they talk about how each of the clients are doing, including their mental and physical health. Step Up also formally tracks outcomes as part of their Common Data Set reporting to the LHIN including number of mental health hospital admissions and days spent in hospital. Hospital admissions for mental health issues have remained relatively low except for 2 clients who each had lengthy hospital admissions in 2016 and in 2017. Staff are in regular contact with the clients and many of them participate in programming and use the community space. Staff are able to see first-hand how the clients are doing through these observations and speaking with the tenants.

## Replication and Advice

- Having strong partnerships is essential. Need to have a group of high support providers who are willing to come together and be part of a coordinated working group.
- Need to have a strong partnership with the hospital. It is important that tenants remain connected to the hospital for quick re-establishment of supports as needed.

- Medication offering program is useful when transitioning clients into lower support housing as these tenants may have had their medications managed for a long period of time. This program can be voluntary and, over time, tenants may decide they no longer need it. Staff work with clients to help them transition off the medication offering program slowly.
- Apartments located near each other. Having the units located in the same building has served as an important feature of the program. In this model, staff can be located on site giving tenants easy access to supports needed and community programs.

## Shared Resources

- Medication Offering Form

### Contact:

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# Social Services Sault Ste. Marie - High Support Program

## Promising Practice

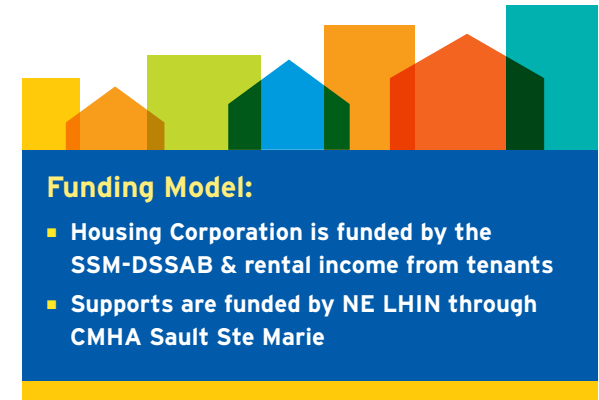
- Partnering between the Sault Ste. Marie Housing Corporation and the Canadian Mental Health Association (CMHA), to incorporate 10 high support units within a building.
- Providing on site supports to improve the safety of the entire building.
- Partnering with other service providers to streamline intake, assessment, and supports.

## Background

The Sault Ste. Marie Housing Corporation is the largest housing provider in the city and district, owning 752 affordable rental units in which it carries out property management and tenant support services. One building was identified as needing greater supports given a disproportionate number of police calls, and reports from tenant support staff of feeling overwhelmed with tenant complaints related to mental health and addictions. When the NE LHIN announced an opportunity for funding for supports in housing, Social Services Sault Ste. Marie (SSSM) started discussions with the local CMHA, who they had worked closely with before. Ten units on one floor were designated for supportive housing tenants in a new high support program.

## Population Served for the CMHA supportive housing program

Tenants must be at least 18 years old and diagnosed with serious and persistent mental illness, with or without an addiction issue. They must be currently stable, have a primary care provider, and be eligible for Rent Geared to Income. They must agree to participate in daily programming and complete a personal care plan with program staff. The program does not serve people who are unable to live independently have age related cognitive decline, have addictions issues only, or who pose a significant risk to others.



## Housing

**Partnering between the Sault Ste. Marie Housing Corporation and CMHA to incorporate 10 high support units within a building.**

The St. George's building owned by the Sault Ste. Marie Housing Corporation (SSMHC) consists of 61 units, 10 of which are supported. It is a low rise building with 60 one bedroom units and 1 two bedroom unit. The entire building is rent geared to income. The support program was designed to house the supported tenants on the same floor, with close proximity to an onsite CMHA office. In order to do this, existing tenants were approached and agreed to move to other available units.

Below are key learnings from establishing a new program in an existing building:

- **Educate the entire building about the new program.** Many of the tenants had concerns about the implementation of a support program within their building. Housing staff circulated a letter about the upcoming changes, but also chose to more actively engage tenants by holding building meetings with a question and answer period and introducing tenants to CMHA staff. They also did personal in home visits to talk to tenants one on one. By being open about the process and giving tenants various opportunities to learn about the new program, the overall responses to the project were positive.
- **Move existing tenants to the top of waitlists for other buildings of their choice.** In order to re-house existing tenants from units needed for the support program, work with each tenant to identify where they would like to live and facilitate that move as much as possible. For SSSSM they were able to move tenants to the top of the waitlist for other units/buildings in the portfolio of their choice.
- **Cover moving costs when re-housing existing tenants.** In order to reduce obstacles for tenants who have agreed to move elsewhere, CMHA was able to cover the associated moving costs for these tenants.

## Support

***Providing on site supports to high support tenants with flexibility to provide softer supports to other residents to improve building safety.***

CMHA provides onsite supports to the 10 high support housing clients including mental and medical health care, addictions supports and any other services needed for clients to live independently. The location of this program is located in a Housing Corporation building that houses many tenants with complex health needs. This often leads support staff to respond to other building needs and provide informal supports to the other 51 tenants in the building, many of whom are part of the urgent homeless housing first program.

Below are some key learnings from this support model:

- **Coordinate intake with other supportive housing providers to best match tenants to the best suited program.** Sault Ste. Marie has a central intake for supportive housing. Four agencies meet regularly to review this waitlist and match tenants depending on their needs. Coming together within a central intake system allows a straightforward system for clients to navigate while allowing supportive housing providers to respond to the nuances of each individual.

- **Provide soft supports to all tenants to improve wellness of the entire community.**

Although CMHA staff are primarily onsite to provide supports to the 10 high support tenants, they regularly go above and beyond and respond to issues with the rest of the tenants as they arise. Many tenants have learned that there are mental health and housing workers onsite and seek them out when needing assistance. Providing these “soft supports” has had a huge impact on the entire community and housing staff attributes much of this to the lessened calls to housing services and emergency response for the entire building.

### Role of Housing Support Workers:

- Service Engagement
- Assessment
- Service Delivery
- Community Relations and Advocacy



*Tenants are aware that CMHA staff are onsite and they frequently pop in for informal support...The CMHA staff have been an influence on the entire community in the building. They provide a sense of comfort and community for everybody who lives in the building.”*

Community and Tenant Coordinator

## Partnerships

### ***Partnering with other service providers to streamline intake, assessment, and supports.***

Partnerships are an important feature of the supportive housing program at the St. George's building. The on-site support partnership with CMHA is a necessary component. The program relies on other partnerships as well including a Mental Health and Addictions Housing Selection Committee with 4 service partners, a Homeless Prevention Team made up primarily of CHPI funded agencies, and a partnership with the local police through SSMHC's Safe Neighbourhoods program.

Below are some key features from each of these partnerships:

- **Clear Communication.** Communication is a challenge in any partnership, but this is especially true in support/housing partnerships where there is often a tension felt between the roles. In the SSMHC/CMHA partnership the agencies have learned to align their goals of keeping the tenants housed while maintaining the safety and maintenance of the building. There are clear communication expectations for CMHA staff to report any issues related to the physical building or units to Housing staff - including things like fire damage, pest issues or safety issues related to clutter. In these situations CMHA staff would inform Housing staff and both partners would work together to respond to issues working towards their common goals.
- **Work towards a common benefit.** SSSSM connects with external partners in mental health and housing through the Mental Health and Addictions Housing Selection Committee. The 4 agencies involved meet monthly to assess clients on the central waitlist for supportive housing and determine eligibility and best placement for those clients. Coordinating this review ensures that clients are housed in the right place at the right time.
- **Include tenants.** Responding to the issues throughout the entire building, SSMHC formed a safe neighbourhood program in partnership with the local police. This partnership brings together tenants, staff and a police officer through their community mobilization team to discuss issues of concern.
- **Embed participation into service agreements.** Housing Services formed a Homelessness Prevention Team to meet weekly for client service planning and to discuss some of the most complex cases in the community. In order to get this group off the ground, participation was embedded into service agreements for agencies receiving CHPI funding. Since then, the committee has grown to include partners who don't receive this funding.

## Outcomes

Performance outcomes were determined from the outset of this program, including reduced evictions, lower use of emergency services, and reduction in mental health hospital admissions. The Housing Corporation uses YARDI software to track housing outcomes; CMHA uses SPDAT as an assessment tool and reports on performance

outcomes to the LHINs including client reporting measures. Each of the performance outcomes have been met by the program.

Some of the client reported outcomes include: having a key to a home for the first time in 5 years, having grandchildren allowed to visit in the resident's home for the first time, sleeping better than ever with about 7 hours a night average.

## Replication and Advice

- Launching a new supportive housing program in a building with existing social issues will improve the well-being of all tenants in the building overall.
- Form partnerships to utilize different areas of expertise and find strength in collaboration.
- Use already existing assessment tools such as SPDAT.
- Have an open dialogue with community members about the new program, including the service manager and housing provider, and demonstrate the benefit of the new program for the client/tenant and the entire community.
  - Come prepared to these discussions with what it would look like, who is going to do what, and what role the service manager would have in all of it.
  - Gather evidence from similar programs and use those examples to share how it has been successful.
- Educate people in the building/community about the program before it opens.

## Outcomes:

- No evictions
- 66% of residents currently participate actively in Activities of Daily Living programming and supports
- Hospital admissions for mental health reduced by 60%
- Hospital days by residents reduced by 90%
- Police interventions reduced by 85%
- Crisis calls reduced by 100%
- Improvement to the entire building. Fewer calls to housing and police services.



## Contact:

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## Shared Resources

- Housing Support Worker Job Description
- RPN Job Description
- Supported Permanent Residential Housing Referral Form





# South Cochrane Addictions Services

## Case Study #10

### Promising Practice

- Building connections with landlords to acquire housing units.
- Balancing flexibility and structure to support tenants for improved health outcomes.
- Partnering between funders and local organizations to deliver an effective supportive housing program.

### Background

South Cochrane Addictions Services (SCAS) is an assessment, referral, case management and community treatment agency for people who have problems related to alcohol, drug use, or gambling. Services offered are free and confidential and funded by the North East LHIN. The agency is designated by French Language Services.

The Addiction Supportive Housing Program SCAS began in 2011, responding to the need for housing among SCAS clients and a recognition that without housing and basic needs being met, treating addictions cannot be as effective.

### Population Served

People who have experienced homelessness and have addictions or concurrent mental health and addictions.

### Housing

***Building connections with landlords to acquire housing units.***

SCAS supportive housing program has 24 scattered site housing units across South Cochrane (Timmins and area) with all units provided by private landlords. The clients living in these units are tenants of the landlord rather than SCAS and pay their rent portion directly to the landlord - most often through pay direct from ODSP or OW. The Rent Supplement portions are paid directly to the landlord as well. In this model, it is necessary for SCAS to work with both tenants and landlords in order to keep their current tenants housed and build relationships with landlords to acquire additional units.



### Funding Model:

- Support and Supplement are funded through coordinated partnerships - one between the CMHA-CT (Housing Supplement flowed from MOHLTC) and SCAS and the other between CDSSAB and SCAS whereby CMHA-CT and CDSSAB provide the Housing Supplement and SCAS provides support services (Case Management)
- Of the 24 total Rent Supplements:
  - 16 are funded by MOHLTC to CMHA-CT
  - 8 of the rent supplements are funded by CDSSAB
- SCAS is funded by the North East LHIN to provide the case management and supports all 24 tenants
- SCAS Case Managers each hold a caseload of 8 clients on Subsidy and an additional 4 Case Management only (total of 12)



Below are key features of working with both tenants and landlords to maintain and acquire units:

- **Facilitate tenant choice.** Portable rent supplements are attached to the tenant rather than the unit. This allows the tenants to work with SCAS to find suitable housing of their choice. One of the only criteria SCAS has is that it must be affordable and include utilities.
- **Liaise between clients and landlords.** Although some of the tenants talk directly to their landlords regarding housing matters and maintenance requests, much of the time Addiction Case Managers (ACMs) handle contact with the landlord as they provide an easy way of reaching tenants. Overall experiences have been positive but there have been occasional challenges where SCAS had to advocate for the tenant's rights when landlord obligations were not being fulfilled. SCAS tenants are seen as desirable because they are connected to an organization and make reliable rent payments.
- **Network with private landlords.** Building a positive reputation for the program has been critical to its success, especially in smaller communities with fewer landlords. Staff at SCAS have found that if landlords are satisfied with the program they speak to each other, contact you when they have apartments available and keep an "open door" for the program and the clients. Staff point out that the relationship building doesn't stop when the clients are housed. ACMs call landlords

on a regular basis. Through this relationship building, landlords have started to contact SCAS when they have units available and created tenancy opportunities for SCAS clients outside of the housing program for apartments that do not require a rent supplement.



*I make a point to actually take time and go talk to landlords, property managers and owners because that facilitates things when you do need an apartment for a client and it just makes it easier. The networking piece is very important and continues after the client moves in."*

Addiction Case Manager

## Support

### ***Balancing flexibility and structure to support tenants for improved health outcomes.***

Addiction Case Managers (ACM) provide a broad range of supports to keep clients housed including intake and assessment, outreach services, ongoing treatment planning, life skills building, and navigating social services and other supports. An essential feature of the support model at SCAS is striking a balance between structured support and flexibility. ACMs use practical tools from intake to support planning but maintain flexibility for staff to support tenants with changing needs.

Below are key learnings from this balanced approach:

- **Structured intake assessment with a priority scoring system.** A formal intake and referral system was put into place in order to ensure equitable admission and to balance staff work load. When clients first come in contact with SCAS they meet with an intake worker who directs them to the best suited program. For the housing program, clients meet with an ACM and complete an application to determine eligibility and support needs. Applications are scored and priority is given to those who have the highest need (see shared resources).
- **Establish a structured daily work plan that accounts for flexibility.** When the program first started there was a sense of urgency from the staff to support as many people as possible. It was quickly realized that this approach was neither effective nor sustainable. In order to prevent staff burnout and to ensure that the time spent with clients had the most impact, a structured schedule was put into place for the ACMs to start and end their day at the office and with guidelines to only see 3 to 4 clients a day. Following this structure allows for each of the 12 clients per ACM to be seen at least once a week with room for flexibility to support clients who need multiple or longer visits. If ACMs need to change their course of the day while they are out in the community, there is a safety procedure in place whereby ACMs send a group text to the other ACMs to update them about their plans.

- **Meet clients “where they are at”** SCAS staff are able to build rapport with clients and connect face-to-face with clients out in the community or in their homes. Code of conduct is respected but formalities and etiquette that are used in office are not required.
- **Ongoing assessment** – Client goals are established with ACM and followed. Service planning is completed as required.

### Addiction Case Manager Daily Schedule

- **8:30am to 9:00am**  
ACMs check in with each other and share plans for the day
- **9:00am to 4:00pm**  
Visit 3 to 4 clients out in the community
- **4:00pm to 4:30pm**  
Return to office to complete case notes and debrief

## Partnerships

### *Partnering between funders and local organizations to deliver an effective supportive housing program.*

The supportive housing program at SCAS relies on partnerships. SCAS partners with the NELHIN, the CDSSAB and CMHA to fund the program, it also collaborates with other ASH programs and the larger community sector in the region.

Below are key partnerships that SCAS are involved in and some of their key features:

- **Funding partners:** The funders include North East LHIN, MOHLTC and DSSAB (Cochrane). This partnership allows for integrated communication between the organizations and a coordination of services. Each partnership has formal MOU agreements that detail communication plans and outcome reporting plans. The formal collaborations have an impact on day-to-day interactions between organizations, creating an atmosphere where staff feel comfortable contacting each other on a regular basis.
- **Collaboration of ASH programs across the region:** Twice a year, staff from the North East Region (North Bay, Sudbury, Muskoka/Parry Sound, Sault Ste. Marie and Timmins) meet at a central location to discuss the type of work they do, lessons learned and challenges. This collaboration between ASH programs has been invaluable for staff to be able to troubleshoot different experiences and ground the work that they do in client stories and feedback. A testimonial from someone with lived experience is part of the full day meeting.
- **Community mobilization table:** 20 agencies come together on a weekly basis to share what they do and give updates about their programming. Although direct service coordination doesn't happen at this table, it does allow providers to learn about available programs so they can seamlessly connect their clients to other available services.

- **Other partnerships:** Including but not limited to Health Links, RAAM, Addiction and Mental Health System Table.

## Outcomes

Program objectives and intended outcomes were determined right from implementation and communicated between the partners.

1. Reduce involvement with addictions, the criminal justice system, and emergency services.
2. Increase successful tenancy.

Staff regularly document client experiences related to these outcomes. A quarterly reporting template is completed and sent to the North East LHIN which includes: occupancy rate of the units, number of clients terminated, number of clients who “complete” the program, visits to the emergency department, hospital admissions and referrals made to other community supports. Other data is reported by staff into DATIS/ Catalyst including a supplemental forms for ASH with additional information.

The SCAS supportive housing program has successfully met all of its intended objectives. Their occupancy rate consistently remains above the intended target of 80%. Visits to the emergency department among SCAS clients dropped radically. Staff attribute these outcomes to the tenants having a safe place to live, a good support network and connections to necessary ongoing health services.



*We help connect individuals with a doctor so they don't have to go to emerge to get prescriptions anymore. Where another person would drink excessively and fall and call 911 that doesn't happen anymore because we're helping them with their addictions."*

Addiction Case Manager

## Replication and Advice

- Instill a sense of team work between all staff levels of the organization.
- Build a good rapport with your clients. Make sure that you are meeting your clients in the community and in their own space.
- Have a good structure to both manage staff workload and effectively serve clients.
- Hire people with strong interpersonal skills to network and build those connections with other service providers, funders, and landlords.

## Shared Resources

- Application Form
- Rating Scale
- Addiction Case Manager Job Description

### Contact:

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# St. Jude Community Homes



## Promising Practice

- Sustaining long term tenancies through supports and creating a sense of community in a dedicated building.
- Supporting long term tenants to age in place.

## Background

St. Jude Community Homes (SJCH) provides permanent supportive housing for people with mental health issues. Located in Toronto's inner city for over 30 years, the majority of units border the Regent Park and Moss Park Neighbourhoods. Most of the housing units are in dedicated buildings, with a smaller number of apartments made available through rent supplements. The main goals of SJCH are to give people a safe place to call home, connection to community, and a place to thrive in their recovery.

## Population Served

Adults who are severely affected by mental health difficulties, in need of affordable housing. Tenants must be connected to a community mental health professional and with 6 months sobriety from an active addiction.

## Housing

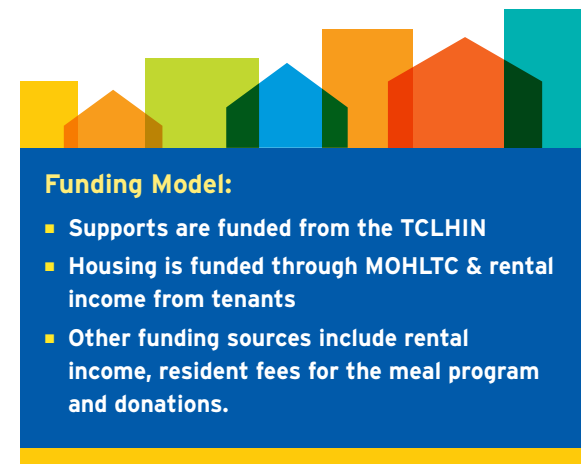
All housing units at SJCH are self-contained bachelors and 1 bedroom units in dedicated buildings. St. Jude's mandate is to providing quality housing - SJCH owns one of the buildings,

another is through a 50 year lease with a city owned property, and a third dedicated building is with a private landlord where SJCH rents 20 units and office space from the landlord and residents lease their units from St. Jude. SJCH also has a few units in a non-profit affordable housing building that has several supportive housing units through a number of service provider partners. Each building that is owned or leased by SJCH has designated community space open 24 hours a day for resident and staff run events, meetings, groups and opportunities for education or socialization. As a landlord, SJCH operates 24/7 365 days a year including on call afterhours support for maintenance and mental health issues.

## Support

***Sustaining long term tenancies through supports and creating a sense of community in a dedicated building.***

Each resident at SJCH is connected with a resource worker who provides one-on-one supports including goal setting, wellness plans, budgeting, life skills, counselling and community



engagement. In addition, each resident has access to support from any member of the resource worker team, as well as access to a range of opportunities to participate in community activities both internal and external to SJCH. SJCH buildings range in levels of support and onsite staffing - staff are available on site 12 hours each day Monday through Friday, 8 hours on weekends and holidays, 365 days a year. Community development is a cornerstone to the supports provided at SJCH, recognizing social connectedness as an important piece of mental health recovery, wellness and overall



health. Ensuring activities are meaningful to tenants is key. The community development program at SJCH includes a meal program, resident education, social events, house/building meetings, a resident advisory group and other tenant run activities.

Below are key community building learnings from St. Jude Community Homes:

- **Speak about community focus to new tenants right from intake.** When meeting with a potential new tenant it is important to describe the community aspect of the housing program and their rights and responsibilities of being a tenant and those of the landlord. Although tenants are not required to participate in social programming, there is an underlying philosophy of connectedness, group problem solving and joint decision-making that runs throughout all of SJCH's operations. It is important for tenants to determine if SJCH is the right housing and community for their support needs.

- **Recognize tenants for their contributions.** St. Jude hands out annual "Good Neighbour Awards" to residents who have gone above and beyond for their fellow community members. Nominations come from other residents as well as staff. Awards are presented at each Annual General Meeting and find that such recognition fosters pride in one's community and care for one's neighbour.
- **Tap into tenant interests and strengths when planning activities.** SJCH uses codesign approach to actively involve tenants. Staff work with tenants to identify, develop and implement tenant needs and interests for community development activities. This can be done through informal check-ins with tenants, brainstorming sessions, focus groups and surveys, ad hoc working groups, and existing structures such a Resident Advisory Group. Self-determination is not only an important principle of community development but also ensures higher participation when the events are known to be of interest to the service users.
- **Support tenant run programs.** Facilitating tenants to develop and run their own programming supports tenants to take on a leadership role in their community and develop new skills and is also a powerful engagement tool for attracting participants. At SJCH, a tenant started and continues to run a popular regular event called "coffee house" where tenants come together and chat over coffee. SJCH supports this tenant by assisting them with printing posters, and covering the cost of supplies. The tenant invites others to participate and participate in running the program. Some other examples of resident

led-programming include a chair yoga class held once a week, and SJCH's quarterly newsletter - where residents can submit articles, artwork, poetry and contribute their editing skills.

- **Building location and design.** Look for communities with nearby accessible amenities such banks, grocery stores, community centres, libraries, and health care. Ensure both safety and community development is considered in your building design from its outset - ensure there is a common space for a range of activities from movies, yoga to cooking classes.
- **Community Safety.** Like building design consider built form to support safety within the building. In addition, regular tenant education sessions and reminders around personal and community watch safety is central to giving people the tools to keep themselves safe.
- **Hold regular house/building meetings and Town Halls.** House meetings happen at each building once a month and town halls for all residents are held every two months. These meetings are an opportunity for neighbours to get to know about what is going on in their communities, share information with each other and guest speakers and bring up issues or concerns that they may have. At these meetings residents also discuss building safety and the safety within the greater community/neighbourhood. These meetings are an important way for tenants to connect but also to do group problem solving whenever issues arise.



- **Bring tenants together to share meals.** As part of the support program, SJCH provides a meal program for residents who pay for the meal plan. Meals allow residents a chance to socialize, get to know their neighbours, and ensure they have access to nutritious food. In this program, residents pay \$250 per month for the food program and are provided with Breakfast and dinner 5 days a week. Residents rotate participating in set up and cleanup of the program. In 2016, SJCH completed a co design process researching the meal program, dining room environment, kitchen operation and food quality and menu analysis. St. Jude used the findings from this assessment, as well as aggregate data on resident health, and annual surveys to improve and adapt meal planning. This ensures the programming offered is well suited and effective and is meeting the health needs of the residents.
- **Resident workers.** SJCH has a team of residents who are responsible for the cleaning and landscaping and has also included other positions such as Administrative Assistant. Tenant involvement enhances sense of ownership and pride in their home and community as well as provides some extra income.
- **Tenant Directors on Board.** Residents have an opportunities to run for election and participate in the organization's governance as Directors of the Board.
- **Involve residents on staff hiring panels.** SJCH ensures a resident is involved as a member of the hiring panel for employees across the organization. Residents have excellent assessment skills and important to use this strength to provide input into future staff.

### **Supporting long term tenants to age in place.**

Residents at SJCH are getting older. Nearly half of the residents are over 55 and approximately 20% are over 65 years old. SJCH took a number of measures to support their tenants to age in place.

Below are some key learnings to support tenant aging in their home.

- **Conduct assessments and link tenants to supports in a coordinated way.** Noticing the changing age demographics in their buildings, SJCH were proactive in assessing and responding to supports needed by coordinating with their local Community Care Access Centre (CCAC) to do an assessment “blitz” with all of their aging tenants. First, resource workers identified tenants that were likely to need supports related to aging and worked with one point person at CCAC to complete the assessments. CCAC assessed for services needed, as well as apartment modifications including bed rails, walkers, shower modifications and other assistive devices. After this coordinated assessment, 27% of the residents at SJCH began to receive ongoing supports from CCAC.
- **Utilize partnerships for additional medical services.** SJCH partnered with a nearby nursing college to provide routine visits from a Registered Practical Nurse (RPN) who is working towards becoming a Registered Nurse (RN). Students come on site to check tenants’ vitals, talk about medication and give medical advice.
- **Complete an accessibility review.** After receiving funding through the Social Housing Improvement Program (SHIP), SJCH hired a consultant and completed a formal accessibility

review for their main building. Upon completion of the assessment, they are now carrying out modifications include push door openers, a fob system and lift mechanisms.

- **Understand limitations and refer to seniors housing when necessary.** Although SJCH aims to support tenants to age in place and lay the groundwork for a vibrant aging community, there are limitations to the level of supports and medical services they can provide. When supports are not adequate SJCH works with tenants on an individual basis to refer them to seniors housing.

### **Partnerships**

St. Jude Community Homes works with a variety of community partners. A formal partnership exists with House of Compassion, a supportive housing agency for which SJCH provides transfer payments and administrative support. SJCH also works closely with service providers who support their tenants including CCAC, ACT teams, CAMH, Impact teams and other case managers. Because resource workers are onsite where the tenants live they often get a clearer picture of how things are going with their tenants and can communicate concerns with the visiting workers.

### **Replication and Advice**

- **One Team - use a one team approach** where each member of the team, from front line, kitchen, peer and maintenance are integral members who contribute to the success of St. Jude's programs.
- **Meal programs meet support needs, combat isolation and provide nutritious food.**



- Providing high quality housing is essential - clean, safe and well maintained homes help to minimize criminal activity as well as enhance tenant pride and ownership.
- Try to start new housing programs in locations with services nearby including community centres and health centres, but also near affordable grocery stores and community events and programming.
- Consider opportunities for a supported employment program. It gives people meaningful work and training in an environment where people understand the worker's challenges.
- Be clear with tenants about responsibilities of being a tenant and have a strong welcome in the community. Give welcome packages and introduce people to each other.
- Build the community internally but also be a part of the wider community.
- Continuous evaluation and monitoring of changes made through evaluations, focus groups and co-design projects.
- Building design is key - creating a shared space which is clean and inviting promotes wellness and improves security of building.

### Outcomes:

#### Housing Stability

- 3 evictions in 30 years
- 36% have lived with SJCH longer than 10 years and 52% between 5 and 10 years.

#### Connection to Health Services

- 90% of residents have a doctor
- 88% have a psychiatrist

#### Reduced Hospitalizations

- In 2016-2017 16 tenants were hospitalized for psychiatric care and 5 residents were hospitalized for physical health care



## Shared Resources

- Resource Worker Job Description

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# Services and Housing In the Province (SHIP) - Hansen Building

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## Promising Practice

- Designing a new mixed-income building with dedicated supportive housing units within it.
- Providing residents a broad range of supports available within the organization.

## Background

Services and Housing In the Province (SHIP) is a multi-service organization with a long history in supportive housing (formerly Supportive Housing In Peel). They are a large organization that houses over 1000 people and provides support services to over 3000 individuals annually. The Hansen building opened for occupancy in Fall 2016. It is a mixed income building with two support programs on site: High Support Phase 2 and Housing in Place (HIP).

## Population Served

High Support Phase 2: tenants come through a partnership with CAMH. This program is available for people coming out of long term hospitalizations including alternate levels of care (ALC) patients and through the mental health forensic program.

HIP: this program supports individuals who are 16 and over who have a serious mental illness and problematic substance use and are homeless or have a high risk of homelessness.

## Housing

*Designing a new building of mixed income apartment units.*

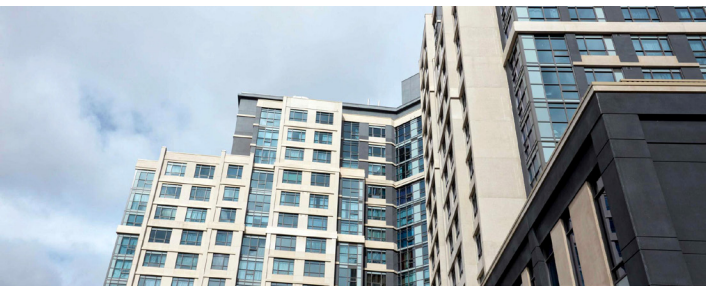
In 2012 SHIP was successful in a Region of Peel RFP to build new affordable housing. Working with an architect, SHIP spent two years planning and developing a mixed income building with 232 units ranging from 1 to 3 bedrooms. Of these, 32 units are supportive housing for two separate programs; 12 of the support units are part of the High Support Phase 2 program and 20 of the units are in the Housing in Place (HIP) program. The building includes a ground level retail space, one level dedicated to older adults housing and 13 storeys of affordable residential housing with communal building amenities located on the top floor. Construction began in 2014 with occupancy in late 2016.

# Case Study #12



Below are some key learnings from SHIP about the development process:

- **Determine design elements that are important to the organization and tenants.** Having a broader framework for organizing a new housing development helps to ensure that design elements meet the needs of future tenants. SHIP utilized their '7 Principles of Healthy Housing' when designing the new build.



These principles are: inclusiveness, accessibility, sustainability, safety, education and training, empowerment, and professional services.

- **Work with a likeminded developer.** When selecting a developer it is ideal to find someone who understands the vision of the organization. SHIP approached a developer who is well known in the Region of Peel and was able to work with the developer to design more comprehensive community spaces than found in typical apartment buildings including a large community room, laundry facilities and a large indoor children's play space. At the Hansen building, the developer owns the ground floor retail space but has committed to selecting businesses that add value to the community such as medical clinics, dentists, etc. The developer has had calls from businesses that do payday loans/cheque cashing but has turned them down with the best interests of the community in mind.

- **Consult with the nearby community.** SHIP was proactive in engaging the nearby community from the onset. SHIP held open houses, created a website, held face-to-face meetings with community stakeholders including engagement with local businesses. SHIP held meetings with a prepared slideshow about the organization and pop ups showing plans for the new development and layouts. SHIP marketed the new Hansen building as not just an affordable housing building but a wellness benefit to the entire community.
- **Utilize expertise from agency staff, partners and board of directors.** SHIP consulted with experts involved with their organization when developing the Hansen building. SHIP's Board of Directors and Senior Management in particular came with specific expertise around social housing and building development.

## Support

### *Providing residents a broad range of needed supports available within the organization.*

The SHIP Hansen building consists of two supportive housing programs. There are 12 supported units through the High Support Phase 2 program which is a partnership with CAMH for tenants coming out of long term hospitalizations, primarily ALC patients or from the mental health forensic program. Also, 20 of the supported units are through the HIP program which is a housing first program for people with mental health and problematic substance use who are homeless or at risk of homelessness. The two programs function separately although they do share similarities in their underlying principles and approaches.

Below are key features of the support programs at the Hansen building:

- **Multi-disciplinary support teams in house.** SHIP employs support staff with a variety of specialty and professional backgrounds. Support staff at SHIP that work within these two support programs include ACT teams (nurses, occupational therapists, social workers, peer support workers, addiction specialists and a psychiatrist), as well as community mental health workers, case managers, addiction specialists, trauma specialists, hoarding specialists, tenant relations, recreational therapists, alternate dispute resolution worker and housing workers. Employing these staff in-house gives SHIP the ability to ensure staff are all working as a team with the same goals in mind, and the ability to provide supports when and where they are needed across the organization.
- **Give tenants choice in housing and supports.** The supports available to residents in both programs at Hansen are determined through tenant choice. For HIP tenants, the choice starts with selecting the location of their unit with support from the housing worker. 20 of the organization's 70 HIP units are in the Hansen building, so tenants can choose to live either in the Hansen building or elsewhere. Although tenants referred to the High Support program do not have a choice in unit selection, they do have a choice in the type of supports they receive and work with staff on self-directed goals.

- **Connect with future residents before move in.** With both programs, staff start to engage with tenants before move in. During this time they are able to build rapport and conduct assessments to plan for types of supports that may be needed upon move in. For the High Support Program, residents also have the choice to stagger their move in dates so that they may start to come to the building for visits during the day, then staying overnight, gradually increasing their time spent in their new unit until they are completely moved in. This has been invaluable for tenants who are transitioning out of long term hospitalization.
- **Include non-clinical supports for activities of daily living and community building.** Social integration is an important piece of mental health and wellness that SHIP addresses through supports at the Hansen building. Staff provide supports including community meals, budgeting, cleaning, grooming/hygiene, social recreational activities and social outings. Non-clinical staff also work with tenants on their identified goals with tenants choosing supports as needed or required. In addition, there is an onsite wellness coordinator dedicated to creating community within the building, providing programs and promoting tenant engagement.
- **Understand that support takes time.** Although staff work with tenants in a goal-oriented way, it is recognized that building a supportive relationship takes time. Most tenants have not lived independently for quite some time and there will likely be a period of adjustment.

In order to achieve their goal of community integration - staff will work with residents on smaller, self-determined goals such as grocery shopping, navigating the transit system, going to the park, and building skills related to living independently.

- **Separate support and housing staff functions.** Housing staff that follow up on tenancy issues, rent, and administration are not the same staff providing mental health or activities of daily living supports. Separating these staff roles ensures that tenants understand that their engagement with support workers does not affect their status as a tenant. Support staff are only involved in housing-related issues where there is an overlap with support services, for examples when hoarding issues may affect the health and safety of the unit or when behaviour negatively affects other tenants in the building. There is a dedicated tenant relations worker, a maintenance coordinator and an alternate dispute resolution worker who supports these efforts.
- **Invest in staff.** At SHIP, the organization makes it a priority to provide staff opportunity for training, and provide support for staff to continue their education. SHIP also provides in-house trainings and recently developed a curriculum for their staff to enhance their learning and skills. SHIP also has an education and training committee that oversees staff development policies, trainings and curriculum development.

## Partnerships

Although SHIP prides itself in offering many of the supports and staff roles in house, they do have a number of important partnerships relating to large advocacy issues including the elimination of homelessness. SHIP is a member of the Peel Alliance to End Homelessness, a collaborative effort from agencies across Peel Region to improve coordination of access and assessment, measure the demographics and service needs of homeless people in Peel and to conduct advocacy for the end of homelessness. SHIP staff also sits on other sector specific committees dedicated to providing system level leadership (i.e. Youth Homelessness in Peel, etc.).

## Outcomes

Across the organization, SHIP uses data and measured outcomes in order to assess whether their programs are meeting their intended goals. SHIP uses a number of formal measures in addition to hearing directly from tenants and their families about how they are doing.

For formal measures, SHIP administers outcome questionnaires. SHIP staff also track outcomes related to housing status, employment status, and participation in education. In addition to these measures, SHIP also has a Quality Assurance Manager who participates in the Excellence through Quality Improvement Project (E-QIP). The data from these measures allow staff to monitor the impact of services on tenants' mental health, substance use and overall wellness and to plan what services and supports are needed.

SHIP recognizes the importance of measuring the outcomes of their support through feedback from tenants and their families. This happens through tools such as the Ontario Perception of Care (OPOC) tool. There is an Advisory Committee that consists of clients, family and community members who provide recommendations to programming. SHIP also has a formal compliments and complaints procedure so people can give their honest opinions and share their ideas. The compliments and complaints are reviewed by a third party so that tenants feel they have the ability to provide honest and frank feedback.

- Assess community resources available. Stay informed of funding opportunities, leverage resources available through partnerships.
- Goals and outcomes are important for SHIP, but the ultimate goal is to successfully house and support residents by meeting them where they are at which is best done by following the person's lead of what they need.
- Be proactive with engaging the community. Meet with the community and share information and education about programs and the benefits they can have on the entire community.

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## Replication and Advice

- Develop a program model with articulated short and long term goals and measures. Monitor the outcomes and make adjustments to optimize the program.
- Invest in good people from leadership to front line staff. Give opportunities for continuous learning and staff development.
- Stay on top of trends and try to predict what service needs will be, identify service gaps and create proactive solutions for future service needs.



# Research Process

A researcher from Addictions and Mental Health Ontario (AMHO) and a small project team consisting of staff from the AMHO, CMHA Ontario, and the Wellesley Institute carried out the research, conducting 12 case studies of promising practices in supportive housing from across Ontario. The project was overseen by an advisory committee of supportive housing sector stakeholders who provided expert guidance, advice, and ongoing feedback for quality control.

Case studies were recommended by sector stakeholders from across the province including supportive housing executives, housing policy researchers, LHINs, and government representatives including from MOHLTC and various municipalities. When selecting case studies, a program was considered to be a promising practice when it was effective at achieving its aim or outcome particularly in the areas of support services, housing, or the coordination of housing and supports as laid out in the provincial government's Supportive Housing Best Practice Guide. Case studies were selected for their replicability and to represent a variety of housing types, partnerships, funding sources, populations served, and geographic regions. A base criteria for all case studies was that tenants were protected by the Residential Tenancy Act (RTA) and that the housing be permanent/long term. Recommendations were reviewed on a rolling basis and specific contacts were approached when gaps were identified.

Information from the case studies were based on semi-structured interviews with key agency staff members, a site visit (where possible) and materials review. Many of the materials are included in the shared resources section of the guide. Throughout the project, the advisory committee was kept up to date on progress and findings and the project team was able to adapt their work based on the committee's feedback.



## Endnotes

- <sup>1</sup> Members of the small research group and advisory committee are involved in this project and were able to speak on the work.
- <sup>2</sup> <http://www.mah.gov.on.ca/AssetFactory.aspx?did=15986>
- <sup>3</sup> <http://www.mah.gov.on.ca/AssetFactory.aspx?did=15988>
- <sup>4</sup> [https://static1.squarespace.com/static/5845afbfbebafb2a2ebd4321/t/5ab29fb5758d46af93d1a03c/1521655735727/AODA\\_EN\\_Advisory\\_Council\\_Annual\\_Report\\_2017FINAL.pdf](https://static1.squarespace.com/static/5845afbfbebafb2a2ebd4321/t/5ab29fb5758d46af93d1a03c/1521655735727/AODA_EN_Advisory_Council_Annual_Report_2017FINAL.pdf)
- <sup>5</sup> <https://static1.squarespace.com/static/5845afbfbebafb2a2ebd4321/t/58c7f88e15d5db6d9dafeeb7/1489500303209/Supportive+Housing+WG+FINAL.pdf>
- <sup>6</sup> <http://www.amho.ca/> (will be available)
- <sup>7</sup> [https://www.mentalhealthcommission.ca/sites/default/files/mhcc\\_at\\_home\\_report\\_national\\_cross-site\\_eng\\_2\\_0.pdf](https://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf)
- <sup>8</sup> [https://www.mentalhealthcommission.ca/sites/default/files/PrimaryCare\\_Turning\\_the\\_Key\\_Full\\_ENG\\_O\\_1.pdf](https://www.mentalhealthcommission.ca/sites/default/files/PrimaryCare_Turning_the_Key_Full_ENG_O_1.pdf)
- <sup>9</sup> <http://www.wellesleyinstitute.com/wp-content/uploads/2015/11/Coming-Together-on-Supported-Housing-in-ON.pdf>
- <sup>10</sup> <http://www.onpha.on.ca/Content/housing-stability-project/housing-stability-project.aspx>

## Shared Resources (found at [www.amho.ca/promisingpractices](http://www.amho.ca/promisingpractices))

### Intake/Outreach

- Housing Support Coordination Document Checklist (Cambridge Step Home)
- Outreach Protocol (FSWE)
- CMHA Housing Intake (CMHA Lambton Kent)
- Supported Permanent Residential Housing Referral Form (SSSSM)
- Application Form & Rating Scale (SCAS)

### Support Provision Tools

- Housing Support Coordinator Guide (5 Stages of Recovery) (Cambridge Step Home)
- Diversion Flow Chart (JHS)
- Medication Offering Form (Regeneration)

### Housing Support Tools

- Unit Viewing Protocol (FSWE)
- Move In Protocol (FSWE)
- Apartment Checklist (CMHA Lambton Kent)
- Communication Booklet (Hong Fook)

### Job Descriptions

- Role of Housing Case Manager (CMHA Lambton Kent)
- Housing Support Worker (SSSSM)
- RPN Job Description (SSSSM)
- Addiction Case Manager (SCAS)
- Resource Worker (St. Jude)

### Data & Research

- HERIN Workbook (FSWE)
- Needs Assessment Tools (Houselink Steps)

### Client Letters/Forms Templates

- Hospital Diversion Consent Form (JHS)
- Ottawa Inner City Health Consent Form (JHS)
- Tenant Warning Letter Template (JHS)





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