Addictions & Mental Health Ontario | Dépendances & santé mentale d'Ontario

SUPPORTIVE HOUSING:
RECOMMENDATIONS FOR THE PROVISION OF SUPPORT SERVICES

April 2017

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EXECUTIVE SUMMARY

Housing has long been recognized as a key social determinant of health. For those with mental health and addiction issues, supportive housing is particularly necessary to support and maintain their recovery. However, in Ontario, lack of investments in this sector has resulted in inadequate supply and long wait lists. In Toronto alone, more than 11,000 people are on the waitlist for supportive housing. The Mental Health and Addictions Leadership Advisory Council Supportive Housing Working group released their Supportive Housing strategy[i] in 2016, which recommends that a minimum of 30,000 additional supportive housing units are required to meet the need for those with mental health and addiction issues over the next decade (2015-2025). The Ontario Government has recognized this need. Both the Ministry of Health and Long Term Care (MOHLTC) and the Ministry of Housing (MHO) have recently announced increased investments into the supportive housing sector. Though the investments are a welcome start, significant additional investments will be required to meet the 30,000 target by 2025.

This report has been developed to support and inform the implementation of supportive housing units, and, to guide the implementation of models *for the provision of support* within housing. The intended outcomes of the recommendations for the design and structure of the system are to guarantee that:

1. The needs of clients seeking supportive housing are met;
2. Supportive housing providers are held accountable for high quality standards in the delivery of services;
3. Support for the integration of the supportive housing system with other parts of the health and social service system is provided; and
4. Investments are allocated in a standardized way across the province while taking into account local characteristics.

RECOMMENDATIONS

1. Guiding Principles for the Models of Support

   The planning and provision of supportive housing for people with mental health and addiction issues should be guided by the following seven key principles:

   a. **Flexibility:** Supports provided should be flexible to meet the different needs of individuals
   b. **Customization**: Supports should be customized to the unique needs of the individuals
   c. **A range of Core Services**: A set of core services should be provided in each supportive housing program
   d. **Community Integration**: Housing is integrated into the community to foster social engagement and connections to the community
   e. **Housing Readiness**: Potential tenants are not required to be ‘Housing Ready’ at the time they are housed.
   f. **A range of Complimentary Services:** A range of complimentary services are available to each individual

g. **Funding Priority:** Priority is given to potential tenants with the highest and greatest needs - For government to meet its commitment to ending homelessness by 2025, supportive housing *should be readily available to anyone who needs it by that date.*

2. Common Assessment of Need

   Ontario's supportive housing providers should adopt and implement a common assessment tool to identify clients' housing-specific needs in a manner that is consistent and equitable across the province.

3. Supportive Housing System Design

   Ontario should establish one or more 'Supportive Housing Systems' and ensure that each 'system' is adequately resourced to deliver the full range of services required to meet the population's needs. A LHIN region or a sub-LHIN region could represent a system, depending on the needs of that population. The proposed system should be developed in collaboration with all bodies including LHINs, Service Managers, DSAAB's, service providers and others involved in the delivery of supportive housing.

4. Supportive Housing Services

   An expert panel should be convened to identify supportive housing core services. These services are defined as those supports which should be available from every supportive housing provider, independent of the design of their program. Once identified, Ontario should recognize those core services as the foundation for Ontario's supportive housing system.

CONCLUSION

A lack of significant investments into the supportive housing sector, coupled with the absence of a consistent overarching framework to guide the delivery of supportive housing has led to huge variability in terms of the way supports within supportive housing is delivered. Providers have had to develop innovative approaches to deliver services to meet the needs of their clients - essentially doing more with less. This has caused the system to move towards a "Do Whatever it Takes" (DWIT) approach to meet the constantly changing needs of the population they serve. Though understandable, this approach is problematic. The system must move away from DWIT to a more rational, equitable model. This can be achieved through the implementation of the recommendations identified in this report. Additional funding and the development of a framework that includes system redesign is necessary to support this transition. LHINs, service managers and other provincial or regional bodies responsible for housing and supports will need to collaborate to ensure that each supportive housing system is adequately resourced to meet the needs of individuals across Ontario. Additional research should be undertaken to develop evidence to identify which models of support work most effectively for which clients.

1. INTRODUCTION

There are 22,000[ii] supportive housing units in Ontario designed to address the needs of people with mental health and/or addictions issues, or those who are chronically homeless. Approximately 6,800 units of these units were added in the last 17 years, at a rate of about 400 new units per year.

These units have become part of a supportive housing 'system'[iii] developed over forty years of diverse policy initiatives – each designed to respond to different social issues, needs and concerns identified by the government of the day, and each reflecting the then-current understanding of the causes and preferred approaches to addressing mental illness, addictions, and homelessness.

With this history, and the lack of a consistent, overarching framework, it should not be surprising that supportive housing in Ontario is less a 'system' and more a collection of programs, operating largely independent of one another, to meet the needs of similar populations.

Though there have been some investments into supportive housing over the past few years, historically the levels of the investments have proved inadequate to meet the needs of the target populations. According to the Access Point waiting list in the City of Toronto, the waitlist for supportive housing stands at over 10,000 as of 2015, having grown from 900 in 2009, the first year of Access Point. Recent estimates suggest that at least 30,000 units across the province will be required to meet the need over the next decade.[iv]

As a result of the increased recognition of housing as a key determinant of health, and in response to the growing need and pressures on the current system, the provincial government has renewed their attention on the supportive housing file. Multiple cross-ministerial policy initiatives[v] have simultaneously identified safe, affordable housing with support as a significant social asset and a critical enabler of recovery. For instance, the Mental Health and Addictions Leadership Advisory Council (the Council) supportive housing working group's strategy calls for increased investments into supportive housing units across Ontario. In response to these recommendations, the Ministry of Health and Long Term Care (MOHLTC) announced in February 2017 that they will invest in an initial 1,150 supportive housing units across the province over the next two years to support people living with mental illness and addictions.[vi]

This report has been developed to support and inform the implementation of new units, and, more specifically, to provide advice and recommendations to guide the implementation of models *for the provision of support* within housing. The recommendations speak to the design and structure of the system, to ensure the following outcomes:

1. To ensure that the needs of clients seeking supportive housing are met
2. To hold supportive housing providers accountable for high quality standards in the delivery of services

3. To support the integration of the supportive housing system with other parts of the system, and
4. To ensure that investments are allocated in a standardized way across the province while taking into account local characteristics.

This report is also intended to serve as a resource for LHINs, service managers and others who will be working together to implement new supportive housing units across the province.

In the pages that follow, the report provides:

- A history of supportive housing in Ontario's mental health and addiction system
- An overview of Ontario government initiatives to address homelessness and supportive housing needs for people with mental health and addiction issues
- A description of the methodology we employed and findings derived through that process
- A conceptual framework for understanding supportive housing
- Recommendations for:
    - Guiding Principles
    - Assessment Tools
    - Core Supports
    - System Design

2. HISTORY OF SUPPORTIVE HOUSING IN ONTARIO'S MENTAL HEALTH AND ADDICTION SYSTEM

To understand the state of Ontario's current supportive housing system, and to make workable recommendations for the next stage in its development, it is may be useful to understand its history.

In Ontario, as elsewhere, the mental health and addiction systems evolved very differently. Consequently, supportive housing in the two sectors has taken very different trajectories.

Mental Health

During the 'deinstitutionalization' movement of the 1960s and '70s, many people with serious mental illness were discharged from Ontario's psychiatric hospitals – places many of them had called home for decades. With little in the way of preparation, former 'patients' were often ill-equipped to function independently. To further compound the problem, the communities in which they found themselves were often poorly prepared to support them.

Motivated in equal parts by compassion for their newly-discharged neighbors, and the need to protect their communities from behaviors they found frightening, groups of concerned citizens pressured the provincial government to address the problem it had created through its deinstitutionalization policy. Consistent with the then-current understanding of serious mental illness,[vii] many of the early programs were custodial in nature - based on a model of *providing*

for people rather than supporting them in learning to *provide for themselves*. Congregate living – in the form of group homes - was the norm.

Over the next three decades, there was a marked a major shift in our understanding of what it means to live with a severe mental illness, and significant advances were made in the psychopharmacology to treat it. Those factors, combined with the rise of the recovery movement and increasing demands from consumer-survivors[viii] to be treated with greater respect, led to the implementation of new supportive housing approaches based on the assumption that people *could and would* improve if provided with the appropriate supports.

Custodial approaches were clearly not consistent with this new ethos. New models that provided flexible support, respected consumer choice and encouraged independence were introduced.

Addictions

'Recovery homes' were among Ontario's first publicly funded addiction treatment programs. Originally an outgrowth of Alcoholics Anonymous, the first recovery homes were small residences where groups of people with substance use issues supported each other in their pursuit of abstinence. Originally staffed by volunteers, residential treatment programs (as they've come to be known) now offer 24/7 professional staffing in programs ranging from 21 to 28 days.[ix] Then, as now, the primary focus of these facilities was helping residents to achieve and maintain a drug and alcohol-free lifestyle. Once individuals completed the program they were discharged – often with little community support.

For many years, recovery homes were thought to be the only legitimate form of treatment for substance use. By the 1980s, however, an expanded range of treatment approaches (most of them non-residential) had demonstrated their efficacy. That, in combination with the cost considerations associated with residential treatment, led the provincial government to shift the system's focus – from one in which residential treatment occupied a central position, to one in which that approach was reserved for those who were assessed as unlikely to benefit from less intensive interventions. Community programs increased over the next decades, while few new residential programs were funded.

By 2008 it had become apparent that many people with substance use issues required housing support in order to live successfully in the community. To address this need, the provincial government provided $16 million in new funding for 1000 units of what it called "Addiction Supportive Housing" (ASH). ASH programs were intended to achieve the following goals:

- *"To reduce the frequency of re-admissions to addiction programs, particularly withdrawal management services*
- *To increase housing stability for people with problematic substance abuse who are homeless, at risk of homelessness or inadequately housed*
- *To reduce pressure on the emergency care and acute care systems.*

- *To reduce the frequency of re-admissions to addiction programs, particularly withdrawal management services."*[x]

In funding ASH programs, the MOHLTC had identified explicit principles for their design – many of which reflected a "Housing First" philosophy.[xi] One such principle was housing permanency – i.e. that clients were entitled to retain their housing indefinitely. Another was the de-linking of housing and support – which requires that housing not be contingent on the tenant accepting treatment.

As the programs developed, however, many of them (sanctioned by their Local Health Integration Networks) made adjustments to the originally-envisioned design in order to respond to the unique needs and conditions in their community. Among those adjustments was the implementation of 'transitional' programs – designed to provide time-limited housing as an adjunct to addiction treatment. Ontario's ASH programs now offer a range of supportive housing options – from permanent to transitional, from those that require abstinence to those that operate on a harm reduction model, and from those based on "Housing First" principles to those that see their role as providing treatment in a housing context. For details on the LHIN funded ASH providers, please refer to section 4.3.

3. OVERVIEW OF ONTARIO GOVERNMENT INITIATIVES TO ADDRESS HOMELESSNESS AND SUPPORTIVE HOUSING NEEDS FOR PEOPLE WITH MENTAL HEALTH AND ADDICTION ISSUES

Open Minds, Healthy Minds – In 2014, Ontario's Ministry of Health and Long-Term Care (MOHLTC) launched the second phase of its 10-year strategy for mental health and addictions. *Open Minds, Healthy Minds: Ontario's Comprehensive Mental and Addiction Strategy* (2014) identified five 'Strategic Pillars'. The third pillar included a commitment to "increasing supportive housing for people with mental health and addictions who are homeless or at risk of homelessness." To support the implementation of this strategy, the Ministry created the Mental Health and Addiction Leadership Advisory Council.

Mental Health and Addictions Leadership Advisory Council (the Council) – The Council was appointed in October 2014 by the MOHLTC and was mandated to provide implementation advice with respect to *Open Minds, Healthy Minds.* In 2015, the Council produced its first annual report, Better *Mental Health Means Better Health.* That report identified five priority areas, including supportive housing.[xii]

The Council's report noted that the provincial government had committed to creating 1,000 more supportive housing units for people with mental health and addictions issues (bringing the total to 13,000), but that this investment would address a fraction of the total demand.

Recognizing that additional investments might not be forthcoming in an environment of fiscal constraint, the Council identified that there is: "*(A) need to work together across sectors to maximize investments, identify opportunities for collaboration, and leverage existing*

resources." To that end, the Council struck a supportive housing working group to *"… provide expert advice and strategic leadership to ensure appropriate linkages are being made with work being done across other parts of the system."* On behalf of the Council, the supportive housing working group developed a supportive housing strategy and made recommendations to the MOHLTC calling for additional investments into supportive housing. The working group recommended that the Ministry should *"…create at least 30,000 units of supportive housing for people with mental health and addiction issues over 10 years*.[xiii]"

Ontario's Long Term Affordable Housing Strategy – In 2015, the Ministry of Housing (MOH) announced that it had set an ambitious target to end chronic homelessness in ten years. Given that people who are homeless are more likely to experience mental health and addiction issues,[xiv] part of that Ministry's plan needs to include strategies for addressing the support needs of this population. In recognition of this, the Ministry in March 2017 announced they will be increasing their operating funding for housing assistance and support services by $100 million annually, ramping up to 2019/20. This funding is expected to help 6,000 individuals and families across Ontario. Additionally, while this work was underway, MOH in collaboration with MOHLTC, MCSS and MCYS, released the Ontario Supportive Housing Policy framework[xv]. This framework is intended to support system transformation initiatives identified by the Ministries. A best practice guide was also released as a companion document to the Supportive Housing Policy framework and is intended to serve as a resource to all those involved in supportive housing and related services/systems.

Implications of these strategies – Responsibility for implementing the MOHLTC strategy will fall to the Local Health integration Networks (LHINs), which are responsible for funding supports. The target set by the MOH will drive the work of municipal service managers, who are responsible for managing social housing programs and District Social Services Administrative Board (DSAABs).

An unprecedented degree of collaboration will be required to meet the target to end homelessness in 2025 and achieve the goals set out in the ten year Mental Health and Addiction strategy. LHINs, service managers municipalities/DSAABs and other bodies responsible for providing housing and supports must work together to develop an efficient supportive housing system to effectively meet the needs of people with mental health and addiction issues.

In addition to providing advice to government, this report, which is based on the sector's experience, is intended to serve as a tool to support collaboration between the different bodies who will be working together to implement new supportive housing units over the next decade. We also hope that this work will add to the framework and further define what supportive housing should look like, based on the sector's input.

4. METHODOLOGY AND FINDINGS

LITERATURE REVIEW

We undertook a literature review for the purpose of identifying evidence on models of support within housing for people with mental health and addiction issues. Our intent was to understand the evidence on best practice when delivering support services within housing to people with mental health and addiction issues, including what supports should be available, optimum level of support for each service based on client need, among other things. Our literature review focused on the following areas:

1. Models of support within housing available for people with varying needs and for specific populations. Among others, we sought information about the following program variables:
    - Whether involvement with the case manager is mandatory or voluntary
    - The frequency and intensity of contact with the case manager
    - Whether group and/or individual support is provided
    - Which types of support are provided
    - What level of support is provided based on need
2. Specific services served within each type of support provided.
3. The effectiveness of each model based on services provided. One of the key characteristics considered was client to staff ratio for each of the functions.

We identified thirty articles that reviewed housing with supports for people with mental health and addiction issues, including eighteen that looked at permanent supportive housing, seven that looked at addiction supportive housing, and nine that discussed housing in general.

Consistently, we found broad consensus on the effectiveness of supportive housing in achieving good mental health and addiction outcomes. A number of studies recognized that supportive housing works, that it is a key social determinant of health, and that it is essential to supporting recovery and/or housing stability for individuals who have mental health and addiction issues.

For instance, “At Home/Chez Soi Project”, a study commissioned by the Mental Health Commission of Canada looked at the benefits of a housing first model versus a treatment as usual model and found that housing first can rapidly reduce homelessness and can improve community functioning and quality of life for clients.[xvi] Leff et. al, (2009)[xvii], found that supportive housing greatly increased client satisfaction among clients. Rog et al. (2014) found a significant reduction in emergency department visits while Tsembaris et al (2012) and Warnes et al (2012) concluded that housing with supports leads to greater housing retention rates for individuals with mental health and addiction issues.

There was, however, little evidence on the relative effectiveness of specific levels of support, or on the attributes or levels of support within housing (e.g. client to staff ratio) that create the best outcomes for individuals based on specific needs. Additionally, none of the studies we reviewed discussed outcomes related to the services served within housing programs that offer support. The Toronto mental health and addiction supportive housing network[xviii] had undertaken some work to identify levels of support for services for those with low medium and high needs but were also unable to identify relevant research that speaks to optimal levels of

support for individuals with differing needs for supportive housing. There was also limited research describing the types of support that need to be available to meet specific population needs. Eight of the studies discussed housing needs for seniors, but none focused on marginalized populations and their needs.

This lack of evidence was, itself, the subject of some discussion in the literature. Pleace et al (2010)[xix], Rog et al (2014)[xx] and Aubry et al (2014)[xxi] concluded that additional research is required to determine which models work most effectively for which clients. Tabol et al (2010)[xxii] and Aubry et al (2014) suggested that supportive housing models had been inadequately defined and that greater model clarity was a necessary enabler of more specific research.

Consistent across all studies was the notion that despite the model of delivery for housing and supports, a number of critical success factors need to exist in order to achieve good outcomes.

Although each list of factors was slightly different, the following seven factors were mentioned repeatedly:

- Low barrier access
- Flexibility and customization (Kirsch et al, 2009; Tabol, 2010; Rog et al, 2014) including;
  - Client centered planning
  - Client choice and control
  - Variable frequency and intensity
  - 24/7 access to support
  - Doing Whatever It Takes (DWIT)[xxiii] (Institute of Urban Studies, University of Winnipeg, 2014)
- A comprehensive range of services and supports (Cityspaces Consulting, 2008; Kirsch et al, 2009)
- A focus on eviction prevention, incl. Activities of Daily Living (Waegemakers-Schiff, 2014)
- A process for matching the type and intensity of support to the client's need (Somers et al, 2007)
- Security of tenure
- Community integration

Another unarguable point that emerged across all studies is that client choice or client-directed care must be an overarching principle. The studies also noted that in order to support client choice, supportive housing systems should include a comprehensive range of services, housing types and levels of support (Kirsh, 2009), and that systems need to be resourced appropriately to provide this range of services.

In the absence of evidence for the efficacy of different models of support, we redirected our attention to the literature that identified 'guidelines' or 'principles,' [xxiv] which was a more fruitful search. We identified ten reports that allowed us to define the principles that should exists within supportive housing for mental health and addiction programs. In addition to these principles, we also identified criteria which further defined what the principle means in the context of supportive housing for people with mental health and addiction issues.

Finally, through the literature search we identified ten broad categories of services that must be provided within supportive housing:

1. Tenancy Support
2. Independent Life Skills Training
3. Social Support
4. Health and Wellness
5. Personal Support
6. Community Linkages
7. Crisis Intervention
8. Eviction Prevention
9. Clinical Support
10. Peer Support

Figure 1: 10 Categories of Services that must be provided within Supportive Housing

Further analysis allowed us to identify specific services within each category. Forty-six such services were identified. Table 1 provides a list of the services identified.

Table 1: Categories and services delivered within supportive housing

Category	Services
Tenancy Support	Unit identification, selection and leasing
	Income verification
	Orientation to agency, staff, policies, etc.
	Orientation to unit/building/complex
	Move-in assistance
	Education re: rights and obligations of tenancy
	Housing-specific goal setting
	Rent collection
Independent Life Skills training	Payment of rent and other bills
	Access to entitlements
	Money management/budgeting
	Food security
	Nutrition counseling
	Food preparation
	Unit maintenance/cleaning
	Use of public transportation
	Use of laundry facilities
	Personal safety
Social Support	Communication Skills
	Assertiveness
Health and Wellness	Specialized health services (e.g. diabetes education)
	Primary care
	Care coordination
	Relapse planning and prevention
	Recovery planning
	Medication education
	Symptom monitoring
	Medication monitoring
Personal Support	Bathing/hygiene
	Dressing
	Medication management
	Meal preparation
	Laundry
Community Linkages	Facilitated access to community resources
	Encouragement of volunteer activities
	Job training/social enterprise opportunities
	Community development activities
Crisis Intervention	Safety planning
	Crisis intervention
	Emergency financial assistance
	Conflict resolution

Eviction Prevention	Landlord liaison
	Legal assistance
	Hoarding intervention
Clinical Support	Assessment, treatment planning and support specifically related to the person's mental health or addiction status
Peer Support	Social and emotional support and mentoring provided by a person with lived experience

To validate both the principles and services, we sought input from a variety of stakeholders including service providers, and mental health and addiction LHIN lead. The recommendations that appear in this report were based on input from key stakeholders and extensive consultations with the sector. Additional details on this process are available in the next section.

STAKEHOLDER CONSULTATION

Stakeholder consultations took three forms: key informant interviews, webinars and a survey. Key informants from across the sector were identified to help validate the principles identified from the literature as well as refine the criteria attached to each principle. To ensure representation from a broad range of perspectives, we selected key informants from rural, urban and suburban communities across Ontario, and from programs that support clients with a wide range of needs. See appendix one for a list of the individuals consulted.

The following questions were put to the key informants:

- Do the "principles" resonate with you?
- Are there other principles you think should be included?
- Do our draft criteria make sense in the context of programs like yours?
    - If so – are there other criteria that should also be applied?
    - If not – what kind of issues would the criteria present for your program?
- Are there any other issues you think are important for us to be aware of?
- Do you have any other "free advice" for us as we move forward?

The following revised set of principles emerged from that process:

1. Supports should be flexible
2. Supports should be customized to address the needs of each tenant
3. A range of core services should be provided by every supportive housing provider
4. A range of complementary services should be provided in each supportive housing system
5. Potential tenants should not be required to be "housing ready" at the time they are housed. Supportive housing programs should be adequately resourced to support potential tenants in acquiring the skills necessary for successful tenancy.
6. Housing supports should be integrated into the community in order to foster social engagement and community connections

7. Priority should be given to potential tenants with the greatest needs and the most pressing issues.

We then held a webinar to get broader sector input into the principles and criteria. Attendees included housing providers from a variety of programs that support individuals with mental health and addiction issues. Over fifty programs were represented.

Having identified the types of support and services that should be provided, we wanted to understand whether Ontario's mental health and addiction supportive housing programs were providing that range of services to their clients. We also hoped to identify the client to staffing ratios for each of the services provided, and core services provided by each program. To that end we surveyed representatives of programs that had participated in the webinar. For the detailed survey, please refer to appendix three.

For each of the forty-six services, respondents were asked to indicate whether the service was available to clients and – if so – whether it was provided by staff of their housing program, by other staff within their own agency, or by staff external to the agency. Further, they were asked to identify, by classification, the staff who provided the service and note the client to staff ratio for that type of position.

Responses to the survey were informative. All forty-six services identified through the literature review as being required within supportive housing were provided by at least one of the service providers or their partners. This confirmed the notion that each of those services should be available to individuals within supportive housing programs.

At the same time, however, we found significant variability across providers in terms of:

- The range of services provided – programs that have the same goal and serve the same target population varied widely in the actual services provided
- The levels of services (client to staff ratio) for each of the identified services
- Which staff group provides which type of service
- Whether programs provided the service themselves or relied on other agencies to provide it.

In order to understand this variability, we consulted with some of the providers who responded to the surveys.

Key informants highlighted that the needs of their client group have become increasingly complex, and that these needs are constantly changing. In the absence of a significant influx of new funding to meet the escalating demands, providers have embraced the 'DWIT' (Do Whatever It Takes) philosophy and developed innovative approaches to meet client needs on a case-by-case basis. Essentially, providers are learning to do more with less.

That approach, while it maximizes a program's ability to address the needs of its clients, leads to significant variability from provider to provider, from LHIN to LHIN and presents a major challenge for any research into the efficacy of specific models of supportive housing.

ANALYSIS OF THE CURRENT STATE OF SUPPORTIVE HOUSING IN ONTARIO

To understand Ontario's existing supportive housing system, we completed a current state analysis, based on data provided by ConnexOntario, a MOHLTC funded agency.[xxv] Unfortunately, only agencies funded by the LHIN report their data into ConnexOntario. As such, the results were limited to only LHIN funded agencies. Other supportive housing providers who are not LHIN funded would not be represented in the data.

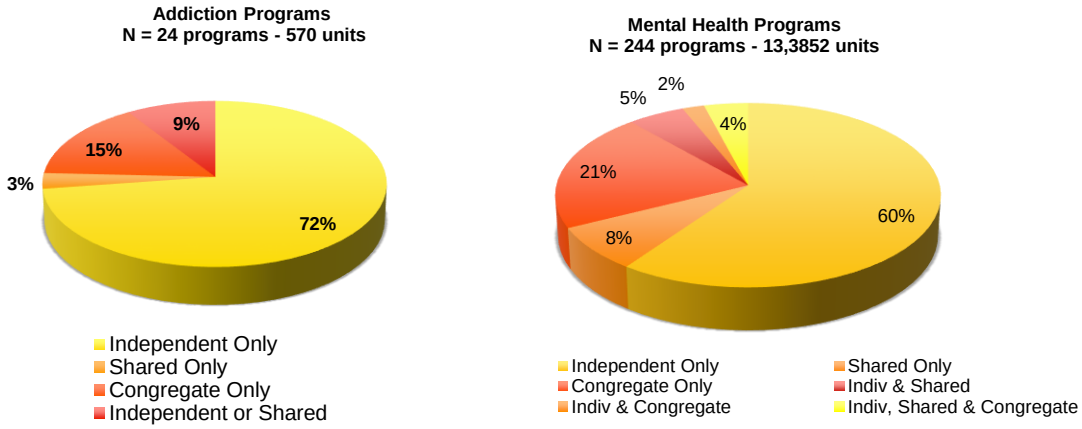
Table 2 provides details on the number of supportive housing providers by LHIN. Based on LHIN funded agencies, we see there are 252 providers that report they provide mental health supportive housing and 50 providers that report providing addiction supportive housing.

Table 2: Number of Supportive Housing Providers by LHIN

LHIN	ADDICTIONS	MENTAL HEALTH
Erie St Clair	1	4
South West	3	25
Waterloo Wellington	3	7
HNHB	6	27
Central West	1	6
Mississauga Halton	3	12
Toronto Central	11	55
Central	1	12
Central East	4	19
South East	1	18
Champlain	4	22
North Simcoe Muskoka	3	6
North East	6	21
North West	3	18
TOTAL	50	252

In addition to understanding the capacity of supportive housing units across the province, we also wanted to understand the types of programs available to meet the various needs of clients seeking support within housing for mental health and addiction issues.

Based on data from Connex, we found that 72% of addiction programs offer independent standalone units compared to 60% reported by mental health providers. However, the mental health supportive housing providers offer more variety in terms of programming, based on what is reported.



Unfortunately, the limitations of the Connex data means that we do not have an accurate picture of Ontario's supportive housing landscape. What is clear is that service levels are inadequate to meet the current need. Prior to determining where investments need to happen, government will have to undertake work to map current supportive housing programs, estimate the needs based on the population and identify gaps so as to determine how to effectively allocate investments. A number of organizations are currently working on analyzing the Access Point's Waitlist data[xxvi] . The findings from this work could be useful in shedding some light on the need, and what the levels of support would be required to meet that need.

5. SUPPORTIVE HOUSING FRAMEWORK

Through the surveys and key informant interviews, we found that significant variability exists across Ontario's supportive housing sector with regards to how providers meet the needs of the people they are serving. This variability appears to be due, in part, to funding shortfalls that have resulted in supply and resource challenges. To successfully meet the needs of their clients, providers have had to be creative and innovative in the ways they deliver service. While they should be congratulated for their ingenuity and adaptability to system challenges and barriers, that very creativity has led to a lack of consistency in service delivery across the supportive housing sector.

Also, as noted in the introduction, Ontario's supportive housing programs developed incrementally over more than forty years, without a consistent framework to guide their design and implementation. However, a framework is necessary to ensure:

1. The needs of those receiving supportive housing are being adequately met consistently across the province
2. Needs are accessed in a consistent and standardized way across the province
3. LHINs and service providers are held accountable for delivery of supportive housing services
4. Investments towards supportive housing are allocated in an efficient and effective manner.

To address these issues, we are proposing that a framework that focuses on the following variables should be developed:

- Program Goals - Permanent vs. Time Limited Supportive Housing
- System Design
- Differentiation of Core and Non-Core Services

As previously mentioned in the introduction, while this work was in progress, the Ministry of Housing, in conjunction with MOHLTC and others, released its Supportive Housing Policy framework, within which they articulate their vision for Ontario's system, present principles that should guide supportive housing, and discuss the outcomes for people living within supportive housing and for the system. They also identify initial priority areas for investment. We hope that this further provides input to Government as they continue to work towards system transformation.

PROGRAM GOALS - PERMANENT VS. TIME LIMITED SUPPORTIVE HOUSING

Supportive housing programs were developed in response to the needs of people leaving hospitals or those needing support in the community, and without a consistent set of overarching principles.

Where principles were established (in the case of addiction supportive housing programs for example), service providers' efforts to tailor programs to respond to local needs resulted in significant diversity in program design. One aspect of that diversity relates to housing tenure.

Addiction supportive housing (ASH) programs were originally mandated to provide permanent housing with no requirement that tenants accept treatment for their substance use. As programs evolved, however, it became clear that there was also a need for programs that offered time limited supportive housing for people receiving addiction treatment. In the words of one of our key informants, the difference between "a housing program with an addiction component, and an addiction program with a housing component" is a critical distinction with implications for service provision.

Consultations with the sector has led us to conclude that there needs to be a large variety of housing programs available in the system to meet the unique goals that clients may have, such as housing stability, symptom reduction, and others. While our research was underway, the MOH initiated a consultation on transitional housing issues. That process concluded that, although housing permanency should remain a general principle, "there is also a need for accommodation with support on a time-limited basis with less than permanent tenure, **but that this should be a program category separate and distinct from supportive housing."** (MHO, 2016). Based on our experience with this research and input from the sector, we support that recommendation.

Program goals that incorporate different client needs should be clearly defined and incorporated into a supportive housing framework.

SYSTEM DESIGN

Ontario's supportive housing programs vary significantly in terms of their size and structure, staffing, and the range of services they provide. Our analysis of programs that responded to our survey found huge variability among the programs. For example services provided by a case manager for services such as tenancy support varied from a client to staff ratio of 1:1 on the low end to 1: 30 on the high end with multiple providers reporting a wide range of ratios in between. Similarly, we found programs that operate as the sole service provided by a small agency and - on the other end of the spectrum - agencies that operate multiple housing programs as part of a large and varied portfolio of services.

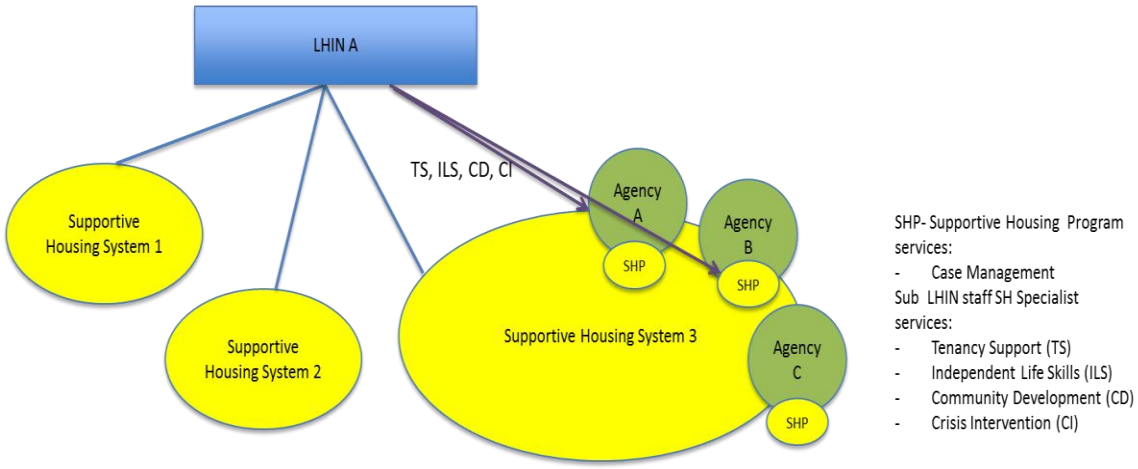
In the latter case, supportive housing clients may have expedited access to the other services offered by a multi-service agency. Smaller, stand-alone programs may have partnerships - formal or informal - with other agencies to provide their clients with the services that they do not offer themselves. In some cases, however, there are no agreements. As a result, clients of those programs may not be able to access the full range of services they need.

Previous work completed by the Toronto Mental Health and Addictions Supportive Housing Network[xxvii] attempted to develop a process to determine levels of support" in terms of tenant to staff ratio's based on different levels of support (low, medium, high) and found similar variability in defining these levels across the sector.

Given the sector's history, variability is understandable. It is not, however, acceptable as it creates confusion across the sector and impedes access to those seeking services given the lack of clarity on service options. Further, given that services are not delivered across the province in a standardized way, it is difficult to develop quality or outcome measures that is essential to supporting quality improvement in the sector. For these reasons, we are proposing the creation of a series of supportive housing 'systems' across Ontario. The details of this model are part of the recommendations available in section 6.

The figure below provides a description of some of the structural options.

Figure 2: Supportive Housing System Design



For example, peer support is a service identified in the literature as important to the effectiveness of supportive housing programs, yet only fifteen percent of the programs we surveyed reported that they had peer specialists on staff.[xxviii] Rather than funding each of the programs to provide peer support, guaranteed access to a peer specialist employed by one member of a supportive housing *system* could address that need. Enhanced funding would be required to allow the agency that provides peer support to respond to the increased demand. It would not be necessary, however, to duplicate that function in each of the other member programs.

In terms of system structure - each LHIN would determine the number of 'systems' to be created and the composition of each of them based on an allocation model that, in part, considers the following variables:

- Population density
- Geography
- The number and size of supportive housing programs

Depending on the need identified within a region, a LHIN could serve as a system, or a sub-LHIN could serve as the system. Ontario should allocate funding that adequately resources providers in each system to provide services that meets the needs of the population in that system. Once a system is established (either LHIN or sub-LHIN) a mapping exercise should be completed in each LHIN that identifies all service providers and describes each of their programs.

SUPPORTIVE HOUSING SERVICES

As mentioned previously, significant variability in terms of services provided from program to program limited our ability to identify core services vs. non-core services. For our purposes, 'core services' can be defined as those which should be available from every supportive housing provider, independent of the design of their program. 'Non-core' services are those that are required to meet the broad range of client needs, but which need not necessarily be provided in every program, so long as clients are assured rapid access to them somewhere in the supportive housing system. We are proposing that within the framework, core services vs. non-core services should be distinguished. Standards should be developed to set the expectations for the delivery of both core and non-core services.

Some work is already in place that is looking at this. For example, The Toronto Mental Health & Addictions Supportive Housing Network (TMHASHN) is working on developing recommendations and next steps for how to provide individual choice in supportive housing. Part of this work involves providing a description of principles and core services that can support appropriate matching of client need and choice with the right housing opportunity. Examples such as these should serve as a reference on further work that should aim at defining services that should be provided within supportive housing.

6. RECOMMENDATIONS

Based on our findings and the framework outlined, we offer the following recommendations:

RECOMMENDATION 1: SUPPORTIVE HOUSING GUIDING PRINCIPLES

It is important to note that though we have identified guiding principles for supportive housing, it was clear to us that tenant choice must be an overarching principle of supportive housing. This point was made clear in both the literature and from our key informant interviews. Supportive housing providers must make every effort to ensure tenant choice is considered and reflected in all aspects of service development and delivery. These recommendations align to those identified in the Best Practice Guide developed by the MOH and are further expanded in this document based on the sector's input.

Recommendation 1: The planning and provision of supportive housing for people with mental health and addiction issues should be guided by the following seven key principles and related criteria:

Table 3: Supportive Housing Guiding Principles and Draft Criteria

Key Principles	Draft Criteria
Flexibility	• Support is provided in a range of locations throughout the community.
	• Support is provided at hours that meet the needs of clients and accommodate their other obligations (e.g. work, school, family).
	• The frequency and intensity of contact with support providers varies according to the client's needs.
	• The program's staffing ratio allows for variable frequency and intensity of contact.
	• More intensive support is provided initially, and/or whenever required, based on client need.
Customization	• Supportive housing providers make every effort to ensure tenant choice is considered and reflected in all aspects of service development and delivery.
	• A comprehensive support plan is developed in collaboration with each client.
	• Measurable short, medium and long-term goals are established with each client.
	• Supports are client-centered and responsive to client need.
	• Each client's support plan and crisis plan is reviewed regularly and updated as required.
A range of core services is provided	• Each supportive housing program provides core services to be defined (see Rec 4) to its own clients.
	• Each supportive housing program is adequately resourced to provide the defined core services.

	• Peer expertise is actively sought out and utilized – The role and expertise of peer specialist is well defined.
	• Supports are available, as required, to assist clients in developing or enhancing independent living skills.
	• Relapse prevention is a focus for both addiction and mental health issues (including relapse to more harmful behaviors, not just relapse from abstinence).
Housing is integrated into the community	• Supports strengthen connections to the community.
	• Supports enhance independence, inclusion, social engagement and participation in community life.
Potential tenants are not required to be 'Housing Ready' (in terms of tenancy and ADL skills) at the time they are housed.	• Applicants whose Activities of Daily Living and tenancy skills require improvement receive the necessary support and training to ensure successful tenancy.
A range of complementary services is available	• Supports are coordinated with complementary services. • There is regular communication between the Case Manager and other relevant service providers.
Priority is given to potential tenants with the greatest needs and the most pressing issues	• A process is in place for assessing acuity using a standardized tool

The last principle (Priority is given to potential tenants with the greatest needs and the most pressing issues) is included solely to provide direction to government on allocations of initial investments. In November 2016, the Auditor General of Ontario released their findings on the audits in three mental health and addiction areas including supportive housing. Based on their findings, one of the conclusions is that given the current resource limitations, the province will need to ensure that investments for housing should be directed to those most in need. We agree that initial investments should be targeted to clients with the highest level of need (e.g. people currently in hospital and identified as requiring an Alternative Level of Care). However, if government is to meet its commitment to ending homelessness by 2025, supportive housing *should be readily available to anyone who needs it by that date.* Supportive housing is a determinant of health and its provision must not be an option but a necessity that must be met.

RECOMMENDATION 2: ASSESSMENT OF NEEDS

Recommendation 2: Ontario's supportive housing providers should adopt and implement a common assessment tool to identify clients' housing-specific needs.

Utilization of a standardized assessment tool will ensure that resources are appropriately matched to client needs and that each supportive housing client receives the specific services they require. We recommend that an advisory committee should be struck to review currently available tools and to recommend the most appropriate tool for use in Ontario. This advisory committee should include key stakeholders who play a role in the delivery of supportive housing within Ontario. The selected instrument should be compatible with other assessment tools and protocols used in the mental health and addiction system.

The following are examples of tools that are currently in use in other jurisdictions, as well as the OCAN in Ontario:

- **Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) -** The VI-SPDAT is a pre-screening tool designed for use at the system level to 'triage' individuals and families who need supportive housing. The VI-SPDAT 'helps identify who should be recommended for each housing and support intervention, moving the discussion from who is eligible for a given intervention to who is eligible and in greatest need of that intervention.' [xxix]
- **Service Prioritization Decision Assistance Tool (SPDAT):** The SPDAT uses 15 dimensions (e.g. self-care and daily living skills, physical health and wellness, managing tenancy) to determine an acuity score that will help providers identify:
    - applicants who will benefit most from supportive housing
    - the areas of the person's life that can be the initial focus of attention in the case management relationship
    - how individuals and families are changing over time as a result of the case management process. [xxx]
- **Multnomah Community Ability Scale - Revised (MCAS - R)** – The MCAS – R utilizes 17 indicators in four categories (health, adaptation, social skills and behavior) to 'assess how well people with psychiatric disabilities function in their world'.[xxxi]
- Ontario Common Assessment of Need (OCAN) [xxxii] – The OCAN tool is a standardized, consumer-led decision making tool that assists with mental health recovery. It was designed to identify individual needs, and help match those needs to existing services and helps identify service gaps. However, it is considered by addiction service providers to be inadequate to assess needs of people with addictions issues.

We also recommend that during the first year of participation in a supportive housing program, re-assessments should be completed every 3-6 months and supports should be adjusted to meet the changing needs accordingly. This is in recognition that over time, individuals needs will decline as their housing and support needs are met and supports should be adjusted accordingly. However, changing needs and supports occur on a continuum rather than one direction, and should be adjusted as required.

RECOMMENDATION 3: SUPPORTIVE HOUSING SYSTEM DESIGN

Recommendation 3: Ontario should establish one or more 'Supportive Housing Systems' and should ensure that each 'system' is adequately resourced to deliver the full range of services required to meet the population's needs.

In this model:

- Each of the LHINs identify one or more 'systems' comprised of existing supportive housing programs. The LHIN itself could be the system or if needed, a sub LHIN could be identified as a system
- Each supportive housing program is formally linked to one or more 'systems'
- People who require supportive housing are identified as clients of the system, in addition to being clients of the program in which they are housed.
- Each program provides core services to its own clients.
- A program with the necessary expertise and resources to provide any of the 'non-core' services provides them to its own clients, and to any client housed elsewhere in the 'system'.
- Formal agreements exist among providers to ensure equitable access to services on the part of all clients.
- Together, the agencies that comprise the 'system' serve all forty-eight of the identified services
- Clients, as a result, have access to the full range of services, regardless of which program houses them.

The proposed system should be developed in collaboration with all bodies including LHINs, Service Managers, DSAAB's, service providers and others involved in the delivery of supportive housing. Those in government responsible for managing housing, managing supports and supportive housing service delivery for clients with addictions and mental health issues will have to work together to develop supportive housing systems across the province that are adequately resourced.

RECOMMENDATION 4: SUPPORTIVE HOUSING SERVICES

Recommendation 4: All supportive housing providers should provide a full range of 'core services' at the appropriate level to meet the needs of their clients.

As part of the survey we identified 46 services that are currently served across supportive housing programs. We recommend that an expert panel be convened to identify core services from among those 46 services, and to determine the optimal client: staff ratios for each service based on the client's level of need. The costs to deliver these services should be identified so as to accurately allocate investments to providers. This committee should include stakeholders from across the province who play a role in the delivery of supportive housing services for individuals with mental illness and addiction. It is important to include people with lived experience in the committee. Once these core services are identified, we recommend that

government recognize those services as the foundation for Ontario's supportive housing system.

Each supportive housing program would have to assess the services it offers to determine whether or not it is providing each of the core services. Programs that are not providing the full range of core services should be required to adjust their service delivery model to do so. In the event that a program is unable to provide all the core supports, at the optimal client: staff ratio, within its current budget, additional funding should be made available.

7. CONCLUSIONS

Housing is a key determinant of health for the entire population. For a significant percentage of people with mental health and addiction issues, access to supportive housing is a key enabler of recovery and community success.

The history of the development of the supportive housing system, coupled with funding shortfalls over several years has pushed the sector towards a 'Do Whatever it Takes' approach, which is not sustainable and will not be effective in the long run. The system must move away from DWIT to a more rational, equitable model. This can be achieved through the implementation of the recommendations identified in this report and the development of the proposed framework. That cannot be done however, without an influx of funding. Additional resources are required across the sector to allow providers to respond to individual needs in a standardized way. LHINs, service managers and any other provincial or regional bodies responsible for housing and supports will need to collaborate to ensure that each supportive housing system is adequately resourced to meet the needs of individuals across Ontario.

Lack of evidence in the literature on effective models means that additional research is required. There is a need to develop evidence on which models work most effectively for which clients. Such evidence will support system-level planning, allow for the most efficient allocation of resources and ensure that those individuals in need of supports within housing are appropriately matched to the services that can most effectively meet their needs.

APPENDICES

APPENDIX 1 - KEY INFORMANTS CONSULTED:

- Glenn Ricketts, ADAPT
- Heather Kerr, Stonehenge
- Ann Zeran, Cornwall Community Hospital
- Noel Simpson, Regeneration House
- Ann Zeran, Cornwall Hospital
- Amanda Falotico, St. Paul's Lamoreaux Centre
- Brigitte Witkowski, Mainstay
- Pam Hill, Addiction Services Thames Valley
- Marion Quigley, CMHA Sudbury
- Donna Rogers, FourCAST
- Charlane Cluett, CMHA Muskoka Parry Sound
- Nicole Latour, Alpha Court
- Holt Sivak, Threshold
- Rob McAdams, Durham Mental Heath Services
- Lisa Kerr, Salus
- Tim Aubry
- Jeanette Waegemaker – Schiff
- Steve Lurie
- Brigitte Witkowski

B: Participants – June 20 Webinar

- Addictions and Mental Health Services - Hastings Prince Edward
- Addiction Services of Thames Valley
- Arid Group Homes
- Bayview Services
- Brain Injury Services of Northern Ontario
- Canadian Mental health Association – Brant Branch
- Canadian Mental health Association – Champlain East Branch
- Canadian Mental health Association – Cochrane-Timiskaming Branch
- Canadian Mental health Association – Halton Region Branch
- Canadian Mental health Association – Lambton Kent Branch
- Canadian Mental health Association – Muskoka Parry Sound Branch
- Canadian Mental health Association – Middlesex Branch
- Canadian Mental health Association – Sault Ste. Marie Branch
- Canadian Mental health Association – Start talking
- Canadian Mental health Association – Sudbury/Manitoulin Branch
- Canadian Mental health Association – Toronto Branch

- Canadian Mental health Association – Waterloo, Wellington and Dufferin Branch
- Canadian Mental health Association – Windsor-Essex County Branch
- Centre for Addiction and Mental Health
- Choices for Change
- Cochrane District Social Services
- Cornwall Hospital
- Crest Support Services
- Fourcast
- Halton ADAPT
- Hope Grey Bruce
- Mackay Manor
- Margaret's
- Mission Services
- Montfort Renaissance
- Ontario Mental Health foundation
- Ontario Non-Profit Housing Association
- Ontario Shores
- Regeneration Community Services
- Sandy Hill Community Health Center
- Sistering
- Stonhenge therapeutic Community
- Shaw
- St. Joes
- Thresholds Supports
- Wayside House of Hamilton
- Westover Treatment Centre

C: Programs Responding to Functional Analysis Survey

- ARID Group Homes
- Addictions and Mental Health Hastings Prince Edward
- Bayview Community Services
- Breakaway Addiction Services
- CMHA Brant
- CMHA Champlain
- CMHA Lambton Kent
- CMHA Middlesex
- CMHA Sault Ste. Marie
- CMHA Simcoe
- CMHA Sudbury
- CMHA Toronto

- Eden Community Homes
- Habitat Services
- Hong Fook Mental Health Association
- House of Friendship - Concurrent Disorders-Capable Supportive Housing
- House of Friendship - Addiction Supportive Housing Permanent
- House of Friendship - Addiction Supportive Housing Complex Needs Transitional
- House of Sophrosyne
- Margaret's Housing
- Madison Community Services
- Matt Talbot House
- Regeneration Community Services
- Salus - Case Management
- Salus - Community Development
- Salus - Fisher Psychosocial Rehabilitation
- Salus - Grove Transitional Rehabilitation Housing Program
- Salus - Housing Coordination
- Salus - Residential Rehabilitation
- Salus - Supports to Social Housing
- Stonehenge - Transitional Housing
- Stonehenge - Longer Term Housing
- Threshold
- True Experience Medium Support Transitional Housing
- Wayside House of Hamilton
- Womankind Addiction Service

APPENDIX 2: PROCESS

The findings and recommendations contained in this report were developed through the following process:

- Review of the literature to identify Best Practices
- Review of data from Connex Ontario to determine current system capacity
- Consultations with:
    - AMHO's Housing Community of Practice
    - Toronto Mental Health and Addiction Supportive Housing Network
    - Mental Health and Addictions Leadership Advisory Council's Supportive Housing Working Group
- Analysis of data from 302[xxxiii] Mental Health and Addiction programs to assess the current state of supportive housing in Ontario
- Interviews with twenty Key Informants
- Development of Draft Best Practices and Criteria

- Presentation of a webinar in which representatives from fifty supportive housing programs commented on the draft best practices
- Revision of the draft best practices to reflect input from the field
- Development of a template to analyze the services served by staff of Ontario's supportive housing programs
- Survey of webinar participants
- Analysis of responses from 39 programs[xxxiv] to determine
    - The number of FTEs providing housing support
    - The positions occupied by those staff
    - The specific services provided
    - Staff to client ratios for each service
- Development of a conceptual framework for Ontario's supportive housing system
- Development of this report

APPENDIX 3: SURVEY

CATEGORY	FUNCTION	SERVICE PROVIDED				
		Y/N	BY WHOM			
			OWN AGENCY STAFF POSITION	STAFF/ CLIENT RATIO	FUNDING SOURCE	STAFF OF OTHER AGENCY
Tenancy Support	Unit identification, selection and leasing					
	Income verification					
	Orientation to agency, staff, policies, etc.					
	Orientation to unit/building/complex					
	Move-in assistance					
	Education re: rights and obligations of tenancy					
	Housing-specific goal setting					
	Rent collection					

CATEGORY	FUNCTION	SERVICE PROVIDED				
		Y/N	BY WHOM			
			OWN AGENCY STAFF POSITION	STAFF/ CLIENT RATIO	FUNDING SOURCE	STAFF OF OTHER AGENCY
	Other (please specify): _____					
Independent Life Skills Training	Payment of rent and other bills					
	Access to entitlements					
	Money management/budgeting					
	Food security					
	Nutrition counseling					
	Food preparation					
	Unit maintenance/cleaning					
	Use of public transportation					
	Use of laundry facilities					
	Personal safety					
	Emergency Preparedness					
	Use of public transportation					
	Other (please specify): _____					
	Communication Skills					

CATEGORY	FUNCTION	SERVICE PROVIDED				
		Y/N	BY WHOM			
			OWN AGENCY STAFF POSITION	STAFF/ CLIENT RATIO	FUNDING SOURCE	STAFF OF OTHER AGENCY
Social Support	Assertiveness					
	Other (please specify): _____					
Health and Wellness	Specialized health services (e.g. diabetes education)					
	Primary care					
Health and Wellness contd.	Care coordination					
	Relapse planning and prevention					
	Recovery planning					
	Medication education					
	Symptom monitoring					
	Medication monitoring					
	Other (please specify): _____					
Personal Support	Bathing/hygiene					
	Dressing					
	Medication management					
	Meal preparation					
	Laundry					

CATEGORY	FUNCTION	SERVICE PROVIDED				
		Y/N	BY WHOM			
			OWN AGENCY STAFF POSITION	STAFF/ CLIENT RATIO	FUNDING SOURCE	STAFF OF OTHER AGENCY
	Other (please specify): _____					
Community Linkages	Facilitated access to community resources					
	Encouragement of volunteer activities					
	Job training/social enterprise opportunities					
	Community development activities					
	Other (please specify): _____					
Crisis Intervention	Safety planning					
	Crisis intervention					
	Other (please specify): _____					
Eviction Prevention	Emergency financial assistance					
	Conflict resolution					
	Landlord liaison					
	Legal assistance					
	Hoarding intervention					
	Other (please specify):					

CATEGORY	FUNCTION	SERVICE PROVIDED				
		Y/N	BY WHOM			
			OWN AGENCY STAFF POSITION	STAFF/ CLIENT RATIO	FUNDING SOURCE	STAFF OF OTHER AGENCY
	_____					
Clinical Support	Assessment, treatment planning and support specifically related to the person's mental health or addiction status					
	Other (please specify): _____					
Peer Support	Social and emotional support and mentoring provided by a person with lived experience					
	Other (please specify): _____					
Other Category (please describe) _____						

ENDNOTES

[i]http://www.health.gov.on.ca/en/common/ministry/publications/reports/bmhmbh_2016/moving_forward_2016.pdf

[ii] According to the Wellesley Institute, 12,000 of those units are funded by the Ministry of Health and Long-Term Care. The additional 10,000 units are funded through municipalities.

[iii] The term "system" has been defined as: *"A set of things working together as parts of a mechanism or an interconnecting network; a complex whole"* (www.oxfordictionaries.com) and *"A group of interacting, interrelated, or interdependent elements forming a complex whole" (www.dictionary.com)*

[iv]http://www.addictionsandmentalhealthontario.ca/uploads/1/8/6/3/18638346/supportive_housing_proposal_from_amh_ontario_final.pdf

[v] Supportive Housing was a central focus of a least five provincial bodies – the Mental Health and Addictions Leadership Advisory Council, the Poverty Reduction Strategy, the Mental Health and Addictions Strategy, the Long-Term Affordable Housing Strategy Update and the Expert Advisory Panel on Homelessness

[vi] https://news.ontario.ca/mohltc/en/2017/02/ontario-providing-faster-access-to-mental-health-services-for-thousands-of-people.html

[vii] i.e. that people with SMI did not recover and that modest improvements in functioning were the best that could be hoped for.

[viii] The language used to describe people with mental health issues has shifted over the years. The term "consumer/survivor" was adopted in the early 1990s.

[ix] A small number of longer-term programs remain in operation

[x] Presentation by Anne Bowlby and Brian Davidson, Ministry of Health and Long-Term Care, to addiction service agencies, September 30, 2008.

[xi] One of the central tenets of the Housing First model is that housing is not contingent on the tenant accepting treatment

[xii] For purposes of this project, "Supportive Housing" is defined as follows: "*A combination of a safe and stable home with the offer of additional supports that enable a person to stay in their home, live independently and/or achieve recovery." Better Mental Health Means Better Health, p. 12.*

[xiii]http://www.health.gov.on.ca/en/common/ministry/publications/reports/bmhmbh_2016/moving_forward_2016.pdf

[xiv] Hwang, 2001; Public Health Agency of Canada, 2006

[xv] http://www.mah.gov.on.ca/Page15268.aspx

[xvi] Vicky Stergiopoulos, Pat O'Campo, Stephen Hwang, Agnes Gozdzik, Jeyagobi Jeyaratnam, Vachan Misir, Rosane Nisenbaum, Suzanne Zerger, & Maritt Kirst (2014). At Home/Chez Soi Project: Toronto Site Final Report. Calgary, AB: Mental Health Commission of Canada. Retrieved from: http://www.mentalhealthcommission.ca

[xvii] Leff et.al. 2009. Does One Size Fit All? What We Can and Can't Learn from a Meta-analysis of housing Models for Persons with Mental illness. Psychiatric Services. Vol 60 (4).

[xviii] http://www.tosupportivehousing.ca/

[xix] Pleace et al. 2010. Homelessness and Homeless Policies in Europe: Lessons from Research. European Consensus Conference on Homelessness.

[xx] Rog et.al. 2014. Permanent Supportive Housing: Assessing the Evidence. Psychiatric Services. Vol 65(3).

[xxi] Aubry et.al. 2014 Supported Housing as a promising housing first approach for people with sever and persistent mental illness. Homelessness and Health in Canada.

[xxii] Tabol et.al. 2010. Studies of ''supported'' and ''supportive'' housing: A comprehensive review of model descriptions and measurement. Evaluation and Program Planning. Vol 33: 446-456.

[xxiii] 'Doing whatever it Takes' was defined as the hallmark of successful supportive housing programs. On a practical level that translates into the program's willingness to provide whatever kind of support, using whatever resources are available to meet the needs of an individual client at any given time.

[xxiv] The terms 'best practices' and 'principles' were both used in the literature to describe the features of supportive housing programs that appear to produce the best results.

[xxv] ConnexOntario is funded by the MOHLTC to maintain comprehensive databases of drug, alcohol, problem gambling, and mental health services in Ontario and to operate three public access helplines.

[xxvi] Working title ""Seeking Supportive Housing: Characteristics, Needs and Outcomes of Access Point Applicants" Authors Frank Sirotich, Anna Durbin, Greg Suttor, Seong-gee Um and Lin Fang. Prepared for The Access Point (Toronto)

[xxvii] https://www.eiseverywhere.com/ehome/121624/agenda

[xxviii] In discussion with providers, we discovered that some programs that do not employ peer specialists, have staff with lived experience in other positions. In such cases, those staff may provide informal peer support in the context of their other roles.

[xxix] Org Code Consulting, last accessed February 7/17 at: http://www.orgcode.com/product/vi-spdat/

[xxx] Org Code Consulting, last accessed February 7/17 at: http://www.orgcode.com/product/spdat/

[xxxi] Last accessed February 7/17 at: http//www.multnomahscale.com

[xxxii]https://www.ccim.on.ca/CMHA/OCAN/Private/Document/Education%20and%20Training%20v2.0/OCAN%202%20Day%20Training%20Materials/OCAN%202%20Day%20Training%20-%20User%20Binder/Tab%201%20-%20OCAN%20User%20Guide.pdf

[xxxiii] This number includes the 50 addiction programs and 252 mental health programs required to report to Connex Ontario under the “Support within Housing” functional centre.[xxxiii] Note that a single agency may report on numerous supportive housing programs.

[xxxiv] Responses were received from 14 addiction programs and 25 mental health programs.