Ministry of Health and Long-Term Care

Housing and Supportive Services for People with Mental Health Issues (Community-Based)

1.0 Summary

The shift from institutional to community mental health services and supports that began in the late 1990s and continued in the decade that followed has increased the need for mental health supportive housing in Ontario. Under four supportive housing programs funded by the Ministry of Health and Long-Term Care (Ministry), the Ontario government subsidizes over 12,300 housing units and funds support services to individuals with serious mental illness who have housing needs. Mental health supportive housing is especially important to those who are homeless or staying in places that may not be promoting their recovery, or who have just been discharged from hospitals. The programs are delivered by mental health housing and support services agencies that contract with the Ministry and/or the Local Health Integration Networks (LHINs) that have a mandate to plan, fund and integrate health services, including mental health services, in 14 geographic areas within Ontario.

Supportive housing includes two components—housing and support services. The Ministry funds and monitors housing, while the LHINs fund and monitor support services. Support services are provided to help housing clients cope with their mental illness and stay housed. They may include case management, counselling and vocational supports. Housing agencies deliver these services to their clients either on their own or in partnership with other mental health agencies.

In 2014, the Ministry created the Mental Health and Addictions Leadership Advisory Council (Council) to help the government move forward with its mental health and addictions strategy, *Open Minds, Healthy Minds*, which was launched in 2011. The Council considers supportive housing a priority area, and will be making recommendations to the Ministry by 2017 on actions needed to meet the objectives of the strategy.

Providing supportive housing for people with mental health challenges who require housing makes economic sense. With the right housing and supports, people recovering from mental illness gain a renewed sense of dignity and hope, and can reintegrate into the community more successfully. Research shows that providing a home to people with mental health challenges can help save money in the long run in hospital, prison and shelter stays, and in other ways as well. One study found that for every $10 invested in housing and supporting a client, an average saving of $15.05 for a high-needs

client and $2.90 for a moderate-needs client can be realized.

Our audit found that the Ministry, the LHINs and service providers do not have adequate information, systems and procedures in place to cost-effectively oversee, co-ordinate and deliver housing with support services to people with mental illness. They also do not sufficiently measure and publicly report on the effectiveness of Ontario's mental health supportive housing programs. Consistent with concerns our Office raised in previous audits of community mental health in 2002 and 2008, and our subsequent follow-up on the latter audit in 2010, we continue to find that the Ministry does not have consolidated information on the demand for mental health supportive housing in the province, does not assess the cost-effectiveness of the four mental health housing programs (as described in **Appendix 1**), and does not measure the outcomes of individuals housed. Similarly, LHINs do not know what types of support services are provided to housing clients on an annual basis, how effective they are, and whether clients are satisfied with supportive housing. The lack of a housing policy framework to guide the provision of mental health supportive housing contributes to the Ministry's and the LHINs' difficulty in sufficiently overseeing and co-ordinating the delivery of supportive housing services to Ontarians.

We also found that clients living in ministry-funded housing may not be receiving similar services across the province. As well, without information on the demand for mental health housing the Ministry cannot set and has not set any goals for how many mental health supportive housing units are to be made available to those in need, and has not developed a housing policy, despite having identified this as an area of need in its own 1999 mental health policy framework. We also found that without standards and expectations, the Ministry cannot reasonably ensure that its funding is contributing to good-quality supportive housing services that meet the needs of clients. Similarly, LHINs have not prescribed the types and duration of support services that should be available to housing clients at different points in their recovery path, and do not require agencies to report aggregate client assessment information to determine areas of unmet needs.

Providing mental health housing with support services can help reduce inequities and allow people living with mental illness to reach their full potential. With limited resources available, the province needs to make careful choices to provide mental health supportive housing to those who would benefit most from it. This could mean some who are currently receiving mental health supportive housing might need to transition to other forms of housing, such as those that are not tied to support. Doing so would help the Ministry focus on providing the available housing and supports to those who have nowhere else to go and have the greatest need for mental health supportive housing, so they can have a better chance to move on with their lives. But it is important that governments have plans in place to connect clients who could live independently to community support services should they need them over the course of their lives, regardless of where they live. This approach has been in place in parts of the United States and has resulted in people continuing to live independently for years after they initially received mental health supportive housing.

Following are some of our significant observations:

- **The Ministry identified the need to develop a policy on housing as early as 1999, but no such policy has been developed since then.** The Ministry and three other ministries (the Ministry of Housing, the Ministry of Children and Youth Services, and the Ministry of Community and Social Services) together operate 14 housing programs in Ontario. Some of these serve seniors, victims of violence and people with chronic illnesses. In 2014, the four ministries together began to transform this fragmented housing system in the long term. At the time of our audit, the four ministries were working on a supportive housing

framework to guide better alignment of existing and/or planned housing initiatives; they intended to release it publicly by early 2017. Since the ministries expect to implement the framework in 10 years, changes in the housing system may not be completely realized until almost three decades since the Ministry first identified the need for a housing policy.

- **The Ministry does not have consolidated regional or agency wait-list information.** Not all LHINs have regional wait lists, and the Ministry does not require housing agencies to maintain wait lists. Without a clear picture of the need for mental health supportive housing in each LHIN region, the Ministry cannot effectively plan for the allocation of housing stock in the province. In any event, the Ministry does not set goals with timelines on how many mental health supportive housing units it needs to fund in the long run.
- **People usually move from the wait list into available housing in the order in which they applied.** People who are ready to be discharged from hospitals but have nowhere to go do not get priority over others in accessing mental health supportive housing, even though the cost of a hospital bed can be as much as nine times the cost of providing supportive housing. Also, those with a higher level of needs, such as 24/7 care including meal preparation or medication management, have difficulty getting into the first available housing because not all units are structured to allow for such levels of care. Individuals who have mobility issues also tend to have longer waits because some units are not outfitted with accommodation that would meet their needs. Meanwhile, shared units remain vacant for up to 39 months because clients usually prefer not to share a unit. The Ministry does not know how many shared units it funds in Ontario.
- **The Ministry considers mental health supportive housing as long term and permanent.** Clients living in Ministry-funded supportive housing consider their house or unit their permanent home. But some supportive housing clients no longer need or want support services. This practice contradicts the principle of supportive housing, which includes an element of support services. One housing agency we visited proposed to the Ministry that there be a continuum of housing, so individuals whose level of support needs changes over the course of tenancy can step up to higher-support housing if necessary, or transition to other settings, such as the private market or social housing, once they stabilize. However, at the time of our audit, the Ministry had not provided any direction to agencies to guide transitioning efforts.
- **The Ministry's approach to mental health supportive housing by default creates a backlog in accessing available housing.** There is no certainty on when occupied units will next become available since supportive housing is permanent housing. Wait times to access mental health supportive housing can be up to seven years in the regions we visited.
- **The Ministry is starting to make progress in updating two older housing programs (Homes for Special Care and Habitat Services) that no longer follow best practices.** Eighty percent of the units in Ontario's mental health supportive housing are provided to individuals living with mental illness under two of the four ministry-funded mental health supportive housing programs, where not-for-profit agencies either own the units, purchased with government funding, or rent from the private market with subsidies from the Ministry. The remaining 20% of the units are in these two older programs that were created decades ago and do not follow current best practices, as they primarily provide room and board only but no significant rehabilitative support services. At the time of our audit, the Ministry was beginning to review one program, and has allowed changes to the other.

We are encouraged to see the Ministry go in this direction, having previously noted in our 1987 audit that residential care homes (which primarily provide room and board) for the mentally ill were not the best housing choice given that they were not required to provide support services.

- **The Ministry's subsidy payments to agencies may not be appropriately geared to tenants' ability to pay their rent.** The Ministry paid just over $100 million in 2015/16 to housing agencies to operate over 12,300 housing units in Ontario, but did not appropriately monitor whether agencies verified tenants' income levels. We found that income was not verified at the required intervals at six of the seven housing agencies we visited. As well, the Ministry did not require housing agencies that own properties containing housing units to conduct building-condition audits, which would have informed both the agency and the Ministry if the capital reserve is in an unfunded liability position (meaning that the agencies lack the reserve funds to pay for needed major repairs and renovations). This could potentially raise issues of safety for clients living in these buildings, and financial exposure for the Ministry, which funds the capital reserve.
- **LHINs do not confirm whether appropriate support services are delivered to housed tenants.** LHINs do not know whether agencies provide these various support services, whether all housing clients receive support services, and whether clients living in one area of the province receive comparable service hours to clients with similar needs living in another area. LHINs give agencies full discretion to deliver to their housing clients whatever support services they deem proper and at whatever frequency and level of service.
- **The Ministry does not collect outcome information on housing clients to determine whether clients live independently and achieve recovery.** The Ministry collects output-based information, such as how many units are occupied but does not collect outcome data, such as if clients' visits to hospitals or encounters with the justice system have decreased, or whether their ability to function has improved. The need to collect outcome data has been identified in many public reports, including the 1999 government implementation plan for mental health reform, and the 2010 report by the Ontario Legislature Select Committee on Mental Health and Addictions. The Mental Health and Addictions Leadership Advisory Council noted in 2015 that it will work on creating a common data set. In other words, the issue of not having outcome data is still not resolved almost two decades after the government itself acknowledged this concern.

In the last three years, the Ministry has been moving in the right direction—it established a cross-ministry working group and a leadership advisory council to address specific issues with mental health supportive housing. But these issues, in areas such as the types of support services, outcome data, housing model and best practices sharing, have already been identified in many provincial reports on mental health in the last three decades. The Ministry and the LHINs can take guidance from these reports to implement changes in the way they plan, oversee and fund mental health supportive housing to ensure housing and support services providers deliver the program to clients requiring such services in a purposeful way.

This report contains 14 recommendations, consisting of 34 actions, to address our audit findings.

OVERALL MINISTRY RESPONSE

The Government of Ontario recognizes that housing is an important social determinant of health and that supportive housing is a critical part of meeting the government's commitments

to reduce poverty and to end chronic homelessness by 2025. It is a proven model for cost-effectively providing housing and services to some of Ontario's most vulnerable citizens. For many, supportive housing is a stepping stone to recovery, greater independence and success in the community.

Four ministries—Health and Long-Term Care, Housing, Community and Social Services and Children and Youth Services—are responsible for 14 supportive housing programs in Ontario. They are working together to reduce barriers to service, increase co-ordination between ministries and systems, and deliver more housing and support services to the people who need them. The Ministry of Health and Long-Term Care (Ministry) has increased its supply of supportive housing by 46% in the last decade. As well, the government is investing in supportive housing—for example, the Ministry invested $16 million to create 1,000 spaces over the past three years.

The government recognizes that improving the supportive housing system is not only about investing more; it is also about investing smarter. That's why the Ministry is working with its three partner ministries and stakeholders to develop programs and services that are evidence-based, committed to continuous improvement, and support the long-term sustainability of the system.

OVERALL LHINS' RESPONSE

Local Health Integration Networks (LHINs) as health system planners, funders and integrators will continue to support initiatives that create more timely access to services and to create greater consistency with respect to outcomes and quality. The three participating LHINs subject to this audit (North West, Toronto Central and Waterloo Wellington) welcome the recommendations along with the Ministry, agencies and clients to strengthen and transform the mental health supportive housing system.

The LHINs fully support the strategic vision put forth by the Mental Health and Addictions Leadership Advisory Council (Council) that "every Ontarian enjoys good mental health and well-being throughout their lifetime, and all Ontarians with mental illness or addictions can recover and participate in welcoming, supportive communities." Phase Two of *Open Minds, Healthy Minds*, Ontario's comprehensive mental health and addictions strategy, is focused on adults, transitional-aged youth, addictions, transitions, funding reform, and performance measurement across the system. LHINs are actively working to engage sector stakeholders to collaboratively plan and implement the Council's recommendations and to inform the Council on deliverables.

In June 2015, the LHIN CEO Council approved the establishment of a Provincial Mental Health and Addictions Advisory Committee (Advisory Committee), bringing together LHINs, associations, and other partners and subject matter experts to share and exchange information, identify leading practices, advance priorities and develop recommendations to the LHIN CEO Council to support and inform the work of the Council. The Advisory Committee has endorsed three pan-LHIN mental health and addictions priorities: ensure accessible and appropriate primary care for those experiencing mental health and addictions conditions; ensure better co-ordinated, centralized and integrated access points for mental health and addictions services; and ensure availability of flexible service support housing options for key populations. Action-oriented work groups have been formed around each of the three pan-LHIN priorities with the mandate to develop, document and implement work plans to create change and positively impact the health and well-being of Ontarians affected by mental health and addictions issues.

2.0 Background

Refer to **Chapter One** for further background on mental health in Ontario.

2.1 What Is Supportive Housing?

The shift from institutional to community mental health services that started in the late 1990s and continued over the next decade has increased the need for mental health supportive housing (that is, housing for mental health clients with support services) in Ontario. The Mental Health and Addictions Leadership Advisory Council (Council), established in 2014 by the Ontario government to work toward the objectives set out in the province's mental health and addictions strategy, *Open Minds, Healthy Minds* (2011), defined supportive housing as "the 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." Housing, education, employment and income, called the four social determinants of health, affect people's sense of competence and connection to others. The Council considers supportive housing to be a priority area of its work.

The term "supportive housing" includes two elements—housing and support services:

- Housing represents the bricks and mortar of supportive housing, and can come in different forms, such as self-contained units, rooming or boarding houses, shared living (for instance, two or more people sharing a house or apartment) or congregate living (where an agency worker maintains a presence to provide needed support to tenants).
- Support services help clients remain housed, and can vary in nature and scope as they respond to the needs of the individual. Examples include social supports (such as life skills, peer support, resident group support and conflict resolution); clinical supports (such as crisis support, case management, counselling, outreach nursing and assertive community treatment teams); and other supports (such as 24-hour support to ensure a stable housing environment, assistance with daily living activities, medication management, assistance with job searches, employment support, house cleaning, meal preparation, child care, individualized planning, and matching individuals to appropriate housing).

Mental health supportive housing, unlike social housing, is designed for clients who have a mental illness and need to be provided with support services as part of their living arrangement. In contrast, social housing is rent-geared-to-income housing aimed at assisting low-income individuals or families, and is not intended for people with mental illness. Also, with social housing, supports are not guaranteed unless there is an established program with the municipality or the Local Health Integration Network (LHIN) region, or if the individual is already connected to a mental health service provider.

2.2 Who Needs Mental Health Supportive Housing?

People with serious mental illness are at an increased risk of poverty and homelessness. It is estimated that one in 40 Ontarians will have a serious mental illness at some point in his or her life. People with serious mental illness have a diagnosis of mental illness such as schizophrenia, depression, bipolar disorder or personality disorder; a long duration of illness; and a significant disability in day-to-day functioning. (These are often referred to as the "three Ds.") According to a study in the health and housing status of homeless and vulnerably housed adults in Ontario and British Columbia conducted by a national, interdisciplinary alliance of research partners (including hospitals, universities and not-for-profit agencies), more than half of the homeless and vulnerably housed adults in Vancouver, Toronto and Ottawa in 2010 reported a past diagnosis of a mental health problem.

Not all individuals who experience mental health issues have housing challenges or are in need of mental health supportive housing. For example, those who can cope with the illness, live independently or with their family, and access mental health and other services in the community do not need this extra level of support. However, for some individuals, such as those leaving the hospital after a long stay, this type of specialized housing with supports can help them establish themselves and reintegrate into the community.

People who live in mental health supportive housing interact with multiple parties who each play a role in supporting the individual to recover from mental illness and stay housed, as shown in **Figure 1**.

2.3 Benefits of Mental Health Supportive Housing

There are many benefits of mental health supportive housing. Studies conducted in Ontario and in other provinces have shown that people with mental illness who are in supportive housing experience a reduction in hospital readmissions, psychiatric symptoms and substance abuse; improved housing and financial stability; and overall better quality of life.

People who live with mental illness and receive supportive housing services can gradually gain independence in their day-to-day functioning; some have become advocates for the mentally ill and have taken positions as tenant board members serving on the boards of the agencies that provide them with their housing. **Figure 2** provides two real-life examples of client experiences in Ontario's mental health supportive housing and the positive impact the program has had on their lives.

In 2014, the Mental Health Commission of Canada (Commission) reported on a project that used a "housing first" approach in Toronto to try to end homelessness for those living with mental illness. It said the project demonstrated that money was saved by providing housing to these clients over a two-year period. The Commission found that for every $10 invested in housing and supporting a client, an average saving of $15.05 for a high-needs client and $2.90 for a moderate-needs client can be realized. The savings come out of areas such as psychiatric hospital stays, home and office visits with health or social service providers, prison stays and shelter stays.

2.4 Types of Mental Health Supportive Housing in Ontario

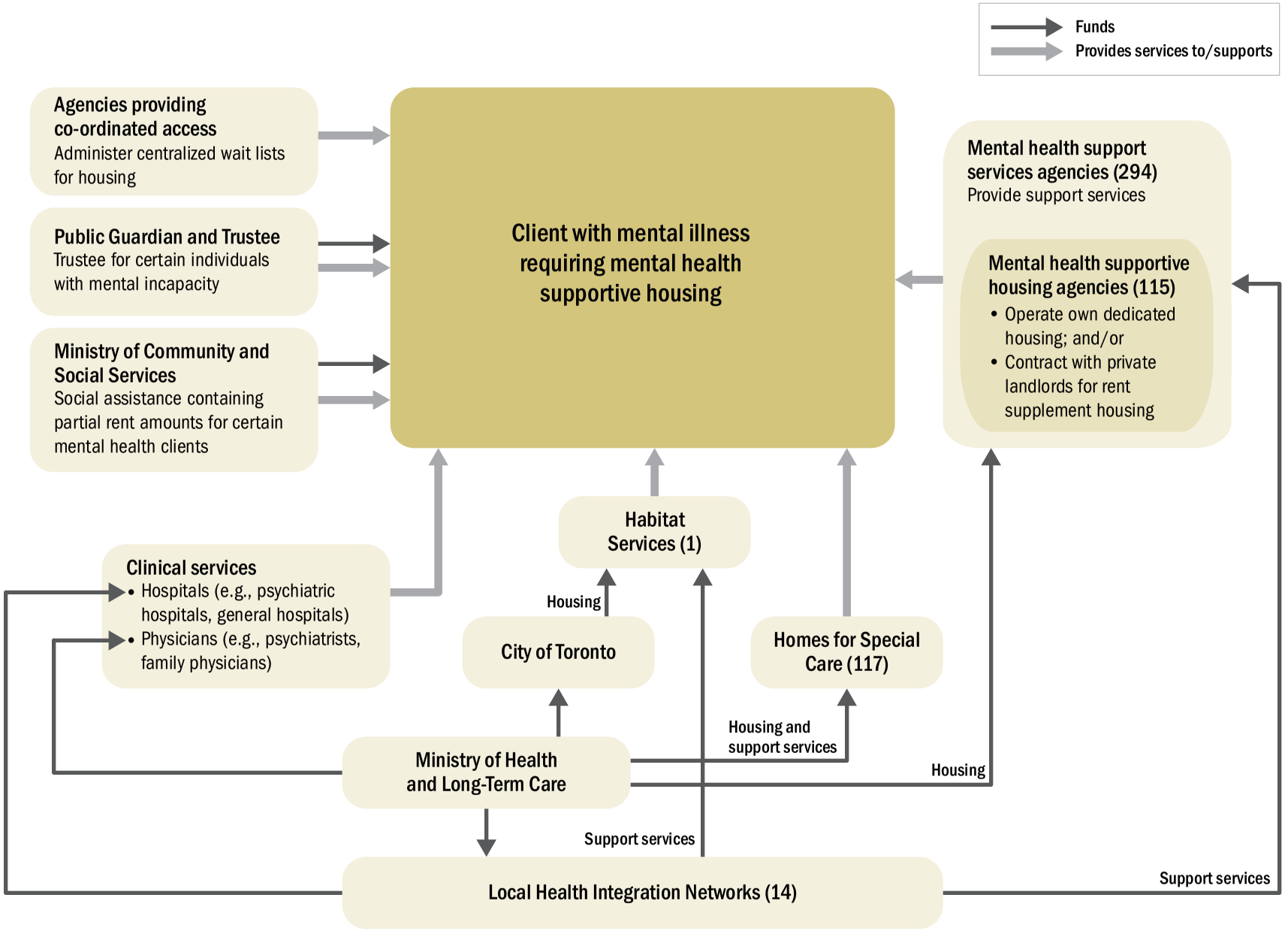
As of March 31, 2016, the Ministry of Health and Long-Term Care (Ministry) was providing funding to over 12,300 supportive housing units under four different broad housing programs to serve those with serious mental illness. The four programs—dedicated housing, rent supplement, Homes for Special Care, and Habitat Services—were first established between 1964 and 2000. While all of the programs are intended to serve people with mental illness, some are targeted to serve specific sub-populations, such as those also with current involvement in the criminal justice system, developmental disability, or substance abuse issues. About 80% of all mental health housing units are provided under the first two programs, operated by 115 housing agencies, and the remaining 20% are provided under the last two programs. **Appendix 1** shows the characteristics of each of these housing programs.

2.5 Funding

For the dedicated housing and rent supplement programs, the Ministry provides funding directly to the 115 not-for-profit housing agencies for the housing component (that is, the "bricks and mortar"). In addition, through the province's 14 Local Health Integration Networks (LHINs), the Ministry funds the same agencies to provide supports. If a housing agency cannot provide the necessary support services to its mental health clients, it partners with another agency, also funded by LHINs, that specializes in providing these services.

Figure 1: Roles and Responsibilities of Key Parties Involved in Mental Health Supportive Housing

Prepared by the Office of the Auditor General of Ontario



The Ministry provides funding directly to homeowners that operate the Homes for Special Care program, and the LHINs provide funding to nine hospitals, including the province's four specialty psychiatric hospitals, that perform inspections on these homes. Ministry funding to homeowners under this program covers housing and certain support services, in that homeowners will provide meals, assist the tenant with self-care, and arrange additional assistance.

For the Habitat Services program, the Ministry and the City of Toronto co-fund Habitat Services, a not-for-profit agency operating in Toronto, for room and meals, and the Toronto Central LHIN funds this agency for support services, and inspection and monitoring of homes.

In the year ending March 31, 2016, the Ministry spent just over $100 million on the operating and capital costs of housing, an increase of 30% since 2006/07, as shown in **Figure 3**. While the Ministry and the LHINs track and monitor the total costs of delivering mental health support services in Ontario, they cannot distinguish and estimate the amounts paid to help those living in supportive housing.

Figure 2: Examples of Client Experiences in Ontario's Mental Health Supportive Housing

Source of data: Selected mental health housing agencies

Note: The names, locations and identifying details have been changed to protect privacy.

Dianne's Story

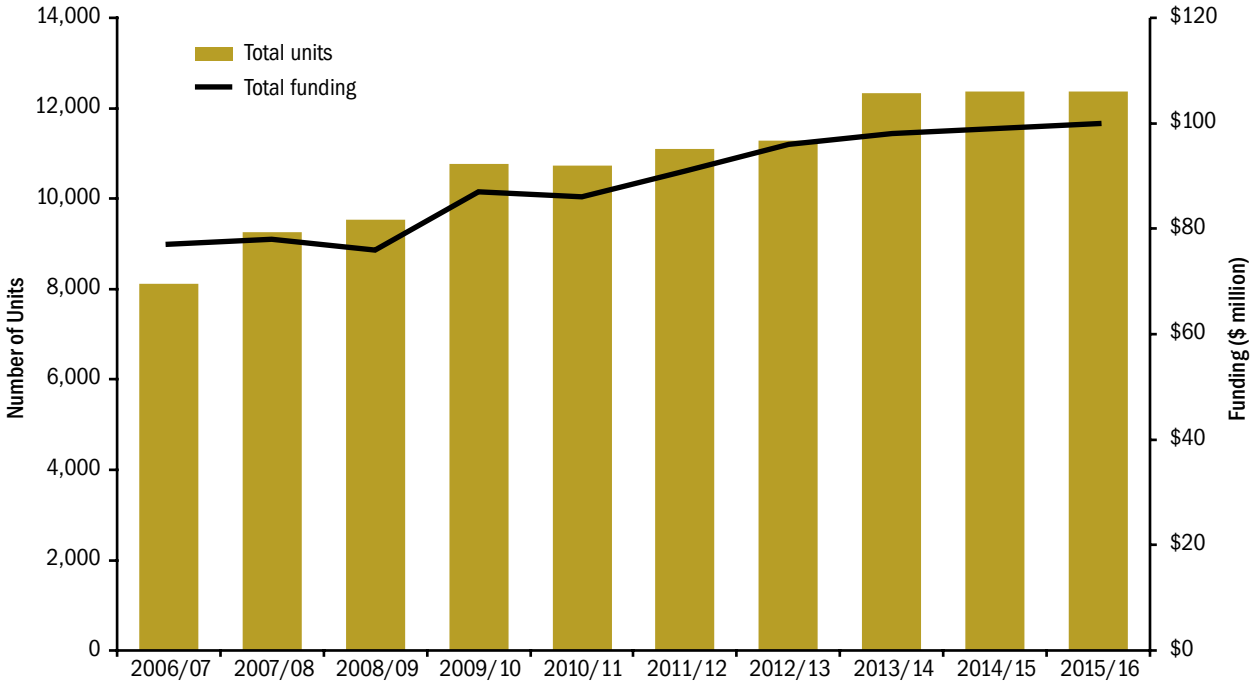
Dianne is a woman in her mid-30s, and has been affiliated with a mental health agency since 2013. She has also been living in an apartment leased to her by the agency in a small rural town in southern Ontario. Dianne was sure she was going to be homeless until she learned that this unit was available while talking to her support worker. The fear and mental health issues were unbearable to Dianne, who also has a daughter. This agency offered her security and peace and helped her build her self-esteem to get her life back together. She was receiving social assistance, and working on her mental state for two years before getting a job. At that time, things started to improve and she could start recovering from her issues. The agency workers have always been compassionate, and she doesn't think she would be where she is today without the help from the housing program and staff. She could not imagine life being as good as it has become. Dianne felt that this program essentially saved her life and helped her become the best person she can be. She knows how blessed she is to have found this organization, and to utilize all the necessary and useful services it provides. This program has shaped her into a productive member of society and taught her there is hope for a better life.

Mike's Story

Mike is 29 years old and the eldest of three siblings. His family immigrated to Canada when he was seven years old. According to his mother, he was considered a good student and was generally well regarded by his peers and teachers. His behaviour changed abruptly after the untimely death of his father when Mike was 13 years old. He began to skip classes, using alcohol and marijuana, and dropped out of school. During this time, Mike had numerous admissions to hospital and was diagnosed with schizophrenia. After being asked to leave the family home because of his aggressive behaviour, Mike lived in shelters and on the street for the next few years until his arrest in 2007 on a charge of assault. He was found not criminally responsible and admitted to the law and mental health program at a provincial specialty psychiatric hospital. Mike spent three years at that hospital as an in-patient. Significant risk factors throughout his hospital admission included lack of insight and non-compliance with medication. In 2010, he moved into a high-support housing unit created as part of a collaboration between the psychiatric hospital and a local service provider. Mike shares a two-bedroom apartment with a co-resident. Staff report that Mike is social and helpful, and has created a sense of community with his co-residents. During his time in supportive housing, Mike has reconnected with family members, who visit him regularly at his apartment, and he is now employed three days a week in a café. He reports that his housing situation gives him a safe space where he enjoys living and that his mental and physical health have greatly improved during his time there. He has not been readmitted to hospital.

Figure 3: Number of Mental Health Supportive Housing Units Funded and Ministry Expenditure on Housing, 2006/07–2015/16

Source of data: Ministry of Health and Long-Term Care



In the year ending March 31, 2016, the Ministry, through the LHINs, spent $629 million on support services on all mental health clients, including those living in mental health supportive housing.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health and Long-Term Care (Ministry), in conjunction with the Local Health Integration Networks (LHINs) and service providers, had effective systems and procedures in place to cost-effectively oversee, co-ordinate and deliver housing with support services to people with mental illness, and measure and publicly report on the effectiveness of Ontario's mental health supportive housing. Senior management at the Ministry reviewed and agreed with our objective and associated criteria.

Our scope covered all four mental health supportive housing programs—rent supplement, dedicated housing, Homes for Special Care and Habitat Services Toronto—funded either fully (in the first three cases) or partly (in the last case) by the Ministry. Although they are referenced in this report, our audit scope did not include housing programs funded by other provincial ministries such as the Ministry of Housing, the Ministry of Children and Youth Services, and the Ministry of Community and Social Services—these housing programs are not intended to serve populations with mental health challenges.

We conducted our audit work at the Ministry, primarily at the Mental Health and Addictions Branch (prior to April 2016 the unit responsible for supportive housing had been part of the Provincial Programs Branch), which funds housing agencies and homeowners that operate the various housing programs, and the Financial Management Branch, which reconciles ministry funding with these

agencies' spending at year-end. LHINs contract with mental health support service providers that provide services to people with mental illness in their region, including those living in ministry-funded housing units. To that end, we visited three of the 14 LHINs—Toronto Central (corporate office in Toronto), Waterloo Wellington (corporate office in Kitchener) and North West (corporate office in Thunder Bay). Their combined expenditures in the fiscal year ending March 31, 2016, on mental health housing and all support services (delivered to all clients in the region, including those living in ministry-funded housing) were $183 million, or 29% of the overall provincial mental health housing and support services expenditures.

At seven supportive housing agencies across these three regions we conducted audit tests, interviewed senior and front-line staff and obtained their perspectives on ways to improve program delivery, visited both occupied and vacant mental health supportive housing units in different Ontario communities, housing individuals at different points in their path of recovery, and spoke to some tenants. At the planning phase of our audit, we also made preliminary visits to two other mental health supportive housing agencies in Toronto and toured a selection of units managed by each agency.

We researched how mental health supportive housing is operated in British Columbia, Alberta, Manitoba, the United States and the United Kingdom. We focused on the housing models used, types of outcomes tracked, service standards and levels of care applied, and how people access mental health supportive housing.

We discussed mental health supportive housing with stakeholder groups such as the Canadian Mental Health Association (Ontario Division and Toronto Chapter), Addictions and Mental Health Ontario, the Ontario Non-Profit Housing Association, and the Centre for Addiction and Mental Health. We also obtained information and perspectives from an Ontario clinician scientist who conducts research in community mental health, including mental health housing. As well, we reviewed studies and reports on mental health housing issued by the Mental Health Commission of Canada and the Select Committee on Mental Health and Addictions of the Ontario Legislature. We also contacted Ombudsman Ontario on complaints it received on mental health housing and considered these in the conduct of our audit.

4.0 Detailed Audit Observations

4.1 Demand for Mental Health Supportive Housing Not Fully Known and Wait Lists Not Well Managed

Ontario lacks a policy framework to guide the provision of mental health supportive housing. Such a policy framework could help the Ministry identify the type of information it needs to collect in order to appropriately plan for mental health supportive housing in Ontario. Because a policy framework is not in place, and there is no consolidated information on the various wait lists that are maintained across the province, the Ministry does not know the full extent of the demand for mental health supportive housing. It is known, however, that for those regions that do maintain centralized wait lists for mental health supportive housing, wait time is long, and can be up to seven years for those clients with the highest level of needs. Meanwhile, hospitalized patients who no longer require care have to wait in hospitals at a higher cost to taxpayers, as there is a critical shortage of supportive housing units in Ontario. People with the highest needs and those who are occupying expensive hospital beds do not always get priority over other candidates for mental health supportive housing, such as those who might be staying with a family member in the interim.

We look at the above issues in detail in the following subsections.

4.1.1 Lack of Housing Policy Framework That Defines Information Needs

Many parties are involved in delivering and overseeing mental health supportive housing in Ontario. While mental health service and housing agencies have shared responsibility for delivering mental health housing with support services in Ontario, the Ministry and the LHINs are accountable to Ontarians for providing sufficient housing and support services across the province, and ensuring that these agencies deliver high-quality mental health housing with support services to those in need.

In 2011, Ontario released the current iteration of its mental health and addictions strategy, *Open Minds, Healthy Minds*. While this strategy recognizes mental health supportive housing as a priority area, it stops short of being a policy framework on mental health supportive housing. A policy framework on mental health supportive housing would define the Ministry's and the LHINs' roles; set measurable goals and program priorities; define the types of data that the Ministry and the LHINs need to collect, measure and analyze; assess risks and options to manage the risks; determine the resources required; and measure the impact of the Ministry's contribution to mental health supportive housing.

The need for a policy framework on mental health housing was underscored in 1999, when the Ministry of Health issued *Making It Happen: Implementation Plan for Mental Health Reform*, noting that it needed to develop a policy on housing and improve access to housing.

Even though the Ministry still did not have such a policy at the time of our audit, in 2011 it had started working with three other ministries that also operate supportive housing programs to improve housing programs in Ontario. The other three ministries are the Ministry of Housing, the Ministry of Community and Social Services, and the Ministry of Children and Youth Services. Together, all four ministries operate 14 housing programs in Ontario, as shown in **Appendix 2**. In 2014, the inter-ministerial group consisting of representatives from these four ministries developed an internal policy framework to guide "long-term system transformation" in the current fragmented system of supportive housing in Ontario. According to this framework, in 10 years, Ontario's housing programs will have a better allocation of existing resources, the system will be better co-ordinated, clients will have housing stability and appropriate supports, client access will be streamlined, and there will be evidence-based data and performance measures to demonstrate value for money invested. This internal framework was approved by the deputy ministers from all four ministries in August 2015, and was intended to inform the development of a public framework, to be released by early 2017. The public framework is intended to guide better alignment of existing and/or planned housing initiatives, with the implementation period to span the following 10 years. As a result, changes at the ground level may not be completely realized until 28 years after the Ministry first identified the need for a housing policy.

RECOMMENDATION 1

To help identify data needed to plan for mental health supportive housing in Ontario such that people with mental illness can recover and live independently, the Ministry of Health and Long-Term Care (Ministry) should develop an implementation plan for its housing policy framework. This policy framework should define the Ministry's and the Local Health Integration Networks' (LHINs') roles; set measurable goals and program priorities; define the types of data that the Ministry and the LHINs need to collect, measure and analyze; assess risks and options to manage the risks; determine the resources required; and measure the impact of the Ministry's contribution to mental health supportive housing.

MINISTRY RESPONSE

The Ministry will work closely with the Ministry of Housing, the LHINs, the Mental Health

and Addictions Leadership Advisory Council and other partners to develop a plan for implementing the Supportive Housing Policy Framework for all Ministry-funded supportive housing. This includes housing for people living with mental health and addictions issues, as well as people living with physical disabilities, acquired brain injuries, and HIV/AIDS, and the frail elderly. The Ministry will work with its partners to ensure that its implementation plan includes the suggested elements in the Auditor General's recommendation.

4.1.2 Overall Demand Not Centrally Tracked

Having complete and current data on the overall demand for mental health supportive housing would allow the Ministry to properly plan for the supply of housing to meet clients' needs. But the Ministry has no consolidated province-wide data on people waiting to access mental health supportive housing, and does not collect local wait information from agencies or regional wait information. Some agencies have chosen to collect wait information in collaboration with other agencies in the same geographic area through a centralized or streamlined access process; some have chosen to track wait information on their own; and some have chosen to not maintain any wait information at all. As a result, the overall demand for mental health supportive housing is not readily known.

In a 2011 report on mental health housing, the Mental Health Commission of Canada estimated that, depending on assumptions made on prevalence of serious mental illness and people's ability to stay housed, Ontario had between 39,800 and 199,000 people who had serious mental illness and were inadequately housed. The same report recommended the development of 100,000 housing units to house people living with mental illness across Canada over the next decade. On the basis of Ontario's population, we estimated that about 38,000 of these units would be needed in Ontario alone, where there is a critical shortage of supportive housing. As noted in **Section 2.4**, as of March 31, 2016, there were over 12,300 supportive housing units in Ontario.

4.1.3 Use of Regional Wait Lists Not Common across 14 LHINs

Clients can access mental health supportive housing on their own by contacting either a supportive housing agency or a wait-list administrator (an organization that is either a mental health housing agency or an agency that provides wait-list administration services, funded by a Local Health Integration Network [LHIN]), or they can be referred to housing by their family or their health service providers. Typically, potential clients who are already connected to a mental health service provider are referred to supportive housing by their mental health case worker. Because there is a chronic under-supply of mental health supportive housing in Ontario, as evidenced by the existence of various wait lists, clients often do not get into housing right away. Instead, they are asked to wait until a unit becomes available. These clients could be homeless or waiting in hospitals or shelters. We discuss this further in **Section 4.1.5**.

The process to access housing varies because not all regions have a single, centralized regional wait list for mental health supportive housing. The Ministry does not require housing agencies located in the same LHIN region to draw up a centralized wait list to facilitate the placement of individuals living in the same region, similar to the process for placing clients in long-term-care homes. As of March 31, 2016, of the 14 LHINs across the province, five had implemented regional wait lists for mental health supportive housing. These five LHINs are Toronto Central, Waterloo Wellington, Central (the wait list does not cover the full LHIN region), Champlain, and Mississauga Halton. In these regions, clients can contact the single central wait-list administrator to get onto the list. Maintaining regional wait information allows for a consistent

access process for clients living in the same communities, which promotes equity across the region. A regional list also allows access to a larger stock of housing than a single agency list, which improves co-ordination among agencies to better serve clients with the most urgent needs.

Clients living in regions that do not have a central regional wait list have to contact individual housing agencies to get on their wait lists to access housing. Of the three regions we visited in this audit, Toronto Central and Waterloo Wellington maintained a regional wait list, and North West did not. As well, of the two housing agencies in the North West LHIN that did not maintain a regional wait list, only one agency maintained its own local wait list, while the other did not. The Ministry does not require LHINs or housing agencies to maintain local wait lists. The collection of demand data was raised in our 2008 audit on Community Mental Health and in our subsequent follow-up done in 2010, when the Ministry advised that it was in the process of addressing this issue.

RECOMMENDATION 2

To sufficiently understand the demand for mental health supportive housing for the purposes of short-term and long-term planning, the Ministry of Health and Long-Term Care should:

- work with Local Health Integration Networks (LHINs) that do not have a central wait list to establish one, adopting existing wait-list technology and best practices from LHINs that have wait-list systems; and
- collect overall information on wait lists and wait times by region on a regular basis to inform provincial planning decisions.

MINISTRY RESPONSE

The Ministry will work with LHINs and partner ministries (Ministry of Housing, Ministry of Community and Social Services, and Ministry of Children and Youth Services) to develop an approach to planning for and assessing demand that can best be used to improve access to appropriate housing and support services and inform short and long-term planning for supportive housing. This will include drawing on best practices and expertise from LHINs that already have wait-list systems.

The Ministry will also explore other methodologies, such as population-based models, and will work with Statistics Canada and partner ministries to understand the demand for supportive housing for persons living with mental health and addictions issues.

4.1.4 Clients Face Long Wait Times to Access Housing

Given that there is no centralized data on how long clients have to wait to access housing, we looked at wait-list and wait-time data maintained by the two LHIN regions we visited that maintained regional wait information. These two wait lists help manage placement of clients in mental health supportive housing in three of the province's 14 LHINs, or health regions, consisting of 28% of the province's population. Depending on the clients' level of need, wait time as of March 2016 ranged from 2.3 years to 4.5 years in one wait list, and from one year to seven years in the other wait list. As of March 31, 2016, there were slightly more than 11,000 people waiting on the first of these lists and about 570 on the other. In the largest centralized wait list in Ontario that co-ordinates access to housing for 21 mental health supportive housing agencies covering the entire Toronto Central LHIN and part of the Central LHIN, for every applicant who came off the list in the year ending March 31, 2016, almost six new applicants came onto the list. Ontarians have expressed their concern over these long wait times in complaints received by Ombudsman Ontario in the three years ending March 31, 2016.

4.1.5 Clients' Current Housing Situation Not Usually a Factor in Priority Access to Housing

According to a 2014 paper on housing conducted by the Centre for Addiction and Mental Health, while people wait for supportive housing, they often remain disconnected from the supports and services that they need, and may end up being readmitted to hospital or visiting emergency rooms, shelters, detoxification centres and jails, which are all higher-cost options. This benefits neither the individual living with mental health challenges nor society.

According to information collected by the administrator of the largest regional wait list in the province, which serves the entire Toronto Central LHIN and part of the Central LHIN, of the people waiting for mental health supportive housing as of March 31, 2016, 45% were listed as being in a shelter or having no fixed address, 25% were living in their privately owned or market-rent accommodation, 6% were in a hospital, 6% were residing in other forms of accommodation such as subsidized or non-profit housing or were in the care of a correctional or probational facility, and 18% had classified their situation as "other" or "unknown" and provided no further details. This wait-list administrator further confirmed that these people waiting for accommodation could be categorized as follows: 58% homeless; 24% at risk of becoming homeless (current economic and/or housing situation uncertain—may become homeless in the immediate or near future if there is no intervention); 18% not homeless. The other regional wait-list administrator we visited in the Waterloo Wellington LHIN did not have data in this format.

It is not known which of the 18% who classified their housing situation as "other" or "unknown" live with friends or family while still wanting to be placed in mental health supportive housing. The Ministry indicated that mental health supportive housing is intended for those who are homeless or at risk of becoming homeless. However, a concern is that some people are at more urgent need for supportive housing than others, yet none of the agencies or central wait-list administrators we examined in this audit would generally give them priority to access available housing. (Exceptions were specific initiatives aimed at reducing homelessness.) In other words, for the most part, available housing is given to the next available client in the order in which the clients' names were put on the list. So if there are two individuals on a wait list, one who is staying at a homeless shelter and the other with a parent, each will be housed in the order in which they applied to access housing—with the only priority being their suitability to the unit.

We researched how other jurisdictions place people with mental illness in their supportive housing, and found that the United Kingdom prioritizes those who are homeless and those who are the most vulnerable, such as the elderly, the mentally ill or people with physical disabilities, for placement in supportive housing.

A 2009 study conducted by health-care and supportive housing provider representatives from the Toronto Central LHIN noted that the insufficient supply of housing has resulted in "bed blocking" in hospitals and has caused system strains in the areas of financial costs and inappropriate level of care, and has affected the quality of life of those living with mental illness. To that end, in an October 2012 report entitled *Road to Recovery, Client Experiences in Supportive Housing*, the Centre for Addiction and Mental Health, one of the four specialty psychiatric hospitals in Ontario—hospitals that serve people living with complex mental illness—recommended that certain mental health patients waiting in hospitals who are on supportive housing wait lists be prioritized. These patients no longer need the care offered by a hospital but remain there due to a lack of suitable housing options. Discharging these patients to supportive housing would aid in their recovery and also free beds for people in need of care, thereby reallocating resources from the costlier hospital stays to the more economical option of community living.

As of March 31, 2016, 72 mental health patients, or about 46% of the 158 mental health patients

who no longer required the care offered by the province's four specialty psychiatric hospitals, were waiting in one of these hospitals to be placed in supervised or assisted living. We were unable to gather similar data on general hospitals, as data from these hospitals does not distinguish between patients with and without mental illness.

Prioritizing mental health patients waiting in hospitals to access mental health supportive housing is just one way to potentially achieve savings for the province; there may be other ways. At the time of our audit, mental health patients were not prioritized to access mental health supportive housing, except in limited circumstances in one of the three regions we visited. The daily cost of hospital care for a mental health in-patient at the province's four specialty psychiatric hospitals ranged from $787 to $1,138 in the year ending March 31, 2016. In comparison, according to a 2011 report issued by the Mental Health Commission of Canada, the estimated daily cost of providing supportive housing was about $82 to $115 for the highest-need clients; in 2016, after adjusting for inflation, this would be about $91 to $127 per day.

RECOMMENDATION 3

To reduce costs in the health-care system and other public services and better serve clients with mental health issues and housing needs, the Ministry of Health and Long-Term Care should evaluate whether certain clients, such as those waiting in hospitals or those who are homeless, should get priority to access housing, and provide direction to housing agencies on its decision.

MINISTRY RESPONSE

The Ministry will work with the LHINs and other partners to evaluate whether certain subpopulations should be granted priority access to supportive housing and what additional resources, if any, are required. Several recent ministry-funded supportive housing programs have targeted vulnerable and at-risk Ontarians, including those who have serious mental health and addictions issues and who are homeless or at risk of homelessness. The Ministry will provide direction to agencies delivering affected programs in the event of a policy change.

4.1.6 Clients with Higher Needs or Requiring Mobility Accommodation Wait Even Longer to Access Housing

Individuals who require higher levels of care are more challenging to house. These individuals may have developmental disabilities along with mental illness, or mental illness with symptoms so pervasive that they require close to 24/7 care, including meal preparation or medication management. Some agencies we visited informed us that there is not enough housing with high support services available in Ontario because most units are scattered in general rental buildings that are not well suited to 24/7 supervision, where staff may have to stay on site. This is confirmed by data we obtained from the wait-list administrator for the entire Toronto Central LHIN and part of the Central LHIN—in the years 2014/15 and 2015/16, the number one reason that agencies deferred a client's placement in supportive housing was that the client's needs were too high. In these two years, of the 325 clients bumped from the top of the list by the agencies, 109 (more than a third) were bumped because their needs were too high. To further put this into perspective, there were only 622 high-needs clients on the wait list, and yet they face the highest deferral rate—approximately one in six.

Of the two wait-list administrators we visited, only one maintains information on where people with high needs reside while waiting for suitable mental health supportive housing. According to this information, approximately 23% were in a hospital, 18% were in a shelter or had no fixed address, and 15% were living in their privately owned or market-rent accommodation. The rest were in other forms of residences, including subsidized housing, rooming or boarding homes, and retirement homes. Again,

about 12% classified their situation as "other" or "unknown" without providing further details.

Similarly, clients with mobility issues require housing adapted to accommodate their needs, such as an access ramp to the front of the building or an elevator to reach a higher floor. Because not all housing units, especially those in older agency-owned dedicated housing properties, are constructed with mobility accommodation, clients who need such accommodation typically have to wait longer to access mental health supportive housing. Some of the agencies we visited had to defer placement of clients because they could not accommodate the clients' accessibility needs. As well, some clients who are housed develop mobility issues as they age, and so they eventually also require special accommodation in their mental health supportive housing units. Two of the seven agencies we visited indicated that they had to transfer existing clients housed in mental health supportive housing who have developed mobility issues to more accessible units, and there is a growing internal demand to accommodate this need.

Given that the supply of housing stock does not meet the demands of the people with mental illness waiting to access supportive housing, the risk exists that clients are pulled (selected for ease of placement) rather than pushed from the wait list (housed according to their priority and needs) when a vacancy arises. Some agencies we visited told us that they had initiated discussions with the Ministry to make available more supportive housing units that meet higher needs and can accommodate people with mobility issues. Some of these discussions originated years ago, but at the time of our audit, the agencies still faced challenges in accommodating their most high-need clients. When suitable housing is not made available to accommodate the various needs of mental health clients, the housing system cannot be fully client-driven, and agencies may have an unintended bias in selecting clients who are easier to serve rather than those who are harder to serve.

RECOMMENDATION 4

To ensure that people with high needs or mobility issues are not subject to an unfair disadvantage of having to wait even longer than other clients for housing, the Ministry of Health and Long-Term Care should have sufficient housing stock to accommodate their needs.

MINISTRY RESPONSE

The Ministry recognizes that demand for all types of supportive housing outweighs the current supply of supportive housing. To meet rising demand, the Ministry has increased the number of supportive housing units that it funds by 46% over the last decade. Going forward, the Ministry will work with the Ministry of Housing and other ministries, LHINs, the community sector and other partners to create sufficient housing stock for all Ontarians in need of supportive housing, including people living with physical disabilities or in need of high levels of support services.

4.1.7 Process for Managing Wait Lists Needs Improvement

We examined the process used by two LHIN regions that administer regional wait lists to determine if the wait lists accurately reflect true demand information, which the Ministry needs to properly plan for the supply and allocation of mental health housing in Ontario. We found the following issues:

- Potential housing clients do not need to prove that they have a mental illness to be on a wait list. None of the wait lists—either regional or at individual agencies—require a potential client to provide medical proof that they have a mental illness diagnosis before putting their name on the list. For example, at one of the regions we visited, potential clients self-report their health condition to the wait-list administrator. It is only when a client's name comes to the top of the wait list that the housing agency with the vacancy would conduct an

intake assessment to assess the client's needs and determine the client's suitability for the vacant unit. At that point, the agency would still not require medical proof, but instead would determine if the client appears to have mental illness based on an in-person interview conducted by an agency staff member who has knowledge of mental illness. This staff person does not need to have a medical background. One housing agency informed us that it has used this approach to decline wait-list clients they assessed as not having a mental illness.

- Wait times are long, and clients on a wait list may have died or no longer require housing even though their names are still on the list. Neither of the two regional wait-list administrators we visited contacts clients regularly and proactively to update their information. Instead, they rely on clients to contact them to self-report changes in their status. The wait-list administrator that serves the entire Toronto Central LHIN and part of the Central LHIN advised us that its office is not funded to do wait-list management on an ongoing basis but received one-time funding from a LHIN a few years ago to hire temporary staff to update applications. Recently, it has received approval through a municipal program to invest in temporary resources to manage the wait list.

RECOMMENDATION 5

To ensure that only clients with demonstrated needs are provided access to mental health supportive housing and that wait lists provide an accurate picture of need in the province for planning purposes, the Ministry of Health and Long-Term Care should require the housing provider or wait-list administrator to confirm clients' mental illness diagnosis before putting their names on the wait list, and clients' suitability to remain on a wait list on an ongoing basis.

MINISTRY RESPONSE

The Ministry recognizes the importance of ensuring that only eligible applicants receive access to supportive housing. Many people living with mental health issues and in need of supportive housing are not in a position to easily obtain a diagnosis; therefore, the Ministry is concerned that requiring wait-list administrators and housing providers to confirm an individual's mental health-related diagnosis at the point of application could create a systemic barrier to accessing services for people who are already marginalized. Nevertheless, the Ministry will identify opportunities to assess eligibility and need to access services, either through diagnosis and/or a standardized assessment of need, in its work with partner ministries and stakeholders on a co-ordinated access system for supportive housing.

4.2 Continuum of Housing and Transitional Services Framework Not in Place in Ontario

One reason for the long wait time for mental health supportive housing in Ontario is that clients who are already housed can stay in these housing units indefinitely because the Ministry funds these homes as permanent housing. Even when clients no longer require support services, they can still stay in the mental health supportive housing. The Ministry has not provided any guidance to housing agencies to assist them in determining when a client can be more suitably housed in other settings.

We look at these issues in detail in the following subsections.

4.2.1 Mental Health Supportive Housing Is Permanent Housing

The Ministry-funded supportive housing program provides permanent housing to people with mental illness. In other words, there are no restrictions

on how long clients can remain in mental health supportive housing. A client can occupy a unit for an indefinite period at his or her wish. The Ministry does not maintain information on the duration of tenancy, but according to information we obtained from the seven housing agencies we visited, 22% of people had stayed beyond 10 years but less than 20 years as of March 2016, and 7% of people had stayed beyond 20 years.

Under a permanent housing approach, a vacancy comes about only through attrition—for instance, when a client decides to move out of supportive housing, dies, is imprisoned or evicted, or is hospitalized on a long-term basis. This approach by default creates a backlog in demand, as there is no certainty on when an occupied unit will become vacant for the next person on the wait list.

According to our research, British Columbia and Alberta follow a permanent housing model for mental health supportive housing.

Agencies, stakeholder associations and experts we spoke to during this audit all agreed that a permanent housing approach promotes stability of the client, and noted that the approach is best practice. Nevertheless, they all acknowledged that in order to create flow in the system there should also be a continuum of housing, which may include less-permanent housing where tenancy is set to a limited time frame, and step-up and step-down programs where clients can transition to either higher- or lower-support settings depending on their needs (we discuss this further in **Section 4.2.2**).

One agency we visited presented a proposal to the Ministry in May 2015 and at a joint meeting with the Ministry and the agency's LHIN in July 2015 on the benefits of a continuum of housing specifically for people whose needs have stabilized and may be transitioned to other forms of housing. According to the agency, with a continuum of housing, individuals can attain the highest level of independence; resources can be targeted at those who need them most; and services can better match needs. At the time of our audit, the Ministry was still considering this proposal.

Other jurisdictions, such as areas of New York, Los Angeles and Chicago, provide a mix of housing models, both permanent and time-limited, with flexible mental health and housing supports to help clients gain independence. For instance, a project in New York City has a 30-year history of successfully graduating people with mental illness from supportive housing to more independent living—fewer than 5% of program graduates returned to homelessness. To achieve this, the program offers vocational or employment supports that help residents to potentially find employment. As well, the program works with residents who have sufficient stability and income to live independently—it helps residents identify affordable housing and make the transition from supported life to independent living. The program credits its success to three factors: moving out is voluntary and not subject to a defined transition date; it is linked to affordable housing; and follow-up after-care services are offered.

4.2.2 Transitioning Clients to Other Forms of Housing Warrants Consideration

Some agencies identified clients in their housing who have stabilized and no longer require ongoing support, but none of the seven agencies we visited consistently transition such clients to other forms of housing. Remaining in a supportive housing unit but not receiving any support services contradicts the principle of supportive housing, which includes both housing and support services components. The agencies cited the following concerns that affect opportunities to transition clients out of mental health supportive housing:

- The lease the client signs as a tenant falls under the *Residential Tenancies Act* (Act). The Ministry intended this to afford clients living in mental health supportive housing full rights under the Act—it does not want a landlord to evict a client because of the client's mental health issues. But also, the Act protects clients from being required to move from mental health supportive housing to other alternative

housing (such as social housing) or into the private housing market.

- Moving can be a stressful event to mental health clients and may trigger their illness even though they have stabilized.
- Few housing alternatives exist for clients who are candidates for transition. Tenants may not have the means to rent from the private market without government assistance, and the wait lists for social housing operated by municipalities are long. The Ontario Non-Profit Housing Association estimated that in 2014 about 168,700 households were waiting for an affordable home, and those who were housed that year waited an average of almost four years.

Although the Ministry considers the province's mental health housing to be permanent and long term, it acknowledges that transitional housing deserves consideration. However, neither the Ministry nor the LHINs have given guidance to housing agencies to provide transitional services to clients or to dedicate part of the housing stock as transitional units. Some agencies have therefore acted on their own to facilitate transition of clients from mental health supportive housing to other forms of housing. For instance, four of the seven agencies we visited work with municipal social housing providers to seek housing arrangements for clients who can transition. However, these practices are not widespread. One of these agencies even requires clients it accepts into mental health supportive housing to also put their names on the municipal social housing wait list. As well, although it is not mandated and there is no formal program, all agencies work with the health sector to transition clients who require long-term care to long-term-care homes.

In our research, we found that British Columbia offers a spectrum of subsidized housing that provides different types of housing assistance for people in a variety of circumstances, enabling people to move from supported living to independent living, or vice versa, as their needs change or stabilize.

RECOMMENDATION 6

To ensure the limited supply of supportive housing is provided to mental health clients who can derive the most benefit from their residency, the Ministry of Health and Long-Term Care should:

- collect data to determine how many housing units that it funds are occupied by individuals who no longer receive or require mental health support services;
- working with housing agencies, determine the profile of clients who are suitable to be transitioned to other forms of housing and develop a transition plan for these clients;
- assess the merits of a housing continuum that offers a mix of time-limited and permanent housing;
- identify alternative settings that can be used to house individuals who no longer require support services; and
- develop strategies and processes to transition individuals who no longer require supportive housing to other forms of housing.

MINISTRY RESPONSE

The Ministry recognizes that supportive housing is permanent and that tenants have the right to security of tenure under the *Residential Tenancies Act, 2006*. The Ministry will work with LHINs and supportive housing providers to develop a profile of supportive housing tenants that would choose to move into other housing options in the community if they had the opportunity. As part of this work, the Ministry will work with housing providers and the LHINs to track units that are occupied by tenants who no longer derive benefit from the professional or peer supports offered by supportive housing.

The Ministry will consider the merits of a housing continuum and start to consider where mental health supportive housing appropriately fits.

The Ministry will work with partner ministries to identify opportunities to support the

successful transition of supportive housing tenants into other housing options in the community.

The current provincially-funded supportive housing system in Ontario administered by the Ministry and three other ministries includes time-limited transitional housing, as well as permanent housing. As part of the updated Long-Term Affordable Housing Strategy, Ontario has recognized that transitional housing providers need to be able to admit clients in need of support, while protecting client rights and helping them successfully transition to independent living. The Ministry of Housing is consulting with stakeholders on amending the *Residential Tenancies Act, 2006*, to facilitate the provision and operation of transitional housing. The Ministry will also consider investing in pilot projects that enable supportive housing tenants to move to other types of housing and will evaluate their success.

4.3 Supply of Housing Stock Not Evaluated for Adequacy, Distribution and Cost-effectiveness

The Ministry has not set any goals for how many units of supportive housing Ontario needs or will need in the future and by when, so it is not possible to determine whether the existing housing supply is being used effectively. In addition, Ontario's 12,365 units of mental health supportive housing across the province's 14 LHIN health regions are not planned with regard to areas with the most need because the Ministry did not and continues to not have complete information on housing demand, as noted in **Section 4.1**. Further, the Ministry has not determined which of the four housing programs is the most cost-effective in the long run to house clients with mental illness, even though our Office noted in our 2002 audit on Community Mental Health that the Ministry had not determined the number or type of housing spaces required to meet the needs of seriously mentally ill individuals or whether existing housing was meeting the needs of the individuals housed.

We look at these issues in detail in the following subsections.

4.3.1 Target Not Established for Quantity of Housing Needed in Ontario

Over the 10-year period between fiscal years 2006/07 and 2015/16, the Ministry has increased the number of supportive housing units it funds for those with mental health and housing needs by 46% (see **Figure 3**). But the current supply of housing stock still does not meet the demand for such housing.

Ontario provides fewer mental health housing units for every 10,000 people than three other provinces, according to a 2011 report issued by the Mental Health Commission of Canada that noted the number of dedicated housing units available to mental health clients in all provinces. As of March 2016, nine mental health housing units on average were available for every 10,000 people across Ontario (for dedicated housing and three other programs), compared to 12.8, 14.7 and 17 units (for dedicated housing only) in Manitoba, Quebec and British Columbia, respectively.

The Ministry does not establish a goal of how many mental health supportive housing units it needs or will need to fund, and by when, so it is not possible to measure whether its recent funding to increase the housing supply was adequate to address unmet needs. Addictions and Mental Health Ontario noted in a March 2014 proposal on mental health housing that the Ontario government should provide over 26,000 new units of supportive housing over seven years.

The need to assess housing needs and the areas with serious housing shortages was raised in our 2008 audit on Community Mental Health. In our subsequent follow-up on that audit in 2010, the Ministry advised us that it was in the process of addressing this issue.

4.3.2 Housing Stock Not Allocated According to Demand

Given that there is a chronic shortage of mental health supportive housing in Ontario, evidenced by the long wait lists and wait times, it is important that the Ministry allocates limited housing stock across the 14 LHIN health regions in the province so that all individuals waiting to be housed in mental health supportive housing have an equal opportunity to access housing in their own communities. The Ministry has more flexibility to reallocate housing stock belonging to the rent supplement program than the dedicated housing program—while the dedicated housing properties are in fixed locations, rent supplement units can be relocated to different areas by sourcing from different landlords.

The Ministry's 46% increase in the housing supply over the last 10 years has been accomplished primarily by way of funding additional rent supplement units. Ideally, the Ministry should allocate these housing units to regions proportional to the number of people waiting to be housed, but the Ministry does not have this information. Instead, it has allocated the units based on existing housing supply and indicators of mental health services demand, including unscheduled emergency department visits and repeat visits within 30 days for mental health and substance abuse conditions; admissions to adult designated mental health units; patient discharges and length of stay in adult designated mental health units; prevalence of mental health problems and addictions; and social demographics.

As we have seen, as of March 2016, nine mental health housing units on average were available for every 10,000 people across the province (a unit is a living quarter that could have one or more beds), but almost two-thirds of the province's 14 LHIN regions had fewer than nine units per every 10,000 people. The Toronto Central LHIN, covering the core of the City of Toronto, with its edges reaching out into Scarborough, North York and Etobicoke, had the highest concentration at 31 units per 10,000 people. Excluding the Toronto Central LHIN, the allocation of mental health housing units across the province's remaining 13 health regions differed significantly, with North East (covering areas including North Bay, Sault Ste. Marie, Sudbury and Timmins) having almost seven times as many units per 10,000 people as Mississauga Halton, as shown in **Figure 4**. A possible reason for this disparity in allocation of housing stock is that each LHIN region's demand for housing and mental health services varies, but the Ministry has not demonstrated that the existing housing stock across 14 LHINs is allocated equitably to address differing demands in each region, because it does not know the demand in each region. The disparity in the distribution of housing supply has contributed to differing wait times for mental health supportive housing across the province, as discussed in **Section 4.1.4**.

In addition, some of the units that the Ministry funds are self-contained units that accommodate one tenant, while others are shared units with multiple beds that accommodate several tenants, all with mental illness. However, the Ministry does not have data on how many of its funded units

Figure 4: Per Capita Distribution of Mental Health Housing Units by Local Health Integration Network, March 2016

Source of data: Ministry of Health and Long-Term Care

LHIN	Units per 10,000 People
Toronto Central	31.1
North East	14.6
North West	14.2
South West	10.6
North Simcoe Muskoka	10.0
South East	8.8
Central	7.1
Erie St. Clair	6.7
Champlain	6.7
Hamilton Niagara Haldimand Brant	6.3
Central West	5.6
Waterloo Wellington	5.1
Central East	4.2
Mississauga Halton	2.1
Province	**9.0**

are shared units and how many are self-contained units, nor on how many beds there are in the shared units. As a result, the Ministry may not always know how many beds exist in its housing stock, further hampering its ability to effectively allocate available housing stock across the province to equitably meet client needs. We discuss our concerns with managing vacancies in shared units later on in **Section 4.4.1**.

4.3.3 No Evaluation Conducted to Identify the Most Cost-effective Way to Provide Supportive Housing

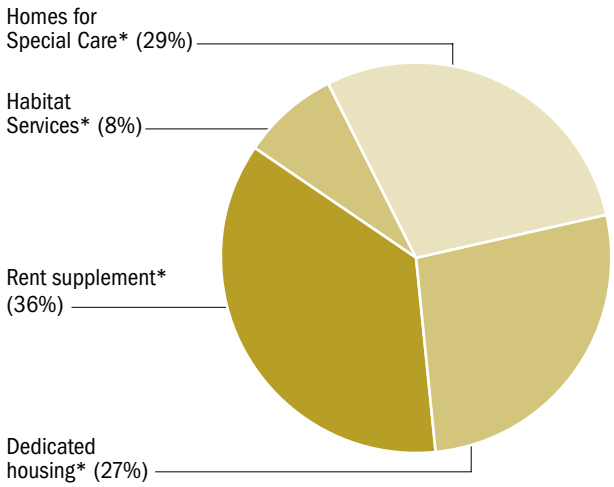
As shown in **Appendix 1**, about 80% of the mental health supportive housing units in Ontario belong to two housing programs—dedicated housing (properties are purchased with ministry funding and owned by housing agencies), and rent supplement (agencies rent in private landlord-owned properties.) The client pays rent to the agency using funds he or she collects from social assistance and/or a public pension for both housing programs, but the Ministry also pays a top-up rent amount to the agency for rent supplement housing.

The Ministry tracks housing cost by housing program. The LHINs, however, do not distinguish expenses for support services delivered to clients in housing versus clients not in housing. As a result, we could not compare spending on both housing and support services by housing program. Based on the Ministry's record of housing costs, in the year ending March 31, 2016, the Ministry spent 36% of its funding on rent supplement housing, followed by 29% on Homes for Special Care, 27% on dedicated housing, and 8% on Habitat Services, as shown in **Figure 5**. In the same year, as shown in **Figure 6**, housing cost by unit varied from $5,175 for rent supplement to $9,064 for dedicated housing. The per unit housing cost of $20,226 for Homes for Special Care is significantly higher than the per unit housing costs of other mental health supportive housing programs because ministry funding to the Homes for Special Care program includes food, medical costs, clothing and other support services, in addition to housing. The Ministry was unable to separate the housing cost from the other expenses for this housing program.

In the last 10 years ending in March 31, 2016, investments of $37.1 million in mental health supportive housing were all directed to rent supplement units. While rent supplement may be the least expensive option in the short term, the Ministry did not evaluate the merits of other housing programs in the long term. For example, dedicated housing builds permanent assets for the province's supportive housing program, which allows for greater flexibility to provide varying level of supports and to appropriately structure the living environment for tenants (issues we take up in **Sections 4.2.1**

Figure 5: Mental Health Supportive Housing Costs by Housing Program, 2015/16

Source of data: Ministry of Health and Long-Term Care



* See **Appendix 1** for definition of programs.

Figure 6: Annual Housing Cost per Unit by Housing Program, 2015/16

Source of data: Ministry of Health and Long-Term Care

Housing Program	Cost per Unit ($)
Homes for Special Care	20,226
Dedicated housing	9,064
Habitat Services	8,795*
Rent supplement	5,175

* This amount excludes approximately 20% of the total housing cost, which was contributed by the City of Toronto.

and **4.2.2**, and **Section 4.5**). We made a similar observation in our 2002 audit on Community Mental Health: we noted that the Ministry had not determined the number or type of housing spaces required to meet the needs of seriously mentally ill individuals or whether existing housing was meeting the needs of the individuals housed.

The Ministry has not addressed this issue. However, the government created the Mental Health and Addictions Leadership Advisory Council (Council)—a three-year advisory body consisting of 20 members representing diverse health sectors, including those with a lived experience of mental illness or addiction—in 2014. Among the Council's mandates was to look at options to expand the province's stock of supportive housing in 2016, including the use of social impact bonds, which allow the government to use private investments to finance interventions delivered by social service providers. If agreed-upon social outcomes and cost savings from these interventions are achieved, financial returns are paid to the private investors out of the savings realized by the government. At the completion of our audit, this work was still ongoing.

With respect to the remaining 20% of housing units, the Ministry has begun transforming the Homes for Special Care program and has allowed changes made to those delivered by Habitat Services through a pilot project, as these forms of housing were developed decades ago and do not necessarily follow current best practices of supportive housing. We noted almost 30 years ago in our *1987 Annual Report* that residential care homes (which primarily provide room and board) for the mentally ill were a poor way to address housing problems since they were not required to provide support services. The Ministry has since 2011 transformed 9% of the units under the Homes for Special Care program to the rent supplement program. The Ministry plans to make further changes to the Homes for Special Care program and expects to finalize this work by 2017. Similarly, the Ministry is also looking to change the Habitat Services program, following a pilot project in 2014 where funding originally provided to a house in the Habitat Services program that was sold was transferred to house the affected clients in self-contained units within private properties. In our view, the Ministry acted prudently in updating these two legacy housing programs, albeit decades late.

RECOMMENDATION 7

To ensure the limited resources available are allocated across the province to meet the housing needs of those with mental illness, the Ministry of Health and Long-Term Care should:

- collect data on the demand for mental health housing and establish a goal for the number of mental health supportive housing units the province should have, along with timelines;
- forecast the expected costs to house clients under each of the housing programs in the short and long term;
- determine and use the most cost-effective approach to house individuals with mental health and housing needs when making additional future investments in this area;
- work with Local Health Integration Networks to identify opportunities to redistribute resources among themselves to provide housing to areas with the greatest needs, considering the mix of self-contained and shared units in its housing stock;
- review input from the Mental Health and Addictions Leadership Advisory Council on ways to expand the province's stock of supportive housing, and determine actions required in an expeditious manner; and
- expedite plans to transform the Homes for Special Care and initiate a review to transform the Habitat Services program.

MINISTRY RESPONSE

The Ministry is working with its partner ministries (Ministry of Housing, Ministry of Community and Social Services, and Ministry of Children

and Youth Services) and other stakeholders to identify performance indicators for supportive housing and the data required. This work will improve the government's understanding of the impact of supportive housing programs and the impact they have on tenants. Once this work is completed, the Ministry will work with LHINs and other partners to collect data on demand for mental health supportive housing. The Ministry will subsequently establish targets and timelines.

As part of its planning, the Ministry will forecast the short and long-term costs of the programs it funds and will determine cost-effective approaches to delivery that consider local market conditions and capacity. This will include exploring opportunities for LHINs to re-allocate supportive housing resources amongst themselves and will use demand, local housing market, and other data to guide future investments.

The Ministry will continue to review the Mental Health and Addictions Leadership Advisory Council's advice to government and will use their advice to guide future supportive housing investment.

The Ministry will continue to modernize the Homes for Special Care program in a way that minimizes disruption to current tenants and will work with partners to develop a plan to modernize the Habitat Services program.

4.4 Limited Ministry Oversight of Housing Programs

Given that the province has limited housing stock, it is important that the Ministry ensure that vacancies are minimized to reap the full benefits of existing housing stock. However, the Ministry is not able to readily identify how many agencies exceed the allowable vacancy rate. Also, agencies are not required to report the reasons for their vacancies. This limits the opportunities for ministry monitoring and management of the housing stock. Additionally, even though agencies, stakeholders and experts recognize the continued use of older, shared housing units as a concern because people with mental illness prefer to live alone or with a loved one as opposed to living with other people with mental illness, the Ministry has not assessed how to better use these units. Lastly, the Ministry did not sufficiently monitor housing agencies to ensure they are being funded appropriately to operate the housing component of supportive housing.

We look at the above issues in detail in the following subsections.

4.4.1 Ministry Lacks Information to Monitor and Analyze Vacancies in Housing Units

Tracking and Reporting on Vacancies

When available mental health supportive housing units remain unoccupied, client wait times may be prolonged unnecessarily. As a result, stress and helplessness are also prolonged unnecessarily for these clients. Housing agencies typically need to prepare a unit for the next client after the previous tenant has moved out. If units have been damaged, agencies may have to spend additional time to repair the damages. With this in mind, the Ministry allows the housing agencies to budget for a 5% vacancy rate each year, meaning that each unit the agency operates can be vacant for up to 18 days a year on average.

While the Ministry requires agencies to report the duration of occupancy and vacancy in months, it has to manually calculate each agency's vacancy rate and compare it against the 5% standard. The Ministry also does not compare vacancy rates among agencies or across health regions. As a result, the Ministry does not know the number and percentage of agencies with vacancies over 5%, the range of vacancy rates between agencies and between regions, and the year-over-year comparison at the regional and provincial level. Without this data the Ministry is limited in its analysis of vacancies and cannot know whether there is improvement or decline in how vacancies are managed. This information would also assist the Ministry in its decisions on new funding for agencies.

Further, the Ministry does not generally require agencies to report the reasons for their vacancies and only does so in limited circumstances. Yet without knowing why a unit is left vacant for longer than expected, the Ministry cannot ensure that the limited available units are put in use on a timely basis to serve people with mental health and housing needs. One agency reported that only one tenant resided in a four-bedroom unit, with the remaining three beds in the unit being left vacant for 12 months. However, its reporting to the Ministry did not include the reasons, and only direct follow-up by the Ministry with the agency would have revealed that the vacancies were due to delays in finalizing a partnership agreement and challenges with transferring the existing tenants to other units. Having agencies proactively report the reasons for their vacancies would improve the efficiency of monitoring, ensure accountability for all vacancies, and create the potential to aggregate this data to allow the Ministry to effectively track the causes of vacancies and identify areas for further investigation.

Improving the collection of vacancy and occupancy data was raised in our 2008 audit on Community Mental Health. In following up on that audit in 2010, we were advised that the Ministry was in the process of addressing this issue.

Shared Housing Versus Self-Contained Housing

As already noted in **Section 4.3.2**, the Ministry does not have data on how many of its funded units are shared units, with multiple beds, and how many are self-contained units. According to the agencies we visited, most clients prefer to live in self-contained units. This was echoed by stakeholder associations and experts we spoke to during this audit. As well, a report that examined client experiences in mental health support housing issued by the Centre for Addiction and Mental Health in 2012 noted that many clients prefer to live alone or with a loved one as opposed to living with other people with mental illness. As a result, when a vacant unit turns up in these shared units, housing agencies have a harder time to fill it. One agency we visited had six shared housing units with long-term vacancies lasting up to 39 months.

The Ministry has not assessed how to effectively utilize shared housing, most of which is within dedicated housing properties that were purchased by housing agencies using government funds years ago and designed as such. To address this concern, agencies have recently proposed to the Ministry ways to better utilize these units, including renovating them into self-contained units or selling them off and replacing them with self-contained units. The Ministry has informed the agencies that it expects them to self-finance any changes to convert or replace these units to self-contained units.

RECOMMENDATION 8

To improve efficiency in monitoring and decision-making, and to ensure housing vacancies are minimized, the Ministry of Health and Long-Term Care should:

- require housing agencies to report vacancy rates and the reasons for vacancies; and
- compare vacancy information reported between agencies and between regions, and analyze this information from year to year.

MINISTRY RESPONSE

The Ministry will require supportive housing providers to report vacancy rates and the reasons for vacancies. The Ministry will then use this data to compare vacancy rates between agencies and between LHIN regions on an annual basis.

4.4.2 Lack of Assurance That Payments Made to Agencies to Provide Housing Are Appropriate

The Ministry regularly pays housing agencies one or more of the following amounts to operate the various types of mental health supportive housing:

- For agencies that operate agency-owned dedicated housing originally set up by the *province*:
  - an operating subsidy to cover mortgages, utilities, maintenance and, if applicable, property taxes (some housing agencies have registered charity status and have applied to their municipalities to be exempt from property tax);
  - a capital reserve to renovate and replace capital items such as roofs, fire alarm systems and brickwork; and
  - a rent subsidy to provide supportive housing so clients can pay affordable rent geared to their income.
- For agencies that operate agency-owned dedicated housing originally set up by the *federal government*: a mortgage subsidy to reduce the mortgage payments from the market rate to a reduced rate (in most cases) and also a rent subsidy for a limited number of properties under a special program.
- For agencies that administer the rent supplement units: a rent supplement subsidy to top up rent that clients pay the agencies, which ultimately pay the private landlords that own these units.

While the Ministry has increased the operating subsidy in each year between 2011/12 and 2015/16 beyond the inflation rate to help agencies cope with annual increases in utility costs, general maintenance and, if applicable, property taxes, we identified concerns with subsidies relating to rent and capital reserve payments:

- For subsidies relating to rent:
  - The Ministry subsidizes agencies using rent factors based on the lower end of market rent, an amount established by the Canada Mortgage and Housing Corporation, and does not adjust the subsidy according to the annual rent increases announced by the province's Landlord and Tenant Board (Board), formerly the Ontario Rental Housing Tribunal. Private landlords have the right to adjust their rent upward as allowed by the Board, so agencies administering the rent supplement program have to find efficiencies within their operations to finance the difference. Agencies also told us that finding private landlords who are willing to rent at the lower end of the market can be challenging.
  - The Ministry relies on the agencies to regularly verify their tenants' income and inform it if any changes should be made to the payment. However, the Ministry does not independently check whether agencies perform this verification. This process is not effective in detecting whether agencies indeed verified tenants' income—at six of the seven agencies we visited, we identified instances where income was not being verified once a year. As a result, the risk exists that the Ministry's subsidy payments to agencies may not be in all cases appropriately geared to tenants' ability to pay their rent, and tenants may be paying more or less rent than they should.
- For the capital reserve payment, the Ministry expects housing agencies to conduct building-condition audits on their own dedicated housing units, but does not formally require them to do so. Such audits are meant to identify the need for potential replacement and repair of capital items for up to 20 years and are typically completed by engineering firms. The Ministry does not specify how often these audits have to be completed and does not track which agencies have completed building-condition audits. Six of the seven agencies we visited own properties, but only three had completed a building-condition audit in accordance with the Ministry's expectation, one in 2014, one in 2013 and the third in 2002. The remaining three agencies either did not complete the recommended audit or instead completed an appraisal report, which provides fewer details and does not contain cost projections.

As well, although the Ministry has visited housing agencies, it does not formally inspect any properties. When agencies do not conduct building-condition reports and the Ministry does not inspect properties, the Ministry does not know if agencies are complying with the terms of their agreement—specifically, if agencies maintain units in a good state of repair and cleanliness fit for occupancy. In addition, the Ministry lacks accurate information needed to appropriately fund the agencies' capital reserves. As a result, agencies may have an unfunded liability balance, meaning that they lack the reserve funds to pay for needed major repairs and renovations on the buildings they own. This situation not only exposes the Ministry to possible eventual (but unknown) financial liabilities for the buildings, it could also pose safety risks to the clients living in these buildings. Based on the studies completed, two agencies expressed concerns with their capital reserves: one expects to be in an unfunded liability position of about $70,000 by 2027; the other expects that it will end up in an unfunded liability position given that its current capital reserve of $11 million is significantly less than the projected capital expenditures of $31.6 million, and the agency does not expect that the Ministry's contribution to the capital reserve in the near future will be sufficient to cover the difference.

RECOMMENDATION 9

To ensure that housing agencies receive appropriate resources to operate the mental health supportive housing program, the Ministry of Health and Long-Term Care should:

- assess if increases to rent supplement subsidies are in line with legally allowed rent increases;
- verify, on a sample basis, whether housing agencies have performed the required client income verifications, and adjust the client subsidy payment accordingly;
- specify to housing agencies the frequency of building-condition audits required; based on the results, work with the housing agencies to determine the appropriate action—for example, dispose of older assets in need of repair and replace these with updated safer units, or adjust payments to the capital reserves accordingly; and
- perform routine site inspection visits to mental health supportive housing properties to assess if agencies are complying with the terms of their agreements; specifically, if agencies maintain properties in a good state of repair and cleanliness fit for occupancy.

MINISTRY RESPONSE

The Ministry will assess its review process to determine if increases in rent supplement subsidies are in line with legally allowed rent increases.

The Ministry will also verify, on a sample basis, that housing agencies are routinely verifying the incomes of their tenants who receive rent assistance.

The Ministry will identify how frequently it will require housing providers to conduct building condition audits. Based on the results of the audits, the Ministry will work with housing providers to identify appropriate next steps.

The Ministry will develop an approach to conducting site visits of Ministry-funded properties to assess compliance with the terms of their agreements and Ministry directives.

4.4.3 Uncertain Status of Dedicated Housing Units with Expired and Soon-to-be-expired Operating Agreements

The Ministry funds the mortgages of all agency-owned dedicated housing properties. The Ministry assumed the funding of these mortgages in 1999 and 2000 from other government entities, such as the federal government and the provincial Ministry

of Housing. Each agency that operates dedicated housing has an operating agreement with the Ministry that is tied to the mortgage payment schedule and sets out the obligations of the agency. The mortgages of some of these properties have already been fully paid off. As of March 31, 2016, just over 6% of the dedicated mental health housing properties have operating agreements that have expired, and just over 8% have operating agreements that will expire in the next three years. By 2033, all mortgages will be paid off.

The operating agreements expire once the mortgages are fully paid. Without an operating agreement, agencies can continue to receive rent from tenants but will no longer receive any funding from the Ministry. The rental income may not be sufficient to cover ongoing operating and capital expenses associated with these units.

As well, even though these agencies can still use the properties purchased using government funding to house tenants with mental illness, the agencies are no longer required to report any information on the units, such as number of units used to house people with mental health issues, duration of occupancy and vacancy, and financial information. Without this information the Ministry cannot monitor these housing units, even though they were purchased with public funding. Under the agencies' letters patent (similar to articles of incorporation), however, agencies are still required to inform the Ministry should they discontinue the use of the housing units as mental health supportive housing, or sell the properties.

The Ministry of Housing has taken the lead to clarify with the federal government the future of the already-expired or soon-to-be-expired agreements for properties that were originally funded by the federal government and later transferred to the provincial government. The Ministry will follow the lead of the federal discussion and will determine options for the properties that were originally funded by provincial money.

RECOMMENDATION 10

To ensure appropriate oversight of agencies whose operating agreements have expired or will soon expire, and to confirm that the agencies still provide housing services to people with mental illness, the Ministry of Health and Long-Term Care should require agencies, regardless of the status of their operating agreements, to continue to report data on occupancy and vacancy, number of units used to house individuals with mental health issues, and financial information such as rent revenue and operating costs of units.

MINISTRY RESPONSE

The Ministry recognizes the importance of maintaining an interest in the dedicated supportive housing portfolio after housing providers' operating agreements have expired. This issue has also been identified by the Ministry of Housing for inclusion in the federal government's proposed National Housing Strategy. The Ministry is working with the Ministry of Housing and other ministry partners to ensure a consistent approach to ensure its supportive housing continues to be available after operating agreements end for all its clients, including those who have mental health and addictions issues.

4.5 More Information Needed to Confirm Delivery of Appropriate Support Services to Housed Tenants

So far in this report, we have discussed the housing component of mental health supportive housing. This section discusses the support services component. Providing support to keep clients housed, as well as crisis intervention, employment assistance, case management and support services to clients with mental illness can help these clients cope with their mental health challenges and live

independently in the community. Some housing agencies provide support services on their own; others partner with other mental health agencies in their geographic area to provide support services to clients living in the properties they manage. While the Ministry funds the housing component, the province's 14 Local Health Integration Networks (LHINs) fund agencies to provide support services to clients living in mental health supportive housing.

LHINs do not collect enough information to inform themselves whether housing clients receive any services at all, or about the types of services they get and the costs of delivering these services. As well, neither the Ministry nor the LHINs provide clients with any expectations of the types of support services and level of care they may be entitled to. They also do not require mental health agencies to use any standard assessment tool and to assess clients' ongoing needs at prescribed intervals while they are residing in mental health supportive housing. As a result, clients in different parts of the province receive different services and are reassessed at different frequencies. Finally, agencies that work with other agencies to provide a continuum of services to clients do not follow formal working protocols, contributing to the uncertainty of whether clients receive all the services that they require.

We look at the above issues in detail in the following subsections.

4.5.1 LHINs Do Not Know Which Support Services Are Delivered to Clients in Mental Health Supportive Housing and the Costs of These Services

Although LHINs fund mental health agencies to deliver support services in mental health supportive housing, the LHINs do not maintain sufficient information on the types, duration and costs of the different support services that are delivered to their clients.

In return for receiving LHIN funding, agencies regularly provide select service activity data to their LHIN. This includes such information as number of clients served, number of face-to-face visits made and number of group sessions delivered. However, the LHINs do not collect information on the types of support services provided to determine whether the services relate to, for instance, intensive case management, crisis intervention, employment assistance or counselling. LHINs also do not collect information on the number of hours of support services delivered. As a result, LHINs cannot determine which, if any, support services their clients receive with the funding they provide to mental health agencies.

As well, across all 14 LHINs, we noted that mental health agencies that provide support services did not always report service expenditures consistently. Some agencies provided cost information in one designated category called "support within housing," but others reported this information to LHINs in multiple cost categories, not distinguishing between clients residing in ministry-funded housing and other clients who use the same support services. As a result, neither the Ministry nor the LHINs could identify or estimate the expenditures on support services provided to clients living in mental health supportive housing. Without such information from the LHINs themselves or from agencies, LHINs cannot identify anomalies in spending on support services in mental health supportive housing.

4.5.2 Level of Care and Types of Support Services Needed for Clients Residing in Mental Health Supportive Housing Not Prescribed

Neither the Ministry nor the LHINs have a prescribed list of support services that agencies need to provide to clients living in mental health housing, but such lists have been compiled in the past. As early as 1988, a ministry-commissioned report by the Provincial Community Mental Health Committee identified a list of mental health support functions that are considered essential. Similar lists

were compiled in 1993 and 2001 in other ministry-commissioned studies. These services include, for example, case management, income support, family support, residential support and vocational support. As discussed in **Section 4.5.1**, there is no reporting or monitoring mechanism to allow the Ministry or the LHINs to confirm that services recommended by previously established expert groups are being delivered to clients living in mental health supportive housing. The Mental Health and Addictions Leadership Advisory Council noted in 2015 that it will create a working group to identify a basket of core mental health and addiction services that should be available to all Ontarians—even though similar lists have already been compiled for the Ministry.

Similarly, the Ministry and the LHINs have not defined the levels of care that should be provided to clients living in mental health supportive housing who are at various levels of needs, so there is little assurance that clients receive equitable service across the province. In comparison, the Ministry of Children and Youth Services in 2015 established a continuum-of-needs framework to help child and youth mental health agencies determine the level of needs and services according to the severity of mental health problems of individual children and youth across four distinct levels of need. As well, the Ministry commissioned the Centre for Addiction and Mental Health to conduct a study, published in 2001, to identify, among other things, a levels-of-care planning model as a guide to the services that should be made available to clients at different levels of care. According to this five-level model, a level one client would be capable of self-management and may use community services and supports intermittently; a level three client would need intensive assistance such as intensive case management, but can still live in the community; and a level five client would need to receive 24-hour in-patient care delivered by a multidisciplinary team of highly trained experts in a secure setting.

According to this 2001 study, regardless of their designated level of care, clients should always have access to a range of services, including in-patient care, crisis services, psychiatric services, client and family initiatives, primary medical care, housing support, income support, vocational and educational support, leisure and recreational activities, and family support. Even though these models are available and could be adapted to clients living in supportive housing, neither the Ministry nor the LHINs have adopted them.

4.5.3 Housing Clients Receive Different Support Services Depending on Where They Reside or None at All

Because neither the Ministry nor the LHINs prescribe to agencies the types and duration of support services supportive housing clients are expected to receive (as discussed in **Section 4.5.2**), the agencies deliver the services they feel are appropriate to their clients. The three LHINs that we visited support this approach, noting that agencies are in the best position to make these decisions. However, leaving service delivery entirely in the hands of the agencies can result in differences in what a client may receive, depending in some cases on where in the province the client lives. All seven agencies we visited offer housing support (services such as helping clients stay housed or manage relationships with landlords, and helping clients with meals) and case management (either through the agency or by partnering with another agency), but only some agencies offer in-house psychiatrists and in-house nurses to their housing clients. We also noted that six of the seven agencies we visited offer vocational or employment supports. Such supports include helping with resumés and interview skills, and assisting with finding jobs. Two of these agencies also hire tenants to do work such as office administration and property maintenance. But none of the agencies had partnerships with private businesses to connect tenants to potential job placements in those businesses.

In addition, neither the Ministry nor the LHINs require agencies to report whether their supportive

housing clients receive support services or not. Representatives from the agencies we visited informed us that some of their tenants do not receive any support services, either because their mental illness has stabilized and they no longer require these services, or because they have refused the services. Of the seven agencies we visited, two reported that a portion of their clients, ranging approximately from 6% to 8%, were not receiving any support services, in some cases because they were no longer required. This is contrary to the principle of supportive housing, which includes support services. Without information on the actual provision of services, the Ministry cannot assess the need for step-down programs or the options for alternative housing.

4.5.4 Clients Could Be Receiving Inappropriate Levels and Types of Care as Needs Are Not Regularly Reassessed

All seven agencies we visited assess their clients from time to time to determine what services they require. However, the assessments were not always conducted on a regular basis, so agencies risk delivering too much, too little or the wrong kind of support to clients living in mental health supportive housing.

All seven agencies have adopted a common assessment tool called the Ontario Common Assessment of Needs (OCAN), although only one of the three LHINs we visited mandated its agencies to use this tool. The tool measures a client's current situation in 24 different areas such as accommodation, self-care and daytime activities; the level of support the client currently receives from friends, family and service providers; and the client's support needs. The OCAN guidelines specify that a reassessment should be done every six months.

Six of the seven agencies we visited adopted these guidelines. The remaining agency reassessed its clients every 12 months instead. This agency explained that it was not cost-effective to reassess every six months and often there was little or no change in the client's needs. (The OCAN guidelines, however, do not say when frequency of reassessment can be reduced.) We reviewed a sample of client assessments at all seven agencies to determine whether they were conducted with the frequency prescribed by the agency's own policy. We found that in 28% of the cases reviewed, reassessment was not conducted with the required frequency as defined by the agency, with some assessments being 12 months overdue. As well, clients' service needs as identified in the OCAN tool could be summarized across the region or the province to determine service gaps, but the LHINs do not obtain aggregate assessment data. At the three LHINs we visited, only one had obtained aggregate data from the assessment tool, though this was only done in 2014 as a one-time exercise. Not having this information means that the LHINs could be providing too much funding to agencies that have clients with the least unmet needs, while short-changing agencies that have clients with the most unmet needs.

We raised the issues of improving the collection of data on unmet needs and assessing the adequacy and appropriateness of care provided to housing clients in our 2008 audit on Community Mental Health. In following up on our recommendations in 2010, the Ministry advised us that it was in the process of addressing these issues.

4.5.5 Partnering between Agencies to Provide Support Services Poses Challenges

Not all housing agencies we visited were able to provide on their own a full range of support services for their clients. To ensure clients' needs are not impacted because one agency cannot provide all the different types of services its clients may require, some agencies partner with others that can provide these services. This arrangement also allows the agency providing the supportive housing to accept clients with complex mental health issues whose level of needs can be met only by a different agency. However, working with other agencies poses the following challenges:

- Assessment information is not always shared with those who may need it—Even though the Ministry implemented the Integrated Assessment Record to help service providers share assessment information with each other, neither the Ministry nor the LHINs require service providers to upload client assessments to this system. The Integrated Assessment Record provides publicly funded health service organizations such as Community Care Access Centres and mental health agencies access to electronic client assessment information in a timely manner to support collaborative care planning. As a result, the benefit of the Integrated Assessment Record, meant to reduce the delay and frustration that clients may experience by having to provide similar information multiple times to various agencies that serve them, cannot be fully realized. We made the same observation in our *2015 Annual Report* in the audit of Community Care Access Centres—Home Care Program.
- Working relationships and protocols have not been formalized to reduce the risk that clients' service needs are not met—There have been disputes as to which agency should be providing a particular support; for instance, one agency reported having difficulty identifying whether it or a partner agency was responsible for helping clients prepare for bed bug extermination. As well, key information that could affect the housing provider is not always communicated by the partner agency that provides support services. For instance, one housing agency informed us that a partner agency had failed to communicate that a client had rejected case management and was without a case manager. Without a case manager, clients' mental health status may deteriorate and they may harm themselves or others and damage property, posing safety and financial risks.

In our 2008 audit on Community Mental Health, we noted that the LHINs need to assist agencies so they can better co-ordinate and collaborate with each other. In 2010, we followed up on our recommendations, and were advised that the LHINs were working with mental health agencies to develop approaches to ensure clients receive appropriate services.

RECOMMENDATION 11

To ensure tenants living in mental health supportive housing receive needed support services, Local Health Integration Networks, in conjunction with the Ministry of Health and Long-Term Care, should:

- set standards on what services and levels of care should be available across the province—for example, consider the model developed by the Centre for Addictions and Mental Health or the model adopted by the children and youth mental health sector—and monitor that these are offered in all regions of the province;
- collect cost and service data on the types of support services provided to clients living in mental health support housing and analyze the data to detect anomalies;
- obtain data on unmet service needs from housing agencies that use common assessment tools and reallocate resources to areas where needs are not being met;
- develop expectations on what assessment tool agencies should use to measure housing clients' needs and the frequency with which it should be used; and
- help mental health agencies establish formal working protocols to work with one another, and intervene when agencies fail to work collaboratively.

MINISTRY RESPONSE

The Mental Health and Addictions Leadership Advisory Council (Council) is working on a recommendation for government to establish a core set of services. The Ministry is awaiting Council recommendations, which may include

establishing the levels and standards of care with respect to supportive housing that should be available across the province.

The Ministry will work with stakeholders and the LHINs to identify appropriate assessment tools that agencies can use to measure tenants' needs and the desired frequency of administration. As part of this work, the LHINs will assess overall unmet needs using results from the assessment tool and, where appropriate, reallocate resources to address those unmet needs.

LHINS' RESPONSE

The LHINs are supportive of the Ministry's response and will work with the Ministry to implement Council recommendations.

LHINs will collect cost and service data on the types of support services provided to supportive housing clients and analyze the data to detect anomalies. LHINs will work with the Ministry to reallocate the required resources where appropriate.

LHINs will help mental health agencies establish formal working protocols to work with one another, and intervene when appropriate.

4.6 Oversight of Supportive Housing Agencies Is Limited

The mental health housing program serves a vulnerable group of the population. In order to ensure that agencies consistently deliver high-quality housing and support services to clients with mental illness, it is critical that the Ministry and the LHINs appropriately monitor these agencies and collect sufficient information about the program. We found that the sector still lacks outcome data decades after this was raised as an issue. As well, there is no provincial aggregation of client satisfaction surveys, complaints, serious incidents and best practices to identify practices worth sharing and areas needing intervention.

We look at the above issues in detail in the following subsections.

4.6.1 Data That Ministry and LHINs Collect Is Not Meaningful in Assessing Impact of Supportive Housing on Tenants

The Ministry and the LHINs regularly collect data, either directly or indirectly, from mental health agencies on the two areas of supportive housing:

- on the housing side—financial information such as agency operational and capital expenditures, number of units (but not clients in shared units), duration of occupancy and vacancy in months;
- on the support services side—number of face-to-face visits; number of interactions with service recipients; number of individuals served; number of group sessions delivered; number of staff (full-time equivalents); and wait time to receive support within housing programs.

Most of this information collected is output based. This type of information, however, does not help the Ministry or the LHINs evaluate whether the mental health supportive housing program is having a positive effect on clients; whether the support services delivered are effective; or whether the program helps reduce the strain on other government areas such as hospital visits and encounters with the justice system. In contrast, outcome-based information on housed clients, such as number of emergency room visits and hospital stays, living arrangements upon leaving mental health supportive housing, improvement in functionality, interactions with law enforcement, and ratio of met to unmet needs, can better help the Ministry assess the effectiveness of the mental health supportive housing program. We looked at how other jurisdictions measure the impact of their mental health housing programs, and found that Alberta measures the percentage of people that stay housed, and whether persons housed have reduced incarcerations, emergency room visits and in-patient hospitalizations.

In that regard, we noted that some agencies do collect hospital readmission data on their own initiative to determine if their housing programs

have made a positive impact, but the Ministry and the LHINs do not require agencies to report such information. All the agencies and LHINs we visited during this audit agreed that outcome data should be collected on housing clients. One of the three LHINs we visited specifically noted in a 2013 analysis it conducted on the demands placed on mental health and addiction services that more outcome indicators are required to improve the program.

Many external bodies, including the Select Committee on Mental Health and Addictions (Select Committee) appointed by the Ontario Legislature in February 2009, have made recommendations to the government over the years on ways to improve the mental health system in Ontario. Similarly, the Ministry itself has issued a number of policy frameworks and strategies to guide the delivery of mental health services in the province. See **Appendix 3** for a list of selected reports issued by either the Ministry or sector partners on mental health since 1988. Two of the 23 recommendations that the Select Committee made in August 2010 are most relevant to this report on mental health supportive housing. **Appendix 4** shows these two recommendations and the status of their implementation as at June 2016.

The lack of outcome data in the mental health sector has been identified in several of these provincial reports in the past. For instance, in 1999, the government issued "Making It Happen: Implementation Plan for Mental Health Reform," which called for the collection of outcome data. Similarly, in 2010, the Select Committee on Mental Health and Addictions asked the government to develop and maintain centralized and standardized mental health and addictions data to improve client outcomes. The Mental Health and Addictions Leadership Advisory Council noted in 2015 that it will establish a working group to identify challenges in creating a common data set and will work with stakeholders to develop solutions at the local and regional level. In other words, the issue of not having outcome data is still not resolved almost two decades after the government itself acknowledged this concern.

Because the Ministry lacks information on outcome data, it is not able to publicly report on the effectiveness of the mental health supportive housing programs. Doing so would help the Ministry demonstrate that its programs are effective and meet the objectives of helping people live independently and achieve recovery from mental illness.

We raised the collection of outcome data as an issue in our 2008 audit on Community Mental Health.

RECOMMENDATION 12

To assess whether the objective of the mental health supportive housing program is being met, the Ministry of Health and Long-Term Care, in conjunction with mental health service agencies and Local Health Integration Networks, should identify outcome indicators, establish performance targets, collect required information, and publicly report on the effectiveness of the province's mental health supportive housing.

MINISTRY RESPONSE

The Ministry recognizes the need to determine whether the objectives of mental health supportive housing program are being met. The Ministry is working with the Ministry of Housing and other stakeholders to identify common outcome-focused performance indicators for the supportive and affordable housing systems. Once the performance indicators have been finalized, the Ministry will work with LHINs and housing providers to establish targets, identify and collect supplementary outcome and performance data, and will publicly report on the results. Data and performance indicators developed will also align with the Ministry's Data and Quality Strategy for Mental Health and Addictions, which is in development.

4.6.2 Customer Satisfaction Surveys Not Standardized and Results Not Evaluated

Surveying clients on their experience in mental health housing can help agencies, LHINs and the Ministry assess whether clients feel they are improving or are having a positive experience. It may also help expose systemic issues that require corrective action. Of the seven agencies we visited, one was in the process of developing a survey at the time of our audit, while the remaining six have previously conducted client satisfaction surveys on their housing clients. These agencies survey their clients at different intervals, either on an occasional basis or annually, and each asks different questions. Only one of the three LHINs we visited requires mental health agencies to ask specific questions regarding client satisfaction and to report the results. Because the surveys do not all ask the same questions and offer consistent response options, aggregation of survey information is not possible. Asking common service satisfaction questions would allow client experience to be consistently measured across the province. The LHINs and the Ministry could also use the results to supplement their monitoring of the program and the service providers.

4.6.3 Complaints and Incidents Not Centrally Tracked

LHINs require in their service agreements with the mental health agencies that the agencies have in place policies and procedures to address complaints. Of the seven agencies we visited, all but one complied with this requirement. The LHINs do not verify if agencies have a formal complaint-handling policy or require agencies to report trends they note in complaints. Tracking complaints can help agencies and the LHINs identify common areas of concern across the system. Only two of the seven agencies formally track complaints. We reviewed the complaints received by the agencies that we visited, and noted that they relate to tenant substance use on premises, disturbances causing security and/or noise concerns, and tenant questions about rent rates. We reviewed the documentation on follow-up actions taken by the agencies and determined that the complaints were appropriately addressed.

While the Ministry requires operators of the Homes for Special Care housing program to report serious incidents, it does not extend this requirement to providers of other supportive housing programs. Of the seven agencies we visited, six report serious incidents informally to their funding LHIN, and the remaining agency only reports internally to its own senior management and board. Nevertheless, the LHINs have not defined what constitutes a serious incident. We reviewed a sample of serious incidents at the agencies we visited, and did not note any major systemic issues that require LHIN or ministry intervention. However, it would be prudent for the Ministry or the LHINs to request reports on serious incidents from all housing providers on a go-forward basis to identify areas that may require intervention.

RECOMMENDATION 13

To ensure that clients in mental health supportive housing receive quality service and to identify systemic concerns, the Ministry of Health and Long-Term Care, in conjunction with Local Health Integration Networks, should:

- require housing and mental health agencies to develop standard questions to measure client satisfaction and collect consolidated response information;
- define what constitutes a serious incident and require agencies to report these; and
- require all housing and mental health agencies to report trends they note in complaints.

MINISTRY RESPONSE

The Ministry will work with the LHINs to require supportive housing providers and support service providers to develop an approach to measure client satisfaction that can be consolidated to inform regional and provincial planning.

The Ministry will also work with the LHINs to develop a standardized definition of a serious incident and will consider developing an approach to collecting serious incident and complaint-related data.

4.6.4 Best Practices Not Always Shared Across LHINs and Service Agencies

In December 2002, the Provincial Forum of Mental Health Implementation Task Force Chairs recommended that the Ministry should apply best practices from other jurisdictions and encourage a wide choice of supported living environments for people living with mental illness. Similarly, eight years later in December 2010, the Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy recommended that the Ministry establish best practices/standards for housing and employment services and supports. However, at the time of our audit there was still no best practices guide for the mental health housing program. The Ministry was working with the Ministry of Housing to develop such a guide, and intends to finalize it in 2017. Regarding best practices standards for employment services and supports, the Ministry noted that since the Ministry of Community and Social Services was leading the development of a provincial employment strategy for people with disabilities, it would provide input to that ministry to ensure that people with mental illness are included in that strategy. In other words, years after these recommendations were made, the mental health supportive housing providers still do not have a set of best practices to refer to for housing and employment services.

At the LHINs and agencies we visited, we noted a number of best practices that could be shared with other LHINs or other agencies but were not widespread. For instance, one LHIN developed a scorecard to evaluate agency performance against targets, and shared the anonymous results as needed with its providers. As well, one agency provided training to local police about their clients and their program to help ensure police de-escalate encounters with their clients by taking them home instead of arresting or jailing them.

RECOMMENDATION 14

To ensure that best practices are effectively identified and shared, the Ministry of Health and Long-Term Care, in conjunction with Local Health Integration Networks, should develop a process to evaluate whether initiatives or projects implemented locally or in other jurisdictions yield good results, and communicate these practices across the province.

MINISTRY RESPONSE

As part of the update of the Province's Long-Term Affordable Housing Strategy Update, the Ministry is working with the Ministry of Housing and other ministry partners to develop a Best Practice Guide (the Guide) for the delivery of supportive housing. The Guide, which outlines evidence-based best practices in supportive housing, will be a resource for all individuals and organizations involved in the delivery of supportive housing and related service systems.

When the Guide is released, the Ministry will work with the LHINs and other stakeholders to communicate best practices to housing providers and community-based agencies. The Ministry will also work with the LHINs and housing providers to identify opportunities to evaluate current and future supportive housing initiatives.

LHINS' RESPONSE

LHINs are supportive of the Ministry's response and are developing a Provincial Leading Practices Framework.

4.6.5 Inspections Performed at Homes for Special Care

As of March 31, 2016, there were about 1,400 mental health supportive housing units in Homes for Special Care in Ontario. These homes are privately owned and provide meals, certain support services, 24/7 supervision and assistance with daily living to persons with serious mental illness. According to a regulation made under the *Homes for Special Care Act*, each home needs to be inspected at regular intervals. In practice, the Ministry delegates the inspection responsibility to hospital staff who work in nine psychiatric hospitals. These staff are expected to visit homes and inspect the following areas:

- physical environment and health and safety issues (for example, are bedrooms no less than 60 square feet, are all sanitary facilities working and in good repair, are laundry receptacles provided for soiled laundry, and are there adequate kitchen equipment, supplies and food storage areas?);
- general health (for example, are meals provided on a flexible time schedule, do tenants receive yearly physical examinations, and is medication stored in a locked cabinet?);
- tenant lifestyles (for example, is the home accessible to tenants on a 24-hour basis, and are tenants' rights regarding race, culture, religion and sexuality respected by the homeowner or home staff?); and
- life skills, social and recreation programs (for example, does the home provide adequate/appropriate in-home activities, does the homeowner or home staff assist the tenants in participating in community activities, and are the tenants aware of their financial status?).

We examined a sample of inspection reports conducted on Homes for Special Care and found that inspections were conducted on an annual basis as required.

Appendix 1: Characteristics of the Four Mental Health Housing Programs with Support Services Funded by the Ministry of Health and Long-Term Care

Source of data: Ministry of Health and Long-Term Care

Program Category	Description	Operated By	Ownership of Properties	# of Units as at March 31, 2016	Year(s) Established
Rent supplement	• Sourced by not-for-profit mental health supportive housing agencies from private landlords; usually in apartment buildings. • If the landlord leases with the agency, the agency pays full rent to landlord and collects rent from clients, whose funds come from either social assistance or private means such as pension. • If the landlord leases with the tenant, the agency, using Ministry funds, tops up the rent that the tenant directly pays to the landlord. ◦ Ministry tops up client's rent to lower end of market rent. • Includes Homes for Special Care that have been converted to rent supplement housing. • Support services provided by either housing agency or other mental health agencies.	115 Not-for-profit mental health supportive housing agencies	Private landlords, non-profit housing corporations, municipalities	7,048	1999–2000

Dedicated housing	• Purchased by not-for-profit mental health supportive housing agencies (housing agencies) using government funding.
	• Prior to the Ministry assuming funding, the dedicated housing portfolio was originally funded by either the federal government or the provincial Ministry of Housing;
	  ◦ For the provincial dedicated portfolio, the Ministry pays housing agencies one or more of: a) operating subsidies to cover utilities, mortgage payments, maintenance and property taxes; b) rent subsidies to provide supportive housing so clients can pay affordable rent geared to their income; and c) funds into a capital reserve to contribute toward capital repairs.
	  ◦ For the federal dedicated portfolio, the Ministry pays housing agencies only a mortgage subsidy (in most cases) and also a rent subsidy for a limited number of properties under the Ontario Community Housing Assistance Program.
	• Support services provided by either housing agency or other mental health agencies.
			Mental health housing agencies	2,959	• Early 1970s for the federal dedicated portfolio.
					• Early 1980s for the provincial dedicated portfolio.
					• The Ministry assumed funding of these portfolios in 1999 and 2000.

Program Category	Description	Operated By	Ownership of Properties	# of Units as at March 31, 2016	Year(s) Established
Homes for Special Care	• Operated by for-profit private homeowners licensed annually by the Ministry to provide 24/7 care to those with serious mental illness. • Ministry pays for housing, food, 24-hour supervision, other support services, medical costs and clothing. • LHINs fund nine hospitals that perform inspections.	117 For-profit homes	Private homeowners	1,427	1964
Habitat Services	• Private boarding and rooming houses owned by for-profit private homeowners. • Ministry and the City of Toronto jointly fund (80/20) Habitat Services, an agency that funds homeowners for the provision of room and board (e.g., room and meals), or in some cases, room only. • The Toronto Central LHIN funds the support services and the inspection/monitoring function provided by Habitat Services.	Habitat Services	Private homeowners	931	Early 1980s
			Total	**12,365**	

Appendix 2: List of All Supportive Housing Programs in Ontario

Source of data: Ministry of Health and Long-Term Care, Ministry of Community and Social Services, Ministry of Housing

	Supportive Housing Program	Responsible Ministry
1*	Rent supplement	Health and Long-Term Care
2*	Dedicated housing	Health and Long-Term Care
3*	Homes for Special Care	Health and Long-Term Care
4*	Habitat Services	Health and Long-Term Care
5	Assisted living services in supportive housing and for high-risk seniors	Health and Long-Term Care
6	Strong Communities Rent Supplement (supportive component)	Housing, but includes supports from Health and Long-Term Care and Community and Social Services
7	Affordable housing program (supportive component)	Housing, but includes supports from Health and Long-Term Care and Community and Social Services
8	Dedicated supportive housing	Community and Social Services
9	Residential supports for adults with a developmental disability	Community and Social Services
10	Transitional and housing support program	Community and Social Services
11	Dedicated supportive housing	Children and Youth Services
12	Community Homeless Prevention Initiative	Housing
13	Investment in Affordable Housing	Housing
14	Social housing	Housing

* Funded by the Ministry of Health and Long-Term Care and serve people with mental health-related needs—within the scope of this audit.

Note: Other supportive housing programs listed serve the following population groups: seniors/frail elderly, persons with physical disabilities, persons with developmental disabilities, persons with acquired brain injuries, persons with terminal or chronic illness (e.g., HIV/AIDS), persons who have a history of homelessness or are at risk of homelessness, youth at risk, victims of violence.

Appendix 3: Selected Reports on Mental Health in Ontario, 1988–2014

Prepared by the Office of the Auditor General of Ontario

Report Name	Issued By	Year
Building Community Support for People: A Plan for Mental Health In Ontario	Provincial Community Mental Health Committee	1988
Putting People First: The Reform of Mental Health Services in Ontario	Ministry of Health and Long-Term Care (MOHLTC)	1993
Making It Happen: Implementation Plan for Mental Health Reform	MOHLTC	1999
Making It Work: Policy Framework for Employment Supports for People with Serious Mental Illness	MOHLTC	2000
Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports	MOHLTC	2001
The Time Is Now: Themes and Recommendations for Mental Health Reform in Ontario (Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs)	Provincial Forum of Mental Health Implementation Task Force Chairs	2002
Making a Difference: Ontario's Community Mental Health Evaluation Initiative	Centre for Addiction and Mental Health, Ontario Mental Health Foundation, Canadian Mental Health Association, MOHLTC	2004
A Program Framework for: Mental Health Diversion/Court Support Services	MOHLTC	2006
Moving in the Right Direction	Centre for Addiction and Mental Health, Ontario Mental Health Foundation, Canadian Mental Health Association, Ontario Federation of Community Mental Health and Addiction Programs, MOHLTC	2009
Every Door Is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy (A Discussion Paper)	MOHLTC	2009
Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy (From the Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy)	MOHLTC	2010
Select Committee on Mental Health and Addictions Final Report: Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians*	Legislative Assembly of Ontario	2010
Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy	MOHLTC	2011
Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (Update)	MOHLTC	2014

* See **Appendix 4** for recommendations relevant to mental health supportive housing.

Appendix 4: August 2010 Recommendations of the Select Committee on Mental Health and Addictions Most Relevant to Mental Health Housing with Support Services, and Status of Implementation as at June 2016

Prepared by the Office of the Auditor General of Ontario with input from the Ministry of Health and Long-Term Care

Recommendations	Status of Implementation
...	
3. Clients and their families should have access to system navigators who will connect them with the appropriate treatment and community support services (e.g., housing, income support, employment, peer support, and recreational opportunities). Those with continuing, complex needs should be supported by a plan that will lead them through their journey to recovery and wellness, particularly on discharge from institutional or residential treatment.	Limited implementation. The Mental Health and Addictions Leadership Advisory Council (Council) is working to identify improvements to the mental health and addictions system, including issues related to access and identifying structural barriers. For example, the Council's System Alignment and Capacity working group will work with sector stakeholders to identify structural barriers that prevent client-centred care at the local, regional and provincial levels and provide expert advice on how to best improve service co-ordination and integration. The Ministry of Health and Long-Term Care (Ministry) funds Connex and the Ministry of Children and Youth Services (MCYS) funds Kids' Help Phone. Both programs provide assistance to clients and families in locating appropriate mental health and/or addictions services. Connex was recently evaluated and one of the findings may be to improve access to services by leveraging these resources. The Ministry also funds the Centre for Addictions and Mental Health (CAMH) to develop "service collaboratives" in local communities to improve access and transitions to mental health and addiction supports for children, youth and families across services and sectors. The Ministry also works with MCYS, CAMH, and stakeholders to explore opportunities to scale up successful initiatives under the collaboratives across the province. Together with the Ministry, the MCYS child and youth mental health system transformation will develop clear pathways for children and youth moving through and across the service system between the community-based mental health sector and other natural access points such as schools, hospitals and primary care. The Ministry is working with MCYS on transitions between the child and youth mental health system and the adult system.
...	
13. Mental Health and Addictions Ontario should ensure, co-ordinate and advocate for the creation of additional affordable and safe housing units, with appropriate levels of support to meet the long-term and transitional needs of people with serious mental illnesses and addictions.	The government did not implement a new umbrella organization called Mental Health and Addictions Ontario to be responsible for designing, managing and co-ordinating the mental health and addictions system, and to ensure that programs and services are delivered consistently and comprehensively across Ontario. Responsibility for mental health and addictions services in Ontario currently rests with the Ministry, MCYS, the Local Health Integration Networks, and community mental health agencies. In the fiscal year 2010/11, the Ministry created 1,000 units of supportive housing for people with problematic substance use. Then in 2014/15, another 1,000 units of supportive housing was announced as part of the Mental Health and Addictions Strategy Phase II. The 1,000 units are being rolled out in three phases: 128 units in 2014/15, 624 units in 2015/16 and 248 units in 2016/17. Subsequent to our audit fieldwork, a private member's bill was introduced in the Legislature on September 21, 2016, that would allow the Mental Health and Addictions Leadership Advisory Council (Council) to continue to operate. If passed, Council would be required to submit a plan to the Minister within one year of the Act coming into force, which would include a timeline for establishing Mental Health and Addictions Ontario, and a recommended governance structure for it.