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Justice-focused Mental Health Supportive Housing in Toronto

Needs Assessment and Action Plan

July 2020

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The project team comprised researchers working with the three sponsoring organizations:

Steve Lurie ..... CMHA Toronto
Jessica Petrillo ..... AMHO
Frank Sirotich ..... CMHA Toronto
Greg Suttor ..... Wellesley Institute
Irma Molina..... CMHA Toronto
Dana Granofsky ..... BGM Strategy Group
Lynette Katsivo..... AMHO

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Advisory Committee Members:

Paul Bruce ..... ED, Cota
Brian Davis ..... ED, Houselink Community Homes
Amber Kellen ..... John Howard Society of Toronto
Steve Lurie ..... ED, CMHA Toronto
Susan Meikle ..... ED, Toronto North Support Services
Vesna Milinkovic ..... Fred Victor
Karen O'Connor ..... LOFT Community Services
Kelly Potvin ..... ED, Elizabeth Fry Society Toronto

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Executive Summary

About the Report

Many people living with mental health and addictions issues are caught in a cycle of homelessness, police encounters, court hearings, hospital stays, and incarceration. This cycle results in significant public costs for jails, policing, hospital use, shelters, and other services. A new approach to supportive housing will reduce many of these costs, and will also lower rates of homelessness, justice involvement, and mitigate the negative impacts of mental health issues and addictions on people's lives.

For some of the people involved, mental illness or addictions is central in their criminal justice issues, while for many the justice involvement relates to drug use, homelessness, extreme poverty, and weak social supports.

This report is a needs assessment, along with recommendations for action in Toronto. It draws from expert interviews, service user and service provider focus groups, analyses of waitlist and clinical data, a review of the research literature, and contributions from an advisory group.

This report has been prepared in a context of rising attention at all levels of government to homelessness and mental health, and supportive housing as a long-term solution. It is intended to inform current and future investments in supportive housing for justice-involved people with mental health and addiction challenges. It should inform program development by providing an assessment of support and housing needs and identifying evidence-based interventions to address these.

This needs assessment is a component of a broader Supportive Housing Growth Plan for Toronto, initiated as a collaboration between the Toronto Alliance to End Homelessness, the Canadian Mental Health Association Toronto Branch and the Wellesley Institute. This broader Growth Plan will bring organizations together across sectors to develop a comprehensive, evidence-informed, consensus-based plan to expand the supportive housing system in Toronto, and support its implementation.

The Current situation

One-quarter of applicants to mental health supportive housing in Toronto are justice-involved. Currently, 2,200 people are waiting for justice-focused housing and this need grows by 200 annually. Of 50,000 people discharged each year from Ontario corrections/detention, 18 per cent have diagnosed mental health issues and 17 per cent have drug/alcohol problems.

Supportive housing helps reduce homelessness, hospitalization and incarceration, and costs far less than provincial detention, or beds in hospitals or homeless shelters.

In Toronto, community mental health agencies operate 631 units of dedicated Mental Health and Justice (MHJ) supportive housing – part of the mental health supportive housing sector comprising about 5,000 units. This includes the forensic-focused Transitional Rehabilitation Housing Program (TRHP). Providers also operate short-term Safe Beds. All are part of a province-wide system funded by the Ministry of Health. Related non-housing services include crisis intervention, diversion, pre-release planning, and case management.

Much of this population also lives in private rental, and City-funded homeless-serving and public housing.

Targets

The shortfall in housing for the MHJ population is assessed using three sources: waitlist trends, a 2018 in-depth analysis of waitlist applicants, and population-based estimates. An annual target of 300 added mental health and justice supportive housing units is recommended, to meet ongoing growth and address unmet needs over a ten-year period. The ten-year total is 3,000 additional units. Within this, 300 to 600 should be transitional housing.

Part of MHJ housing need should be met in targeted MHJ housing, and part by improved access and supports for justice-involved persons in overall mental health supportive housing. It will be important to maintain a coherent, integrated supportive housing system as the transition to Ontario Health Teams proceeds.

Support Needs

In supportive housing, trained staff help people sustain stable housing and deal with the issues that underlie mental illness and justice involvement. Five main types of support needs are prevalent among justice-involved persons with mental health and addictions (MHA) challenges:

- **Substance use:** Problematic drug and alcohol use is prevalent in the justice-involved population with mental health issues.
- **Crisis prevention/management:** Once people have stable housing, there is a risk that a drug-related or mental health crisis can destabilize their housing and lead to more justice involvement.
- **Daytime activities, social connections and employment:** Many people leaving custody, or with serious drug use, have weakened social and family supports and challenges finding a job or other meaningful daily activities. To succeed, they need to find new daily routines and social connections.
- **Trauma:** Many MHJ clients have had trauma in childhood and youth, and disruption in their lives from mental illness, drug use, homelessness, and detention.
- **Criminogenic risk/need:** A person's risk of further justice involvement can be assessed, and mitigated in specific ways by trained staff.

These support needs can be addressed using evidence-based interventions in multi-disciplinary teams which can flex the nature and intensity of support provided to the changing needs of individual clients.

This report also identifies five population groups that require specific approaches:

- **Women:** Women comprise one-fifth of the justice-involved population. Women in the correctional system have higher rates of serious mental illness, substance use, anxiety disorder and trauma. These issues require women-centred and trauma-responsive supports. For women whose children are in or at risk of entering the child welfare system, parental support and training programs are also an identified need.

- **Racialized communities:** Some groups, notably Black communities, are overrepresented in the justice system, underserved in community mental health, and face racism in housing and employment. Culturally appropriate social supports and mental health services are required. Some of these services exist, but not enough for the number of people in need from these communities.

- **Indigenous communities:** For Toronto's Indigenous population, a needs assessment led by Indigenous organizations is needed, in collaboration with mental health and justice providers and researchers.

- **Cognitive and developmental issues:** These are common among justice-involved people, especially dual diagnosis (mental health issues in combination with intellectual or developmental impairments), acquired brain injury (ABI) and fetal alcohol spectrum disorders (FASD). Addressing this as part of MHJ supports requires enhanced skills provided by behavioural specialists and/or through ongoing consultation with specially trained psychologists.

- **Forensic mental health:** Many forensic patients can be successful living in supportive housing with suitable supports. Many need relatively high supports at first, which lessen over time.

Assessing each individual's needs and risks, and arranging supports for these, is central in housing stability, community reintegration after detention, reduced criminal involvement, and better personal well-being. Continuing to take steps toward more effective assessment will ensure that clients' diverse needs are well served, that providers do not refuse applicants due to uncertain risks, and that people are matched to housing and supports where they can succeed in reintegration and recovery.

Housing Needs

People with mental health disabilities, very low incomes, criminal records, and frayed social connections face barriers obtaining and keeping housing. Affordable housing with supports provides a path to community reintegration and is effective in preventing homelessness.

Housing targeted to MHJ clients is one important way to address this. Offering MHJ-related supports in other mental health supportive housing is also important, so that this population has fair access to that wider system and are not excluded on the basis of past criminal history.

Urgent and transitional needs: Two distinct populations require transitional housing and support:

- **Bail and post-incarceration:** Many MHJ clients get discharged from custody with no home to go to and little support. People who are homeless or using drugs – considered likely to re-offend or to fail to reappear in court – are often denied bail. Rapid, urgent access to time-limited housing is essential for these situations. It can prevent a destabilizing situation, while offering pathways to permanent housing. Addressing these needs requires involvement by Ontario's justice and correctional institutions and ministries, not just those in the health sphere.

- **Forensic mental health:** Many people under Ontario Review Board (ORB) orders and who have had long hospital stays require high support and supervision initially, but can transition to regular MHJ supportive housing over time.

Other aspects of housing provision for MHJ clients:

- Many MHJ needs can be met with Housing First – i.e. direct access from homelessness to housing, minimal preconditions, no "treatment first" rule, independent tenancies, and de-linked supports.

- Supportive housing can be effectively provided either with 'scattered' supported units in private-rental buildings, including headleases, or in 'dedicated' (project-based) housing. Each has advantages and disadvantages in terms of flexible supports, staffing costs, social supports, and community integration.

- It is increasingly difficult to get or keep private-sector units in Toronto's tight rental market; available units often have poor housing quality and neighbourhood conditions. Non-profit-owned housing has higher short- to medium-term costs than rent supplement in private-landlord units, but lower long-run costs.

- A flexible range of housing and support options is needed, to meet diverse individual needs, including two and three bedroom units for justice-involved people who are caring for their children.

Moving Forward

The report includes nine recommendations for the expansion and improvement of justice-focused mental health and addictions supportive housing in Toronto. These recommendations are informed by 26 action steps included in the report for the Ministry of Health, Ontario Health, other ministries and organizations, community-based providers, and the City of Toronto.

Recommendations

1. The Ministry of Health, collaborating with providers and other ministries, should add 300 supportive housing units annually in Toronto for justice-involved people with mental health and addictions issues (total 3,000 units in 2020-2029).

2. Between 10 and 20 per cent of added mental health and justice housing in Toronto (300 to 600 units) should be transitional housing, with urgent access to facilitate bail release and community re-integration.

3. The Ministry of Health and providers should ensure that supports in mental health and justice housing address five main needs: substance use; crisis prevention/management; social connections and daytime activities; trauma; and criminogenic risk.

4. The Ministry of Health and providers should add mental health and justice housing targeted to the specific needs of (a) women, (b) racialized communities, (c) forensic mental health clients, and (d) clients with developmental disabilities, acquired brain injury, or fetal alcohol disorders.

5. Researchers and providers should collaborate in an Indigenous-led process to assess needs and develop a supportive housing strategy for justice-involved Indigenous people with mental health or addictions issues.

6. The Ministry of Health, collaborating with providers and other ministries, should ensure that transitional housing for non-forensic justice-involved clients has (a) time-limited tenure suited to each person's needs; (b) access priority for people discharged from custody, seeking bail, homeless, in Safe Beds, etc. (c) suitable post-incarceration supports, and (d) access to permanent justice-focused supportive housing afterwards.

7. The Ministry of Health should ensure that justice-specific mental health and addictions supportive housing programs have (a) capacity to assess criminogenic and other support needs using validated instruments, (b) multi-disciplinary teams and 24/7 capacity to meet complex support needs, (c) evidence-based supports that respond to changing individual needs, address criminogenic risks, and foster pro-social skills.

8. The Ministry of Health in collaboration with providers and others should implement a housing delivery model of (a) rent subsidies with supports in scattered private rental and (b) non-profit-owned supportive housing.

9. To address funding gaps in MHJ housing, the Ministry of Health should increase the amount of monthly rent supplement per unit to levels reflecting moderate market rents, and adjust funding annually to reflect changes in the market.

SECTION 01

Introduction

1.1 Context and Purpose

The mental health and addictions (MHA) supportive housing system in Toronto houses over 5,000 people. Just over 10 percent of those units are in a Mental Health and Justice (MHJ) program targeted specifically to people with criminal justice system involvement, although other housing also serves some of this population. The waitlist for MHA supportive housing has reached over 18,000 people and grows by over 2,000 each year. The waitlist for MHJ housing specifically exceeds 2,100.

One quarter of applicants to MHA supportive housing have justice involvement, and many more people cycle through the health system, corrections, and homelessness without ever reaching the supportive housing system. The shortfall of supportive housing means that housing is not available when people are discharged from provincial jails and courts, or (see below) from urgent-need MHJ Safe Beds. There is a pressing need to strengthen the justice-focused segment of the supportive housing system.

This report is a needs assessment of justice-focused mental health and addictions supportive housing in Toronto, with the following components:

- An overview of the existing system and services, identifying strengths that can be shared, spread and amplified
- An assessment of support needs and housing needs, and evidence-based interventions to address those needs
- Related specific action steps along with broader strategies to improve the mental health and addictions supportive housing system.

In this report, the population with mental health and addictions issues and justice involvement is referred to as the *MHJ population*. This does not refer only to those in the MHJ Program. *Supportive housing* refers to various ways of providing affordable housing and support services – whether or not they are directly linked, offered by the same or different providers, or offered by private or non-profit landlords.

This report has been prepared in a context not only of unmet needs and shortfalls, but also of opportunities that can help meet MHJ population needs. Ontario government priorities include augmenting housing supports for mental health and addictions. The *Canada-Ontario Home and Community Care and Mental Health and Addictions Services Agreement* (January 2019) provides an additional $78 million annualized for mental health and justice supportive housing services by 2022. Health system restructuring, including the implementation of Ontario Health Teams, offers potential to integrate these priorities into local service planning and delivery. Provision of housing with supports can be supported by federal programs under the National Housing Strategy.[1] The City of Toronto has adopted a new ten-year affordable housing plan, in which supportive housing is one focus.[2]

This report has also been prepared in the context of emerging work on a broader Supportive Housing Growth Plan for Toronto. This is being initiated as a collaboration of the Toronto Alliance to End Homelessness, the Canadian Mental Health Association Toronto Branch, and Wellesley Institute. The Supportive Housing Growth Plan will bring together organizations across sectors to develop a comprehensive, evidence-informed, consensus-based plan to expand the supportive housing system in

Toronto, and support its implementation. The present report on justice-focused mental health supportive housing is intended as an early component of the larger growth plan.

Finally, this report is also intended to inform program decisions by policy-makers, system planners and providers, in regard to supportive housing for justice-involved people with mental health or addictions issues. Such decisions include ensuring that the complex needs of this population are met through evidence-based approaches to support and housing.

This needs assessment was a collaboration between Canadian Mental Health Association Toronto Branch, Wellesley Institute, and Addictions and Mental Health Ontario. It benefited from input from an advisory committee which helped interpret and validate findings and provide strategic direction (see acknowledgments).

1.2 Objectives

This project to assess needs and identify required actions had four overall objectives:

1. Examine the current justice-focused mental health and addictions supportive housing system and identify strengths and shortfalls;

2. Identify the support needs of people with mental health and addictions issues and justice involvement who require supportive housing, and interventions to address these;

3. Identify the housing needs of people with mental health and addictions issues and justice involvement who require supportive housing, and interventions to address these;

4. Identify specific action steps to increase access to supportive housing, and promote the effectiveness of justice-focused supportive housing.

1.3 Methods

This study used a five-part methodology.

Literature review

In order to account for the breadth of topics involved and to maintain flexibility to respond to advice from the advisory committee and key informants, the literature review followed a grounded approach. It includes a mix of peer reviewed journal articles, and non-academic literature (including reports by MHJ-relevant organizations). The first phase of the literature review used broad searches through academic journal databases and specialty online resource libraries (e.g. Homeless Hub, HSJCC, EENet, and relevant research institutes) and articles provided by the project team. In this phase, the literature was examined under broad themes related to the current supportive housing system and client needs and best practices and approaches. Specialized approaches and populations, based on findings in the secondary data analysis, were then also examined. These initial findings were presented to the advisory committee for validation and further refinement. The literature review process

remained flexible, with additional sources incorporated based on input from the advisory committee and key informants.

Key informant interviews

Nineteen key informant interviews were completed with twenty-five participants. Key informants were identified by the project team, advisory committee members, and other key informants. The focus of the interviews was housing and support needs for mental health and justice clients, including gaps and unmet needs; successful approaches; specialized populations; and suggestions for action and next steps. The key informants were selected for their expertise and experience in MHJ housing issues, and consisted of executive directors, managers and frontline service providers, researchers, advocates, other experts, and policy staff from the City of Toronto and the Ministry of Health.

Focus groups

Five focus groups were conducted at three different supportive housing locations. Two groups were composed of MHJ housing residents/clients while the other three were service providers. Each focus group had five to ten participants; the 31 individual participants included 15 residents, and 16 service providers from eight organizations. The purpose of the focus groups was to identify service needs, strengths, gaps, and potential recommendations. All focus groups were facilitated by the Peer Program Evaluation Project (PPEP) team at CMHA Toronto.

Secondary data analysis

Analysis of secondary data was conducted, primarily from the Access Point waitlist data (2009-2015) and Ontario Common Assessment of Need (OCAN) data (2011-2016). The Access Point is the coordinated access system for mental health and addictions supportive housing in Toronto; data used here included anonymized application information as well as data on wait times and service outcomes. OCAN is a standardized assessment tool to identify the needs of clients receiving community-based mental health and addictions services in Ontario, including a consumer-self assessment and a staff assessment portion. OCAN data are uploaded to the Integrated Assessment Reader by service providers. Anonymized record-level OCAN data were made available to staff on the project team.

Survey of mental health and justice service providers

A survey of mental health and justice supportive housing providers was undertaken by the project team, to identify the amount and key characteristics of housing in the MHJ supportive housing program.

Limitations

One of the main limitations of the assessment is the absence of Indigenous organizations and Indigenous participants. The research team acknowledges that there is an overrepresentation of Indigenous populations in the criminal justice system, and therefore a need to assess Indigenous needs in regard to mental health and justice supportive housing. However, the First Nations principles of OCAP (Ownership, Control, Access and Possession) mandates the convening of an Indigenous community advisory board to approve the collection of data, and this was beyond the timeline and scope of this assessment.

Indigenous needs must be addressed as an integral part of the broader supportive housing plan noted in section 1.1. Researchers and providers in the supportive housing and the justice sectors should partner with Indigenous organizations and, under their leadership, determine and carry a process to assess needs and develop strategies for supportive housing to serve justice-involved Indigenous people with these needs. A recommendation on this is made in section 3.2.

Additional limitations of this needs assessment include the relatively small sample of key informants and focus group participants, which potentially limits the generalizability of findings. Analysis of The Access Point data was limited by the fact that data were collected from applicants at the time of referral and the support needs may change as individuals wait for housing on the supportive housing waitlist. On the other hand, the OCAN data sample was a convenience sample of individuals in supportive housing. It is not known how representative these data are of the broader population of individuals in supportive housing who have justice-involvement. Additionally, analysis of these secondary data is limited by the nature of variables collected, missing data and possible inconsistencies in reporting practices across providers. Inconsistencies in reporting practices may also limit findings of the survey of housing providers about the nature of their housing stock as the survey did not include detailed operational definitions to inform the classification of housing stock into high (24 hour), medium (daily) and low support (less than daily) supportive housing. Finally, the literature review we undertook while comprehensive was not exhaustive. Though each of the methods we used had limitations, as do all research methods, we sought to mitigate these limitations by triangulating and synthesizing data across sources to provide a holistic picture of the current and possible future state of justice-focused supportive housing in Toronto.

SECTION 02

Mental Health and Justice: Overview of Population and Current Supportive Housing

This section, responding to the first research objective, provides a general description of the justice-involved population, followed by a description of the current system of housing and supports for this population, and its strengths and shortfalls.

2.1 Interrelation of Mental Illness, Justice Involvement, and Homelessness

Mental health and addictions issues, justice involvement, and chronic or episodic homelessness are strongly interrelated:

- People in the justice system have a high prevalence of mental illness or addictions issues. In the Ontario correctional system, 41 percent have at least one current, severe symptom of a mental health problem, including 13 percent with two or more such symptoms.[3] In the federal system, 36 percent of persons at admission needed psychiatric or psychological follow-up, and the number of mental health care interventions exceeded 45 percent of the prison population.[4]

- Among people discharged from provincial corrections and detention (including remand) in 2016, 6.8% had mood disorders, 3.9% schizophrenia, 7.7% anxiety disorders (each 6 to 9 times the prevalence in the general population), and 16.9% had substance-related disorders (14 times the general prevalence).[5]

- Many people in prison or jail are homeless before or after incarceration. Among a recent sample in provincial correctional facilities, 22 percent were homeless at the time of incarceration, and 85 percent of this group expected to be homeless again at discharge.[6] One-third or more of people leaving provincial correctional facilities are released with no fixed address.[7] It is reported that half of CAMH clients at the Toronto South and Vanier detention centres are homeless.[8]

- Homeless people with MHA issues have high justice involvement. For example, at the outset of Canada's landmark *At Home/Chez Soi* Housing First demonstration study, 45 percent of participants reported recent criminal justice involvement, including arrests, detention, charges, court appearances, and incarceration.[9] Homelessness is a strong predictor of reincarceration.[10]

A negative reinforcing cycle is found between mental health or addictions issues, justice involvement, and homelessness. Mental health and addictions issues are major contributing factors in homelessness.[11] In turn, homelessness tends to exacerbate both mental health and justice issues: a homeless person has higher risk of being arrested,[12] and is more likely to be denied bail.[13] An emergency shelter is a destabilizing experience for many people, and often a milieu with much drug use and high risks of re-offending.

Once arrested, many people cannot return to their former residence due to the nature of their charges and bail conditions. Bail conditions often require the person to abstain from using alcohol and illicit drugs or attend a treatment program – creating higher risk of breaching these conditions.[14] Incarceration often means poor health care.[15] All this can set the person up to fail, and reinforce a revolving door between community, detention, and court.[16] People not getting needed support will burn bridges, lose personal supports, and end up with higher needs.

Providing housing with supports is an essential way to interrupt this cycle. Being housed, with supports to ensure housing stability and address underlying issues, plays a preventive and recovery role. It tends to improve mental health, reduce illicit drug use, and reduce justice involvement.[17] It reduces arrests for public nuisance and drug-related offenses.[18]

Housing and support services together create positive synergies that neither alone provides – a foundation for recovery and housing stability. Housing subsidies which in turn provide low/affordable rent and therefore

residential stability can count for at least as much as support services in ensuring housing stability.[19] Many support services are less effective without the personal anchor of stable housing. The housing also serves as a place to engage in a non-pressured way with helpful services, or directly as a site to provide needed services. At the same time, supports are often needed to sustain a stable tenancy.

2.2 The MHJ Population: Introduction and Overview

People who have both mental health/addictions challenges and involvement in the justice system face distinct barriers to accessing housing, including supportive housing; and many require specific types of support. These unique characteristics point to a need for justice-specific MHA supportive housing, as well as a need to better serve the MHJ population in the overall mental health supportive housing system.

Barriers to obtaining housing arise in factors including low income, poor employment history, criminal record, and lack of social supports. Nine out of ten justice-involved MHA supportive housing applicants have very low income or no income.[20] They also face discrimination in housing due to mental illness/addictions and criminal justice involvement (see section 4). Many also face racial discrimination by private landlords; and they are more likely than other applicants to be declined by supportive housing providers due to the levels of support needed, or perceived risks.[21]

Very prominent in this population is a high prevalence of addiction issues. Many people in this population need low-barrier access – eligibility criteria and approaches to providing housing and supports in ways that are more accommodating of the associated behaviours and risks. For specific subsets of the MHJ population, especially those with a history of violent or sexual crimes or of arson, the barriers are much higher.[22] Addiction issues translate to particular support needs. Compared to other supportive housing applicants, those with justice involvement have more needs or risk in the area of managing drug/alcohol use, dealing with crises, avoiding unsafe situations, and histories of drug/alcohol use causing harm (see section 3 for more detail).

Compared to the general MHA population, a larger share of those with justice involvement also have issues and support needs related to anger or violence (see section 3).

Four specific sub-populations require particular attention and specialized responses, for varying reasons. They are covered in more detail in section 3.2 and elsewhere in this report. There is also a need for collaboration with Indigenous organizations regarding Indigenous needs and services.

Women: Although they represent a relatively small proportion of people with justice-involvement, women in the correctional system have higher rates of major mental illness, substance abuse, anxiety disorder and trauma. While they often have many of the same support needs as their male counterparts, the nature of how services are provided should be women-centred and tailored to their experiences and preferences.

Racialized populations: Certain racialized groups are overrepresented in the justice system and in the MHJ population. Particularly affected is the Black (Afro-Canadian) population of Toronto. Responses to address needs in this group include culturally specific services.

MHJ with cognitive or developmental issues: Significant numbers in the MHA population also have cognitive or developmental issues. This includes those with an Acquired Brain Injury (ABI), a Dual Diagnosis (mental illness and intellectual or developmental disability), or Fetal Alcohol Spectrum Disorders (FASD).

Forensic mental health: The forensic mental health population – people determined as not criminally responsible (NCR) for a criminal offence by reason of mental disorder – is a subset of the broader MHJ population. Persons found NCR by a court normally fall under the purview of the Ontario Review Board (ORB), which decides the related conditions and level of supervision, and reviews these each year.

For much of the MHJ population, justice involvement is about petty crime and illicit drugs – associated with extreme poverty, homelessness, and addictions, rather than danger to the public.

Although it has attracted political attention, the forensic mental health population is not the main focus of this report. These clients are more likely to have a severe mental illness (e.g. psychosis) which, along with their legal status, can affect the housing and support required. Many in the forensic population can succeed in supportive housing, and the TRHP program has successfully housed these clients in the community since 2007. Compared to residing in hospital, supportive housing is far less costly and promotes rehabilitation.[23]

2.3 Description of Current System

Since 2005/06, the Ministry of Health, in collaboration with LHINs and experienced providers, has operated the Mental Health and Justice (MHJ) program within the mental health supportive housing programs.[24] This provides rent subsidies and intensive case management for people with mental health issues who are homeless and are involved or at significant risk of involvement with the justice system. Within this program, 631 units are in the City of Toronto, including 65 forensic units. Objectives included keeping persons with mental health challenges, including addictions, out of the criminal justice system.

Eligibility criteria for MHJ housing include the combination of:

- Having mental health challenges including addictions
- Being homeless or at immediate risk of homelessness
- Having current involvement with the criminal justice system at time of housing application
- Being referred by a priority referral source, such as professionals working in the justice system.

MHJ housing offers various levels of support intensity, but the majority is weekly or less than weekly (reflecting clients' needs described in section 3.1). In Toronto, the housing is provided by four MHJ lead agencies designated by the Ministry. Reflecting the type of program funding, most units are leased from private-sector landlords rather than being non-profit owned. Most involve headleases – where the housing provider leases the dwelling from the landlord and sublets to the supportive housing resident.

MHJ housing is part of a range of programs that seek to address the needs of justice-involved people with mental health and addictions issues. Other services include Mobile Crisis Intervention Teams, MHJ Prevention (Pre-charge diversion) services, Diversion and Court Support services, Release from Custody Planning services; and MHJ case management services. These support services also refer people in need, as applicants to MHJ housing.

Housing with supports serving people with justice involvement and mental health and addiction issues includes some housing units in several other programs:

- **Mental health supportive housing:** Significant numbers of people who apply for housing in the broader mental health supportive housing sector have criminal justice involvement.

- **Addictions Supportive Housing (ASH):** Within the Ministry of Health supportive housing programs, this one is targeted to people with problematic substance use (also known as Supportive Housing for People with Problematic Substance Use or SHPPSU in Toronto).

- **MHJ short-term residential crisis beds (Safe Beds):** This program provides 24/7 support in four residential facilities for up to 30 days for individuals with a mental health challenge who have current involvement in the criminal justice system and are homeless or at significant risk of homelessness. (See further information in subsection 3.1.)

- **Transitional Rehabilitation Housing Program:** TRHP helps forensic mental health patients with low to moderate risk to transition from hospital to community settings. It offers 24-hour high support, along with case management supports as needed. (See also subsection 3.2.)

- **'Alternative' housing funded by the City of Toronto:** An estimated 1,600 units are owned and operated by providers serving people who have experienced chronic/episodic homelessness – a population with high prevalence addictions, homelessness, and justice involvement.[25]

- **Short-term housing allowances and homelessness follow-up supports:** Coordinated by the City of Toronto using a mix of federal, provincial and City funding; delivered by community providers including agencies serving justice-involved persons. This includes units funded through the Streets to Homes and Home for Good programs. Clients have a high prevalence of mental health issues and substance use.

- **Housing with supports in municipal housing:** Numerous units in Toronto Community Housing (TCHC) are occupied by tenants with mental health issues, addictions, and histories of homelessness – population groups with a high prevalence of criminal justice involvement.[26] This arises from placement priorities for homeless people as well as headlease arrangements which supportive housing and support providers have arranged with TCHC.

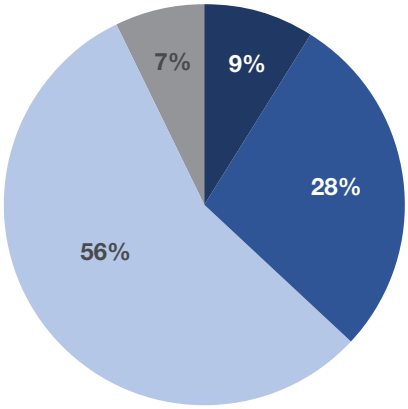
FIGURE 2.1 Mental Health and Justice Supportive Housing at-a-glance

631 units

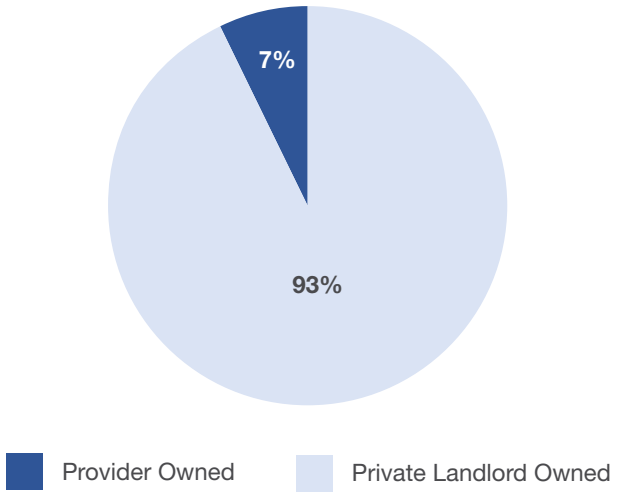
across Toronto, including 65 forensic supportive housing units

Support levels vary from 24 hour to occasional

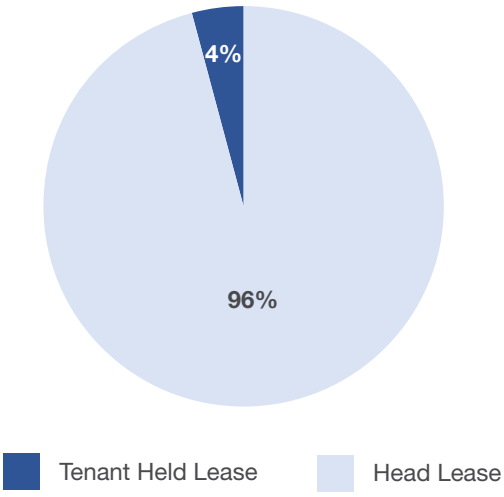
Existing MHJ Program Units by Level of Support



Provider Owned vs Private Landlord Owned Justice-Dedicated Units



Leases Held by Tenants vs Head Leases Among Justice-Dedicated Units



(Source: Survey of MHJ Service Providers)

2.4 Strengths of the Current MHJ System

Serving people with criminal justice involvement in housing with appropriate supports has benefits in terms of public costs, usage of public services, recidivism, and individual well-being and health outcomes. Justice-specific MHA supportive housing is cost effective at about $91 to $127 per day[27] compared to $787 to $1,186 daily for a provincial hospital bed.[28] Living in supportive housing results in less use of the emergency department, inpatient beds, and psychiatric beds.[29] It also reduces rates of recidivism.[30] In addition, justice-specific MHA supportive housing results in improved personal outcomes, higher quality of life.[31] It achieves good housing stability, with documented rates of eviction of only 5 percent annually.[32]

Participants in focus groups for this needs assessment identified overall various strengths of the MHJ housing program. These included: providing immediate access to permanent housing with supports; getting an apartment of one's own; having a rent supplement; and lowering recidivism. They also noted types of supports they considered a strength of the program: having 24/7 supports available, access to inter-disciplinary care, meal programs, and supports with daily living.[33]

FIGURE 2.2 Strengths of Existing Mental Health and Justice Housing from Focus Group Participants

Service Users	Service Providers	Both Service Users and Provider
• Low/affordable rent • Rent subsidy • Access to free laundry • Access to food banks • Pets permitted in units • Staff on-site 24/7 (at dedicated sites) • Security cameras in the buildings • Sense of community	• Inclusion of nurses • Inclusion of housing coordinators	• "Long-term," "guaranteed," and "affordable" housing • Case management and staff supports • Stable housing contributes to reduced levels of recidivism

Despite these successes, there are various shortcomings and gaps, and opportunities for system and service enhancements. Section 3 examines the support needs of individuals with mental health challenges and justice involvement, and identifies evidence-based interventions or promising practices that can address these needs. Building on these strengths and addressing the challenges can increase the impact of supportive housing for the justice-involved population.

While the findings of Section 3 can inform future program decisions and ensure the greatest effectiveness of justice-focused supportive housing, the existing program is broadly effective. The largest challenge is not in how MHJ housing provides supports or provides housing, but in the large shortfall in how much MHJ housing and support is provided. This is the focus of subsection 2.5.

2.5 Shortfall in Scale of the Current MHJ System

The number of people with mental health or addictions issues and justice involvement far exceeds the available housing and support. The analysis in this subsection points to targets of approximately 300 additional MHJ housing units annually.

The magnitude of unmet MHJ supportive housing need in Toronto can be estimated from three sources.[34] These sources are analysed here and used as the basis for evidence-based targets.

a. Data from The Access Point on applications to the MHJ (Mental Health and Justice) supportive housing program, and trends, provide a basis to estimate unmet needs and targets.

b. The 2018 waitlist analysis of Access Point applicants provides broader data on justice involvement among applicants for MHA supportive housing in Toronto.[35]

c. A 2017 Wellesley report provides population-based estimates of need for mental health supportive housing in Ontario, based on MHA prevalence and other intervening factors.[36]

The first two approaches use MHJ administrative data, while the third triangulates using population-based estimates.[37]

a) MHJ – Current Data and Trends from The Access Point

The number of applicants to the MHJ supportive housing program averaged 258 (fiscal years 2014/15–2018/19), with volumes between 220 and 240 for most years.[38] With an annual average of just 37 people placed in this housing, the shortfall is approximately 200 (modal year) to 220 (average year).

In addition to new applicants are people currently on the MHJ waitlist – 2,135 at year-end 2018.[39] This number is a general indicator of existing unmet need, but not a direct measure of an ongoing backlog. Many people on the waitlist will cease to be justice-involved and MHJ-eligible over time. If one-quarter to one-half of those on the waitlist remain justice-involved and MHJ-eligible, this equates to a backlog of 500 to 1,100 (rounded). To address this need over ten years would require an additional 50 to 110 units annually (rounded).

Combining the 200–220 (new applicants annually) with the existing unmet need (50–110 annually over ten years) produces an estimate of approximately 250 to 330 additional MHJ housing units required annually.

b) Access Point Waitlist Analysis

The Access Point waitlist analysis (2018) covered 12,733 applicants over the years 2009–2015.[40] Applicants include most of the Toronto MHA population that needs supportive housing, and the waitlist is therefore believed to be broadly representative.

In that analysis, 25 percent of applicants had justice involvement.[41] This includes a range of situations: facing current criminal charges; residing in a correctional/detention facility; being on probation or parole; being under the purview of the ORB or awaiting ORB disposition; or screened as eligible for MHJ housing. Just 10 percent of justice-involved applicants were in correctional facilities when they applied. Of justice-involved applicants, half had applied for MHJ housing.[42] Some may become ineligible as time

passes, which might suggest 25 percent is a high estimate;[43] but on the other hand it is difficult for many people to apply for MHA housing while in custody. This 25 percent is a standard estimate of the justice-involved share of applicants.

The 25 percent justice-involved share can be applied to the full Access Point waitlist population (year-end 2018) to provide a broader estimate of the justice-involved applicant population (Table 2.1).

TABLE 2.1 Justice Supportive Housing Need among Access Point Applicants

Share of MHA housing applicants with justice involvement*	25%
Number of applicants on The Access Point waiting list ‡	18,748
Resulting estimate of MHJ need (rounded)	4,700

* (Sirotich et al., 2018)
‡ Administrative data, year-end 2018.

The resulting 4,700 is not an exact measure of point-in-time need, or annual need. It captures a broad population with a range of justice involvement over a period of years. If translated to a ten-year program to address this unmet need, this would equate to 470 MHJ units annually in Toronto. This reflects a wide definition of justice involvement, including people not meeting eligibility criteria for MHJ housing. Therefore this is a 'high' estimate, not a conservative or mid-range estimate.

c) Triangulating with Population-based Estimates of MHA Housing Need

Population-based estimates of need[44] have been provided for Ontario, with attention to Greater Toronto. Starting with the prevalence of mental health issues and addictions, the analysis considered key intervening factors: household formation rates, poverty, need for housing-related supports, and exclusions for those not ready to leave institutions or already served. The resulting need for MHA housing equates to between 0.5 percent and 1.0 percent of the adult population. The analysis also considered population growth, of 11 percent per decade (Ontario) and 15–16 percent (Greater Toronto).

The low end of these estimates generates a net Ontario requirement of 33,000 units for existing need, plus over 600 units annually to meet ongoing growth. If translated to a ten-year program to address unmet need, this equates to 3,900 units annually (backlog 33,000/10 years + 600 annual growth).

This can be used to estimate need in the City of Toronto, in two steps as follows:

- The City of Toronto, although it has 20 percent of Ontario population, has one-quarter to one-third of Ontario's lower-income and higher-needs population.[45] This arises because in the GTA (half of Ontario population), the City of Toronto has dominant shares of lower-cost rental, low-income population, homelessness, and social and health services for people with higher needs.

- The share of this number which is justice-involved can be estimated by applying the 25 percent found in the Access Point waitlist analysis (heading 'b' above).

Translating these results to estimate of MHJ needs in the City of Toronto produces a requirement of 240-320 units annually in Toronto (Table 2.2).

TABLE 2.2 Deriving Estimates of Annual MHJ Need in Toronto

Mental Health & Addictions Supportive Housing: Shortfall (requirement)			Justice-involved share (25%)
Ontario		**Toronto**	**Toronto**
3,900	Toronto share of Ontario's high-need population – 1/4 to 1/3	975-1,300	240-320 (rounded)

Source: See text. MHA shortfall from Suttor (2017), 25% MHJ share from Sirotich et al. (2018).

d) Summary and Resulting Targets

The three approaches above all produce estimates of MHJ need of similar magnitude, to meet the backlog of existing unmet MHJ need as well as growth-related need:

On this basis, approximately 250 to 400 additional units of supportive housing are required each year, for persons with mental health or addictions issues and justice involvement in the City of Toronto. A target of 300 units annually is recommended for the next 10 years (2020-2029), for a total of 3,000 additional units.

	Annual requirement
• Waiting list and annual applications to MHJ housing	250–330
• Access Point applicants – justice-involved prevalence:	470
• Applying Toronto share and MHJ share to provincial MHA shortfall	240-320

The analysis in section 3 points to a need to serve the justice-involved population both in general MHA supportive housing and in housing that is specifically MHJ-targeted. As noted, Access Point data show that half of those with justice involvement were screened as eligible for MHJ housing. In implementation, decisions would be needed on what share to serve in MHJ-specific housing and what share to serve in general mental health and addictions supportive housing.

Action step #1

The Ministry of Health, Ontario Health, and providers, in collaboration with the Ontario Ministry of the Attorney General and Ministry of the Solicitor General, should adopt a target of 300 additional supportive housing units annually in Toronto, targeted to justice-involved people with mental health and addictions issues, for the ten-year period 2020-2029 (total 3,000 units).

e) Targets for Transitional Housing

The research team and advisory committee have considered targets for transitional housing need, discussed in subsection 4.3. This includes two distinct categories: transitional housing with urgent access at bail hearings and after release from custody; and transitional housing for the forensic mental health population. The following are proposed, subject to further analysis.

With respect to transitional housing at bail hearings and after release from custody, approximately 10 percent of the justice-involved MHA population were in custody at time of application to The Access

Point. Others have urgent need but do not apply to The Access Point.[46] Given the urgency of need, it is equitable to allocate more than 10 percent of additional MHJ housing units to this population. A range of 10 to 20 percent is recommended. This should be prioritized in the early years of MHJ expansion, and therefore is not expressed as an annual target.

Input from TRHP program staff for this report pointed to potential need in Toronto for up to 20 units at present. Further research and validation should be undertaken to confirm a specific number each year, based on the needs of the individuals involved at each point in time.

Action step #2

The Ministry of Health, Ontario Health, and providers, in collaboration with the Ministry of the Solicitor General and Ministry of the Attorney General, should create transitional housing comprising 10 to 20 percent of added mental health and justice housing in Toronto (300 to 600 units), for persons needing urgent rapid housing access to facilitate bail release or for community re-integration following a custodial sentence (within the broader ten-year, 3,000-unit MHJ housing target).

Action step #3

The Ministry of Health, Ontario Health, and providers should adopt regular annual targets for forensic mental health housing in Toronto (within the broader housing target for mental health and addictions issues and justice involvement), based on the needs of individuals involved each year.

SECTION 03

Support Needs and Program Responses

Section 2 noted that the justice-focused supportive housing system improves personal and health outcomes for the people it serves. This section addresses the second research objective, identifying in more specific ways the support needs of people with mental health and addictions issues and justice involvement, and interventions to address these. Understanding the most prominent needs, and how to address them with evidence-based practices, can ensure the most effective approach in the existing system and in program expansion. Needs were documented using secondary data from The Access Point waitlist (See Figure B1 and Figure B2 for need profile in Appendix B) and from Ontario Common Assessment of Need (OCAN) (See Figure B3 for need profile, Appendix B). This information was combined with findings from the key informant interviews and validated with the advisory committee. Best practices and promising practices were identified from the literature and from discussions with key informants.

3.1 Needs Profiles and Best Practices

The most prominent needs identified for the justice-involved people with mental health issues or addictions are:

- Substance use
- Crisis prevention/management
- Daytime activities, social connections and employment
- Trauma
- Criminogenic risk/need

a) Substance Use

Problematic substance use is prevalent in the justice-involved MHA population. It was the top identified need by key informants, and well documented in our secondary data analysis and in the literature. Stable housing itself has a clear impact on mental health and substance use disorders; one study showed that treatment for people with concurrent disorder has greater effectiveness when provided in long-term

FIGURE 3.1 Supportive Housing Applicants with Justice Involvement Compared to Applicants without Justice Involvement

	Justice Specific	General
Managing alcohol and/or drug use	53%	25%
Dealing with crises	52%	36%
Avoiding unsafe situations	45%	31%
History of drug use causing harm	42%	20%
History of problems controlling anger	37%	21%
History of alcohol use causing harm	36%	20%
History of assaulting others	36%	12%
More likely reported violence towards others	23%	7%

(Sirotich et al., 2018)

settings rather than in a short-term residential program. Key informants pointed out some of the strengths of services in justice-specific supportive housing include being a 'harm reduction provider' (see below), addressing trauma, and using CBT techniques to address problematic substance use. The biggest gaps identified were access to withdrawal services and intensive addiction treatment. The prevalence of alcohol and drug use problems, and their association with criminal justice involvement underscore the need for supports targeted at these needs.

These supports are also required to mitigate the risk of death related to drug overdose. Drug overdose is the leading cause of death internationally among individuals recently released from custodial facilities.[47] In Ontario one in ten deaths due to a drug overdose occurred within twelve months of release from a correctional facility.[48] Below are four evidence-based practices that can be implemented in the justice-specific MHA supportive housing sector.

Integrated Dual Disorders Treatment (IDDT)

IDDT is an evidence-based approach[49] recommended in the Pathways Housing First model.[50] In IDDT, addiction services and mental health supports come from the same team of providers. IDDT provides a harm reduction framework and incorporates psychotherapeutic modalities including motivational interviewing, cognitive behavioural therapy (CBT), stages of change and self-help groups. While CBT and group intervention may remain the focus of concurrent disorder specialists, two other core clinical skills in which all housing support staff should be trained are motivational interviewing and stages of change.

Core components of IDDT include: multi-disciplinary team; stage-wise interventions; access to comprehensive services; time unlimited services; assertive outreach; motivational interviewing; substance abuse counselling groups; group treatment; family psychosocial education; participation in alcohol and drug self-help groups; pharmacological treatment; interventions to promote health; secondary interventions for treatment of non-responders.[51]

FIGURE 3.2 Substance Use: The Numbers

NEEDS IDENTIFIED AT TIME OF SUPPORTIVE HOUSING APPLICATION

Those with criminal justice involvement compared to other applicants.

	Justice Involvement	Other
Concurrent disorder	41%	18%
Managing problematic drug or alcohol use	53%	25%
History of drug use resulting in harm	42%	20%
History of alcohol use resulting in harm	36%	20%

(Sirotich et al., 2018)

NEEDS IDENTIFIED ON OCAN

Those with criminal justice involvement compared to other applicants at admission.

	Justice Involvement	Other
Concurrent disorder	53%	19%
Needs related to drug use	38%	15%
Needs related to alcohol use	30%	15%

(OCAN Analysis)

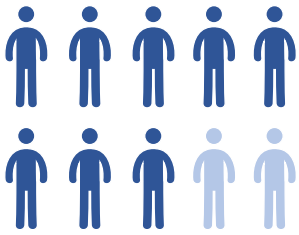
TENANCY

MHJ tenants with unsuccessful tenancies vs successful tenancies.

	Unsuccessful	Successful
Concurrent disorder	80%	45%
Substance use identified as a presenting problem	57%	25%

(Sirotich & Betancourt, 2012)

PREVALENCE IN FEDERAL CORRECTIONAL FACILITIES



80% of persons in custody were identified as “having a substance abuse problem that is associated with their criminal behaviour on admission to prison”

(John Howard Society of Ontario, 2016)

Cognitive Behavioural Therapy (CBT)

CBT is a practical, short-term form of psychotherapy and component of IDDT addiction treatment. Key informants identified CBT as a core feature of substance use treatment that can be provided by supportive housing providers. There is strong evidence that CBT reduces recidivism both generally[52] and among those with substance-related offences.[53] Specific approaches for substance use treatment include: relapse prevention model; guided self-change; behavioural couples therapy; and community reinforcement approach.

Wet/Damp/Dry Housing:

- **Wet** housing is for clients in the engagement stage where the primary purpose of housing is to provide safety and shelter without requirements.
- **Damp** housing is for people in early active treatment stages, there are some expectations about clients' substance use but understanding it may occur off premises.
- **Dry** housing is for clients that endorse abstinence as a goal. Expectation clients will not use substances on or off the premises.

Integrated Trauma Supports[54]

Trauma was frequently mentioned by key informants as an essential part of holistic care, and particularly important for substance use. CAMH defines trauma as "the lasting emotional response that often results from living through a distressing event."[55] There is a large prevalence of trauma in the justice-involved population generally, described in more detail below. Women in this population have especially high prevalence, with an estimated 30-90 percent of those in substance abuse treatment having experiences with trauma.[56] Trauma was raised frequently in relation to problematic substance use specifically, and there is benefit in including trauma supports as part of addictions treatment and supports. Integrated trauma supports address the interrelatedness between trauma, substance use disorders and mental health. Services to address this can either be trauma-informed, meaning that they take into account knowledge about trauma in all aspects of service delivery; or they can be trauma-specific services that directly address the impact of trauma on people's lives, and facilitate trauma recovery and healing.[57]

Trauma informed substance abuse service settings can do the following:

- Integrate understanding of trauma and substance abuse throughout the program.
- Simultaneously address trauma and substance abuse.
- Ensure consumers' physical and emotional safety.
- Focus on empowerment by empowering clients to engage in collaborative decision making for themselves during all phases of treatment.
- Recognize that ancillary services are necessary components of comprehensive, whole-person interventions.

(Finkelstein et al., 2004)

Harm Reduction

Harm Reduction is an evidence-based, client-centered approach that seeks to reduce harms associated with addiction and substance use.[58] It has been recognized as one principle of Housing First.[59] Harm Reduction services do not require people to necessarily stop their drug use, although harm reduction can be a valuable engagement tool. There are a range of harm reduction services including supervised consumption, providing safe supplies and education, overdose prevention, and medical services and counselling.

Harm reduction applies to providing housing as well as to supports, in the concept of 'harm reduction landlord'. One of the MHJ supportive housing providers reported on these approaches[60] including:

not rejecting someone from housing due to their alcohol or drug use; focusing on tenant responsibilities (e.g. paying rent, not interfering with other tenants' reasonable enjoyment, not damaging the property); having rules related to behaviour rather than use (substances not tolerated in common areas; fire safety etc.); staff roles in education; and conflict resolution that follows harm reduction principles.

b) Crisis Prevention/Management

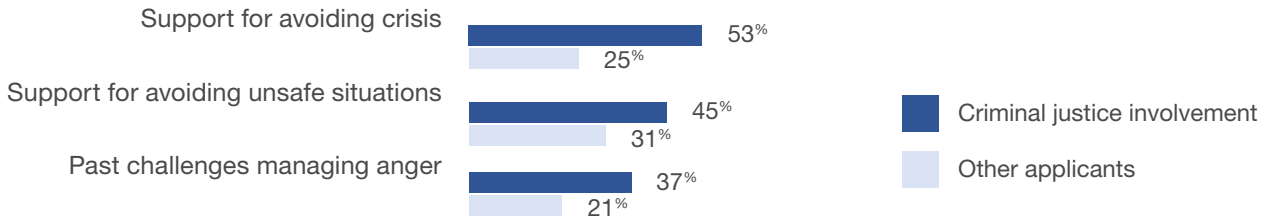
Crisis management and prevention through social rehabilitation was identified as much needed by key informants.

Our research identified some key learnings on crisis prevention and management. Services should be

FIGURE 3.3 Crisis Prevention/Management: The Numbers

NEEDS IDENTIFIED AT TIME OF SUPPORTIVE HOUSING APPLICATION

Those with criminal justice involvement compared to other applicants.



(Sirotich et al., 2018)

available in the home or local community; multi-disciplinary teams should be used; workers must be trained and competent in assessment, crisis prevention planning, and crisis response; and crisis prevention services should be trauma informed and developed with the client. Key informants and research literature point to several evidence-based and promising practices that address the need for crisis prevention/management approaches, as follows.

MHJ short term residential crisis beds (Safe Beds)

A key feature of the justice-specific MHA sector in Toronto is the MHJ Short Term Residential Crisis beds (Safe Bed) network.[61] Thirty-four short-term MHJ beds exist at 4 sites across the city, for persons experiencing homelessness or risk of homelessness and currently involved in the criminal justice system. They serve about 500 to 600 persons annually. They offer a broad range of services including: crisis support and counselling, provision of basic living needs (e.g. food, clothing, personal care items), and referrals and linkages to community-based services and supports.

The Safe beds are accessed through priority referral sources which include police, correctional and detention facilities, probation and parole offices, court diversion programs, pre-charge diversion programs, mobile crisis intervention teams, and related community-based providers. To access these beds, individuals must be 16 or over, have a serious mental health challenge, have current involvement in the criminal justice system, be homeless or at risk of homelessness and be referred by one of the above-noted priority referral sources.

Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT)

Some specific approaches within CBT address crisis prevention. One key informant pointed to the ABCD therapy technique commonly used for anger management problems: A-Activating event, B-Belief System, C-Consequences, D-Dispute.[62] In DBT, clients are taught about "the existence of opposites" with acceptance and change[63] and also emotion regulation and distress tolerance skills. DBT has been found to reduce self-injurious behaviour, suicide attempts and use of emergency department and inpatient services among people with borderline personality disorder.[64] There is evidence to support the incorporation of components of DBT into delivery of case management services.[65] In crisis prevention, tenants can learn how to make changes managing emotions and moving forward from past events.

Wellness Recovery Action Plan (WRAP)

Joint crisis planning is valued by key informants and recognized as being a best practice.[66] One technique is WRAP, a tool that includes crisis planning and post-crisis planning. WRAP tools can be completed by the client themselves, or with assistance; assistance completing WRAP is especially useful if created jointly with a peer worker.[67] In a randomized controlled trial, WRAP was found to reduce psychiatric symptoms, increase hopefulness, and improve quality of life among community mental health clients.[68]

Service resolution tables

Key informants discussed mitigating risks through service resolution tables such as FOCUS Toronto. This joint initiative, led by the City of Toronto, United Way of Greater Toronto, and Toronto Police Service, brings together support agencies to weekly situation tables in several districts of the city, to plan services and response for individuals and families at high risk of criminal actions or victimization.[69]

c) Daytime Activities, Social Connections and Employment

The need for daily structure and meaningful activities and social connections is an important way to reduce

FIGURE 3.4 Daytime Activities: The Numbers

NEEDS IDENTIFIED AT TIME OF SUPPORTIVE HOUSING APPLICATION

Those with criminal justice involvement compared to other applicants.

	Criminal Justice Involvement	Other Applicants
Obtaining employment	64%	50%
Developing relationships	60%	51%
Structured daytime activities	55%	47%
Meeting new people	55%	52%

(Sirotich et al., 2018)

recidivism[70] and improve mental health. Community integration is a core principle of Housing First[71] (see also section 4.4, regarding Housing First), and included in the Ontario *Supportive Housing Best Practice Guide*.[72] Key informants and service users in the focus groups described the importance of activities and social connection – among the most frequently mentioned needs. The types of community that people are connected to is especially important. One study found that connectedness to the community at large positively predicted reintegration in society, but connectedness to criminal community predicted recidivism during the first year after release from detention.[73] This concern was echoed by key informants who spoke of tenants released from custody but found themselves in the same social milieu once housed, and therefore had difficulty getting the fresh start they wanted.

These findings suggest that community development must work towards both reducing involvement with criminal communities, and creating opportunities to engage in wider communities. Key informants mentioned many approaches to engage tenants in activities including: meal/food programs (especially where staff sit and eat with the tenants); social recreation activities designed and run by tenants themselves; events open to the entire community, not just clients; and engaging with family members.

Obtaining employment is one of the most requested daytime activity supports in justice-specific MHA housing applications. Supported employment for people with mental health issues is an evidence-based practice. Between 40-60 percent of service users enrolled in supported employment subsequently obtain regular employment in the labour market, compared to less than 20 percent of service users who do not engage in these services.[74] In Ontario's first provincial policy framework for employment supports, the following key program elements were outlined: job development/creation; skills development/training before the job; on the job training; job search skills/job placement; employment planning/career counseling; supported education; supports to sustaining education/employment; and leadership training.[75]

Individual Placement and Supports (IPS)

The IPS model is the most empirically validated model of vocational rehabilitation for persons with schizophrenia or other serious mental illness. IPS supported employment has the following principles: (1) inclusion of all clients who want to work; (2) integration of vocational and clinical services; (3) focus on competitive employment; (4) rapid job search and no required prevocational skills training; (5) job development by the employment specialist; (6) attention to client preferences about desired work and disclosure of mental illness to prospective employers; (7) benefits counseling; and (8) follow-along supports after a job is obtained.[76] The IPS model is shown to be an effective model for helping justice-involved clients achieve employment.[77]

Working for Recovery – Description from a justice-focused MHA Provider:

- Partner with employment agencies where members are supported in their work.
- SH provider does job recruitment, workplace supervision and general support
- Jobs are accommodated: the hours are flexible and support is available to change or adapt one's work based on ability
- The jobs are real, not "make work"
- Advice for other programs: adequate funding for community networking (including job development and partnerships); strong peer support and resources; include support workers and paid training and education.

(James et al., 2013)

Choose-Get-Keep and Diversified Placement Approach

This approach blends employment and mental health supports with an emphasis on longer-term employment. This model works on gradual introductions to employment, eventually moving

towards paid work in the regular labour market.[78] This model is considered a good approach for clients who seem to face insuperable barriers to working in the competitive job market.

d) Trauma

Trauma was raised frequently in the key informant interviews as a major support need for people with justice involvement and mental health and addiction issues, and an important matter for supportive housing providers. Key informants spoke of clients who have experiences of trauma throughout their life and from their experience of the justice system itself. A considerable literature has documented the relationship between trauma/child abuse and subsequent criminal acts.[79] Integrated trauma supports were identified above as a key approach (see heading 'a' above – substance use).

Specific models that could be incorporated in the justice-focused MHA supportive housing system include: ATRIUM; Beyond Trauma: a Healing Journey for Women; Concurrent Treatment of PTSD and Cocaine Dependence; Integrated CBT; Seeking Safety; Substance Dependence PTSD Therapy; Trauma Recovery and Empowerment Model (TREM); Triad Women's Project.[80] Many of these models are manual-based and designed to use in variety of settings that could include supportive housing.

e) Criminogenic Risk/Need

Research has identified a number of risk factors for criminal behaviour, which can point to corresponding support needs. These risk factors are the same for people with or without mental health issues. There are 4 risk factors that are strongly linked to recidivism and four with moderate risk, together referred to as the "Central Eight". Starting with the strong then moderate, they are:

- criminal history;
- an antisocial personality pattern;
- anti-social cognitions;
- anti-social associates,
- substance abuse;
- employment instability;
- family problems;
- low engagement in prosocial leisure pursuits.[81]

Criminogenic Risk Assessments:

- LSI-R – Level of Service Inventory
  - Well validated
  - Assess the "Central Eight" risk factors to predict recidivism
- LS/CMI
  - Level of Service – Case Management Inventory
  - Built upon LSI-R – combines risk assessment and case management planning into one tool
  - Focuses on people's strengths
- HCR-20 (Historical Clinical Risk Management -20
  - Used in the TRHP program and recommended by KI because it is the same tool CAMH uses
  - Includes variables such as "acute symptoms" that are unique to mental illness
- SPIn (Service Planning Instrument)
  - Highly recommended by a KI participant
  - 90 item tool for assessing risk, need and protective factors.
  - Goal of SPIN is to gather and analyze objective information for developing case plans that will ultimately reduce recidivism
    - » Critical feature is to link assessment results in an immediate way to the process of individualized case planning and appropriate service provision

Criminogenic risk factors are categorized as dynamic or static. Static risk factors are features in client's histories that predict recidivism but are not changeable through intervention (e.g. prior offences). Dynamic risk includes potentially changeable factors, such as substance use.[82] Several support needs described above are identified in the research literature as either risk factors for, or protective factors against, criminal recidivism (e.g. substance use; prosocial connections, employment and daytime structure).

Justice-involved people with mental health challenges should be assessed not only for their mental health and psychosocial needs but also for criminogenic needs. This would enable providers to identify risk factors for future justice involvement, and develop a care plan to address these needs and mitigate recidivism risk. There are a number of validated tools (see textbox above page). Whichever tool is selected, it is important to ensure that it has been assessed for interrater reliability, validity and predictive utility for people with mental health challenges.

Interventions That Address Criminogenic Need

The Risk Need Responsivity (RNR) model is a well-recognized support and risk assessment model to address criminogenic risk and need. It is based on 3 principles: 1) the risk principle asserts that criminal behaviour can be reliably predicted and that treatment should focus on persons with higher risk; 2) the need principle highlights the importance of identifying specific criminogenic needs in the design and delivery of treatment; and 3) the responsivity principle focuses on matching and/or adapting modes of treatment to individuals' abilities and learning styles.[83]

Cognitive behavioural therapy is also effective at addressing risk of recidivism. CBT can be used to target anti-social beliefs and attitudes, and provide strategies to practice pro-social skills including problem solving, interpersonal interactions and self-management. Specific CBT models that target anti-social attitudes and beliefs include: Reasoning and Rehabilitation; Moral Reconation Therapy; and Thinking for a Change.[84]

On the basis of this subsection 3.1, the following are recommended:

Action step #4

The Ministry of Health, Ontario Health, and providers should ensure that supports in justice-specific MHA housing address five main areas of need: substance use; crisis prevention/management; social connections/daytime activities including employment; trauma; and criminogenic risk/need.

Action step #5

The Ministry of Health, and Ontario Health, in collaboration with the Ontario Ministry of the Attorney General and Ministry of the Solicitor General and with providers, should ensure that justice-specific MHA supportive housing programs:

a. Have standards to assess criminogenic and other support needs using validated instruments;

b. Include multi-disciplinary teams (e.g. case managers, nurses, personal support workers, social workers, psychiatrists, and concurrent disorder, employment, peer support, trauma and behavioural specialists) to address the complex support needs of justice-involved clients with 24/7 response ability;

c. Provide supports that are evidenced based, flexible in nature and intensity, and able to respond to changing needs of individual clients (stepped care);

d. Use evidence-based interventions to address the criminogenic needs of clients such as adoption of the Risk-Need-Responsivity model as well as cognitive behavioural interventions targeting anti-social beliefs and enhancing pro-social skills.

Action step #6

The Ministry of Health, Ontario Health, and providers should ensure the provision of specialized and appropriate supports through:

a. Training which enhances the capacity of supportive housing staff, including justice MHA providers, to provide evidence-based interventions to address support needs (e.g. substance use, crisis prevention/ management etc.);

b. Partnering between housing providers and agencies with specialized or complementary staff skills and capacities (e.g. agencies with employment support programs, addictions programs).

3.2 Specific Populations

This subsection discusses particular populations served by justice-specific MHA supportive housing. Five groups were identified as needing particular attention. These are defined and chosen on diverse criteria, ranging from cultural or sociological reasons, to diagnostic complexity, to legal factors.

The five populations discussed here are women, racialized communities, especially people from Black communities; Indigenous communities; people with cognitive and developmental issues including Acquired Brain Injury (ABI), Dual Diagnosis (DD) and Fetal Alcohol Spectrum Disorders (FASD); and the forensic mental health population.

These five groups are not the only ones that may require specialized approaches in supportive housing. Key informants and focus groups also identified older adults, gender non-conforming, and LGBTQ populations as needing specific attention. The focus here on these five populations was based on frequent mentions by key informants and in focus groups, as well as secondary data sources.

a) Women

Women account for one in every five people involved in the criminal justice system, and approximately 1 in 20 of the incarcerated population.[85] Though they represent a smaller proportion of individuals in the justice system, incarcerated women have higher rates of mental health problems and illnesses than their male counterparts. Complex Trauma is also more commonly reported for justice-involved women as were estimates of physical and sexual abuse (ranging between 50% and 90%).[86] The greater prevalence of trauma was echoed by our key informants. In addition to trauma, high rates of non-suicidal self-injurious behavior was noted in the research literature, with the estimates ranging between 43% and 58% of incarcerated females.[87]

Just over one quarter of TAP applicants (27%) for supportive housing with justice-involvement in Toronto were women.[88] Compared to male applicants with justice involvement, female applicants were more likely to report having no source of income (22% vs 9%), to be residing in a custodial facility at referral (15% v 9%) and to have a primary diagnosis of a mood disorder (43% vs 30%). Differences in support needs between men and women with justice involvement at referral to supportive housing were modest across most need domains (see Figure B4 in Appendix B); however, women reported somewhat higher rates of a history of suicidal ideation, suicide attempts and self-injurious behavior (see Figure B5 in Appendix B).

Both our key informants and the research literature noted the importance of women-centred programming, trauma-specific services and trauma-informed care for women with justice-involvement and histories of trauma[89] (see sections 3.1a and 3.1e above for a description of trauma responsive

interventions and service frameworks). In addition to creating physical and psychological safe spaces which support healing from past traumas, trauma informed approaches increase responsivity to evidence-based cognitive behavioural programming found to reduce criminogenic risk factors.[90] Motivational interviewing is also recommended to encourage engagement in evidence-based programming as dropout rates from samples of women who have experienced prior histories of victimization is as high as 80%.[91] Early histories of abuse and trauma can result in a loss of trust and suspicion in the motives of others and a reluctance to participate in treatment programming. Two CBT derivate interventions profiled in the literature

PREVALENCE RATES: Women vs Men

ONTARIO CORRECTIONAL CENTRES

1/2 of incarcerated women & **1/3** of incarcerated men **had a mental health alert on their file**

(Auditor General of Ontario, Annual Report 2019)

FEDERAL PENITENTIARIES

	Major mental illness	Substance use disorders	Anxiety disorders	PTSD
♀	17%	76%	54%	33%
♂	12%	50%	30%	11%

(Brown et al, 2018; Beaudette et al, 2015; Derkzen et al., 2017; Beaudette and Stewart, 2016)

NEEDS IDENTIFIED AT TIME OF SUPPORTIVE HOUSING APPLICATION

Those of women with justice involvement compared to men.

	Women	Men
History of suicidal ideation	44%	36%
History of suicide attempts	28%	19%
History of self-harm	23%	14%

(Sirotich et al., 2018)

for justice-involved women were Mindfulness Based Therapy (MBT) and DBT.[92] MBT assists people with ruminations of negative thoughts, depression, anxiety, stress reduction, substance use problems and low level PTSD.[93] DBT has been found effective in addressing risk of suicide and self-injurious behavior,[94] substance abuse,[95] emotion dysregulation,[96] complex trauma[97] and comorbid personality disorders.[98]

In addition to treatment interventions, our key informants noted the need for assistance with accessing parental support and training programs for women whose children are in the care of a children's aid society or who are at risk of an apprehension.

Action step #7

To address the support needs of justice-involved women with MHA challenges:

a. Women-centred and trauma-responsive programming should be made available, including programming targeting self-injurious behaviour and emotional dysregulation;

b. Parental support and training programs should be accessible for women whose children are in care or who are at risk of a child welfare apprehension.

b) Racialized Communities

There is an overrepresentation of Black people and Indigenous people in the criminal justice system.[99] Official statistics on racialized groups within the criminal court and provincial/territorial corrections system are scarce, as race and ethnicity are not systematically recorded or reported. Over-representation of Indigenous and Black communities within the federal correctional system is well-documented[100] (see textbox).

Overrepresentation of Black and Indigenous populations in the criminal justice system:

- **5%** of the Canadian population identify as Indigenous, Indigenous adults account for **27%** of provincial and territorial custodial admissions and **28%** of federal custodial admissions (Reitano, 2017)
- **2.9%** of Canada's population is Black but account for **8.6%** of the federal prison population (Sapers, 2013)
- Black adults are admitted to provincial correctional facilities at five times the rate of white adults (Beatie et al. 2013)

Information from key informants is that Black and Indigenous people are under-represented in the MHJ housing program, compared to their presence in the criminal justice system; but hard data are not available. Although data are collected on race and ethnicity for applicants to supportive housing in Toronto, this is missing in more than 40 percent of cases. New data sources offer promise to track this information, particularly the addition of race and ethnicity data in the revised OCAN, and LHIN efforts to better track the demographics of service users.[101]

Housing First models can be effective for Black and ethnic minority tenants. An adapted Housing First intervention in Toronto, incorporating anti-racist and anti-oppressive practices (AOP), was evaluated for its effect on improving health and well-being outcomes for Black and ethnic minority groups. Intensive Case Management (ICM) services were provided by an agency exclusively serving ethnic minority groups using an anti-racist and AOP framework of practice.[102] This model of Housing First improved housing stability and community functioning among ethnically diverse homeless adults with mental illness. (See also section 4.4, regarding Housing First.)

Housing First Anti-Racism and Anti-Oppressive Program Description:

- Hiring practices and regular staff training in anti-racist/anti-oppressive practices
- Services delivered in a physical environment that is inclusive and welcoming of ethno-racial communities, offering linguistic and culturally accessible programming and services onsite
- Offer a variety of unique services including: art therapy; community kitchen; computer program etc.
- Staff explicitly address oppression and mental health together, adapting delivery of service to clients' pace and recognizing variety in healing approaches
- Involves families and peer networks early in the recovery process

(Stergiopoulos et al., 2016)

Action step #8

To address the support needs of justice-involved MHA clients in under-served racialized and ethnocultural communities, system planners/ funders and providers should:

a. Engage with ethno-specific community organizations to develop ways to achieve equity of access and meet needs in culturally appropriate ways;

b. Collect and share socio-demographic information, including OCAN and other data, to quantify the needs and target interventions accordingly.

c) Indigenous Communities

Indigenous populations are overrepresented in the criminal justice system, and have particular service needs; transitional and supportive housing is a priority for many Indigenous voices.[103] Literature on housing and supports for Indigenous people emphasize the provision of housing by Indigenous organizations.[104] Key informants and prior studies also point to other ways to better serve Indigenous people, including partnering by mainstream organizations with Indigenous organizations, hiring Indigenous staff, and incorporating traditional cultural practices.[105]

Transitional and supportive housing is a priority for many Indigenous communities,[106] and the literature on housing and supports for Indigenous peoples emphasizes the provision of housing by Indigenous organizations.[107] Section 1.3 noted the limitations of this study in this regard.

Indigenous needs must be addressed as an integral part of the broader supportive housing plan noted in section 1.1, in a process led by Indigenous organizations in collaboration with mental health and housing researchers.

Action step #9

To address the needs of Indigenous justice-involved persons with mental health and addiction issues in Toronto:

a. Researchers and providers in the supportive housing and the justice sectors should collaborate in an Indigenous-led process to assess needs and develop a strategy for supportive housing to serve justice-involved Indigenous people with these needs;

b. The Ministry of Health should fund culturally appropriate services for Indigenous people, in collaboration with Indigenous organizations and other providers.

d) Cognitive and Developmental Issues: Acquired Brain Injury, Dual Diagnosis and Fetal Alcohol Spectrum Disorders

Cognitive and developmental impairments are common among justice-involved people. Various key informants believe many justice-involved tenants

may have undiagnosed cognitive or developmental impairments, due to an acquired brain injury (ABI), an intellectual or developmental disability or fetal alcohol spectrum disorders (FASD). It is estimated that 50 percent of incarcerated males and 38 percent of incarcerated females reported a previous traumatic brain injury,[108] while 10 percent of incarcerated male and females meet criteria for FASD.[109]

Prevalence rates for intellectual and developmental disabilities among justice-involved individuals range between two and 40 percent due to differences in study methods.[110] Among TAP supportive housing applicants with justice involvement, 8% reported a dual diagnosis (DD) (i.e. mental illness and intellectual or developmental disability) (see Figure B6 and Figure B7 in Appendix B for detailed need profile).

Recommendations from the research on serving people with ABI/DD/FASD include: ensuring that staff are trained to identify a history of ABI, intellectual and developmental disabilities and FASD and to have access to other professionals with expertise; co-occurring needs should be the expectation and not the exception; and making use of behavioural specialists.[111]

FIGURE 3.5 Dual Diagnosis: The Numbers

NEEDS IDENTIFIED AT TIME OF SUPPORTIVE HOUSING APPLICATION

Those with DD and criminal justice involvement compared to other applicants with justice involvement.

	DD & Justice Involvement	Other
Developing relationships	75%	60%
Meeting new people	68%	49%
Problematic alcohol or drug use	65%	52%
Avoiding crisis	64%	49%
Avoiding unsafe situations	56%	45%
Self-care	38%	23%
Looking after the home	38%	27%
Using transportation	37%	23%
Shopping	37%	25%
Meal preparation	33%	20%

(Sirotich et al., 2018)

Action step #10

Justice-specific supportive housing access systems and providers should address the needs of people with dual diagnosis (intellectual/developmental disabilities and mental illness), acquired brain injury (ABI) and fetal alcohol spectrum disorders (FASD) by:

a. Partnering and engaging with existing dual diagnosis, ABI and FASD programs and providers;

b. Offering dual diagnosis, ABI and FASD assessments as needed;

c. Incorporating behavioural specialists on multi-disciplinary teams.

f) Forensic Mental Health

The forensic population consists of people who have been found Not Criminally Responsible (NCR) by a criminal court and are under the purview of the Ontario Review Board. Many (but not all) have been long term psychiatric patients in hospital forensic beds. Compared to the broader justice-involved MHA population, they are more likely to be diagnosed with a psychotic spectrum disorder.[112] They are also more likely to have needs maintaining treatment adherence and addressing activities of daily living (see Figure B8 and Figure B9 in Appendix B for detailed need profile).

Many forensic patients are likely to be successful living in supportive housing with proper levels of supports. One key informant with wide experience reported that many who do best upon discharge with ORB conditions are those in supportive housing. Research has also found that supportive housing is an important factor contributing to forensic patients' successful transition to the community. Forensic patients residing in supportive housing have been found to be 2.5 times less likely to commit a new offense and 1.4 times less likely to be readmitted for psychiatric treatment than those in other housing.[113]

Evidence is also emerging for the forensic assertive community treatment (FACT) model as an effective intervention in reducing criminal justice involvement and hospital use and in promoting engagement in outpatient mental health services. The FACT model consists of four components, including high-fidelity ACT, identification and targeting of criminogenic risk factors, use of legal authority to promote engagement in necessary interventions and collaboration between mental health and criminal justice staff to promote effective problem solving. In a randomized control trial of patients diagnosed with psychosis, patients receiving FACT services had lower rates of criminal justice involvement, hospital use and greater engagement in outpatient services than patients receiving treatment as usual.[114]

Forensic Transitional Housing

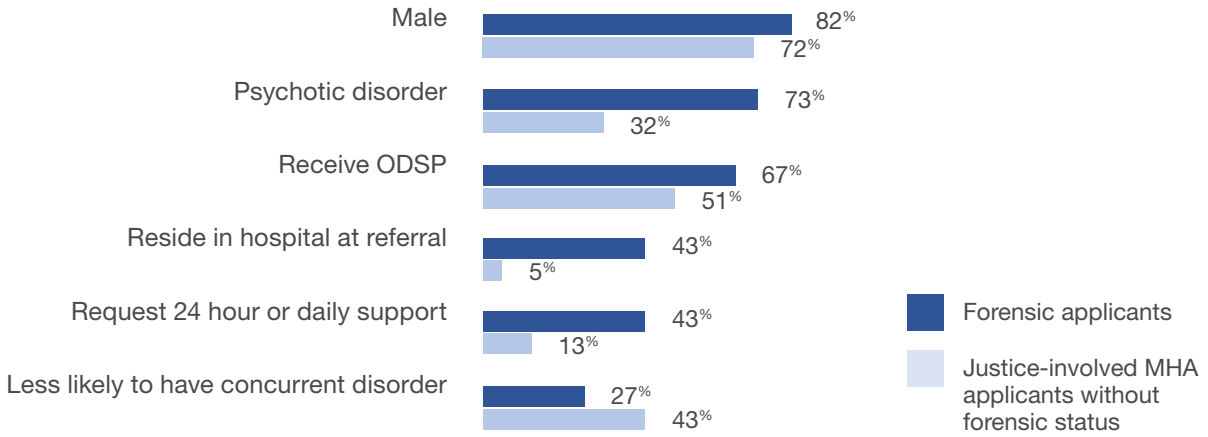
In 2007 Ontario began to fund the TRHP program in Toronto and Ottawa to provide supportive housing to forensic patients. The goal was to transition patients with low to moderate risk from hospital to community settings. The program now is operated in many Ontario communities; it has begun to target people with intellectual and developmental disabilities who have forensic involvement.

The program involves 24-hour high support housing with dedicated staffing and the eventual transition to supportive housing in the community, along with case management supports as needed. A 2013 evaluation[115] found that the program served clients who would not otherwise be housed in the community. It concluded that TRHP, followed by a transition to long term supported housing, is an appropriate treatment option for forensic clients discharged from hospital.

Recidivism rates among forensic patients are relatively low: 17 to 22 percent, compared with 34 percent among the non-forensic justice-involved population, and 70 percent for incarcerated individuals treated for mental disorder.[116]

FIGURE 3.6 Forensic Population: The Numbers

FORENSIC APPLICANTS COMPARED TO JUSTICE-INVOLVED MHA APPLICANTS WITHOUT FORENSIC STATUS.



SUPPORT NEEDS

	Forensic Applicants	Justice-Involved Without Forensic Status Applicants
Managing medications	48%	29%
Looking after the home	36%	27%
Shopping	32%	25%
Self-care	29%	23%
Meals provided	22%	10%

(Sirotich et al., 2018)

Key informants noted that many forensic clients have upfront needs that may lessen over time – including activities of daily living, medication management and monitoring, managing the home and community life after long-term institutionalization. These support needs are congruent with TRHP program strengths identified by its residents in a peer evaluation at CMHA Toronto.[117] TRHP help with immediate needs plays a key role in recovery and reintegration into the community. Tenants identified help with skills to maintain tenancies, and 24/7 available staff , as program strengths that helped residents maintain housing stability, stay healthy, and be involved in the community.[118]

This suggests that justice-involved persons with high needs may benefit from a similar housing program coupled with clinical treatment. The TRHP model could potentially be expanded to support non-forensic justice-involved clients with high needs, particularly needs related to activities of daily living.

Action step #11

To support re-integration of forensic mental health patients into the community, and to reduce unnecessary hospital use, the Ministry of Health should:

a. Fund additional transitional housing facilities with intensive supports;

b. Include forensic-targeted transitional multi-disciplinary supports with high staff-to-patient ratios in some MHA housing with permanent (non-transitional) tenure.

Action step #12

The Ministry of Health and providers should continue to ensure that transitional forensic mental health housing:

a. Has supports such as case managers or personal support workers to address functional needs in activities of daily living (ADL) and adhering to treatment regimens;

b. Has close links with permanent supportive housing, and access geared to tenant readiness;

c. Applies evidenced based practices including risk assessment and client placement service planning;

d. Incorporates effective practices from the existing Transitional Rehabilitation Housing Program (TRHP);

e. Builds in priority access routes to permanent justice-focused supportive housing for those who need it.

Action step #13

To support re-integration of persons leaving correctional facilities who are not forensic mental health clients but may need 24-hour onsite support, the Ministry of Health and providers should explore adapting the Forensic Transitional Housing Rehabilitative Program (TRHP) model to this population.

SECTION 04

Housing Needs and Program Responses

4.1 MHJ Housing Needs – Introduction

Housing is a key social determinant of health, and all the more so for people with disabilities including mental health issues and addictions.[119] The housing needs of the MHJ population are a severe version of those experienced by other people with mental health issues or addictions, and extreme poverty.

Very low income means few units that are affordable, very constrained choice, and inability to compete with others when seeking a unit. It often means settling for poor quality housing in neighbourhoods seen as less desirable. People with disabilities, including mental health, more often live in poor-quality rental housing, and often in low-quality rented rooms.[120] Our focus groups and key informants confirmed these problems – more so for private-landlord buildings than for non-profits.[121] Low-cost rental housing is often in neighbourhoods where social conditions, quality of life, and safety are large concerns.[122]

The housing component of supportive housing therefore addresses several interrelated housing issues: helping people obtain housing, making it affordable at low income, having acceptable quality and safety, offering options outside disadvantaged neighbourhoods, and ensuring secure tenure. The MHJ population has particular needs in regard to obtaining housing and in urgent and transitional needs (subsections 4.2 and 4.3). As well, the research literature offers important evidence on cost, social integration, Housing First as an approach, and other matters applicable to MHJ housing (subsection 4.4).

4.2 Access Issues for the MHJ Population

a) Nature of Access Issues

The justice-involved with MHA population faces compound and severe barriers in access – ability to obtain housing.[123] This relates to structural disadvantage, and discrimination on income, disability, criminal history, and racial group.

- People with low income, especially social assistance, face structural disadvantages in the rental market. They cannot compete with middle-class applicants with steady jobs, who are less likely to have histories of unstable tenancies and arrears, or are perceived as presenting little risk. They face screening-out practices by landlords, related to these matters and ability to pay.[124]

- Many landlords discriminate on the basis of disabilities, including mental health. This is more likely to be experienced with a mental health disability, as one can face eviction for disability-related behaviours and landlords' failure to accommodate disability-related needs.[125]

- Having a criminal record is an impediment to obtaining an apartment to rent. People working with MHJ clients report that landlords discriminate against this population. A criminal record is also a huge barrier to getting a job, which reinforces low income and unstable tenancies.[126]

- Much of the population affected is also racialized and faces discrimination on that basis.[127]

Subgroups within the MHJ population have greater difficulties. Examples include people with a history of sex-related crimes, arson, or violence. Key informants described the difficulty of managing risk for these populations, without limiting access. Access barriers

extend to supportive housing, with various providers cautious in housing people with criminal histories. Such providers believe they are not qualified to assess level of risk of recidivism or harm to self or others in the housing; are unable to provide the level of supports needed; or are concerned about relations with landlords they are leasing from.[128]

Addressing these issues involves how supports are provided and how housing is provided. In regard to supports, Section 3 pointed to assessment tools and risk management strategies. In housing provision, these issues point to the need for access priorities to offset disadvantage, and also MHJ-specific housing.

b) Addressing Needs in MHJ Housing as well as Other Mental Health Supportive Housing

Many people with MHJ issues can be accommodated in general mental health supportive housing. Many of the support needs are about homelessness, deep poverty, mental illness, drug use, and managing the related behaviours – not dissimilar to other MHA support needs[129] (see also Section 3). For many, the risk of recidivism is relatively low and they do not require specific interventions targeting criminogenic needs.

At the same time there is value in MHJ-specific housing. It is one way of overcoming the extreme disadvantage that MHJ clients face in the rental market; and it offsets other housing providers' tendency to under-serve people with criminal justice involvement. It can address the particular high needs and/or safety risks of people who have significant criminal histories, or are NCR, or pose a risk to the community. As well, there is value in dedicated transitional housing for jail discharge, as discussed below. Where active ongoing addictions are involved, specialized housing and supports may also be needed. On the other hand, there are concerns that targeted MHJ housing perpetuates the stigma against persons with current or prior justice-involvement.[130]

c) Safe Beds

The Safe Bed system was described in section 3.1. When this program started in 2005/06, concurrently with the MHJ supportive housing program, people exiting the Safe Bed system were able to move into newly added MHJ housing. With MHJ supportive housing system now at capacity with low turnover, Safe Bed clients are often being discharged into homelessness – continuing the cycle of homelessness and incarceration. Moreover, the 30-day limit now being applied in Safe Beds is not sufficient. In 30 days, most clients cannot find housing in private rental, let alone supportive housing, and cannot "put together a plan to put their life on track" in that time.[131]

This points to the need for two responses. Diminishing security of tenure in MHJ or other supportive housing is not the answer. One response is to develop priority access protocols for Safe Bed clients to access long-term MHJ or other supportive housing. Another is to add portable subsidies and flexible supports, so that existing MHJ/MHA tenants can move on to other options if they choose. These responses will require collaboration by MHJ supportive housing providers with the Toronto MHJ Safe Bed Network, as well as suitable policy and funding support from the Ministry of Health.

These beds have limited ability to serve the needs of most people who are in custody, according to key informants. Safe Beds cannot be reserved for the time when a person is discharged, and there are few beds and few openings compared to the needs. Other options are needed to meet needs at discharge.

d) Security of Tenure during Short-term Incarceration

In addition to initial access to supportive housing, maintaining that housing through short periods of incarceration can often be a barrier to housing stability. Some individuals in justice-specific supportive housing may have subsequent involvement with the justice system that lead to short periods of incarceration or bail restrictions affecting their place of residence. It is

important to ensure that people in this situation can keep their housing during short-term incarceration, to avoid homelessness and foster better long-term outcomes.[132] While recognizing that rent payments cannot be sustained for prolonged incarceration, it is essential to help the person retain their housing for shorter periods. To address this may require adjustments in program rules, operating practices of providers, and funding.

Action step #14

Justice-specific MHA supportive housing providers should engage with the Toronto Safe Bed Network to build shared understanding of the housing and support needs of clients upon discharge from safe beds, and develop protocols for priority access to long-term justice-focused supportive housing.

Action step #15

Justice-specific MHA supportive housing providers should consider prioritizing access for persons who are incarcerated and homeless, with very high needs and risk of recidivism.

Action step #16

The Ministry of Health and providers should promote housing stability through policies, program rules, funding, and practices that enable residents to retain their housing during short-term incarceration (e.g. up to 3 months).

4.3 Urgent and Transitional Needs

Literature, key informants, and advisory committee feedback point to three distinct populations where transitional housing and support is needed. The first and largest group is people with urgent housing needs when they are discharged from custody, or who risk being held in custody at bail hearings because of their homeless status. A second group, a smaller population but with high needs, is people leaving long term hospitalization including forensic clients. A third group is people with MHJ needs discharged from federal prisons after longer sentences, who lack social or health-related supports and are at risk of becoming homeless.

a) Urgent Access and Transitional Housing at the Bail Stage or Post-Incarceration

Many people with mental health or addiction issues are discharged from custody with no place to go and little support. Others are denied bail because they lack an address, with underlying concerns that homeless people will not reappear in court or will re-offend (Section 2). Others face residence restrictions within the bail, probation or parole conditions, leaving them unable to return home. Many of these people cycle through custody and homelessness.

At the end of incarceration, many people also need rapid access to transitional housing, to enable

> Transitional housing for justice-involved population would typically include:
>
> - Assessment upon intake
> - Case management
> - Alcohol and drug treatment
> - Financial counselling,
> - Employment services
> - Rapid access to temporary housing and referral to long term housing and supports.
>
> (Fred Victor et al., 2012)

successful re-integration into the community. Having an initial landing place at discharge from detention, with support services, is vital in avoiding a return to homelessness, getting help with re-entry into society, and dealing with mental health, trauma, and addiction issues.[133] Support services do not suffice: without a place to stay with services at hand and daily structure, there are higher risks of becoming homeless, restarting drug use, and being disconnected from support services.

To meet these acute and widespread needs, there is a need for transitional and short-term housing with supports, for people in short-term detention and appearing in court, and for those discharged after longer periods of detention. Although transitional supportive housing falls short on the principle of long-term or permanent housing, it is vital to meet urgent needs despite the shortfall of affordable housing.

Transitional supportive housing provides an opportunity to have people assessed, and referred to services they need, etc. Key informants pointed to the Critical Time Intervention model (CTI) used in the USA, with a support team provided for at least 3 months after discharge. Transitional housing for the MHJ population requires features including access policies and practices to ensure priority to those in need; time-limited housing tenure; suitable post-discharge supports provided on site; and subsequent access to permanent supportive housing for many of the transitional clients.[134] To meet clients' needs and implement this effectively requires ongoing, structured channels of communication between correctional institutions and the community-based providers that serve people after discharge.

For transitional housing to remain that, residents must move on to other housing to create openings for others leaving custody. The scarcity of long-term affordable housing makes this challenging, but local experience points to some parts of the answer. The Residential Tenancies Act (RTA) permits transitional tenancies, primarily for supportive housing, with 2017 amendments reflecting a new policy framework and consultation.[135]

Within the existing supportive housing system, shared accommodation in boarding homes and congregate houses functions de facto as a shorter-stay segment: because it is less desirable its residents seek out other options, creating more openings in it. Transitional housing providers also work with clients to find suitable longer-term options; some go on to rejoin their family, into regular social housing, or back into a job that enables them to afford market rent – not all need long-term supportive housing.[136] The challenges of "flow" in transitional housing are great, but not insurmountable.

b) Transitional Housing for Forensic Mental Health Clients

Transitional housing is also needed by some of the forensic (NCR) population. Typically the client has resided in hospital for some time, with high levels of support and supervision. Some forensic clients require high supports in several domains including mental health, daily structure, meal provision and sometimes personal care. Supervision is also needed in regard to meeting the conditions set by the ORB. These high levels of support are normally, but not always, provided in a dedicated facility.

Providers in Toronto and elsewhere in Ontario have relevant experience with the Transitional Rehabilitation Housing Program (TRHP). It provides stability for clients after long institutionalization, and time for clinicians to assess skills in activities of daily living, and risk, and to monitor medications. They are also able to use this time to form a service plan and become alerted to potential problems (see also Section 3).

Action step #17

The Ministry of Health and providers, in collaboration with the Ministry of the Attorney General and Ministry of the Solicitor General, should ensure that transitional housing for justice-involved, non-forensic clients:

a. Has time-limited tenure appropriate to each person's needs;

b. Has special access policies and practices for justice-focused supportive housing that ensures priority to people who are being discharged from custody, seeking bail, cycling between custody and shelters, temporarily residing in MHJ Safe beds or in related situations;

c. Offers suitable post-incarceration supports;

d. Ensures priority access to permanent justice-focused supportive housing at the end of the transitional housing tenure, with continuity of needed supports.

4.4 Other housing considerations for MHJ

The research literature on housing policy choices and on Housing First provides evidence that is broadly applicable to MHJ supportive housing. This subsection summarizes this to inform policy choices.

a) Housing First

Research including *At Home/Chez Soi* has documented the success of Housing First in providing stable housing for homeless people with serious mental illness, improving health and social outcomes, and reducing use of health and emergency services. Essential Housing First elements are direct access from homelessness to housing, minimal preconditions and no "treatment first" rule, independent tenancies, and de-linked housing and supports. With 45 percent of *At Home/Chez Soi* clients having some justice involvement (section 2 above), Housing First principles are applicable to much of the MHJ population.

At the same time, a broader survey of evidence points to varied ways to provide housing on Housing First principles, nuanced approaches to social integration, and flexibility in the de-linking of housing and supports. This is summarized in the remainder of subsection 4.4.

b) Supports Tied to Housing versus Not Tied to Housing

Separation of supports from housing tenure is recognized as a best practice in supportive housing, since the 1980's.[137] This means that housing access is not tied to a particular arrangement for support, and housing tenure is secure if support needs shift. Normally the support provider is different from the housing provider, avoiding the risk that landlord-tenant issues may compromise support relationships. This paradigm reflects ideas of personal choice, independence and recovery, full participation in society, and individualized, person-directed supports.

Research also identifies situations where linking housing and supports serves clients effectively. This approach has advantages for people whose homelessness involves severe alcoholism or jail discharge.[138] It can be effective for high-support housing – where on-site staff are required, meals are provided, staff supervise or administer medications, or support includes activities of daily living.[139] Safe Beds with 24-hour high support normally mean 'linked', and there can be benefits of linked housing and supports for other transitional housing as well.[140] On-site staff can help those clients who need help getting to court dates and probation meetings, to avoid re-incarceration.[141] For high staff/client ratios on-site supports can be more cost-efficient, with less staff travel time and cost.

Linked housing and supports typically involves 'dedicated' supportive housing (also known as 'project-based' or 'single-site'), discussed below. An alternative approach is a cluster of clients supported by a staff team within a larger non-supportive building, or in a neighbourhood.[142]

c) Self-Contained versus Shared/ Congregate Housing

Self-contained apartments are generally preferred for mental health supportive housing, including justice-specific MHA housing. Self-contained units help people integrate in the community with independent tenancies in 'normal housing';[143] this works best for most people and fosters long-term stable tenure. It avoids the tensions and conflicts and resulting support needs that arise when sharing household space with others. Only 5 percent of MHJ applicants request only shared housing;[144] they often decline offers of shared housing; and its residents move on sooner in pursuit of better housing.[145]

But congregate/shared housing meets some people's needs. (Congregate here means dwellings where separate tenants share kitchens, bathrooms, living rooms, etc. – not clustered apartments.) For some people the shared living and community of peers are integral in the model of support. The higher turnover has a positive side, providing openings and availability for others. Key informants noted that different people have divergent needs. Some do well in shared/ congregate housing, and would be socially isolated if housed in scattered apartments. It can be helpful if a provider can offer more than one option if the other is not working for a given resident.[146]

d) Social Integration in Scattered versus Dedicated Housing

Much research literature points to rent supplement in scattered private-landlord apartments as the way to integrate people into normal residential settings and avoid ghettoization.[147]

For the justice-involved MHA population, there is a need to avoiding clustering clients in a way that may foster criminal behaviour. For example, it can be hard to achieve harm reduction if one's neighbours are using drugs[148] or one's friends and associates are involved in crime. Scattered rent supplement, or scattered units in larger social or private rental buildings, have advantages in this regard. This type of housing is also preferred by people living with their young children.

Other research points to some advantages of 'dedicated' (project-based) supportive housing, fully targeted to the client group. This can offer community-building via social activities and shared meals and peer support, and avoid the social isolation that can arise in scattered rental.[149] The on-site "community within the broader community" can be a place where issues of mental health, addiction, or criminal history are not stigmatized.[150] It can facilitate easier access to case managers and casual, daily contact to build rapport. This can be especially important for people with higher needs, who frequently do not succeed in stable tenancies in scattered units.[152]

e) Social Integration in Private-landlord versus Non-profit-owned Housing

Housing First literature frequently reflects a premise that scattered private-landlord apartments achieve better social integration than social housing. But housing research shows very mixed evidence on which approach achieves more social mix.

In the USA, scattered rent supplement (voucher) recipients live in better neighbourhoods than inner-city public housing – with less poverty and crime and some better social outcomes.[153] But rent supplement is not a universal tool for social mix. Its locations are very constrained by the location of low-cost private rental, mostly in low-income neighbourhoods. Moreover, new US affordable rental is in far more dispersed locations than voucher households.[154] European social housing, a larger sector relatively than in the USA and with less concentrated inner-city locations, contributes to much less socio-economic and ethno-racial segregation in most European cities than in the USA. European social housing is spatially correlated with low neighbourhood income in some cities and not in others.[155]

f) Effectiveness of Non-profit versus Scattered Private-landlord Housing

Although much research considers scattered private rental as an integral element of Housing First,[156] it is also being implemented in other ways. In Northwestern Europe, where social housing comprises a majority of rental apartments, Housing First has often used units scattered in social housing;[157] in Australia it has been a mix of social housing and private rental.[158] In Toronto, 'Dedicated' providers have implemented Housing First principles, housed homeless people directly without mandatory supports, and often used support from third-party agencies.[159] A recent analysis in Chicago found not a binary scattered-versus-dedicated choice, but six diverse approaches to providing supportive housing.[160] In New York, the 'FUSE' initiative has housed homeless people in a mix of non-profit-owned and scattered private-landlord housing, with benefits in housing stability, drug use, and corrections involvement.[161]

A recent review of studies assessed the evidence for dedicated supportive housing, scattered private rental with supports and rent supplement, and 'treatment as usual'. The first two approaches both have benefits in health outcomes, other well-being, and health care costs; neither is clearly superior.[162]

In non-profit-owned buildings, support workers can help reduce entry of non-residents who may present criminogenic or substance use risk. In this model, staff also have more scope to intervene in matters such as noise complaints and damage to units.[163]

Headleases are a hybrid arrangement where the supportive housing providers leases units from a private landlord and then sublets to clients. These can work well for the justice-involved population.[164] Clients have assured access to the units, in a variety of locations. Landlords have an assured revenue stream with minimal risk of arrears on the part of the providers. Landlords can leave it to the support provider to deal with many of the tenancy issues, as well as covering damages and doing repairs that arises from tenant behaviour.

g) Housing Quality in Private-landlord and Non-profit-owned Housing

Poor housing quality and disrepair are major concerns in lower-cost private rental. In the housing market, people with less income tend to live in housing with lower rents, lower quality and more disrepair, and lesser neighbourhood quality. This arises because people's housing choices are constrained and they often have to settle for lower quality to get lower rent; and landlords in such areas can be pulled toward a business model of less maintenance to sustain profitability at lower rents.[165] While quality is also an issue in some social housing, that can be directly addressed by adequate funding.

Rent supplements, by providing more purchasing power, can soften these effects but not eliminate them. Housing quality in private rental available to people with mental health disabilities was a significant concern expressed in the focus groups for this report, and by some key informants.[166]

h) Cost Considerations in Private-landlord and Non-profit-owned Housing

Non-profit-owned housing costs 40 to 70 percent more per household than rent supplement, in the short to medium term.[167] If costs are compared over 20 to 35 years, affordable supply is the more cost-effective option, once mortgages are paid down, and market rents escalate well beyond long-run costs of non-profit operation. In gentrifying areas, affordable supply ensures long-term affordability.[168] Acquisition and rehabilitation of existing buildings is a lower-cost option than building new housing.[169]

This shifting cost comparison has been experienced recently in Toronto as market rents have escalated. Many supportive housing providers are finding a widening gap between market rents in their private-landlord units, and what residents on Ontario Disability Support Program (ODSP) and Ontario Works (OW) can afford. Available funding amounts no longer cover that widening gap. Various providers have therefore had to

reduce the number of units they are able to provide, or end up substituting units that are below their standards for location, maintenance and safety.[170]

When MHJ or other supportive housing is provided through arrangements with private landlords, it is important to provide sufficient funding to secure units and make them affordable to clients. The Ministry of Health should ensure that funding reflects evidence-based market benchmarks, such as survey data from Canada Mortgage and Housing Corporation's Rental Market Report.

Action step #18

To lessen the barriers that justice-involved clients encounter in obtaining and retaining supportive housing, and mitigate related risks to providers, access systems and providers should:

a. Implement Housing First principles of direct access from homelessness to housing, minimal preconditions and no "treatment first" rule, and independent tenancies;

b. Develop protocols including 'situation tables' for people determined to have high risks or needs, to ensure that required specialized supports from partner agencies are available at the time of placement in housing.

Action step #19

To address shortfalls in housing affordability, quality, and location, meet housing market opportunities, enable client choice and successful tenancies, and leverage intergovernmental resources, the Ministry of Health and the City of Toronto should fund and implement a dual housing delivery model of:

a. Rent subsidies with supports in private rental of decent quality (headleases or individual tenancies);

b. Non-profit-owned supportive housing.

Action step #20

To address funding gaps in MHJ housing, the Ministry of Health should increase the amount of monthly rent supplement per unit to levels reflecting moderate market rents, and provide such subsidies on a long-term basis.

Action step #21

To meet client needs and preferences and thereby foster stable housing tenure, the Ministry of Health and providers should provide most additional supportive housing in the form of self-contained apartments.

Action step #22

The Ministry of Health and providers should promote social integration through diverse ways of providing housing, including:

a. Scattered apartments in private-sector or social housing for many residents, including two and three bedroom units for justice-involved people who are caring for their children;

b. Dedicated (project-based, single-site) non-profit-owned housing;

c. Avoiding clustering persons with higher criminogenic risks;

d. Units that are accessible to people with physical disabilities.

SECTION 05

Ways to move Forward

The evidence and analysis in this needs assessment point to a need to move forward on several fronts. This section distills these into eight thematic priorities, broader than the specific action steps.

1) Expand the system to meet needs, with more MHJ-targeted supportive housing and steps to better serve MHJ clients in the mainstream of mental health supportive housing.

This report has documented the barriers to obtaining housing that the MHJ population faces, and severe shortfalls in capacity to meet the numbers of people in need. Many people with mental health and addiction issues are cycling in and out of homelessness and jail. Lack of available housing and supports creates unstable living situations, and contributes to further substance use and risk of police involvement and detention.

Criminal justice involvement, shelter use, and the associated demands on health care and emergency services all create public costs much higher than funding supportive housing.

The severe access barriers and support needs of people with mental health and addiction issues and justice involvement point to a need to add more supportive housing targeted specifically to this population.

At the same time, the prevalence of justice involvement among the population with mental health or addiction issues points to the need to ensure that MHA supportive housing, in general, serves the MHJ population.

Expanding this system is primarily a provincial responsibility, reflecting its lead role in community mental health as well as corrections. Expanding the system requires more funding for capital cost, rent subsidies, and support workers. Collaborating actively with the supportive housing sector, the City of Toronto and the federal government can make use of additional resources and ensure effective delivery.

2) Achieve a more flexible range of housing, including transitional housing, adapting some existing supportive housing to serve different clients, and creating options for its tenants to move on to.

This needs assessment has pointed to the diversity of MHJ housing and support needs, and the complexity of matching individuals to what will best meet their needs.

For some clients, transitional supports or transitional housing tenure provides an important step in rebuilding one's life after release from custody. In MHJ housing more broadly, the low tenant turnover, reflecting the scarcity of affordable supported options, creates barriers for new applicants. The Safe Bed system has too few beds compared to needs, and few options to move to after a short stay – leading to discharge into homelessness, and pressure to shorten the standard lengths of stay.

These point to a need to work toward a more flexible system. In addition to permanent housing, there is a need for transitional housing – including non-permanent housing tenure and supports that can shift over time.

The main tool to create options for existing supportive housing tenants to move on to is rent supplement with flexible supports. This is the way to respect the important principle of secure housing tenure, while creating movement in the system. Some can be portable by the tenant and others can be negotiated by providers with private landlords.

In some (not all) cases this can facilitate adaptation of 'dedicated' non-profit-owned properties to house a different mix of needs, including in some cases a focus on those with higher needs. Having more options in 'dedicated' supportive housing as well as more rent supplement will also create options for Safe Bed users to obtain permanent housing and avoid discharge into homelessness.

3) Adopt effective practices in housing provision and respond to market pressures, through market-based approaches to private-landlord rent supplement, together with non-profit-owned housing.

The research evidence in this report points to advantages and disadvantages in both 'scattered' private-landlord rent supplement and non-profit-owned housing.

The private rental sector continues to offer the largest number of openings and the widest range of locations. But the shortcomings of relying only on 'scattered' private-landlord rent supplement are evident in recent experience and research literature. Rental market conditions have changed greatly, with escalating rents and therefore rising rent subsidy needs, low vacancies and few units available, far more competition for units, and termination of supportive housing leases by various landlords. It is challenging for providers to ensure access to private rental for clients with complex needs, and to offer high supports in scattered locations.

Non-profit housing has advantages in assured access; ensuring stable tenancies for complex clients; a wider range of locations outside downmarket rental neighbourhoods; social supports and community connections on site; cost-effective provision of more intensive supports; and lower long-run and lifetime housing costs. But non-profit-owned housing has much higher short/medium-term costs; sometimes it leads to less flexible adjustment of supports as needs shift; and in some cases the clustering of clients presents criminogenic risk.

Effective housing provision will make flexible use of both approaches.

4) Adopt better eligibility criteria and assessment processes, to ensure clients with varied needs are served, that they are well matched to supports they need, and that providers need not refuse applicants due to undue concerns about risk.

Matching clients with diverse and often complex and shifting needs to suitable support and housing is a complex matter. This research documented a need to enhance current systems and practices.

Many MHJ applicants are not accepted by private landlords. They are declined by supportive housing providers too, more often than other applicants, often on the grounds of perceived risk without a clear or adequate assessment of this. This applies especially to clients with a history of violence, arson, or sexual crimes. In some cases, clients with low risk of recidivism are placed in MHJ housing targeted to people with higher risk or needs.

Opportunities exist to improve the system of assessment and matching of MHJ applicants to suitable supports. This report has pointed to validated tools to assess criminogenic risk, which can inform supports tailored to individual needs, and avoid excluding people from MHJ units. Effective assessment also means doing this before people are released from custody, with active collaboration by correctional institutions and staff, so that suitable options can be arranged.

There is a need to enhance the priority for client groups with high or urgent needs, within the broad MHJ population. This includes a diverse range of clients: forensic mental health (see #5 below), and people who urgently need housing upon discharge from corrections. 'Situation tables' can be used for higher-risk clients, to match people to suitable supportive housing and mitigate risks. High-need clients are important but not exclusive priorities, and they must be balanced with addressing overall MHJ needs.

5) Establish distinct approaches to housing and supports for distinct populations, especially forensic mental health clients, women, racialized and cultural groups, and MHJ clients with cognitive and developmental disabilities.

This report has pointed to many unmet needs of five MHJ subpopulations in particular.

Forensic mental health clients are a current focus of policy and political concern. Most forensic patients can be successfully housed in the community if appropriate housing and supports are provided, with minimal risk to the public, large savings in hospital costs, and better client outcomes.

Women in the correctional system have higher rates of mental health challenges than their male counterparts. Women-centred and trauma-responsive supports and parental support programs are required to address their unique needs and experiences.

Racialized and cultural minority groups are overrepresented in the criminal justice system and are believed to be under-served in justice-focused supportive housing. This points to a need to develop culturally appropriate practices and supports within the supportive housing system in general, and to work with culturally specific community agencies to ensure effective service delivery to these groups.

Indigenous people in Toronto are also overrepresented in the criminal justice system and may be under-served in justice-focused supportive housing. Meeting these needs requires a collaboration with Indigenous researchers and service providers in a focused needs assessment and strategy. It also requires further steps by mainstream MHA providers to serve Indigenous clients in culturally competent ways.

Co-occurring conditions such as cognitive and developmental disabilities are common among justice-involved people with mental health challenges. These conditions require appropriate assessment and interventions provided by behavioural specialists and/or ongoing consultation with specially trained psychologists.

6) Sustain a system that can match complex needs to suitable housing and supports, by maintaining a coherent supportive housing sector as the transition to OHTs proceeds, rather than fragmenting it.

The diversity of clients and needs in Toronto can best be addressed by maintaining a coherent supportive housing system during the health system shift to Ontario Health Teams (OHTs). This will ensure the widest, flexible opportunities to match people to specialized supports, find housing in local communities across the city, and allow equitable treatment of all applicants.

The Access Point has taken on an enhanced role in assessment. Effective assessment and matching, and equitable treatment of people across the city, will be best achieved by maintaining the centralized access system for MHA and MHJ housing.

Action step #23

To promote service coordination and continuity during and after a period of health system restructuring, Ontario Health Teams (OHTs) should work with Toronto justice-specific MHA service providers, the Toronto Mental Health and Addictions Supportive Housing Network and The Access Point to connect justice-involved supportive housing clients to community-based services and housing.

7) Integrate MHJ strategic priorities in this report into related strategies, including provincial mental health, ALC and correctional policy; City of Toronto housing strategies; the federal government's National Housing Strategy and strategic priorities of OHTs.

MHJ needs require a purposeful approach, but cannot be addressed in a silo. Serving justice-involved clients' needs to be integral in supportive housing and embedded in related strategies.

These related policy areas and strategic opportunities include provincial mental health policy, actions on ALC and hallway medicine, and correctional policy. They include priorities of the community-based supportive housing sector and homeless-serving providers, the City of Toronto in its affordable housing strategy, the federal government's National Housing Strategy, and the emerging work on a 'Supportive Housing Growth Plan' for Toronto. Supportive housing needs including those of justice-involved clients should also be among the community mental health priorities of Ontario Health Teams.

Many of the issues and policy/program implications in this report, pertaining to discharge from courts and corrections, also involve the Ontario Ministry of the Attorney General (MAG) and Ministry of the Solicitor General (SOLGEN), and correctional institutions. Their involvement is also essential for the large share of persons in provincial custody who are on remand, with uncertain discharge dates or other outcomes, and limited discharge planning of housing or support options for them. This report should inform action within the MAG and SOLGEN spheres of responsibility as well as the Health sphere.

Action step #24

The Ministry of the Attorney General and Ministry of the Solicitor General should review the findings and recommendations of this report, take related actions within their purview, and collaborate with the Ministry of Health and community-based providers on other actions as needed.

Action step #25

The Ministry of Health and supportive housing providers should identify opportunities to use funds from the federal government's National Housing Strategy to increase the supply of supportive housing units.

Action step #26

The Ministry of the Attorney General and Ministry of the Solicitor General should consider options for establishing bail residences, halfway houses, and/or related transitional accommodation, including appropriate supports for mental health and addiction issues.

8) Build the foundation for more evidence-based policy, through enhanced data and more research and evaluation.

This research has uncovered a range of gaps in program information and research evidence on justice-related mental health supportive housing in Ontario and Toronto.

For example, there is a lack of common data to measure reasons for discharge or housing outcomes, across the various providers. Such data would enable better comparison of tenancy outcomes, facilitate trend analyses over time, and inform future program development. As well, there is scarce hard research evidence on which client groups benefit most from the transitional housing model, or what approaches to this are effective. There is limited public evidence on program costs across various types of housing provision. While research literature offers evidence on the costs and efficacy of scattered private-landlord rent supplement versus non-profit-owned housing, this is not specific to MHJ housing.

There is limited research and evaluation on the effectiveness of MHJ-specific housing, or how to best serve this population in mental health supportive housing overall. Future research and program evaluation can examine the housing, mental health, and criminal justice outcomes of various models, find which approaches work best for which client groups, and examine transitional housing tenure and/or supports. It can probe more specifically the needs and best options for forensic clients, people from underserved racialized or cultural communities, people with cognitive and developmental as well as MHJ issues, and Indigenous people with mental health or addictions issues and justice involvement.

Appendix

A: Consolidated Action Steps

#1 The Ministry of Health, Ontario Health, and providers, in collaboration with the Ontario Ministry of the Attorney General and Ministry of the Solicitor General, should adopt a target of 300 additional supportive housing units annually in Toronto, targeted to justice-involved people with mental health and addictions issues, for the ten-year period 2020-2029 (total 3,000 units).

#2 The Ministry of Health, Ontario Health, and providers, in collaboration with the Ministry of the Solicitor General and Ministry of the Attorney General, should create transitional housing comprising 10 to 20 percent of added mental health and justice housing in Toronto (300 to 600 units), for persons needing urgent rapid housing access to facilitate bail release or for community re-integration following a custodial sentence (within the broader ten-year, 3,000-unit MHJ housing target).

#3 The Ministry of Health, Ontario Health, and providers should adopt regular annual targets for forensic mental health housing in Toronto (within the broader housing target for mental health and addictions issues and justice involvement), based on the needs of individuals involved each year.

#4 The Ministry of Health, Ontario Health, and providers should ensure that supports in justice-specific MHA housing address five main areas of need: substance use; crisis prevention/management; social connections/daytime activities including employment; trauma; and criminogenic risk/need.

#5 The Ministry of Health and Ontario Health, in collaboration with the Ontario Ministry of the Attorney General and Ministry of the Solicitor General and with providers, should ensure that justice-specific MHA supportive housing programs:

- **a.** Have the capacity to assess criminogenic and other support needs using validated instruments;
- **b.** Include multi-disciplinary teams (e.g. case managers, nurses, personal support workers, social workers, psychiatrists, and concurrent disorder, employment, peer support, trauma and behavioural specialists) to address the complex support needs of justice-involved clients with 24/7 response ability;
- **c.** Provide supports that are evidenced based and able to respond to changing needs of individual clients including the need for greater or less service intensity (stepped care);
- **d.** Use evidence-based interventions to address the criminogenic needs of clients such as adoption of the Risk-Need-Responsivity model as well as cognitive-behavioural interventions targeting anti-social beliefs and enhancing pro-social skills.

#6 The Ministry of Health, Ontario Health, and providers should ensure the provision of specialized and appropriate supports through:

- **a.** Training which enhances the capacity of supportive housing staff, including justice MHA providers, to provide evidence-based interventions to address support needs (e.g. substance use, crisis prevention/management etc.);
- **b.** Partnering between housing providers and agencies with specialized or complementary staff skills and capacities (e.g. agencies with employment support programs, addictions programs).

#7 To address the support needs of justice-involved women with MHA challenges:

- **a.** Women-centred and trauma-responsive programming should be made available, including programming targeting self-injurious behaviour and emotional dysregulation;
- **b.** Parental support and training programs should be accessible for women whose children are in care or who are at risk of a child welfare apprehension.

#8 To address the support needs of justice-involved MHA clients in under-served racialized and ethnocultural communities, system planners/funders and providers should:

- **a.** Engage with ethno-specific community organizations to develop ways to achieve equity of access and meet needs in culturally appropriate ways;

b. Collect and share socio-demographic information, including OCAN and other data, to quantify the needs and target interventions accordingly.

#9 To address the needs of Indigenous justice-involved persons with mental health and addiction issues in Toronto:

a. Researchers and providers in the supportive housing and the justice sectors should collaborate in an Indigenous-led process to assess needs and develop a strategy for supportive housing to serve justice-involved Indigenous people with these needs;

b. The Ministry of Health should fund culturally appropriate services for Indigenous people, in collaboration with Indigenous organizations and other providers.

#10 Justice-specific supportive housing access systems and providers should address the needs of people with dual diagnosis (intellectual or developmental disabilities and mental illness), acquired brain injury (ABI) and fetal alcohol spectrum disorders (FASD) by:

a. Partnering and engaging with existing dual diagnosis, ABI and FASD programs and providers;

b. Offering dual diagnosis, ABI and FASD assessment as needed;

c. Incorporating behavioural specialists on multi-disciplinary teams.

#11 To support re-integration of forensic mental health patients into the community, and to reduce unnecessary hospital use, the Ministry of Health should:

a. Fund additional transitional housing facilities with intensive supports;

b. Include forensic-targeted transitional multi-disciplinary supports with high staff to patient ratios in some MHA housing with permanent (non-transitional) tenure.

#12 The Ministry of Health and providers should continue to ensure that transitional forensic mental health housing:

a. Has supports such as case managers or personal support workers to address functional needs in activities of daily living (ADL) and adhering to treatment regimen;

b. Has close links with permanent supportive housing, and access geared to tenant readiness;

c. Applies evidenced based practices including risk assessment and client placement service planning;

d. Incorporates effective practices from the existing Transitional Rehabilitation Housing Program (TRHP);

e. Builds in priority access routes to permanent justice-focused supportive housing for those who need it.

#13 To support re-integration of persons leaving correctional facilities who are not forensic mental health clients but may need 24-hour onsite support, the Ministry of Health and providers should explore adapting the Forensic Transitional Housing Rehabilitative Program (TRHP) model to this population.

#14 Justice-specific MHA supportive housing providers should engage with the Toronto Safe Bed Network to build shared understanding of the housing and support needs of clients upon discharge from Safe Beds, and develop protocols for priority access to long-term justice-focused supportive housing.

#15 Justice-specific MHA supportive housing providers should consider prioritizing access for persons who are incarcerated and homeless, with very high needs and risk of recidivism.

#16 The Ministry of Health and providers should promote housing stability through policies, program rules, funding, and practices that enable residents to retain their housing during short-term incarceration (e.g. up to 3 months).

#17 The Ministry of Health and providers, in collaboration with the Ministry of the Attorney General and Ministry of the Solicitor General, should ensure that transitional housing for justice-involved, non-forensic clients:

a. Has time-limited tenure appropriate to each person's needs;

b. Has special access policies and practices for justice-focused supportive housing that ensures priority to people who are being discharged from custody, seeking bail, cycling between custody and shelters, temporarily residing in MHJ Safe Beds or in related situations;

c. Offers suitable post-incarceration supports;

d. Ensures priority access to permanent justice-focused supportive housing at the end of the transitional housing tenure, with continuity of needed supports.

#18 To lessen the barriers that justice-involved clients encounter in obtaining and retaining supportive housing, and mitigate related risks to providers, access systems and providers should:

a. Implement Housing First principles of direct access from homelessness to housing, minimal preconditions and no "treatment first" rule, and independent tenancies;

b. Develop protocols including 'situation tables' for people determined to have high risks or needs, to ensure that required specialized supports from partner agencies are available at the time of placement in housing.

#19 To address shortfalls in housing affordability, quality, and location, meet housing market opportunities, enable client choice and successful tenancies, and leverage intergovernmental resources, the Ministry of Health, City of Toronto, Ministry of the Attorney General and Ministry of the Solicitor General should fund and implement a dual housing delivery model of:

a. Rent subsidies with supports in private rental of decent quality (headleases or individual tenancies);

b. Non-profit-owned supportive housing.

#20 To address funding gaps in MHJ housing, the Ministry of Health should increase the amount of monthly rent supplement per unit to levels reflecting moderate market rents, and provide such subsidies on a long-term basis.

#21 To meet client needs and preferences and thereby foster stable housing tenure, the Ministry of Health and providers should provide most additional supportive housing in the form of self-contained apartments.

#22 The Ministry of Health and providers should promote social integration through diverse ways of providing housing, including:

a. Scattered apartments in private-sector or social housing for many residents, including two and three bedroom units for justice-involved people who are caring for their children;

b. Dedicated (project-based, single-site) non-profit-owned housing;

c. Avoiding clustering persons with higher criminogenic risks.

d. Units that are accessible to people with physical disabilities.

#23 To promote service coordination and continuity during and after a period of health system restructuring, Ontario Health Teams (OHTs) should work with Toronto justice-specific MHA service providers, the Toronto Mental Health and Addictions Supportive Housing Network, and The Access Point, to connect justice-involved supportive housing clients to community-based services and housing.

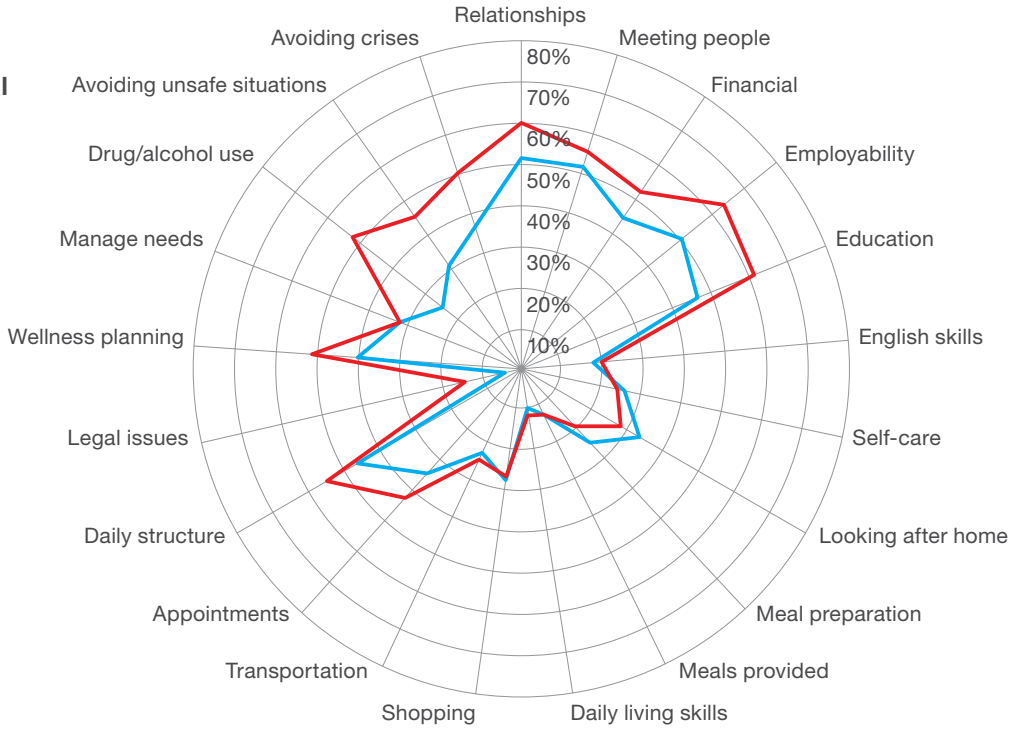
#24 The Ministry of the Attorney General and Ministry of the Solicitor General should review the findings and recommendations of this report, take related actions within their purview, and collaborate with the Ministry of Health and community-based providers on other actions as needed.

#25 The Ministry of Health and supportive housing providers should identify opportunities to use funds from the federal government's National Housing Strategy to increase the supply of supportive housing units.

#26 The Ministry of the Attorney General and Ministry of the Solicitor General should consider options for establishing bail residences, halfway houses, and/or related transitional accommodation, including appropriate supports for mental health and addiction issues.

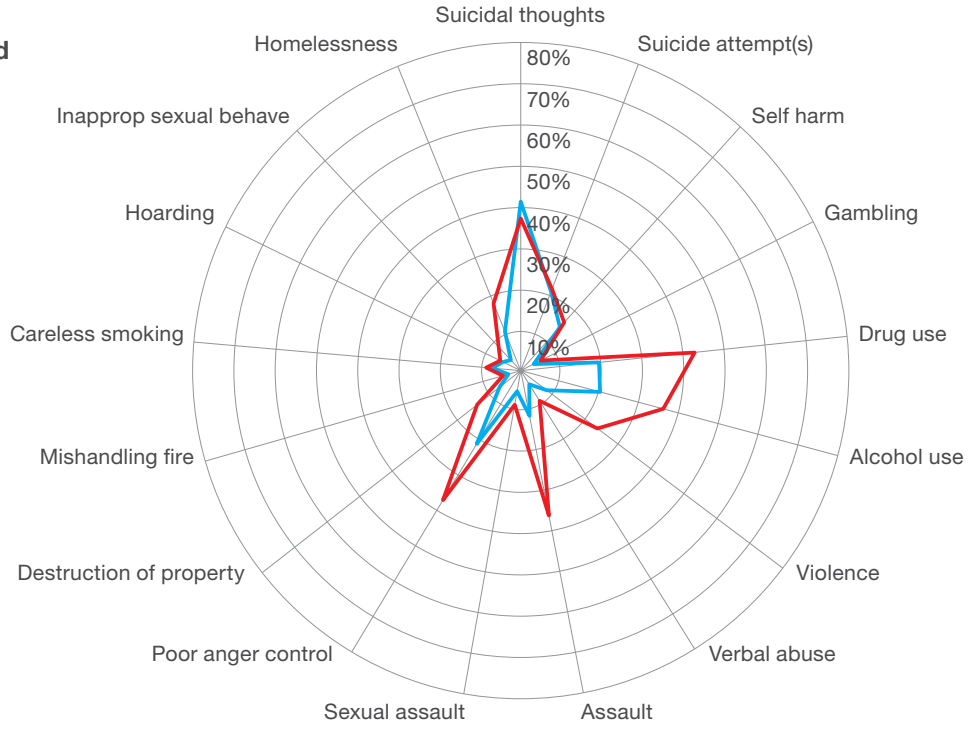
B: Need Profiles of Supportive Housing Applicants and Clients with Justice Involvement

Figure B1
Support Needs for Access Point Applicants with and without Criminal Justice Involvement (2009-2015)



- No criminal justice involvement (n=9,560)
- Criminal justice involvement (n=3,173)

Figure B2
Safety Risks for Access Point Applicants with and without Criminal Justice Involvement (2009-2015)



- No criminal justice involvement (n=9,560)
- Criminal justice involvement (n=3,173)

Figure B3

Staff-reported OCAN Needs (Met or Unmet) among Supportive Housing Clients in Toronto with and without Justice Involvement at First Assessment (N=918) (2011-2016)

- No criminal justice involvement (n=699)
- Criminal justice involvement (n=219)

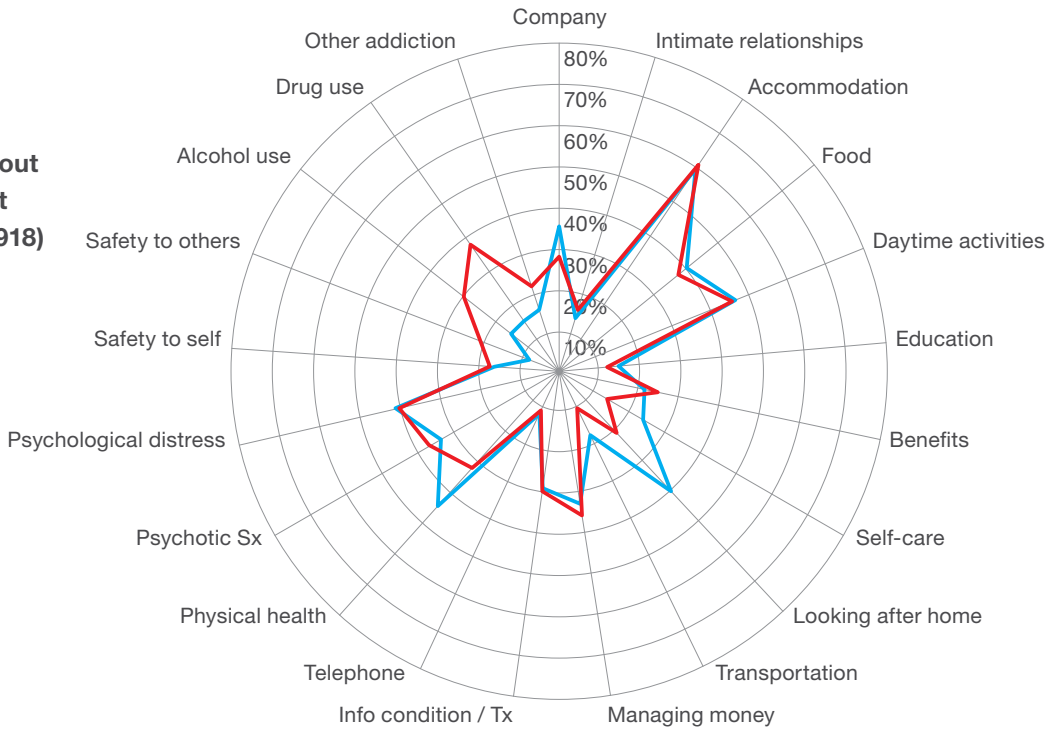


Figure B4

Comparison of Support Needs of Male and Female Access Point Supportive Housing Applicants with Criminal Justice Involvement (2009-2015)

- Males with justice involvement (n=2234)
- Females with justice involvement (n=823)

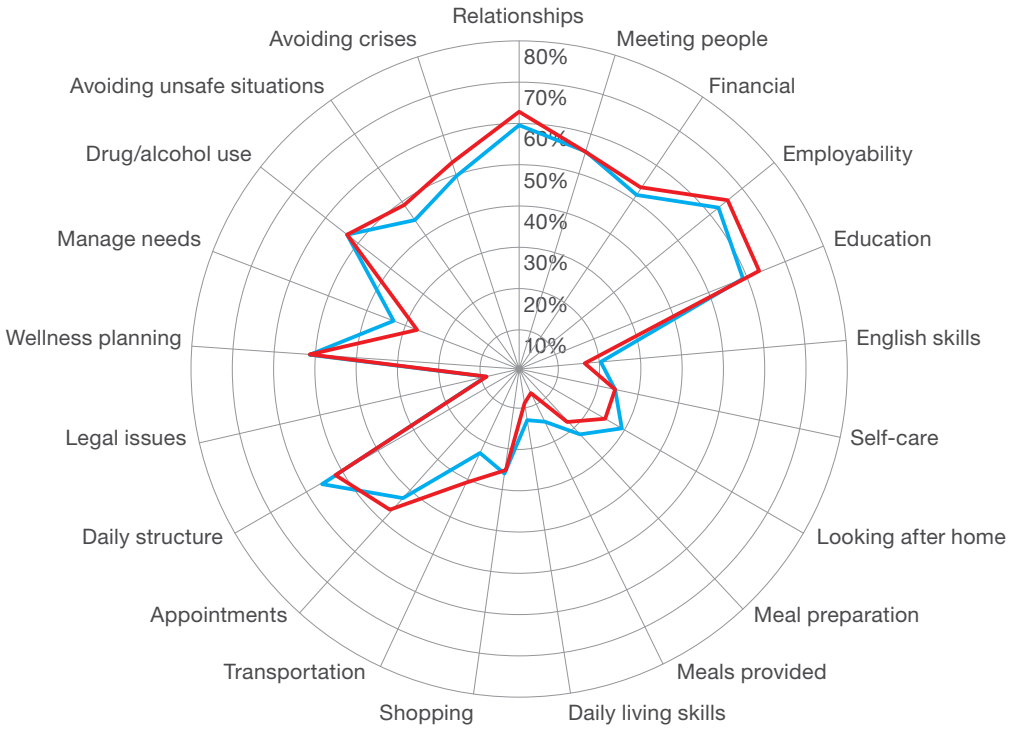


Figure B5

Comparison of Safety Issues for Male and Female Access Point Supportive Housing Applicants with Justice Involvement (2009-2015)

- Males with justice involvement (n=2234)
- Females with justice involvement (n=823)

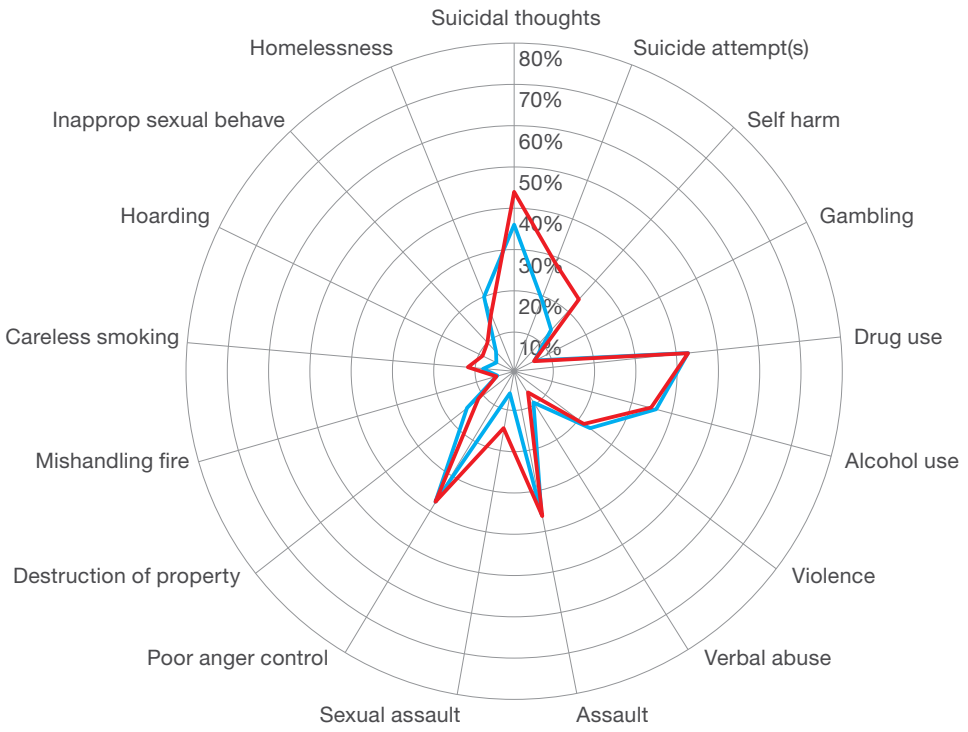


Figure B6

Comparison of Support Needs of Justice-Involved Supportive Housing Applicants with and without a Dual Diagnosis (Access Point 2009-2015)

- No Dual Dx and justice involvement (n=2830)
- Dual Dx and justice involvement (n=227)

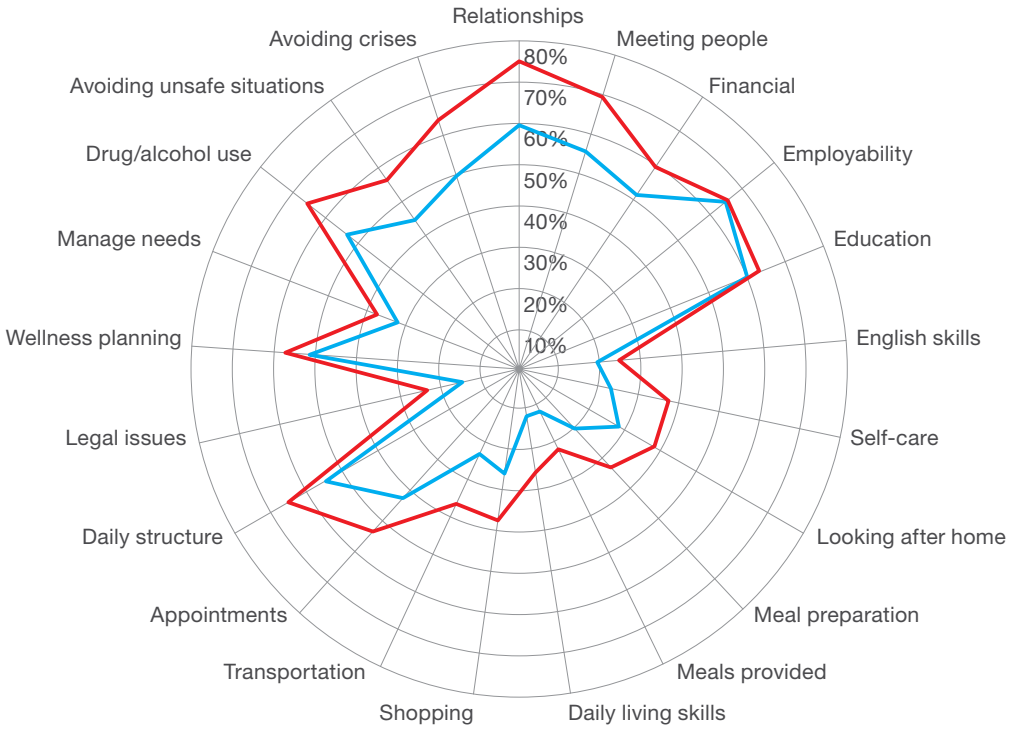


Figure B7

Comparison of Safety Issues of Justice-Involved Supportive Housing Applicants with and without a Dual Diagnosis (Access Point 2009-2015)

- No Dual Dx and justice involvement (n=2830)
- Dual Dx and justice involvement (n=227)

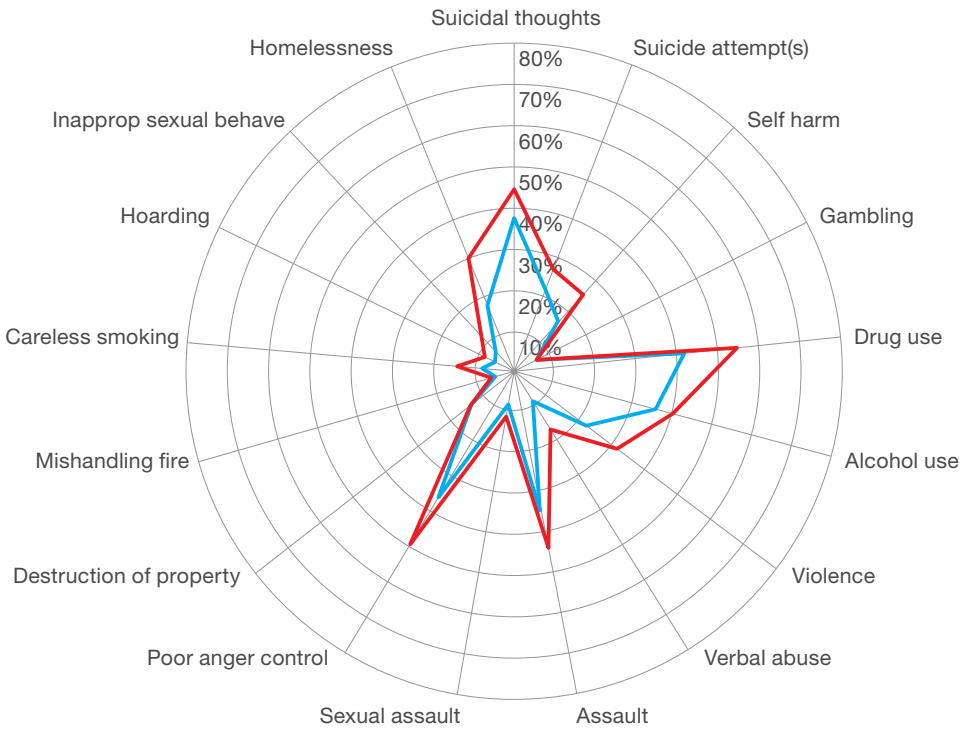


Figure B8

Support Needs of Forensic and Other Justice-Involved Supportive Housing Applicants (Access Point 2009-2015)

- Other justice involved applicants (n=2824)
- Forensic applicants (n=349)

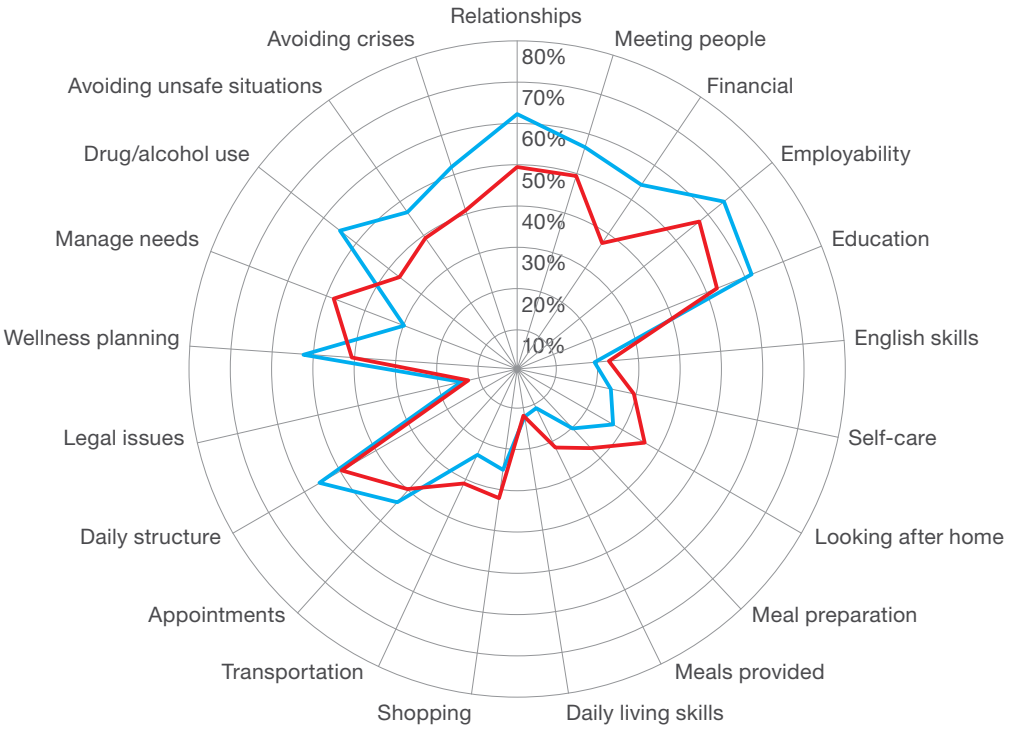
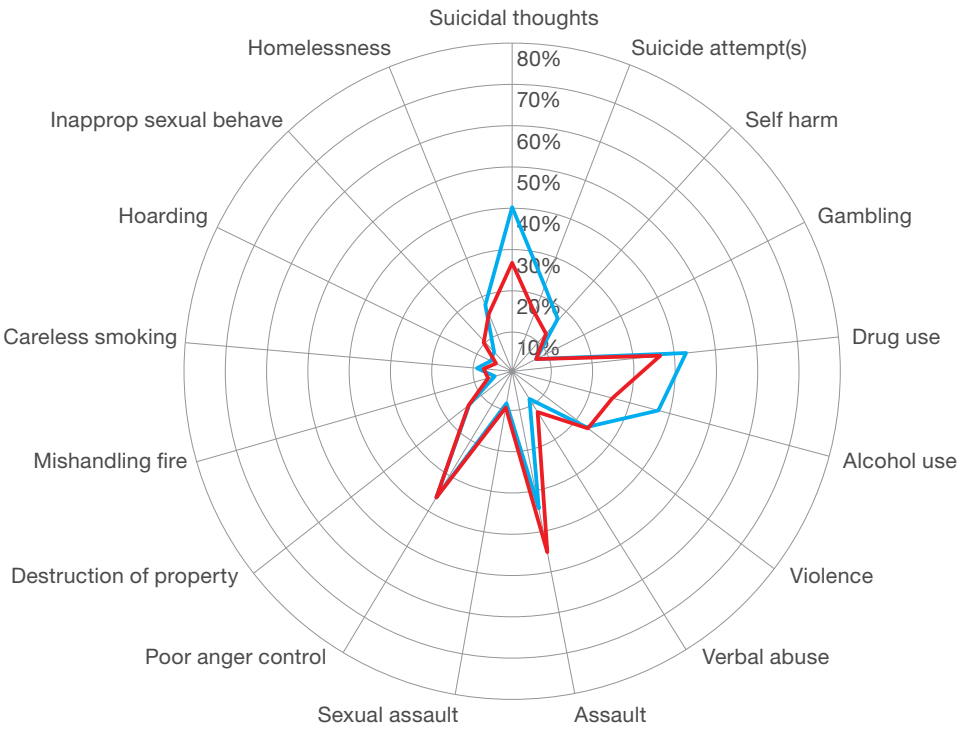


Figure B9

Safety Risks for Forensic and Other Justice-Involved Supportive Housing Applicants (Access Point 2009-2015)



- Other justice involved applicants (n=2824)
- Forensic applicants (n=349)

C: Key Informant Interview Guide

Domain	Themes or Subdomains	Prompt Question	Probes
Background		Can you tell me about your role at _____ and involvement with mental health and justice supportive housing?	(Direct Service Provider) • What is the main goal/purpose/mission of your organization? • How many tenants/clients do you support/house? • How long have you been operating an MHJ program? (Researcher/Policy Analyst etc.) • Can you tell me about recent or particularly important/ relevant MHJ projects that you/your organization have produced?

Housing and Support Needs	Current system
	Needs profile of MHJ clients
	Needs that remain unmet
		What are some of the particular housing and support needs that MHJ clients have?	• How do the needs of MHJ clients differ from supportive housing clients without criminal justice involvement?
			• What are some of the support needs of current MHJ clients that remain unmet?
			  • What do you think could be done to meet these needs? (partnerships, referral, increased capacity etc.)
			  • What are some service gaps that you have noticed?
			  • Are there services your clients need that you are unable to provide and have nowhere to refer them/ or long waitlists?
			• What population groups in need are the least well served?

Support – Successful Approaches (stable housing, improved health and well-being, reduced criminal justice involvement)	Outcomes Specific programs (e.g. MHJ, safe beds etc.) Collaborations (MCSCS & MOHLTC)	What are some of the best or most successful approaches to support and housing for MHJ clients?	• What housing models have worked best? (dedicated, scattered, congregate/single occupancy, temporary, safe bed etc.?) • What support approaches or intervention have worked best? (types of supports provided, staffing composition, intensity of supports) (intervention e.g. – motivational interviewing, stages of change, concurrent disorder supports) • How do successes vary for people with different types of needs? • How do you know if a program is successful? • Are there measurable outcomes that you can point to that demonstrate success? (e.g. housing stability, improved health and well-being, reduced criminal justice involvement etc.) • What other ways do you know a program is successful? • What collaborations between corrections-funded and health-funded community agencies have been beneficial?

Specialized populations (Indigenous, racialized/ black, youth, women, NCR…) (Justice involvement with addictions, with chronic homelessness, with CTO…)	Successful specialized approaches Specific considerations for various sub groups Gaps in services/unmet needs	Can you tell me about specialized approaches to supports and housing that you are aware of for sub groups with particular needs?	• Are there specialized approaches you can share for people who are disproportionately represented in the criminal justice system? (egg Indigenous, racialized/ black people) • Are there specialized approaches you are aware of for other groups with particular needs such as youth/ women/those with compound needs (addictions, homelessness, people with CTO etc.) • What are specific considerations for these (ones spoken about in last response) subgroups? • What are support needs that are not being met? • What are the needs of people immediately after discharge from incarceration? • What specialized approaches for housing have been successful? • What specialized approaches for supports have been successful?
Action Steps to Guide the Expansion of MHJ Housing in Toronto	Types of housing models Support models	When considering program expansion for MHJ supportive housing in Toronto – what do you think some of the next steps should be?	• What types of housing models should be the priority? • What best practices for supports should be a priority?
Project Next Steps	Literature Key people to talk to	Is there anything we didn't talk about today that you think I should know for this project?	• Are there any key pieces of literature/reports/documents that you can point me to? • Are there specific people who I should reach out to?

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