Building on Collaboration: Learnings from Toronto's Supportive Housing System

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Executive Summary

Mental health supportive housing relies on municipal-health sector collaboration. It straddles the Local Health Integration Network (LHIN) mandate of coordinating integrated local health systems and the municipal responsibility for local housing and homelessness initiatives.

In recent years, municipalities and LHINs have initiated collaborative work to address the overlap of their roles in supportive housing. However, the ongoing transformation of Ontario's health system presents obstacles for sustaining this collaboration. Sector reorganization can cause uncertainty about responsibilities and disruptions to collaborative projects.

For health system transformation to strengthen existing supportive housing collaboration, rather than diminish it, it will be important to apply the lessons learned to date about effective intersectoral collaboration. This project explores case studies of municipal-health collaboration in supportive housing in Toronto and captures the strengths and challenges experienced by collaborators. Learnings from these case studies can inform supportive housing collaboration under new coordination structures.

Interviews with key informants from the municipal, health, and community mental health sectors produced three central themes. The first theme focused on relationship building and system planning among senior leadership. The second theme focused on the delivery of joint supportive housing interventions through community agencies. The third theme drew these dimensions of collaboration together to discuss connections between the system and service delivery levels.

Theme 1: Bridging Health and Housing Systems

- The municipal and health sectors had a strong sense of shared population health priorities.
- Logistical challenges of bridging two systems included the misalignment of funding opportunities and budget cycles, and the need for one municipality to work with multiple health jurisdictions.
- Sectors had differing concepts of their health-and-housing responsibilities, where housing and homelessness sat uneasily within the health sector's more clinical mandate of mental health supports delivery.

Theme 2: Striking a Balance in Service Delivery

- Supportive housing providers had to balance planning ahead proactively, adjusting service delivery approaches in real time, and responding to contextual factors.
- Intentional planning and clearly defined complementary roles were seen as approaches to address Toronto's constrained housing market and funding context.
- Barriers to successful service delivery included restrictions on intersectoral data sharing and funder requirements for a single formalized (rather than flexible) intervention model.

Theme 3: Weak System-Service Delivery Links

- Limited connectivity between system-level and service delivery collaboration was observed.
- Collaboration was often dependent on sector champions to drive efforts, rather than formal collaborative structures.
- Collaborative planning processes ended up as forum for information sharing rather than implementing interventions, since there was no funding to allocate to service delivery.
- Supportive housing providers felt insufficiently engaged in system planning and faced a resource trade-off between collaborative process participation and service quality.
- Uncertainty about long-term funding at the system level resulted in pilot or short-term initiatives that could not be sustained.

The findings of this project emphasize the importance of viewing intersectoral collaboration at the system level and the service delivery level as interrelated components of the supportive housing system. With a growing context of collaboration and strong agreement on population health priorities, recent progress on supportive housing can be carried forward in the ongoing priority-setting and planning of the health system.

Opportunities for collaboration in supportive housing are timely. Ontario's recent funding commitments in mental health and the City of Toronto's *Housing TO 2020-2030 Action Plan* encourage collaboration across governments on supportive housing. Coordination of these intersectoral opportunities can facilitate an expansion of Toronto's supportive housing system that optimizes resources and enacts a common vision for health in the City.

Introduction

Municipal and provincial mandates have considerable overlap in addressing high-needs populations, including people experiencing mental health and addictions issues.[1,2] While clinical health services are a provincial responsibility, these services rely on social support systems and other policy and programs areas that are partly municipal responsibilities. The coordination of these overlapping program and policy spheres is central to acting on the social determinants of health and reducing health disparities.

Supportive housing for people experiencing mental health and addictions issues is a key area of municipal-health sector intersection.[1,2,3,4] In this report, supportive housing refers to any combination of housing and support services for people with mental health and addictions issues that aims to manage health and maintain stable tenancies.[a] This includes a range of approaches across housing sectors (e.g. private rental, social housing) and supports models (e.g. bundled and not bundled with housing, case management, tenancy supports).

Over the last decade, municipalities and Local Health Integration Networks (LHINs) have initiated collaborative work to address the overlap of their roles in supportive housing. With the provincial health system transformation in progress, there is an opportunity to apply the lessons learned in this recent collaboration to new coordination structures. This report examines five Toronto-based cases of municipal-health sector collaboration in supportive housing to inform future coordinated action on mental health supportive housing.

Background

Mental health supportive housing is essential to reducing chronic homelessness and meeting the provincial government's goal of ending hallway medicine.[3,6,7] Unstable housing, lack of access to community supports, and mental health issues are significant contributors to emergency room usage and hospital readmissions.[8] In Ontario, over 9% of people who have been waiting in hospital for more than 30 days for an alternate level of care (ALC) are those with complex mental health needs, who could be transitioned to supportive housing for more appropriate and less costly support services.[6,9]

Supportive housing relies on municipal-health sector collaboration. It straddles the LHIN mandate of coordinating integrated local health systems and the municipal responsibility for coordinating local housing and homelessness initiatives.[2,10,11,12,13] The Ministry of Health and Long-Term Care (MOHLTC) and LHINs, the Ministry of Municipal Affairs and Housing (MMAH), and municipalities all fund and/or coordinate parts of Ontario's supportive housing system.[4,14]

In recent years, municipalities and LHINs have expanded and formalized their collaborative relationships, including those in supportive housing.[2] This collaboration has spanned from relationship-building and system planning among senior leadership to the delivery of joint supportive housing interventions through community agencies.

The ongoing shift in Ontario's health system to local service delivery by Ontario Health Teams[b] and system coordination by regional entities and Ontario Health[c] presents obstacles for current supportive housing collaboration. Sector reorganization can cause uncertainty about activities and responsibilities; changes in staff, department or service boundaries; and disruptions to collaborative planning and projects.[15] Carrying forward current collaboration is important for supportive housing because partnerships between the medical and social systems can facilitate the development of adequate and appropriate interventions, equitable service access, and reductions in program duplication.[16,17]

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[a] This definition is drawn from previous Wellesley Institute publications on supportive housing, including Taking Stock of Supportive Housing for Mental Health and Addictions in Ontario (Suttor, 2016) and Promising Practices: 12 Case Studies in Supportive Housing for People with Mental Health and Addictions Issues (AMHO, CMHA, Wellesley Institute, 2018).

[b] Ontario Health Teams (OHTs) are groups of health care providers that coordinate and deliver services to a geographically defined patient population. This model was introduced by Ontario in 2019 to promote coordinated, accountable, and efficient health care, with a first cohort of 24 OHTs announced in late 2019 and future cohorts being rolled out in 2020 onward.

[c] Ontario Health is the provincial agency charged with oversight of health care delivery, quality, and performance as of 2019. The agency includes previous provincial health agencies – Cancer Care Ontario, Health Quality Ontario, eHealth Ontario, Trillium Gift of Life Network, Health Shared Services Ontario, HealthForceOntario, and the non-home and community care functions of the 14 Ontario Local Health Integration Networks.

For health system transformation to sustain and strengthen existing supportive housing collaboration, rather than diminish it, it will be important to apply the lessons learned to date about effective municipal-health sector collaboration. However, there has not been an effort to examine recent experiences in supportive housing collaboration and document these learnings.

This project aims to address to this gap by exploring case studies of municipal-health sector collaboration in supportive housing in Toronto and capturing the strengths and challenges experienced by collaborators.

Methods

This project was made up of four stages: (1) expert consultations to identify case studies; (2) key informant interviews to gather firsthand experiences with municipal-health collaboration in supportive housing; (3) a document review to supplement key informant remarks; and (4) a facilitated discussion session for experts to comment on emerging findings. These stages are detailed below.

Expert Consultations

To better understand the current collaborative context in Toronto's supportive housing system, four supportive housing experts were consulted. These experts were selected from existing Wellesley Institute contacts to gather perspectives from four stakeholder organizations: the City of Toronto, a Toronto-area LHIN, the MOHLTC, and a community mental health agency.

Consultations included unstructured discussion on municipal-health collaboration in supportive housing and recommendations of supportive housing cases (and corresponding documents and key informants) to be examined.

Consultations provided a set of fifteen Toronto-based cases to consider for inclusion in the project (Appendix A). Documents on these cases were examined to identify collaborations that: (a) connected to supportive housing, (b) involved clear municipal-health sector partnership, and (c) had resources available (e.g. key informants, written materials) for analysis. Five cases met these inclusion criteria and were included in the project (Table 1).

Key Informant Interviews

Semi-structured interviews were conducted with 15 key informants from the municipal (n=3), health (n=5), and community mental health (n=7) sectors to learn about experiences with municipal-health sector collaboration in supportive housing. A list of potential key informants was generated from: expert recommendations during consultations; documents reviewed to select cases; and research team expertise in Toronto's supportive housing system. The final set of key informants was selected because of their significant involvement with one or more of the collaborative cases described in Table 1 and to represent a range of roles in the supportive housing system (e.g. policy officers, system planners, program managers).

A master interview guide was developed with open-ended questions to collect details of the included cases and key informant experiences with collaboration. Key informant interview guidelines informed the structure of the guide.[21] Topics of discussion included key informants' roles in collaborative work; the components, strengths, and challenges of the selected cases; and lessons learned about municipal-health sector collaboration in supportive housing. The specific questions used in each interview were drawn from the master guide and tailored to reflect key informants' experience with or knowledge of specific cases.

Recruitment occurred through direct email invitation to participate in an interview. Interviews were held in key informants' place of work, lasted approximately one hour, and were audio-recorded. The researcher conducted all interviews.

Table 1: Description of included collaborative cases

Collaborative Case	Description
City of Toronto – 5 GTA LHIN Leadership Table[18]	Intersectoral table established in 2013 to coordinate collaborative action on key health, community, and social issues in Toronto. Membership included senior leadership from the 5 GTA LHINs (Toronto Central, Central East, Central, Central West, Mississauga Halton), 7 City divisions (Toronto Paramedic Services, Toronto Employment and Social Services, Long-Term Care Homes and Services, Parks, Forestry and Recreation, City Planning, Shelter, Support and Housing Administration, Social Development, Finance and Administration) and 3 City agencies/corporations (Toronto Community Housing Corporation, Toronto Police Services, Toronto Public Health).
Resilient Tenancy and Services Work Group[19]	Work group established in 2015 out of the City of Toronto – 5 GTA LHIN Leadership Table, with representatives from the 5 GTA LHINs and the City divisions of Shelter, Support and Housing Administration and Social Development, Finance and Administration. Members aimed to develop opportunities to align municipal housing allowances and health-funded supports funding, though a draft joint request for proposals (RFP) was never implemented.
Health-Funded Supports in Toronto Community Housing[20]	Series of initiatives, beginning with a pilot project at 291 George St in 2013 and expanding to other locations, in which health-funded community agencies partner with Toronto Community Housing staff to deliver supports to clients/tenants and buildings with complex needs.
Health-Funded Supports in City-Delivered New Affordable Rental	Model of supportive housing in which developers or non-profit housing providers receive municipal capital funding to develop affordable housing, and then arrange with health-funded community agencies to deliver supports to clients/tenants.
Provider Pairing of Health-Funded Supports and Municipal Housing Allowances	Model of supportive housing in which supportive housing providers obtain support funding from the LHIN and housing allowances/rent supplements from the City and put these together to deliver supports to clients/tenants in affordable housing units.

The key informant interview plan was assessed by the Ryerson University Research Ethics Board (REB) and determined not to require REB review due to the project objective and nature of the interview questions. An internal ethics protocol was followed to obtain participant consent and maintain confidentiality in line with the principles of the TCPS. No compensation was provided for participation.

Audio recordings were used to prepare notes on each interview. Thematic analysis was applied to identify patterns in the data.[22] Interview notes were examined independently by the researcher and a research supervisor to generate common ideas emerging from the interview data. These common ideas were discussed to unify and reach consensus on observations and then collated into broader themes. The research team consulted their research director to review the interview notes alongside identified themes and validate that they reflected one another.

Document Review

A review of organizational documents and grey literature was conducted to corroborate descriptive details of key informant interviews and supplement information on included collaborative cases. Documents were collected through expert and key informant referrals and targeted website browsing.[23] Specific reference to municipal-health sector collaboration in supportive housing in the Toronto context[d] was required for inclusion in the review.

Included documents (*n*=42) represented a variety of sources and document types (e.g. meeting minutes, requests for proposals, white papers, partnership agreements) and thus, the approach to extract information reflected this patchwork of materials. Summary notes were prepared on each document, with details elaborated for information directly relevant to the research focus and interview themes. The document review was not intended to be comprehensive, nor was it used to generate themes; its role was to substantiate, corroborate, extend, and situate the interview data.

Facilitated Discussion Session

Following preliminary analysis of key informant interview data, a group of multisector supportive housing experts (*n*=6) participated in a facilitated discussion session on emerging results. Invited experts were selected from existing Wellesley Institute contacts closely involved in supportive housing work and to represent the three sectors (municipal, health, community mental health) involved in the project. Themes from key informant interviews were shared and attendees provided feedback on their accuracy and alignment with their experiences. Overall, expert comments validated the findings of this project.

Results

During consultations, experts noted two distinct levels of ongoing intersectoral collaboration:

- **System-level collaborative processes:** Collaboration among senior leadership aimed at building relationships between sectors and setting joint priorities for population health, often through planning tables or working groups.
- **Collaborative service delivery initiatives:** Collaboration among community agencies to implement jointly funded and delivered supportive housing interventions.

The two levels were seen by experts as parallel streams of collaboration, with uncertainty about the presence or strength of connections between them. This distinction was used to structure the project's findings.

Three central themes emerged from key informant interviews (Table 2). The first theme focuses on system-level collaboration among senior leadership and explores the often-challenging experience of bridging the health and municipal housing sectors. The second theme connects to service delivery collaboration, highlighting the competing needs and contextual factors that facilitated or inhibited collaborative supportive housing initiatives. The final theme draws these dimensions of collaboration together to comment on the connections, or lack thereof, between the system and service delivery levels.

[d] Documents with an Ontario-wide focus were included in the review if they contained examples of Toronto-specific collaborative work or had direct implications for work to be carried out by Toronto supportive housing stakeholders.

Table 2: Summary of interview themes

Theme	Collaboration Level	Primary Case	Description
Bridging Health and Housing Systems	System-level collaborative processes	Resilient Tenancy and Services Work Group	Challenges of coordinating a system that straddles municipal housing and health responsibilities
Striking a Balance in Service Delivery	Collaborative service delivery initiatives	Health-Funded Supports in Toronto Community Housing	Competing needs of supportive housing initiatives to plan ahead, adjust in real time, and respond to contextual factors
Weak System-Service Delivery Links	Connections between system-level processes and service delivery initiatives	N/A	Lack of infrastructure or frameworks to connect system-level collaboration with service delivery collaboration

During key informant interviews, two of the five included cases emerged as having richer data: the Resilient Tenancy and Services Work Group and the provision of health-funded supports in Toronto Community Housing (TCH). Therefore, these examples are each considered the *primary case* of their respective level of collaboration within the project's findings. Document review information is discussed in this section in the context of key informant interview findings.

Theme 1: Bridging Health and Housing Systems

Primary Case – Resilient Tenancy and Services Work Group

The Resilient Tenancy and Services Work Group was created by senior leadership from the City of Toronto and TC-LHIN as part of series of collaborative tables to address key municipal-health intersections. Its aim was to build opportunities to align municipal housing allowances with health-funded support services. Representatives came from the five GTA LHINs and the City divisions of Shelter, Support and Housing Administration and Social Development, Finance and Administration. The main project of the Work Group was to develop a joint Request for Proposals (RFP) that would allocate both City housing allowances and LHIN-funded supportive housing services through a single application process. To inform this work, a Request for Information (RFI) was sent to agencies providing housing and support services in order to create an inventory of projects that combined the two funding sources. The RFI response was strong and shaped the planned priority themes for the RFP – seniors aging in place; individuals experiencing homelessness and mental health, addictions, and/or complex health issues; and individuals in transition from emergency or institutional care. While the planned RFP went through several drafts, it was ultimately not implemented due to funding commitment challenges.

Key informants from the municipal and health sectors described system coordination as a complex endeavour, where two sectors had to be bridged to act on the single intervention of supportive housing. Interview discussions emphasized difficulties with navigating work that straddled the municipal housing and health systems. The level of intersectoral collaboration necessary to make progress on supportive housing planning and priority-setting was seen as intensive. Elements to bridge spanned from the priorities and paradigms that each sector operates under to the logistics of developing opportunities and procedures to collaborate.

Ease of reaching shared priorities
According to key informants, initial priority-setting exercises to set the context for collaboration proceeded positively; there was prompt recognition that the City and LHINs were aiming to address the same vulnerable populations and issues. Reaching a common vision for population health and related overarching priorities was described as an easy first step in this system-level collaboration – sometimes to the surprise of participating key informants, who anticipated sector silos would create challenges for alignment.

Different sector concepts of health-and-housing
Movement from general priority-setting to focused planning created new challenges for bridging; here, key informants felt that sector-specific paradigms and definitions of supportive housing created barriers for collaboration. They noted LHINs' narrower, more clinical conceptualization of supportive housing that concentrated on mental health and addictions service delivery, which left housing and homelessness as issues that sat uneasily within the health sector mandate. Shared responsibility for supportive housing was hindered by viewing populations as either the City's responsibility (i.e. those experiencing or exiting homelessness) or the LHIN's responsibility (i.e. those receiving provincially funded health supports).

This divide was less present in the reviewed documents. A population-based planning approach put forward by TC-LHIN in 2009 identified people who are homeless as a priority group and targeted the first of a series of multi-sectoral mental health and addictions forums to homelessness.[24] TC-LHIN also produced a report recognizing housing as a key social determinant of health, with a role for LHINs to play in preventing homelessness and supporting housing stability.[25] Documents from LHINs' collaborative planning acknowledged supportive housing as a tool to act on health system priorities, such as reductions in emergency room visits and ALCs.[19,26,27,28] Yet these documents also raised challenges about sectors operating under conflicting models of service delivery (i.e. medical model vs. social service model) and lacking common terms and definitions to facilitate shared understanding. The nuance of these definitions was seen throughout the development process of the Resilient Tenancy and Services Work Group's proposed joint Request for Proposals (RFP), which initially restricted the funding opportunity to health service providers, but later permitted applications from any non-profit agency.[19,29]

Misalignment of funding opportunities and budget cycles
Bridging the municipal housing and health sectors was also discussed by key informants on a practical level, with concerns about the misalignment of City and LHIN funding opportunities and budget cycles. With decisions about annual spending being made at different times of year in each sector, it felt incredibly ambitious to coordinate nondiscretionary funding allocations. Attempts to create joint funding opportunities were described as succumbing to a similar pattern: one sector would establish an idea, offer partial funding, and request for the other sector to contribute the remaining resources – but by the time that sector could identify and commit the requested funds, the opportunity for the initial sector to participate would have passed. Key informants viewed these logistical roadblocks as preventing system-level processes from meeting their objectives. The Resilient Tenancy and Services Work Group was specifically created to align funding opportunities, yet this objective proved too difficult to meet even within a dedicated forum.[29] The significance of this funding misalignment for supportive housing was noted in the City's 2015 progress report on *Housing Opportunities Toronto*, which identified the Work Group as one of four key action items to help homeless and vulnerable people find and maintain housing.[30]

As part of these budget challenges, key informants also commented on the level of government that should be responsible for collaboration between the municipal housing and health sectors. With the main resource allocation decisions occurring at the Ministry level, prerequisites for collaboration were considered to be outside the control of those participating in collaborative processes. In the eyes of key informants, it was the MOHLTC and the MMAH who held the power to enact timely larger-scale funding changes and dictate explicit collaborative protocols. An example of this decision-making structure was seen in the MOHLTC's directive to permit coordination of their supportive housing rent supplements with City-administered affordable housing programs, where a Ministry procedure change created a new opportunity for securing affordable rents.[31]

Interplay of multiple health geographies

Throughout system-level collaboration, the City had to bridge itself across five distinct health jurisdictions – the five LHINs that fall within its geographic boundaries. A municipal sector key informant outlined their experience of trying to convene a collaborative table involving all five GTA LHINs: the City had to engage with five different reporting structures, five different funding pools, and five different approval processes, creating a significant administrative burden. Key informants also indicated that working with multiple health geographies allowed for differential participation between LHINs, some with waning attendance over time. In the case of the Resilient Tenancy and Services Work Group, it was mentioned that only two LHINs regularly participated in the process, corroborated by attendance records and outstanding communications about some LHINs' commitments to the planned joint RFP.[26,29]

Theme 2: Striking a Balance in Service Delivery Initiatives

Primary Case – Health-Funded Supports in Toronto Community Housing

The provision of health-funded supports in Toronto Community Housing (TCH) began as a pilot project in 2013 at 291 George Street – a building adjacent to Seaton House with high rates of police and community safety unit calls, poor housekeeping, arrears, vacancies, and emergency room use. To address these challenges, Toronto Central LHIN (TC-LHIN) funded an innovative model of on-site support, comprised of a mental health worker (via Houselink), a community development worker (via Fred Victor), unit cleaning, and building maintenance. TCHC provided the team with an office in the building and increased its security. Other key partners worked closely with support staff to carry out the initiative – Toronto Police Services, the Inner City Health Program at St. Michael's Hospital, Seaton House, and local City councillors. After its initial year, the pilot yielded several positive outcomes: police and community safety unit calls decreased, tenants were linked with health care providers and supports agencies, pest and cluster issues were largely eliminated, evictions were prevented, and community activities saw higher participation. To sustain its impact, the pilot project was made permanent at George Street and initially expanded to two nearby buildings – though positive outcomes were not observed to the same degree at these sites. In the years since, the model has been systematized and replicated across TCH's portfolio with several health-funded providers responsible for delivering supports.

A second theme pertained to service delivery collaborations, where municipal housing and health partners were implementing a community-level supportive housing initiative. Key informants spoke to the components that had either strengthened or posed challenges for their collaborative work. Viewed together, these described the balancing act of supportive housing initiatives to plan ahead proactively, adjust service delivery approaches in real time, and respond to contextual constraints.

Intentionality and complementarity

Intentionality – acting deliberately and proactively to achieve a pre-determined objective – emerged as an important component of collaborative service delivery initiatives. Key informants recognized that Toronto's constrained housing market and multiple supportive housing funding streams often left providers scrambling to make quick decisions, improvise solutions, and create ad-hoc partnerships. They noted that this reactive approach exacerbated predictable challenges of service collaborations, like role confusion, unclear communication channels, and funding sustainability. Key informants saw purposeful planning to optimize resources (e.g. MOUs, partnership agreements) as a way to mitigate these challenges.

Complementary roles were also seen as part of intentional service delivery. Key informants emphasized that each collaborator's role should be clearly defined and based on organizational expertise to avoid duplication. They viewed this as a strategy to ensure collaboration was motivated by the value added by each organization, rather than convenience, funding requirements, or the optics of working across sectors.

Support for intentionality and complementarity was echoed in the reviewed documents. In multi-site case studies of the TCH supports initiative, staff suggested establishing role clarity and expected outcomes from the onset, with

deliberate planning to account for what services are already available and what gaps needed to be filled.[32,33] These ideas are reiterated in the key learnings from a province-wide survey of LHINs, which found that successful intersectoral collaborations require pre-implementation planning of role division and procedures for addressing day-to-day operational issues.[34]

Data sharing restrictions

Service delivery initiatives were impacted by limitations on data sharing between sectors. In Ontario, only authorized health care practitioners and organizations are permitted to access personal data collected during health service delivery, and disclosure of this data requires patient consent. When providing supports in TCH, key informants reported that health service providers were unable to share certain data with their TCH counterparts, even when working with the same client/tenant. Restricted information flow meant partners could not pool data to inform service delivery and further reinforced silos between sectors. Reviewed documents repeat this concern, with planning materials from the TCH initiative citing privacy breaches as a risk of the intervention model and identifying legal consultation and information release protocols as mitigation strategies, analogous to recommendations about supports in social housing from the Mayor's Task Force on Toronto Community Housing and the Ontario Non-Profit Housing Association.[20,35,36]

Flexibility versus codification

According to key informants, service delivery initiatives involved a balancing act between flexible approaches that could adapt to building-specific needs and funder requirements for a formalized initiative model that would allow for expansion to additional sites. In the George Street pilot, several key informants attributed the improvements in police calls, housing stability, service referrals, and other indicators to the autonomy and flexibility of LHIN staff working on the mental health and addictions portfolio. Interview comments from both the health and community sectors highlighted the freedom and institutional support in place to develop new partnerships and test innovative service delivery approaches, allowing them to discover in real time what worked best for the building.

When interest in expanding the initiative arose, along with the need to secure additional funding, it required codifying features of a service delivery model that could be replicated elsewhere. However, key informants perceived some of the expansion sites to be less successful than the initial George Street initiative, associating the codification of a service delivery model with a reduced ability to adapt supports to the unique context and needs of each building. This 'cookie-cutter approach' was discussed as producing a fundamental tension of the work, where the features that facilitated the discovery of successful service delivery (i.e. flexibility) contrasted with those that lent themselves to efficiently scaling and sustaining the initiative (i.e. codification). Key informants noted that collaborative supportive housing initiatives must balance these two elements, a view affirmed by a TCH statement that the approach used at George Street should not be taken as the universal solution for high needs buildings, as each site will necessitate its own service model.[37]

Theme 3: Weak System-Service Delivery Links

The idea of connections between system-level and service delivery collaboration did not resonate strongly with key informants. Their observations pointed to a system with limited connectivity between the two levels of collaboration. While system-level processes strengthened relationships and developed shared priorities among senior leadership, these activities did not directly facilitate or fund community-level supportive housing initiatives. Key informant remarks signalled weak system-service delivery links, evidenced by planning processes that were unable to move through to an implemented initiative and barriers to mutual support between concurrent system- and service-level collaborations. Discussions on connected collaboration referenced language from the City and TC-LHIN's *Partnership for a Healthier Toronto*[e], where intersectoral activities are described as 'threads' that connect the municipal and health sectors, with a need to be woven into the 'cloth' of strategic and operational collaboration.[2]

[e] A framework signed by the City of Toronto and TC-LHIN in 2017 to formalize existing collaboration and coordinate a sustainable, strategic approach to collective action on the social determinants of health. The Partnership outlines three primary areas of intervention: planning for population growth and demographic change; effective, coherent program delivery; and advancing population health.

Dependence on sector champions

An indication of weak links between levels of collaboration was the reported importance of sector champions. Several key informants recounted experiences where collaborative work would not have happened without a champion – a vocal advocate for collaboration, who holds sway in decision-making and is motivated to spearhead efforts and mediate the municipal housing and health worlds. Champions were found in both sectors and both levels of collaboration; their key feature was having strong relationships with a variety of supportive housing stakeholders. This allowed them to secure commitments from multiple entities and understand differences in sector cultures. As a key informant from the community sector noted, champions can be useful in driving collaboration, but this approach may indicate a lack of formalized collaborative rules.

Lack of resources dedicated to system-level processes

Weak system-service links were also illustrated by key informants' descriptions of collaborative processes being used primarily for information sharing, rather than moving into co-funding and implementing supportive housing initiatives. Key informants associated this disconnect with the absence of resources to tie the system-level and community-level together – senior leadership would express interest and agreement in pursuing certain collaborative initiatives, but there was no budget allocated to do so. Key informants considered a discretionary funding pool linked to system-level processes a prerequisite for undertaking action items. Documents from the RFP development process of the Resilient Tenancy and Services Work Group depict this barrier; even as work progressed to solidify the RFP's parameters (e.g. eligibility criteria, submission deadlines, administration protocols), funding commitments for the initiative remained marked as unknown.[19,29,38]

This barrier impacted service delivery initiatives further by creating a resource trade-off for providers. They described how finite resources had to be split between participation in system-level processes and providing quality services. This trade-off occurred for both human and financial resources; key informants from the community sector reported the challenging expectation of attending processes as an in-kind commitment and the time burden on staff of identifying and participating in multiple system-level processes. Community sector key informants found themselves needing to make difficult prioritization decisions, demonstrating how system-level collaboration did not always act to support service delivery collaborators.

Provider engagement in system-level processes

Key informants noted insufficient engagement of providers at the system level. Providers were aware that the City and the LHINs were meeting often to discuss mutually relevant topics, yet they only rarely saw an invitation to the table or tangible progress as a result. Key informants acknowledged that some system-level discussions had limited relevance to service delivery, however, they felt others may have missed valuable community sector perspectives on resource needs, effective service approaches, and adjustments to existing initiatives – losing an opportunity to link the two dimensions of collaboration. Interview comments also raised the frustration that supportive housing decision-makers seemed to be exclusively senior leadership or policy officers, omitting the provider perspective, and thus weakening the connection between system-level and service delivery collaboration.

A strong example of provider engagement identified by some key informants and present in the document review was the Resilient Tenancy and Services Work Group Request for Information (RFI).[39] As a starting point of this system-level process, an RFI was put out to providers to share current and planned collaborative initiatives that combined City-funded housing allowances and LHIN-funded support services. The aim of this RFI was to develop an inventory of service delivery practices that could inform joint planning of the Work Group. Responses to the RFI shaped the priority themes and populations for their planned joint RFP, expressing system-level recognition of provider knowledge and, had the RFP proceeded to implementation, creating a link between collaborative dimensions.[26]

Service funding sustainability as product of system context

A final indication of weak links between system and service delivery collaborations discussed in interviews was the relationship between initiative success and funding. Key informants often raised the issue of funding sustainability for health-funded supports in TCH. This initiative was marked by several pilots, one-time or repeated short-term funding allocations, and a budget model that meant reduced supports once the pilot phase of 'building stabilization' was complete.[20,35,40] Key informants saw this decrease in support levels as working against sustaining the positive

outcomes observed in the pilot phase, for the long term. This challenge was thought to arise from operating within a system context where municipal-health sector collaboration was subject to uncertainty around long-term funding commitments. Key informants saw a resulting disconnect between the two levels of collaboration, in which the system level was unable to predict the length of its collaborative relationship or its funding, while service delivery success was dependent on consistent funding commitments to run long-term initiatives.

Discussion

Key informant reflections on selected cases of municipal-health sector collaboration in supportive housing offered insights into two distinct levels of collaborative work, each with its own strengths, challenges, and opportunities. In system-level collaboration among senior leadership, there was a contrast between the strong sense of shared population health priorities and the differential conceptualizations of supportive housing rooted in clinical versus social paradigms of health. Logistical challenges for system-level collaborative processes included the misalignment of municipal and health sector funding opportunities and budget cycles, along with the interplay of one municipality working across multiple health jurisdictions and the ultimate decision-making power held by the Province.

In service delivery collaboration, intentional planning and clearly defined complementary roles were seen as approaches to address Toronto's constrained housing market and funding context. Key informants saw restrictions on intersectoral data sharing as a barrier to successful supports delivery and a reinforcer of municipal-health silos. The provision of health-funded supports in TCH was subject to a difficult balancing act between flexible service delivery approaches that could adapt to building-specific needs and funder requirements for a formalized model that would allow for expansion to additional sites.

Key informant comments indicated limited connectivity between system-level collaboration and service delivery collaboration. Sectors relied on champions to kickstart collaboration, but without funding to allocate, collaborative processes ended up as a forum for information sharing rather than implementing interventions. Supportive housing providers described their insufficient engagement in system planning, while facing a resource trade-off between collaborative process participation and service quality. Weak system-service delivery links were underscored by challenges with funding sustainability, where uncertainty about system-level collaborative relationships and resources trickled down to produce pilot or short-term initiatives without long-term impact.

The distinction between system-level and service delivery collaboration, and the role of connections between them, is in line with literature on *horizontal* and *vertical* forms of collaboration.[16] *Horizontal collaboration* consists of partners situated at the same level (e.g. different sector organizations delivering community-level services). In contrast, *vertical collaboration* consists of partners across different levels (e.g. federal and provincial governments planning a policy or strategy). Horizontal collaboration can allow for optimizing existing resources and expertise, while vertical collaboration can allow for consistent policy frameworks, sustainable funding structures, and integration across policy implementation.[16] The importance of vertical collaboration in supportive housing and population health is highlighted in previous case study research, where effective intersectoral collaboration involved interconnected system-level and community-level solutions and integration across policy and service interventions.[15,41]

The findings of this project are consistent with the literature on the strengths and challenges of intersectoral collaboration on population health issues. Key informants' experiences align with evidence on facilitators of intersectoral collaboration with the health sector: a common vision for health and wellbeing; an effective mix of partners with clear understanding of roles and responsibilities; aligned mandates with a common language; and a collaborative champion to sustain support.[15,16,42,43,44] Similarly, many of the challenges described in this study overlap with previous findings on barriers to collaborating with the health sector. These include data sharing restrictions; the balance between formal models to guide collaborative work at the system level and the flexible nature of collaborative work at the community level; and the trade-off between resources invested in collaboration itself and resources needed to deliver services.[42,43,44] Other case study research on intersectoral collaboration in supportive housing has found an overall lack of strategic coordination between the mental health and housing sectors.[15] In this other work, effective collaboration was prevented by the difficulty of working with multiple funding sources and

the health sector's emphasis on a medical model that undervalued non-clinical supports – both obstacles discussed frequently by key informants in this project.

Limitations

While this work offers informative insights into municipal-health collaboration in Toronto's supportive housing system, interpretation of its results should consider limitations posed by the project's design. The generalizability of findings is constrained by the case study approach, which only captures experiences of select key informants in a particular set of collaborative cases. Moreover, the three sectors included in this project (municipal, health, community mental health) had unequal representation in key informant interviews, with a notably small municipal sample, further limiting the generalizability of the findings to the broad range of stakeholders in the supportive housing system.

The document review approach used in this project cannot provide a comprehensive picture of materials on supportive housing collaboration in Toronto. Documents were collected through a non-systematic process and may not reflect the full range of document types and viewpoints. Since document information was included in the context of the interview data, its addition to this report is not intended to validate interview findings.

As noted in the results, key informants offered richer data on what became the two primary cases of the project, which further limits generalizability. The emphasis on health-funded supports in TCH should not imply that this service delivery model is the sole focus of collaboration in Toronto's supportive housing system. The two other service delivery cases intended to be explored in this project (health-funded supports in City-delivered new affordable rental, provider pairing of health-funded supports and municipal housing allowances) are important ways forward in municipal-health collaboration in supportive housing, but their more informal nature and earlier stage of widespread implementation presented challenges for data collection.

Similarly, key informants offered limited explicit comments on the connections between system-level and service delivery collaborations. This may reflect a lack of emphasis on vertical collaboration in the supportive housing system. Due to the nature of key informant comments, the theme of *weak system-service delivery links* was generated by drawing together subthemes of key informant data to infer understanding about collaborative connections.[22] Accordingly, this theme was most subject to research team interpretations.

Conclusions

In the supportive housing system in Toronto, effective municipal-health sector collaboration involves the acknowledgement of shared roles and responsibilities, recognition of each sector's context and constraints, and commitment from senior leadership that includes coordinated, long-term funding opportunities. The findings of this project emphasize the importance of viewing intersectoral collaboration at the system level and the service delivery level as interrelated components of the supportive housing system.

The existing partnerships and collaborative assets explored in this project can be leveraged in the context of Ontario's health system transformation to prevent restarting intersectoral efforts on supportive housing. Key informants recognized a growing context of collaboration and strong agreement on population health priorities between the municipal and health sectors; this progress can be carried forward in the ongoing priority-setting and planning of the health system. Logistical challenges raised by key informants (e.g. data sharing restrictions, misalignment of funding opportunities) can also be considered in future decision-making.

Opportunities for collaboration in supportive housing are timely. The Province has recently designated funding for community-based mental health services and housing supports for people experiencing homelessness and mental health and addictions.[45,46] Ontario Health will include a new Mental Health and Addictions Centre of Excellence to better connect services and supports.[47] The City of Toronto's *HousingTO 2020-2030 Action Plan* calls for provincial subsidies to increase the availability of supportive housing in Toronto and recommends the development of a joint supportive housing strategy.[48] Coordination of these intersectoral opportunities can facilitate an expansion of Toronto's supportive housing system that optimizes resources and enacts a common vision for health in the City.

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Appendix A – Full Set of Collaborative Cases Considered for Inclusion

Collaborative Case	Description
City of Toronto – 5 GTA LHIN Leadership Table	Intersectoral table established in 2013 to coordinate collaborative action on key health, community, and social issues in Toronto. Membership included senior leadership from the 5 GTA LHINs, 7 City divisions and 3 City agencies/corporations.
City-funded supports in Toronto Community Housing rooming houses	Home for Good funding allocated by the City to housing support providers to provide, coordinate, and oversee delivery of support services to tenants of 22 Toronto Community Housing rooming houses from 2018-2020.
Community paramedics in Toronto Community Housing	Drop-in community paramedic clinics in Toronto Community Housing buildings with high emergency calls, coordinated by Toronto Paramedic Services since 2014 and funded through Toronto-area LHINs since 2017.
Coordinated Access to Care from Hospital (CATCH)	Program to help people who have unmet complex health care needs to access health resources in the community through transitional case management in emergency departments. Includes a sub-program for people experiencing homelessness, with or without mental health or addiction issues. The program is a collaboration between Toronto-area hospitals and community agencies and is funded by TC-LHIN.
Health-funded supports in Toronto Community Housing	Series of initiatives, beginning with a pilot project at 291 George St in 2013 and expanding throughout Toronto, in which health-funded community agencies partner with Toronto Community Housing staff to deliver supports to clients/tenants and buildings with complex needs.
Health-funded supports in City-delivered new affordable rental	Model of supportive housing in which developers or non-profit housing providers receive municipal capital funding to develop affordable housing, and then arrange with health-funded community agencies to deliver supports to clients/tenants.
LOFT-Humber River Community Re-Integration Program	Transitional housing units with supports for seniors who have been hospitalized to move safely back into the community. Targeted at addressing Alternate Level of Care patients waiting for a place in long-term care, rehabilitation, complex continuing care, or home care.
Mobile Crisis Intervention Teams	Program to dispatch a mental heath clinician and a police officer trained in crisis intervention to police situations by request. The program is a collaboration between six Toronto-area hospitals and Toronto Police Services (TPS) and is jointly funded by TC-LHIN and TPS.
Mobile Multidisciplinary Outreach Team (M-DOT)	Through referrals from the City's Streets to Homes program, a specialized team of providers helps clients experiencing homelessness to find housing, medical services, and/or income supports. The program is a partnership between TC-LHIN, City of Toronto, and several Toronto-area health and community organizations.

Appendix A – Full Set of Collaborative Cases Considered for Inclusion

Collaborative Case	Description
Multidisciplinary Access to Care and Housing (MATCH)	Initiative coming out of the CATCH and MDOT programs (see above) to provide ongoing intensive case management and health support to referred individuals who need continued involvement beyond transitional supports.
Provider pairing of health-funded supports and municipal housing allowances	Model of supportive housing in which supportive housing providers apply separately for supports funding from the LHIN and housing allowances/rent supplements from the City and put these together to deliver supports to clients/tenants in affordable housing units.
Resilient Tenancy and Services Work Group	Work group established in 2015 out of the City of Toronto – 5 GTA LHIN Leadership Table, with representatives from the 5 GTA LHINs and the City divisions of Shelter, Support and Housing Administration and Social Development, Finance and Administration. Members aimed to develop opportunities to align municipal housing allowances and health-funded supports funding, though a draft joint request for proposals (RFP) was never implemented.
Seaton House Redevelopment / George Street Revitalization	City plan to revitalize the northern block of George Street, including redevelopment of Seaton House shelter into a specialized care facility with long-term care, emergency shelter beds, transitional living, supportive housing, and a service hub. A review of health services is under way to transition delivery from the City to TC-LHIN and other health sector stakeholders.
Shelter Health Services Design Project	TC-LHIN and City project to design a coordinated health and shelter services model for the 54 shelters operating in Toronto, as part of priorities identified in the City-LHIN Partnership Agreement signed in 2017. The service model will include MOUs between the shelter operator and lead health service provider responsible for service coordination.
YWCA Elm Centre targeted supportive housing units	Supportive housing units for women and women-led families, with units dedicated to Indigenous families. Built with support from all three levels of government and land purchased by the City and leased to YWCA.