Supportive Housing for Addictions
Position Paper

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Introduction

The Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP), Addictions Ontario (AO) and the Centre for Addiction and Mental Health (CAMH) commissioned this paper in response to an announcement from the Ministry of Health and Long-Term Care (MOHLTC) of its commitment to developing supportive housing services for people with substance use issues.

Our organizations applaud the MOHLTC for its intention to ensure that such critical services are available across Ontario, and that the people we serve receive the help and support they so desperately need. The Ministry, and the field, will be breaking new ground with this initiative. Although there is no tested "blueprint" that will ensure our success, there are models we can draw on and lessons to be learned from other jurisdictions. We welcome this opportunity to work as your partners toward our common goals.

We are also eager to comment on the principles according to which those services will be designed and delivered, to recommend minor adjustments to the approach proposed by the MOHLTC, and to highlight existing services which may serve as models for program development.

Background

In March, 2008 the Ministry committed an additional $80 million for enhancements to mental health and addiction services in Ontario. That amount included funding for the development of 1,000 supportive housing units for people with addictions. The MOHLTC's commitment to providing those new services was based on its belief that:

- *Stable housing for people with substance abuse is central to attaining treatment goals*
- *Housing must be a part of any comprehensive treatment program*
- *Most people who have problematic substance use or concurrent disorders can be successfully housed if they are given the right supports when they want them*
- *Most people with substance abuse or concurrent disorders will not accept an environment that is too restrictive or rigid or heavily controlled*[1]

In its presentations to the field, The MOHLTC cited the following objectives for the province's new supportive housing services:

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

The MOHLTC proposes to achieve those objectives by targeting services to a population described as:

[1] MOHLTC Presentation – November 24, 2008

"Persons with problematic substance use who:
- *Are involved in or completed an addiction treatment program;*
- *Are high users of the addiction system;*
- *Are homeless, at risk of homelessness or inadequately housed;*
- *Are assessed as having a high probability of being successful in supportive housing;"*

More specifically, the plan notes that: *"People receiving methadone maintenance treatment or with HIV/AIDS will not be excluded".*

The MOHLTC also articulated principles for the development and delivery of supportive housing to people with substance use issues. Principles were identified for both the Program Framework and Local Program Design. Program Framework principles specified criteria for acceptable service delivery models, described access mechanisms, and identified the MOHLTC's intended approach to outcome measurement and accountability:

Principles for Program Framework:
- *Program is client-centred and responsive to the unique needs of individuals*
- *Services are based on a "Housing First" model for supportive housing*
- *Program is responsive to relapsing nature of problematic substance use*
- *Services are based on a harm reduction approach and recovery model*
- *Housing is integrated into the community*
- *Clients should feel safe and secure in housing environment*
- *Mental health and addictions support services (are) provided through integrated, multi-disciplinary teams, e.g. housing coordination and addiction support services*
- *'No wrong door' regional coordination of access, application process*
- *Build on existing data systems in place such as the Drug and Alcohol Treatment Information System (DATIS) to measure client outcomes and ensure program accountability*

Principles for Local Program Design provided direction to the Local Health Integration Networks (LHINs) with respect to stakeholder involvement in the planning process, definition of the target population, and the criteria to be applied when assessing proposals:

Principles for Local Program Design:
- *Participation of client target group in planning and implementation of models*
- *LHIN planning processes to include representation from addiction agencies and mental health and other health and social service providers, e.g. AIDS service organizations*
- *Targeted to people with problematic substance use who are homeless or at risk of homelessness*
- *Support is flexible and variable depending on client needs*
- *Built on existing service system links to on-going community support services*
- *Collaboration in service delivery to clients is expected*
- *Housing support must be accompanied by corresponding community support services such as case management or crisis services*
- *Case management services will be funded at client/staff ratio of 8:1; no housing provider receives less than 8 units*

- *Housing provider has experience providing rent supplement units*

Service Provider Eligibility Criteria:
In addition, the MOHLTC identified a number of eligibility characteristics for service providers, noting that:

"Preference will be given to providers that have experience with:
1. *The target population*
2. *Demonstrated partnership experience with the addiction and mental health system (e.g. referral sources, access to treatment, rehab, medical, social and peer support services)*
3. *Knowledge of best practices in provision of addiction services*
4. *Staff skilled and knowledgeable with both addiction treatment and mental health treatment (for concurrent disorders)*
5. *Experience with or ability to partner with a TP (transfer payment) agency who has administered rent supplement supportive housing units, including experience with the Residential Tenancies Act and landlord/tenant issues*
6. *Ability to submit all mandatory documentation and data, including complying with evaluation requirements*
7. *Ability to implement initiative in a timely manner"*

Our Consultation Process

The positions expressed in this paper were developed through a multi-faceted process. Our approach centred on a facilitated consultation session, which was jointly sponsored by our organizations, and involved 36 representatives from Ontario's addiction, mental health and supportive housing agencies[2]. Following a presentation by the MOHLTC[3] and an update on recently completed research into supportive housing[4], participants commented on the Ministry's plan, debated the principles that underpin it, and identified areas of agreement and concern.

That rich input from the field was subsequently refined by the leadership of the three partner organizations to produce the following comments and recommendations:

Summary Observations

In general, the OFCMHAP, AO and CAMH strongly support this initiative and the objectives to which the MOHLTC is committed. For the most part, our organizations also agree with the approach outlined by the MOHLTC. Specific areas of agreement are detailed below.

[2] See *Appendix A: Consultation Attendees*
[3] John Van Damme and Debbie Babington, MOHLTC
[4] Wayne Skinner, Centre for Addiction and Mental Health

Areas of Agreement
Participants in the November 24, 2008 consultation session offered unanimous support for many of the identified principles– at both the system design and service delivery level:

Principles for Program Framework:
Unequivocal support was expressed for each of the following program principles:
- Program is client-centred and responsive to the unique needs of individuals
- Clients should feel safe and secure in housing environment
- Mental health and addictions support services (are) provided through integrated, multi-disciplinary teams, e.g. housing coordination and addiction support services

Principles for Local Program Design:
Similarly, participants indicated their agreement with most of the MOHLTC's principles for local program design:
- Support is flexible and variable depending on client needs
- Collaboration in service delivery to clients is expected
- Participation of client target group in planning and implementation of models
- LHIN planning processes to include representation from addiction agencies and mental health and other health and social service providers, e.g. AIDS service organizations

Areas of Concern

Notwithstanding that generally positive response, some of our members expressed reservations or concerns about certain other aspects of the plan, including the following principles:

Target Population

The MOHLTC's definition of the target population includes the following characteristics: *"'Persons with problematic substance' use who are:*
- *Homeless, at risk of homelessness or inadequately housed*
- *Involved in or completed an addiction treatment program"*

Our organizations believe that these criteria may be unnecessarily constraining, and that limiting eligibility to those with a history of homelessness, or with *recent* involvement with the addiction treatment system may result in the exclusion of people who might stand to benefit significantly from supportive housing, and thus contribute to the MOHLTC's achievement of its objectives.

Principles for Program Framework

"No Wrong Door" Regional Coordination of Access, Application Process In a system in which there is "no wrong door" each agency functions as a first point of

contact with the entire system.[5,6,7] Prospective clients who approach *any* agency can access the programs and services of *every* service provider.

Successful implementation of "no wrong door" access requires that staff understand that they are working *on behalf of the system* to identify the appropriate resources for each client – no matter which agency provides them. Assisting clients and families to negotiate their way through the complexities of the health care system thus becomes a part of every health care worker's job. With the extensive information resources available through Connex Ontario, this is an achievable objective.

"Regional coordination" on the other hand, may suggest a variety of models, including those that depend on centralized access and a common application process. In this approach potential clients may be directed to a single "door" through which they then enter the service delivery system.

These models are significantly different. Consequently, we are unclear about which approach the MOHLTC intends to support, and whether the same strategy will be applied across Ontario.

Assuming that the Ministry has not yet identified a single preferred approach, we offer the following comments to guide development of the system access model:

- Above all else, the model must meet the needs of the target population and ease their entry into the supportive housing system
- The selected approach must help to develop a "culture of integration" within the health care community
- From the perspective of the client, "No wrong door" may equal "Big Black Hole" if the necessary processes are not in place to ensure smooth transfer between agencies. The MOHLTC must support the development of inter-agency protocols and coordination agreements
- Mechanisms must be developed to ensure that one individual is not on multiple waiting lists
- If the selected model requires a standardized assessment, the Ministry must review and support that work
- If the MOHLTC opts to implement a centralized "single point of access" system:
  - Which sector (or which agencies within a sector) will be the "gatekeeper"?
  - What are the principles that will guide the system's development and operations? Will they be consistent across the province?

[5] Association of Ontario Health Centres, Ontario Community Support Association and the Ontario Federation of Community Mental Health and Addiction Programs. (2006). *Every Door Leads to Service: Enhancing Access and Building a Culture of Service Integration for a Made in Ontario Health System.* Toronto. Available at:
www.ofcmhap.on.ca/sites/ofcmhap.on.ca/files/AOHC-OCSA-OFCMHAP%20Discussion%20Paper%20July-06.pdf

[6] National Treatment Strategy Working Group. (2008). *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy.* Ottawa: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada. Available at:
http://www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf

[7] British Columbia Ministry of Health Services. (2004) *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* available at:
www.housing.gov.bc.ca/ptf/framework_for_substance_use_and_addiction.pdf

- What are the mechanisms through which coordinated access will be assured? Will they be consistent across the province?
- Will a triage process be developed to ensure that clients who are most in need receive help first?

Services are Based on a "Housing First" Model for Supportive Housing
One of the central tenets of the Housing First concept is that housing is a basic human right to which everyone should have access. We support that principle and the related assumption that recovery is not possible without a safe and secure place to live.[8] We do not believe, however, that housing is the *only* essential ingredient in the recovery process. For everyone, and for this target population in particular, an inclusive community and access to professional supports and services are necessary prerequisites to making and sustaining profound life changes. Consequently, we urge the MOHLTC to ensure that adequate funding is available for services that will meet the needs of residents in the newly acquired units. Without such support we may be undermining clients' potential to recover and setting them up for failure.

Further, we caution the Ministry that rigid adherence to this model could limit the range of options available to people. One of the "critical elements" of the Housing First concept is that housing is not contingent on compliance with services[9]. That raises the question of whether service providers would be able to impose *any* rules or expectations beyond those contained in a standard lease agreement.[10] If not, it is difficult to imagine that congregate living arrangements would be possible under this model.

We also believe that completely severing the link between compliance and eligibility may, in some cases, limit clients' motivation to make the necessary changes in their lifestyle. Finally, we are concerned that addiction agencies that espouse abstinence as the ultimate goal will be unable or unwilling to work within this model. In parts of the province where there are few, if any, other service providers "Housing First" may limit, rather than enhance access to supportive housing.

Build on Existing Data Systems Such as the Drug and Alcohol Treatment Information System (DATIS) to Measure Client Outcomes and Ensure Program Accountability
Although we support the use of existing data systems, we urge caution with respect to three issues:

- Any data on which the MOHTLC bases its decisions and assesses its funded programs must be accurate and complete. We encourage the Ministry to assess the information held by potential data sources to ensure that it meets those criteria.
- With respect to DATIS specifically, we believe that the MOHLTC should provide additional training for addictions agency staff to ensure that they can make optimal use of this system. A modest investment could help to ensure that DATIS realizes its full potential to support this new initiative.

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[8] This principle is reinforced in *Every Door is the Right Door* (2004) which states that" An individual's housing situation can significantly influence the impact substance use has on their health. It can also compromise the effectiveness of treatment. To improve their prospects of recovery, clients who do not have stable and supportive home environments (such as those living on the streets, in sub-standard housing or with a substance-dependent or abusive partner) need to be linked with appropriate supports to help them find stable housing." (p. 81)
[9] National Alliance to End Homelessness at www.endhomeless.org
[10] As permitted under the *Residential Tenancies Act, 2006. S.O. 2006, C. 17*

- Measuring client outcomes requires the assessment of many inter-related variables. Consequently, we believe that a multi-faceted approach is required. Evaluation strategies that rely on any single data source will not adequately describe the full range of client experience or program performance.

Services are Based on a Harm Reduction Approach and Recovery Model
Clients' needs are varied and complex. Responding to that complexity requires that a range of supportive housing options be available. For some clients, moderated use will be a viable goal. For others, abstinence will be the only effective path to recovery. Both choices must be respected, just as both types of programs should be funded and both options understood as points along the "harm reduction" continuum.[11]

Housing is Integrated into the Community
We believe that supportive housing programs can *only* be successful if they are fully integrated into their communities. We believe, as well, that integration requires community acceptance. Based on our experience in the mental health system, however, we know that inclusive communities rarely develop spontaneously and that stigma remains a significant barrier. Community integration must be nurtured and supported. Strategies for community engagement should be developed in parallel with new supportive housing programs.

Principles for Local Program Design

Case Management Services will be Funded at Client/Staff Ratio of 8:1;
No Housing Provider Receives Less Than 8 Units
We support the client/staff ratio identified by the MOHLTC and agree, in principle, with the establishment of a minimum number of units per provider. We are concerned, however, that a rigid application of that policy could disqualify small communities in which the eight bed minimum cannot be justified. If that were to happen, clients would be required to travel long distances to access the residential services and supports they need – thus undermining the principle articulated in *Setting the Course* that entitles Ontarians to receive service "as close to home as possible".

To avoid that possibility we suggest that the MOHLTC invite expressions of interest from cross-community agency partnerships. Although one of those agencies could be identified as the managing partner, each of them would have responsibility for unit maintenance and the support services provided in their own communities.

Housing Provider Has Experience Providing Rent Supplement Units

[11] The Government of British Columbia provided the following definition of Harm Reduction in its 2004 paper Every Door is the Right Door": "Harm reduction is a public health philosophy that makes the reduction of potential harm from substance use the highest priority. Itsupports policies and practices aimed at addressing risky substance use behaviours without requiring abstinence." (emphasis ours) Consistent with that definition, we believe that abstinence is one of many legitimate strategies for reducing the harm associated with problematic substance abuse and that the decision to identify abstinence as the ultimate goal should rest with the individual receiving treatment.

We are familiar with the administrative challenges involved in administering rent supplements. Further, we agree that that *function* should be performed by agencies which have the required experience and the necessary systems and processes already in place. We do not believe, however, that funding should necessarily rest with those agencies. Instead, we urge the MOHLTC to direct the LHINs to consider each of the criteria articulated as "Provider Requirements" (see below) when assessing funding proposals. Where an agency meets the rest of the requirements, but has not administered rent supplements, we recommend that they establish a formal partnership with an agency that has the necessary experience, and that the contractual relationship be recognized as fulfilling this criterion.

Provider Requirements

The MOHLTC has indicated that supportive housing providers must have the following qualifications:

- *Experience with the target population*
- *Demonstrated partnership experience with the addiction and mental health system (e.g. referral sources, access to treatment, rehab, medical, social and peer support services)*
- *Knowledge of best practices in the provision of addiction services*
- *Staff skilled and knowledgeable with both addiction treatment and mental health treatment (for concurrent disorders)*
- *Experience with or ability to partner with a TP agency who has administered rent supplement supportive housing units, including experience with the Residential Tenancies Act and landlord/tenant issues*
- *Ability to submit all mandatory documentation and data, including complying with evaluation requirements*
- *Ability to implement the initiative in a timely manner"*

We believe these to be relevant criteria. We are concerned, however, that overly rigid application of these, or any other criteria, could impair the ability of smaller agencies to compete successfully for supportive housing funding. To level the playing field we suggest that each proposal be assessed on its merits and that, where these criteria are not fulfilled, the applicant be given the opportunity to demonstrate its capacity to deliver the program and achieve the goals of this initiative.

Successful Models

As indicated in our introduction, we are aware of many successful programs that provide supportive housing services for people with serious substance abuse. They represent a range of models and approaches – four of which are described below:

Housing and Support Peel

Housing and Support Peel (HASP) provides permanent housing, with support, to clients with serious mental illness. Forty-one of the 166 supportive housing units are dedicated to clients with complex co-occurring disorders - a severe and persistent mental illness, with multiple hospitalizations, in combination with a significant substance abuse problem. All of those tenants were homeless or at risk of becoming homeless before they came to HASP. With moderate support, however, they are able to live independently.

That assistance is provided by one of HASP's support workers, with whom each client meets at least weekly (most meet more frequently). Every month, one or more of those meetings takes place in the tenant's own apartment. With their worker's support, clients identify and work toward their goals - which may or may not include abstinence. Once those goals have been achieved and their condition has stabilized, they may 'graduate' from the program - maintaining their housing, but no longer receiving formal support from HASP. In some cases, their unit is transferred to market rent status, and another unit is secured for the program. HASP graduates can fast-track access to program services again, if and when they need to return.

HASP is a partnership of eight health and social service agencies. [12] With expertise in areas such as addictions, dual diagnosis, mental health, housing and settlement, each partner plays a critical role in ensuring clients' success. All housing-related matters (such as maintenance and repairs, unit transfers and tenancy agreements) are managed by staff of a supportive housing agency. Other types of assistance are provided by the client's own support worker – with whom the housing agency maintains a close relationship. Policies and procedures guide the partnership and ensure that roles and responsibilities are clearly defined.

The Bridges – Cambridge Shelter

The Bridges facility in Cambridge Ontario is a unique model of supportive housing that integrates the best features of many different approaches.

Cambridge Shelter Corporation operates this 40-bed shelter for men and women aged 16 years and over as part of its portfolio of housing options. Three units for homeless families and 20 transitional bachelor apartments complete the Corporation's holdings.

[12] Supportive Housing in Peel; Peel Addiction, Assessment and Referral Centre; the Centre for Addiction and Mental Health; the Canadian Mental Health Association, Peel Region Branch; India Rainbow, Peach Ranch, Reconnect Mental Health Centre, Trillium Health Centre

The facility practices a “whole person” approach - addressing every issue that arises for an individual as they move toward life changes. Although not limited specifically to people with addictions, the majority of clients at the Bridges do have substance abuse issues. Abstinence is a policy at the shelter, but a harm reduction approach is also supported, based on the Bridge’s understanding that not every individual will opt for recovery or engage in traditional treatment.

The facility itself is designed to meet a broad range of needs across the harm reduction/recovery continuum. The 40-bed shelter is on the bottom floor, offering temporary housing and programming for up to three weeks. This level provides traditional shelter beds for the homeless in addition to pre-treatment beds for those waiting for residential treatment, and stabilization beds for those leaving withdrawal management or participating in community withdrawal management or other outpatient treatment.

In the first week of their stay, individuals are encouraged to commit to a “change goal”. To help them achieve that goal, service providers come to the shelter and offer a broad range of programs - creating a true “one stop” approach. When the necessary programming cannot be offered “in house”, the Bridges’ outreach workers, caseworkers, and housing support workers jointly create a comprehensive plan for the individual to get the services they need elsewhere. Access to the program’s transportation fund ensures that the plan is workable.

The upper level of the shelter consists of 20 transitional bachelor units with bedroom, bathroom and kitchenette. These units are for shelter clients who have made a commitment to significant life change, who can demonstrate some level of stability in the abstinence model and who need a safe place to use as a transition point to permanent housing in the community. The daily programming and services of the main floor shelter are offered to these clients – either on a regular basis, or in the event of a crisis or relapse. Separate entranceways and security features offer privacy and safety and create a sense of stability. Length of stay is open-ended, with tenants staying 1.5 years, on average.

Many clients progress from the shelter and programs on the main level to these transitional apartments. Others enter directly from a treatment program. In 2007, 232 clients moved from the Bridges to permanent housing. Although they no longer live in the building, the outreach team and other services remain available to them to help ensure their stability in the community.

This model integrates pre-treatment, stabilization and post treatment-shelter while supporting a harm reduction philosophy. This fluid continuum of supportive housing resources, supplemented by case management and community outreach helps to ensure that no one sleeps out in the cold and that they receive the help they need to change their life.

Wayside House of Hamilton

In January of 2007 the Board of Directors of Wayside House of Hamilton made the decision to invest in supported housing for clients completing the agency's residential program. In cooperation with a local realtor, the Board secured four houses with a total of twenty-one, single occupancy rooms. These fully furnished units – an extension of the existing residential program – are intended to provide safe, secure housing for men who are maintaining their recovery goals and living an abstinence-based lifestyle.

Wayside House offers a variety of supports through regular house visits. Staff assist residents in developing and maintaining house rules, resolving conflicts, and maintaining a clean, well organized home. They offer both individual and group counselling and provide support at the weekly meetings. Staff of the Canadian Mental Health Association provide ongoing mental health support for clients with concurrent disorders.

In the event of a crisis, staff offer support and guidance. If any resident is at risk or has lapsed with alcohol or drug use, he may be brought back into the residential program and readmitted to the most appropriate phase. If not, he may simply come for the day and participate in activities with the agency's residential clients. At no time will he lose his housing, providing he is fully engaged in treatment.

Residents work together, as a collective, in managing their own homes. Each of them commits to remaining abstinent, attending weekly aftercare and participating in house-related activities. They remain clients of Wayside House.

Since January 2007, the program has provided supported housing to 35 residents through this pilot program. Over 50% of graduates have returned to work and 20% to school. Even more remarkably, they've experienced a 97% reduction in their use of withdrawal management services, and a 78% drop in the number of Emergency Department visits. Not one of those residents has been arrested since becoming involved with the program, despite the 18 arrests recorded before treatment.

Seaton House - Toronto

The Annex Harm Reduction Program at Seaton House is home to 140 homeless, chronic alcohol abusers. After decades of significant problems, many of these men had resorted to drinking rubbing alcohol or mouthwash while living on the streets.

The Annex supplies its clients with monitored quantities of wine (one glass per hour) to help keep them safe and reduce the risk of further harm from their abuse of alcohol. That approach has allowed some clients to reduce their drinking from levels as high as 46 a day to as little as eight a day.

The results have been remarkable. Annex clients reduced their emergency department visits by 84%, and their admission to withdrawal management services by 93%. This

approach also works with clients with severe mental illness. Six months after the Fusion of Care program began to address the needs of that population, 33% of clients with a severe mental illness experienced an improvement in the severity of their symptoms and 45% had obtained housing.

Recommendations

The Ontario Federation of Community Mental Health and Addiction Programs, Addictions Ontario and the Centre for Addiction and Mental Health respectfully submit the following recommendations:

Recommendation One – Target Population:
That the MOHLTC expand the target population for this initiative to include anyone with a significant substance use/abuse problem who requires supportive housing to achieve their recovery goals.

Recommendation Two – Access Model:
That, for purposes of this initiative, the MOHLTC endorse and adopt the access model described in *Every Door Leads to Service: Enhancing Access and Building a Culture of Service Integration*[13] and that it provide the necessary tools, training and resources to ensure the successful implementation of this model by all addiction service providers. Resources should include templates for, and support for the negotiation of inter-agency referral protocols and mechanisms for the coordination of waiting lists.

Recommendation Three – Funding for Support Services:
That the MOHLTC provide sufficient funding to addiction service providers to ensure that adequate support services are available for residents in the newly acquired units.

Recommendation Four- Flexibility of the Model:
That the MOHLTC entertain proposals from addiction service providers for a range of housing models. – including congregate living settings in which residents are required to meet minimum specified program expectations, in addition to fulfilling their requirements as tenants under the *Residential Tenancies Act (2006)*.

Recommendation Five – Measuring Client Outcomes
That the MOHLTC develop and implement a multi-faceted strategy for measuring client outcomes that is centred on, but not limited to, analysis of the data available through the Drug and Alcohol Treatment Information System (DATIS). Further, that the MOHLTC provide additional training for addictions agency staff to ensure that the data submitted to DATIS is consistent, accurate and reliable.

Recommendation Six – Clarify the MOHLTC's Use of the Term Harm Reduction"
That the MOHLTC confirm that it understands the "harm reduction" approach as one which embraces a range of potentially successful strategies to address the risks associated with problematic substance use/abuse. Further, that it consider agencies that encourage (but don't require) residents to identify abstinence as their ultimate goal to be eligible for funding through this initiative.

[13] Association of Ontario Health Centres, Ontario Community Support Association and the Ontario Federation of Community Mental Health and Addiction Programs. (2006). *Every Door Leads to Service: Enhancing Access and Building a Culture of Service Integration for a Made in Ontario Health System.* Toronto. Available at:
www.ofcmhap.on.ca/sites/ofcmhap.on.ca/files/AOHC-OCSA-OFCMHAP%20Discussion%20Paper%20July-06.pdf

Recommendation Seven – Community Integration:
That the MOHLTC support addiction service providers in developing and implementing community engagement strategies to enhance community acceptance and to help ensure the success of any new supportive housing programs that are developed as a result of this new investment.

Recommendation Seven – Provider Eligibility (Minimum Bed Requirements):
That, in communities in which the need for eight beds cannot be demonstrated, the MOHLTC direct the LHINs to invite expressions of interest from cross-community agency partnerships, in which one of the agencies is identified as the managing partner and each agency retains responsibility for unit maintenance and the support services provided in their own communities.

Recommendation Eight – Provider Eligibility (Rent Supplements):
That the MOHLTC direct the LHINs to entertain proposals from agencies that have not previously administered rent supplements, *if* they satisfy the other specified criteria *and* they have entered into a formal partnership with an agency that has the necessary experience.

Recommendation Nine – Provider Eligibility (General)
That the MOHLTC direct the LHINs to assess each proposal submitted through this initiative on its own merits and that, where the specified criteria are not fulfilled, the applicant be given the opportunity to demonstrate its capacity to deliver the program and achieve the goals of this initiative.

Respectfully Submitted

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