

Taking Stock of Supportive Housing for Mental Health and Addictions in Ontario

Executive Summary



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In Ontario, there is great concern about chronic homelessness and renewed attention to supportive housing for people who live with mental illness or addictions. Energy is devoted to local initiatives, new provincial funding is provided, and attention is given to housing first.

This in-depth report takes a broader look at supportive housing for these populations. We ask, what exists today, and how did it come to be? What different approaches exist? What ideas and goals – and what layers of history – do they embody? Understanding this context can help policy-makers, funders, providers, and others interested to see more clearly where recent initiatives and new proposals fit from this broader perspective.

Taking Stock of Supportive Housing uses a broad definition of supportive housing (housing with supports). It includes units for people who have been chronically homeless, as well as those specifically targeted to people with mental illness or addictions. It includes models where supports are directly bundled or linked with the housing, and models where they are not.

Diversity of Programs and Models

The Ontario system of supportive housing for mental health, addictions, and chronic homelessness includes several different programs. These range from boarding homes and high-support congregate facilities to independent rent-subsidized apartments with flexible supports tailored to individual needs. Publicly funded community-based agencies provide most housing and supports, and almost all of their housing is part of these programs.

Different programs are associated with different approaches to providing housing with support. While diversity is generally positive, the existing mix is a somewhat accidental product of ideas and policy contexts that evolved over the years, leaving an enduring imprint in program models and properties.

The core of the system (12,900 units) is funded by the Ministry of Health and Long-Term Care (MOHLTC). This includes about 3,000 dedicated supportive housing units, both congregate (collective) dwellings and independent apartments. These were originally funded under the social housing programs of the 1980s and early 1990s, and continue today under long-term legal agreements. Congregate high-support housing (group homes) forms a small part of the sector. This MOHLTC system also includes about 7,400 units which mostly involve rent supplement in private-rental housing, along with supports; these were created through a series of MOHLTC initiatives every couple of years since 1999. The Funding for supports in this system flows to providers through the Local Health Integration Networks (LHINs), while rent supplement flows directly from the Ministry. The MOHLTC system also includes boarding homes, discussed below.

Also significant is housing in programs administered by Service Managers and overseen by the Ministry of Housing. Service Manager refers to the 47 single-tier or upper-tier municipalities and District Social Services Administration Boards that are designated by the provincial government to fund and administer social housing and homeless-related programs. This part of the system includes alternative social housing targeted to people who have experienced chronic homelessness. It also includes some transitional accommodation that receives emergency shelter funding; boarding homes; and dispersed housing first programs. It includes a significant share of the new affordable rental supply that has been funded by all levels of government since 2000, and delivered by Service Managers. The municipally administered housing with supports accounts for an estimated 10,000 units, although there is no precise count. In addition, there are various supported units in ordinary public and non-profit social housing administered and funded by Service Managers.

Almost one-quarter of the housing for people with mental illness or addictions consists of the 5,300 beds in boarding homes. This includes Health-funded Homes for Special Care and Habitat Services which exists in the City of Toronto. It includes Housing with Related Support (domiciliary hostels) funded through the Community Homelessness Prevention Initiative. The latter program, administered by Service Managers, accounts for half of the mental health and addictions boarding home beds in Ontario, and about two-thirds of its residents have mental health issues.

Evolution of the Various Program Models

The system has grown and changed over the past forty years in ways that reflect two main influences: evolving thinking and best practice in the mental health and addictions sector, and a shifting housing policy regime and market context. This review, using more internally consistent program categories, puts in question the classic three-part typology of custodial / supported / supportive housing used in some mental health housing literature.

The dominant models of the 1960s and 1970s were subsidized boarding homes and residential care facilities – two different approaches but each having a fixed (often mandatory) package of supports that was bundled and integral with residency. The dominant approach in the 1980s and early 1990s was dedicated supportive social housing which took the form of small apartment buildings or shared houses, with flexible supports provided on site either by the supportive housing provider or a separate support agency. Since 2000 the dominant model has been private-sector rental apartments with subsidized rents and flexible supports. Each of these remains part of today's programs.

Congregate housing was the preferred model in the 1960s and 1970s for several reasons: assumptions about the need for supervised living, lower capital costs, ineligibility of singles for rent-geared-to-income social housing, and houses as a way to integrate people in ordinary neighbourhoods. Congregate housing today is a diverse category, including high-support congregate housing (group homes), rooming houses, boarding homes, and shared houses or apartments operated by non-profit housing providers.

Boarding home programs emerged partly as a way for mental health hospitals and agencies to house people with mental health support needs in the community in the era of deinstitutionalization. They were also a way of regulating and improving the room-and-board accommodation which was a predominant market response to the housing demand of this very low-income population, but which often resulted in poor living conditions, low housing quality, and adverse neighbourhood impacts. Boarding homes were soon critiqued as custodial housing that did not foster recovery, autonomy and opportunity for residents. Recent years have seen some case-by-case adaptation of some boarding homes to non-profit, recovery-based approaches; this has been seen in all three boarding home programs.

Shelter funding has also been used to create and sustain various congregate transitional housing or supported residential accommodation. This occurred as a pragmatic response to the needs of people who are homeless, using a program that offered flexible – and until 2011 expandable – funding for municipalities and providers to use.

Independent apartments with flexible supports became the preferred model in the 1980s. This reflected evolving mental health ideas and practice that emphasized personal autonomy, recovery, and what the mental health literature characterized as normal housing in the community. It also reflected a new priority, in social and subsidized housing policy, for people with mental illness and other disabilities and chronic conditions, who were made eligible for rent-geared-to-income subsidies.

Research literature has emphasized that independent apartments with flexible supports are best at implementing recovery principles for most people. However, some people also benefit from other models including congregate (collective) living arrangements and higher levels of support, sometimes bundled with the housing.

In the period when independent apartments with flexible supports was first implemented (circa 1987-

1995), this was done in different ways in the US and Ontario, as a function of different housing policy regimes. In the US this was provided mostly by way of scattered rent supplement in private-rental – an approach fostered by US federal housing policy and mental health policy, and by prominent agencies such as Pathways to Housing. In Ontario, with more active social housing production in that period, independent apartments with flexible supports were provided in dedicated and alternative social housing. The stages model, to which housing first is contrasted, was formally entrenched and mandated in official US federal housing policy and thereby in local strategies in the latter 1980s to mid 1990s, but this was not the case in Ontario. Dedicated and alternative housing remain important parts of the Ontario system today.

System Expansion in Recent Years

The system has expanded significantly in 1999-2016, with about half the units in the combined Health-funded and municipally administered systems dating from this period.

The health-funded system was expanded through seven successive program initiatives from 1999 to 2016. Expansion in the municipally administered programs has included an estimated one-fifth of the new affordable housing supply funded since 2000 through federal-provincial-municipal programs (Investment in Affordable Housing as well as the Homelessness Partnering Strategy and related programs).

In 1999–2016, most expansion of Ontario’s health-funded mental health and addictions supportive housing system has been by way of scattered private rent supplement with supports. The preference for this approach in Ontario has been supported by the extensive mental health research and evidence on outcomes in US models, and Canada’s 2010-2013 At Home / Chez Soi demonstration project. It also reflects Ontario’s market and policy context moving closer to the US experience with less new social housing, fewer openings (less turnover) in that sector, higher market-rental vacancies, tighter fiscal limits on housing programs, market-oriented federal and provincial policy, and chronic homelessness prompting pragmatic local responses using available private-rental supply.

Dedicated supportive housing and scattered rent supplement each have different advantages and disadvantages. The emergence of dispersed housing first program models (rent-subsidized scattered private rental with flexible supports) has occurred in both the health-funded and municipally administered systems. Provision of new supply with supports has occurred largely in the municipally administered system, reflecting local priorities, provider proposals, and knowledge of local housing market conditions.

Support to tenants with mental health and addiction issues in municipally administered public and non-profit housing is emerging as an area of significant need, and of small support initiatives by LHINs and housing providers. Turnover of this regular social housing to a high-needs population has been driven by factors including formal access policies, pragmatic ad hoc use of this stock to house homeless people, and overall residualization of social housing.

The broad effect of system expansion in 1999–2016 has been to create a system with mixed models. This

includes numerous providers that operate both dedicated supportive housing projects and scattered rent supplement. It includes partnerships between Health-funded agencies and alternative housing providers that are municipally funded and administered; and partnerships between mental health housing or support agencies on one side and addiction service providers and homeless-serving agencies on the other.

The diversity of program models and approaches is a potential strength of the Ontario system. There is a need, however, to better understand and evaluate the various approaches, to move boarding homes toward more recovery-based approaches, to address unmet needs, and to more strategically manage the relation between the Service Manager (municipal) programs and the health-funded ones.

Wellesley Institute works in research and policy to improve health and health equity in the Greater Toronto Area through action on the social determinants of health.

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