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

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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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Taking Stock of Supportive Housing for Mental Health and Addictions in Ontario| Report
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Executive Summary

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.

1. Introduction

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 being devoted to local initiatives, new provincial funding is being provided, and attention is being given to *housing first*.

This report provides a description of supportive housing in Ontario for people living with mental illness, addiction, or chronic homelessness, and an explanation of how this came to be. It has been prepared as a one foundation for Ontario policy development, and as a resource for practitioners, policy-makers, and interested members of the public.

The document provides a catalogue of what exists, with descriptions of numbers of units and how the various programs are funded and administered. It offers more detail on the programs of 1999-2016 period. The second half of the report is a contextual explanation of how the system emerged and evolved. The report is not intended as an analysis of the effectiveness of programs or of gaps in the system.

The report has a dual geographic scope. The first focus is Ontario-wide, because within this province, supportive housing policy is shaped primarily at that level. The second is the Greater Toronto Area and especially the City of Toronto, reflecting Wellesley Institute's primary mandate.

This report uses the term supportive housing to refer to a wide range of approaches. It includes not only housing funded by the Ministry of Health and Long Term Care, but that part of the housing funded and administered by municipalities and others that serves much of the same population. It includes housing where the support is de-linked from housing tenure – sometimes called *supported* housing – as well as models where they are bundled together. As well as independent supported dwellings it includes boarding homes, congregate housing, transitional shelters, and other forms, each of them discussed specifically in the report.

This report focuses more on the housing dimension than the support dimension, although they are quite entwined. It does not deal with models of support except as these are interrelated to housing, and it does not address type or intensity of supports.

Supportive housing for people with mental illness or addictions is one of several main supportive housing sectors. Others include housing for youth; people with age-related health or cognitive issues; developmental disabilities; physical disabilities; escaping domestic violence; acquired brain injury; and other chronic illnesses. This report focuses on supportive housing for mental health and addictions, but it also includes housing targeted to people experiencing chronic homelessness, as explained in section 2.

2. Existing Supportive Housing

2.1 Typology

An understanding of what exists is an important basis for policy and program decisions in this sphere. Supportive housing comes in diverse forms and there have been significant debates about the relative merits of different approaches. It is therefore useful to set out a typology of existing supportive housing.

This report focuses on arrangements where housing and support are both provided by community agencies or governments, with some level of public funding. Many people with mental health issues or

addictions live in other housing situations and receive support. In particular, this report does not cover two situations of housing with support that apply to large number of people:

- Many people with mental health issues or addictions live with their family of origin, a partner, and sometimes relatives or a family of choice. Family members are often an important source of support. This report recognizes the importance of these housing situations and of family and professional support in that context. Nevertheless, this form of housing and support falls outside the scope of publicly funded housing and support provision that this report is concerned with.
- Many people receive publicly funded mental health or addictions supports while living in housing of all sorts – dispersed in communities and not involving any housing-related government program or community agency. This is the typical living situation for people with lower-middle to upper incomes who need mental health or addictions supports. This too falls outside the scope of the housing and support provision that this report is concerned with.

As a starting point, Figure 2.1 sets out a typology based two dimensions:

- Flexibility of supports – the extent to which these are a fixed package, bundled with residency;
- Built form and housing sector.

These two dimensions are chosen because they have been central elements in the policy choices and evolution of program models over the past three decades, and they remain central concerns in the related research literature and policy debates.

The evolution of housing and program models has tended to evolve from the lower left toward the upper right on the chart. See section 3 for a fuller discussion of the related issues.

- Models of the 1960s and 1970s were either subsidized boarding homes, where a package of housekeeping and support was integral with residency; or residential care facilities (group homes) where a mandatory supervision/rehabilitation program was integral with residency.

Figure 2.1
Typology of Supportive Housing

Built Form and Housing Sector		Model of Supports			
		Mandatory Programs or high support associated with residency	Meals, housekeeping, and miscellaneous support	Flexible supports, support agency is also landlord	Flexible supports, by agency other than landlord
Built Form and Housing Sector	Apartment in private rental building				Private-rental apartment with supports
				Private-rental apartment (headlease) with supports	
	Apartment in mixed social housing				Social housing apartment with supports
					Social housing apartment with supports and referral agreement
	Apartment in a dedicated supportive housing building			Social housing apartment (dedicated supportive project) with supports	
	Shared house or apartment	High-support Congregate Housing (group home / residential care facility)		Social housing shared house/apt (dedicated supportive project) with supports	
	Boarding or congregate facility		Homes for Special Care, Habitat, and Domiciliary Hostels		
		Crisis care facility			
	Quasi-Institutional	Some long-stay shelter beds			

- The dominant models of supportive housing in the 1980s and early 1990s were *dedicated* supportive social housing,[1] in the form of a small apartment building or a shared house, and with flexible supports provided either by the housing provider or by a separate support agency.
- The dominant model in 2000-2015 has been apartments with rent supplement in the rental market, with flexible supports.

The shift over time toward flexible supports and independent apartments is generally considered as an evolution toward program models that better implement principles of recovery and community integration. The question of whether apartments are rented in the market or provided as social housing is more complex, and so is the valid role of congregate and linked models. These are discussed in section 3 with reference to the research literature.

2.2 Inventory of Supported Housing

2.2.1 General Inventory

Table 2.1 summarizes existing supportive housing for mental health and addictions in Ontario and in Toronto.

The supportive housing research literature and the experience of providers have involved debates over definitions supportive housing. The categories used here are informed by the typology set out in Figure 2.1, and reflect the various program models through which the housing and supports are funded.

As well as mental illness or addictions, this inventory includes units targeted to people experiencing chronic homelessness, particularly the units officially known as *alternative* housing, and some transitional accommodation. This inclusion is warranted by the high prevalence of mental illness and addictions in the chronic homeless population,[2] as well as the interrelated evolution and roles of the *alternative* and mental health supportive housing sectors in Ontario, described more fully in sections 3.5 to 3.8.[3] Fuller descriptions of each program category are provided in section 2.2.2. Further details of the 1999-2016 initiatives are given section 2.3. Highlights of the inventory:
- The total system across Ontario has an estimated 23,000 units. This includes all health-funded housing plus units in the municipally administered system that are targeted to people with mental illness or addictions or chronic homelessness. Additional units exist in regular devolved social housing but no count is available.
- The total health-funded system is 12,700 units. This includes supported *dedicated* units, boarding homes, and supported dispersed private rental.
- The health-funded system net of boarding homes is 10,400 units. This comprises 3,032 *dedicated* supported units developed up to the 1990s, and 7,368 units under the mental health housing initiatives of 1999-2016. The latter component is primarily in dispersed private rental, with rent supplement

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1   Social housing refers to housing provided on a non-market basis by public or non-profit agencies, targeted primarily to low and moderate incomes in terms of rent levels and access, and with public assistance in respect of production costs, financing (amortization) and/or rent subsidies.

2   For example, Grinman et al. (2010) found that 40 percent of shelter users in Toronto had active recent drug problems; City of Toronto (2013. p. 36), *Street Needs Assessment*, showed the following (overlapping) shares of homeless respondents identifying a need for mental health or addiction supports: 32% mental health supports, 21% "help getting alcohol or drug treatment," 18% harm reduction, 16% help getting detox services. These were percent of the total homeless respondents and would be notably higher for those who are chronically homeless.

3   This inventory does not include the Violence against Women sector, such as women's shelters and YWCA supportive housing. A significant part of the population it serves has mental health issues or addictions: for example, City of Toronto (2013. p. 35), *Street Needs Assessment*, showed large shares of VAW shelter respondents requesting detox services, alcohol/drug treatment, mental health supports, or harm reduction supports. However, this sector also has a broader mandate and serves a wider population.

and supports.

- The relevant units in the municipally administered system are estimated at 10,000. This comprises estimates of 1,000 long-term and transitional shelter beds, 3,000 CHPI supportive units (Dom Hostels), a conservatively estimated 2,000 in devolved *alternative* providers, 3,000 for people with mental illness, addictions or chronic homelessness under post-1999 new affordable housing and homelessness programs, and 1,000 dispersed private rental. (The 10,000 excludes Habitat Services to avoid double-counting.)
- Boarding homes housing people with mental illness or addictions total approximately 5,300 units of which 2,300 are Health-funded and an estimated 3,000 are MMAH/municipal-funded. The latter includes the documented share of the larger CHPI supportive (Dom Hostel) category which houses people with mental illness or addictions, as well as Habitat Services.
- The system, net of 5,300 beds in boarding homes and an estimated 1,200 in high-support congregate housing, totals 16,200 units.
- These 16,200 units (mental health and addictions or chronic homelessness, net of boarding homes and high-support congregate housing) equate to 5.7 percent of Ontario's 282,000 units of social housing, and 7.7 percent of the subset of social housing that has rents geared to income (RGI – estimated at 210,000 units).[4]

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4   A few of the 16,200 units, such as AHP/IAH, S2H, etc., do not form part of the social housing denominator.

Table 2.1
Inventory of Mental Health & Addictions Supportive Housing in Ontario

Program Category	Number of Units: Ontario	Number of Units: City of Toronto	Explanatory Comments
1 Transitional or long-term shelter			
Various accommodation funded within CHPI shelter budgets	>1,000	>500 estimated	Beds in programs within municipal emergency shelter system, but transitional or long-term. Usually with referral protocols or criteria, related programming, and no emergency intake.
2 Subsidized boarding homes (predominantly private-sector owner-operators)			
2a CHPI 'Housing with Related Support' funded via Community Homelessness Prevention Initiative (Domiciliary Hostel)	Approx. 3,000 (of 4,700-5,000 total)	0	Boarding homes funded via provincial-municipal CHPI program for homeless-related services; local program admin. About ½–¾ (3,000) of 4,700-5,000 total residents have serious mental illness or addictions.
2b Homes for Special Care	1,386	51	Boarding homes funded by MOHLTC. Program administration jointly by MOHLTC & mental health hospitals. All residents have serious mental illness.
2c Habitat Boarding Home	931	931	Toronto-specific program for boarding homes; access and monitoring of standards by a support agency. MOHLTC/municipal program administration.
3 Dedicated mental health and addictions supportive housing (funded by MOHLTC; admin by MOHLTC re housing, by LHINs re supports)			
3a Congregate high-support housing			Congregate housing with supervised or high-support program (staff all day or 24 hrs every day)
3b Dedicated supported apartments, shared houses and rooming houses	3,032	1,483	Supported apartments or houses developed under social housing programs of 1978-1995, targeted fully to people with mental illness & addictions, owned and operated by health-funded providers.
4 1999-2016 mental health housing initiatives (funded by MOHLTC; administration by MOHLTC re housing funding, by LHINs re support)			
Supported apartments and a few other units.	7,368	2,528	Supported apartments of health-funded social housing providers, funded 1999 onwards; mostly rent supplement in private rental.
5 Devolved alternative housing (housing programs administered and funded municipally)			
Specialized, mandated alternative providers, with supported apartments, shared houses, and rooming houses	>2,000 estimated	1,600 estimated	Supported houses or apartments developed under the social housing programs of 1978-1995. Providers have mandates to house people who were homeless or have addictions or related needs. (Estimate here is units for people in these categories; excludes abused women, HIV/AIDS, etc.)

Program Category	Number of Units: Ontario	Number of Units: City of Toronto	Explanatory Comments
6 **Other supported units and residents in mixed social housing** (housing programs administered and funded municipally)			
Supported apartment or shared dwelling in mixed social housing	*	*	Supported houses or apartments in social housing managed by municipal or other providers.
7 **New supply programs 1999-2016** (federal or federal-provincial programs administered municipally, with municipal contributions)			
Supported apartment or other dwelling (AHP, IAH, SCPI, HPS, etc.).	3,000 estimated	>1,400 estimated	A significant number of projects under these programs are supportive housing. Counts known for Toronto (Table 2.3), estimated for Ontario.
8 **Dispersed housing first**			
Streets to Homes transitional supports (Toronto) and equivalent housing first in other municipalities	>1,000 estimated	>800 estimated	Supports on a time-limited basis, once person has moved from homelessness to housing. A large share of those served have mental health issues or addictions, although other populations (e.g. youth) are also served. Known count in Toronto; unknown counts in other areas. (216 units from At Home / Chez Soi are included in row 4 above)
9 **Supportive housing not funded by public programs**			
Various legacies, donations, fundraising, etc.	*	*	
TOTAL (rounded)	**23,000 estimated**	**9,000 estimate**	**Data rounded to nearest 1,000 to reflect imprecise counts for some components.**

Sources and Notes for Table 2.1

* Data not known or not available.

(1) City of Toronto shelter report cites transitional beds at 1,081 (capacity) 1,007 (occupancy); this varies somewhat over time as programs evolve. A lower estimate of 500 is used here because the 1,007 or 1,081 include some units which are institutional more than housing, or which serve clients other than chronically homeless. See Toronto, Shelter Support and Housing Administration Division (2015), "Infrastructure and Service Improvement Plan for the Emergency Shelter System" (report to March meeting of the Community Development and Recreation Committee of City Council).

(2a) The estimate of ½ -¾ mental heath and addictions is a generalization from Hwang et al. (2009), **A Survey of Domiciliary Hostel Program Tenants in Ontario.**

(2b) Data from MOHLTC. There are four properties in this category in the City of Toronto.

(2c) Data from MOHLTC and Habitat Services.

(3) MOHLTC data do not distinguish between these different housing types within dedicated supportive housing. The 3,032 (Ontario) and 1,483 (City of Toronto) are MOHLTC data. George et al (2005) cite an incomplete 2,659.

Provincial data show 7,267 transferred to MOHLTC; this larger number also includes ABI and other non-SMI/addictions categories.

Durbin et al. (2005), Ontario-wide data for 1999-2002 (not current), show 643 units in 'co-op/group home' facilities with on-site or 24-hours supports.

Other MOHLTC counts show 1,529 and 1,053 long term care supportive housing but these are not mental health and addictions.

(4) See details in Table 2.2. The 7,368 is from MOHLTC. Most units are rent supplement in private-sector rental; a few owned by providers. A few units may be shared houses rather than independent apartments. Data include all the 2014-2016 1,000-unit rent supplement initiative.

(5) Novac & Quance (1998) showed 688 dwelling units plus 962 places in shared or congregate houses, total 1,650 units.

Connelly & Roberts (2009) cite 2,086 'alternative' in City of Toronto, which also includes categories other than homelessness.

(6) No data are systematically compiled for supported apartments in mixed social housing.

(7) No comprehensive data are compiled on MH&A supportive units in the 1999-2015 new supply programs. See data for City of Toronto in Table 2.3; same percentage of total AHP/IAH is applied to Ontario.

(8) Streets to Homes transitional: Estimate of typical point-in-time caseload, based on communication from City of Toronto staff. See text re other municipalities.

It was not possible to obtain systematic data on York, Peel, Durham and Halton regions for this report. Selected data are as follows:

- For Peel, a key source is SHS Consulting and Region of Peel (2016), Supportive Housing Demand and Supply Analysis and Action Plan, which shows 252 supportive units targeted to mental illness, and 27 units targeted to substance use.
- For Durham, a key source is Durham Mental Health Services (2016), Mental Health and Addictions Housing and Homelessness in Durham Region, which shows 225 independent units, 59 group living units, 127 Homes for Special Care beds, and 28 transitional units.
- MOHLTC data for the '905' GTA included 461 HSC units and 64 SHPPSU.
- Dom hostel beds include York 411 beds, Halton 152 beds (from Waterloo Region (2012), Exploring Promising Practices in the Domiciliary Hostel Program; Peel 95 beds (from Peel Regional Municipality (2014), Housing and Homelessness Plan: A Community Strategy 2014-2024); Durham 43 beds (from Durham Region, "Summary Report of 2014 Homelessness Programs" – Council report 2015-SH-02).

2.2.2 Description of Main Program Categories:

The following is a brief description of each category of supportive housing listed in table 2.1. Further explanation is given in section 3 on the general evolution of housing and support programs. The numbering corresponds to Table 2.1

1. Transitional or Long-Term Shelter

These are beds in transitional and long-term programs within the municipally administered emergency shelter system. This subset of shelter beds involves referral protocols or criteria, specific programming and support services, and no emergency intake. The target populations and program models vary. This system is now funded under as part of the Community Homelessness Prevention Initiative (CHPI). Until 2011 shelters were funded under a separate program, in which the formal cost-sharing was 80 percent provincial and 20 percent municipal. De facto cost-sharing in some cases had a significantly higher municipal share (e.g. 30 percent or more), due to enriched programs whose costs were beyond the cost-shared ceilings. These approximate net shares of cost have been carried over into CHPI in many Service Manager areas.

Some shelters operated directly by the municipality while others are operated by community agencies.

Examples in Toronto include Beatrice House, Strachan House, and transitional programs at Seaton House (see further description in Section 3.1).

2a. CHPI Housing with Related Support (Domiciliary Hostel)

This program accounts for over half the residents (beds) in boarding homes housing people with mental illness or addictions in Ontario. These are private-sector boarding homes that receive subsidies under a program administered by Service Manager municipalities (DSSABs – District Social Services Administration Boards – in Northern Ontario), within the Community Homelessness Prevention Initiative (CHPI). CHPI primarily funds homeless emergency and prevention services. These are still often referred to as "Dom Hostels" although the official name has changed.

The historical funding shares for domiciliary hostels were 80 percent provincial, 20 percent municipal, and approximately this cost-sharing has carried over into CHPI.

While these homes serve people with a mix of chronic conditions and disabilities, about two-thirds to three-quarters of residents have serious mental illness and/or addictions – more than in Homes for Special Care and Habitat Services combined. Specifically, a 2009 CRICH survey showed that 52 percent had serious mental illness diagnoses, 5 percent had high substance dependence, and 8 percent had moderate substance dependence; the extent of overlap was not reported. HSCs housed very few people who had recently been homeless although 35 percent had been homeless at some point in their lives.[5]

Provincial regulations under the *Housing Services Act* (HSA) require each Service Manager to set standards

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5   See Hwang et al. (2009), *A Survey of Domiciliary Hostel Program Tenants in Ontario*. This report documented 57% of Dom Hostels residents have Serious Mental Illness or "high substance dependence;" total mental illness and less severe substance use was higher than this. That report cited 4,700 total Dom Hostel beds based on data from MOHLTC which then oversaw the program, in collaboration with municipalities. 57% of 4,700 units is 2,700. An alternative higher estimate is in Centre for Addiction and Mental Health (2012), *From this Point Forward: Ending Custodial Housing*. That report cites 3,700 or 73% out of a stated 5,100 Dom Hostel stock per CAMH, *From this Point Forward*, footnote on p. 3. The latter figure is consistent with the 5,000 estimated in Raymond Chabot Grant Thornton (2012), *Study of Domiciliary Hostel Costs and the Domiciliary Hostel Program Per Diem Rate* (consultant report for OHSNA).

of care, consistent with provincial criteria.[6] Municipal regulatory regimes vary, but usually involve periodic reporting by the operator and inspections by municipal staff.[7] In many cases, a boarding home operator receives funding for less than all beds in the home, and in some cases receives CHPI funding for some beds and HSC funding for others in the same property.[8] Some municipalities issue licenses[9] while others have a legal agreement with the operator. Residents pay their full OW or ODSP cheque to the operator, and receive a small Personal Needs Allowance (PNA).

As a custodial model, this is not best practice in supportive housing, but practices and standards vary among operators. Since the advent of CHPI in 2011, program reform in this sector is becoming more widespread. Subsidies are in some cases being redeployed to more recovery-based supportive housing models and to forms of housing other than boarding homes. There are no properties in this category in the City of Toronto: see Habitat Services, below.

2b. Homes for Special Care

These are private-sector boarding homes that receive subsidies from the Ministry of Health and Long Term Care.[10] Residents live in a single or shared room, receive meals and housekeeping services, may get some level of other support, and receive a small Personal Needs Allowance (PNA) of $140 per month. People who are otherwise eligible to receive OW or ODSP do not receive it while residing in a Home for Special Care.

Each operator has a license under Ontario's *Homes for Special Care Act* (R.S.O. 1990, a successor to earlier statutes). Ontario Regulation 636 under that Act sets out provisions on licenses, inspections, standards, funding, and program administration. Program administration is carried out jointly by the Ministry's Mental Health Branch and the specialized mental health hospitals. The Ministry carries out licensing, per-diem funding, and payments to operators and other vendors for various supplies and residents' needs. The mental health hospital carries out inspections, handles selection and placement of clients through referrals to the homes, and also approves invoices for the diverse payments to operators for supplies etc. In some cases, a boarding home operator receives HSC funding for less than all beds in the home, and in some cases receives CHPI funding for other beds in the same property.

As a custodial model, it is not best practice in supportive housing, but the practices and standards vary among operators. As opportunities arise case by case, some HSC subsidies are being redeployed to more recovery-based supportive housing models and to forms of housing other than boarding homes.

2c. Habitat Boarding Home

The Habitat Services program, which is specific to the City of Toronto, subsidizes private boarding homes. Per-diem monthly payments are cost-shared approximately 80/20 by the Ministry of Health and Long Term Care and the City of Toronto. Program administration is carried out by Habitat Services, an agency established for the purpose, under a legal agreement with the City. Operators must meet standards

6   Ontario Ministry of Municipal Affairs and Housing (2014), *Community Homelessness Prevention Initiative (CHPI): Guide to the Housing with Related Supports Service Category*.

7   An overview is provided in Waterloo Social Services Department (2012), *Exploring Promising Practices in the Domiciliary Hostel Program*.

8   Waterloo Social Services Department (2012), *Exploring Promising Practices in the Domiciliary Hostel Program*; communication from Ministry of Health and Long Term Care staff.

9   Because the licensing system is not standard and statutory as in the case of HSC (below), it is less significant as an element in the regulatory regime and as a property asset.

10   See Ontario Ministry of Health and Long-Term Care (2011, *Operating Guidelines For Homes for Special Care*); Centre for Addiction and Mental Health (2012), *From this Point Forward: Ending Custodial Housing*.

of housing and of care as a condition of funding, and must provide access by support workers from the community support agency Cota, which receives funding for this purpose. Residents generally pay their full OW or ODSP cheque to the operator as rent, and receive a small Personal Needs Allowance (PNA). In the City of Toronto, this program serves the same market segment and client group as Homes for Special Care and CHPI Housing with Related Support (Dom Hostels). The genesis of this distinct approach in Toronto is discussed in section 3.

There are some variations within the Habitat category and program. A few of the Habitat homes are rooming houses (i.e. without meals and housekeeping) rather than boarding homes. Habitat funding is also used as a form of operating and support assistance for six non-profit congregate or boarding homes, and more recently three supportive housing apartment buildings (including the Parkdale Activity-Recreation Centre project in Table 2.3).

3a. Congregate High-Support Housing

These are beds (rooms or shared rooms) in houses that operate with a program model usually involving high staff-to-client ratio (often all day or 24/7 staffing) and supervised living. Properties were originally funded by the Ministry of Heath or in some cases through the social housing programs of 1978-1985.[11] In this report, "congregate" does not refer to self-contained apartments clustered in a building.

Congregate high-support housing is a specific subset of the broader *dedicated* mental health supportive housing programs. It is distinctive in its tenure and high supports. In common usage, outside the housing sector, this is usually referred to as *group homes* and in land use law and policy it is often termed *residential care facilities*.

The 2005 review of supportive housing by Durbin *et al*.[12] documented 1,263 units (excluding Homes for Special Care and approved homes), that had 24/7 staffing or on-site day staff and were located in either a rooming or boarding home or a group home or shared house.[13] This comprised 29 percent of the Health-funded supportive housing sector at the time; it would be 10 percent of the 12,800 units in today's larger Health-funded supportive housing system, but the count may well have declined absolutely. Many properties that originated as congregate high-support facilities for people with mental illness or addictions were converted in the 1990s onwards to become shared supportive housing with flexible supports (see section 3.4).

3b. Dedicated Mental Health Supported Apartments, Shared Houses and Rooming Houses

This is social housing with linked or partly linked housing-related support, in a program administered by the Ministry of Health and Long Term Care. Properties were developed (built or acquired) under the social housing programs of 1978-1995 and the nature of the housing funding reflects those program models. All residents must have a diagnosed serious mental illness or active serious addiction or associated symptoms and behaviour. The housing is permanent for the resident, and in most cases rents are RGI. A large majority of providers operate on a model of flexible supports tailored to individual needs; in many

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11   The social housing programs of 1978-1985, in addition to their primary role of funding permanent social housing with independent tenancies and apartments, were also used to pay for the property costs of a wide range of shelters, retirement homes, residential care facilities, and other high-support facilities. In these cases the housing program paid for the facility by way of a government-guaranteed mortgage and 35 to 50-year subsidies for its amortization, but the residential and support model was quite different from permanent social housing with independent tenancies and apartments. The social housing programs of 1986-1995 were not used in this way, with rare exceptions.

12   1998-2002 data used in Durbin et al. (2005), *Review of Ontario Mental Health Supportive Housing System*.

13   The Durbin et al. categories were "Rooming/boarding house" and "Co-op/group home" Co-op refers to shared or congregate houses (following Houselink usage); it does not refer to apartments in co-operative social housing buildings.

cases a third-party agency also provides housing-related support. Housing-related subsidies are provincial[14] and are administered by the MOHLTC Mental Health Branch. Most properties receive ongoing subsidies to cover mortgage amortization, RGI rent subsidies, and good repair, but some properties dating from before 1986 may have social housing mortgage subsidies only. Funding for housing-related support staff is provided by the LHIN in which the project (or provider head office) is located.

A substantial share of units are shared houses or other congregate living arrangements, and a substantial share are independent supported apartments, usually in small buildings of 30 units or less where all apartments and residents are in this program.

4. Supported Apartment, 1999-2016 Mental Health Housing Initiatives

Since 1999, the Ministry of Health and Long Term Care has significantly expanded the system of mental health supportive housing through a series of successive initiatives. These were carried out by community agencies and all funding is provincial. Virtually all units are independent apartments; most are in private-sector buildings with rent supplement to achieve RGI rents; and virtually all units have flexible supports. About 700 units are in properties acquired by the supportive housing providers with provincial capital funding in 1999-2002. The funding arrangements are parallel to *dedicated* supportive housing: the funding for rent supplement flows from the Mental Health Branch of the Ministry; the housing-related support is funded by the LHIN in which the project (or provider head office) is located. These unit counts include 216 units of At Home / Chez Soi.

This category is discussed in detail in section 2.3.

5. Alternative Social Housing

This is non-profit housing, usually with linked or partly-linked support, within the social housing system administered by Service Manager municipalities (DSSABs in Northern Ontario) and subsidized with municipal and federal dollars. Projects were developed primarily in 1987-1995 but in some cases earlier, within the active social housing production of the period. *Alternative* housing providers are designated under the *Housing Services Act* as having a "mandate, under section 76 of the Act, to provide housing to households that are homeless or hard to house,"[15] and this means an exemption from the normal requirement to take applicants from the general social housing waiting list. This definition includes housing and providers targeted to people other than those who have experienced chronic homelessness, but only the latter (comprising the majority of the *alternative* category) is considered in this report.

Many residents have significant mental illness or addictions, but projects are not specifically targeted to people with such a diagnosis or clinically identified chronic condition. *Alternative* housing has emphasized "provision and maintenance of stable housing and community development, rather than medical or psycho-social programs."[16]

The housing is permanent for the resident, and all rents are RGI. Virtually all providers operate on a model of flexible supports. The housing subsidies support amortization of capital costs, RGI rents, and good repair. Supports are funded from various sources including Supports to Daily Living (SDL) within the Community Homelessness Prevention Initiative (CHPI), and church, United Way, and fundraised sources.

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14   Some federal dollars from the annual social housing transfer to Ontario may be included in this funding (amounts are not publicly known).

15   O.Reg. 367/11, s. 49; also City of Toronto, *RGI Administration Manual*, chapter 1. (http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=77fcd4b4920c0410VgnVCM10000071d60f89RCRD)

16   ONPHA, "Glossary of terms and acronyms" https://www.onpha.on.ca/onpha/web/Non-profit_housing/Glossary/Content/About_Non-Profit_Housing/Glossary_of_terms.aspx?hkey=9b9dc7c3-90d7-48ed-915d-2cb2e0a14856 (accessed November 2015).

The devolved *alternative* housing category includes independent supported apartments and shared houses and rooming houses. These distinctions are discussed in section 3.

6. Supported Apartment or Shared Dwelling in Mixed Social Housing

A significant number of supported units are provided in devolved social housing, in projects other than those of *alternative* providers. There is no overall count of such units for Ontario or for the City of Toronto. Some properties or apartment units have been leased by municipal social housing agencies to supportive housing providers, to be operated as *alternative* or supportive housing. In other cases, municipal or other social housing providers have entered into referral agreements with support agencies whereby the latter select residents for designated units and provide supports, sometimes under a headlease arrangement. In still other cases, housing-related support services are being provided by LHIN-funded providers in high-need buildings, notably the recent pilot projects in Toronto Community Housing buildings that have large numbers of low-income single tenants.[17] Virtually all rents are RGI.

7. Supported Apartment, New Supply Programs 1999-2015

A significant number of projects funded under the new supply programs operating since 1999 are housing with supports. The main programs as of 2015/16 are *Investment in Affordable Housing* (IAH), formerly AHP,[18] and the relevant program stream of the *Homelessness Partnering Strategy* (HPS), formerly SCPI.[19] The prominence of projects serving people with mental illness or addictions or chronic homelessness arose from municipal priorities, federal HPS program parameters, and provincial IAH targets at certain points. Some rents in these projects are RGI while others are low-end market or below-market rents, i.e. not more than 80 percent of average market rents.

The AHP-IAH housing programs are administered by the Service Manager municipality (DSSAB in Northern Ontario), within broad parameters set at the provincial level. The housing funded under HPS/SCPI is administered by the "community entity" according to federal program parameters, usually either a Service Manager municipality, a United Way, or third sector coalition body.

Supports are primarily from health transfer agencies funded from the community mental health budget of the relevant LHIN. These supports are funded, and coordinated with housing, in diverse ways for different projects and by different providers. For example, various projects have been undertaken by health-funded *dedicated* providers. In other cases agencies such as Cota and the former CRCT have provided ongoing housing supports in projects sponsored by other agencies.

8. Streets to Homes and Housing First Time-Limited Supports

The City of Toronto's *Streets to Homes* program includes street and shelter outreach, rapid placement of clients in housing without the delays of a coordinated access or waiting list process, and follow-up supports. Clients are supported on a 12 to 18 month transitional basis, once the program has helped them move from homelessness to an independent apartment. Some of the units are in social housing with RGI

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17   On the latter, see Toronto Central LHIN (2015), "Briefing Note: Toronto Central Local Health Integration Network Board of Directors Meeting: June 24, 2015", pp. 9-19.

18   Before 2011, IAH was called the *Affordable Housing Initiative* (IAH), known in Ontario as the *Community Rental Housing Program* (2002-2003), later renamed AHP Pilot, and the *Canada-Ontario Affordable Housing Program* (AHP, 2003-2011).

19   The predecessor of the Homelessness Partnering Strategy was the Supporting Communities Partnership Initiative (SCPI) within the National Homelessness Initiative (NHI).

rents funded in various ways[20] but a majority are in private-rental buildings; overall about half of clients received rent subsidies. Streets to Homes outreach and follow-up support is resourced by a combination of federal funds through the Homeless Partnering Strategy (HPS) and municipal funds.[21] A large share of the persons served has mental health and addictions issues, but some do not. The main support agencies in this program include ones that provide LHIN-funded mental health supports,[22] although their Streets to Homes supports are not LHIN-funded.

Comparable programs exist in other municipalities.[23] This supports an inference that scores of additional units, and possibly one or two hundred, are supported in this way across the province, and that the province-wide totals exceed 1,000 units. But reliable province-wide information is not available.

9. Supportive Housing Outside Public Programs: Legacy Properties and/or Fundraised Dollars

Properties and resources outside of publicly funded programs are part of the range of supportive housing. Some organizations, especially those with church-sponsored origins, have properties that were acquired from parent organizations or bequests, etc. Fundraised, United Way, and church/faith denominational support is also an element in operating resources for certain supportive housing organizations. These resources are a relatively small part of overall stock of housing and operating funds that sustain the supportive housing sector.

2.3 Initiatives of 1999–2016

The initiatives of the 17 years since 1999 have added 7,368 units to the health-funded sector of housing with supports system for people with mental illness and addictions. Virtually all rents are RGI. Table 2.2 provides a summary of these initiatives.

These health-funded initiatives and the relevant projects in the programs for new affordable housing and homelessness have increased the scale of the pre-existing system by two-thirds. Netting out the boarding homes, they have increased the combined supportive and homeless-focused *alternative* sectors by 140 percent.

2.3.1 Ministry of Health and Long Term Care Initiatives 1999-2016

Phase 1 and 2 Mental Health Homelessness initiative[24]

The Phase I and II *Mental Health Homelessness Initiative* were implemented in 1999-2003 by the Ministry of Health and Long Term Care, adding approximately 3,000 units over and above the *dedicated* supportive housing system. The program goal was to enable homeless people with serious mental illness to be provided

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20   See Falvo (2010), "Toronto's Streets to Homes Program," in *Finding Home*. At the time of that document was researched, approximately 60 percent were in private rental (one in four of these receiving a housing allowance); approximately 20 percent in mental health supportive housing or 'Alternative' housing, and approximately 20 percent in other social housing.

21   See also Raine and Marcellin (2007), *What Housing First Means for People: Results of Streets to Homes 2007 Post-Occupancy* Research.

22   These include Cota and Toronto North Support Services.

23   For other larger Ontario cities, see for example, Fiona Scott (2013), "Hamilton, Ontario: Transitions to Home"; Waterloo Regional Municipality Social Services Department, (2011), *STEP Home Year 3 Evaluation Report*; Waterloo Regional Municipality, Social Services Department, (2011), *Program Review Resource Guide: Selected Longer Term Housing Stability Programs for People Experiencing Homelessness in Hamilton, Toronto and Ottawa*. Various HPS community plans and Service Mangers' ten-year plans for housing and homelessness give priority to such approaches.

24   Ontario, Auditor General, 2002 report, p. 104; Sylvestre et al. (2004), *Evaluation of Phase I of the Mental Health Homelessness Initiative,* pp. 1-2; Ontario news release, November 22, 2000, "Ontario provides $72 million to help house and support people suffering from mental illness"; Ontario news release, Oct. 7, 1999, "Ontario to provide $24 million for housing and services for homeless persons with serious mental illness."

stable permanent housing with supports. Clients were required to have a diagnosis of serious mental illness and to be homeless or at high risk. Only health transfer agencies with experience in mental health supportive housing were eligible, setting an approach that carried through virtually all the initiatives of 1999-2016.

Table 2.2
Added Mental Health and Related Homelessness Supported Housing in Ontario and the Toronto Area, 1999-2016

		Date Implemented	Housing Units		Notes
			Ontario	City of Toronto	
	A. Ministry of Health and Long Term Care Initiatives				
1	Mental Health Homelessness Initiative Phase 1	1999-2001	962	724	Included 160 units in Toronto with capital funding.
2	Mental Health Homelessness Initiative Phase 2	2000-2003	2,000 ap-prox.	348	Included 144 units in Toronto with capital funding.
3	Mental Health and Justice	2005-2006	1,000	710	
3	Mental Health Initiative	2006-2007	1,250	315	
5	People with Problematic Substance Use Program (SHPPSU) (Addictions)	2008-2011	1,000	304	
6	Phase 2 of Mental Health & Addictions Strategy	2014-2016	1,000	127	
	Subtotal MOHLTC		7,368	2,528	From MOHLTC.
	B. Post-1999 New Affordable Rental Supply				
7	SCPI-HPS Housing (federal homeless-ness program)	2000 - present		1,400	Approximate estimate. See details in table 2.3.
8	AHP/IAH (Affordable Housing Program / Investment in Affordable Housing)	2003 - present			
	Subtotal Municipal		3,000	1,400	Approximate estimates
	C. Dispersed housing first and Other Rent Supplement				
9	Streets to Homes and housing first in other municipalities	2005 - present	>1,000	800	Approximate estimate.
10	Strong Communities Rent Supp (men-tal health targeted units)	1999-2002	*	*	Approximately 1/5 to 1/4 of 1,296 various supportive units
11	At Home / Chez Soi (Mental Health Commission of Canada)	2010 - present	216	216	Ontario funded these units upon expiry of federal pilot.
	TOTALS (estimated)		**>11,000**	**>5,000**	

Sources by row:
1 to 6. Information from MOHLTC documents and staff. Also Johnston Consulting 2013 for SHPSSU/ASH; City of Toronto reports.
7 and 8. Toronto: Estimate tallied from municipal housing project approvals reports. For Ontario, see text.
9 City of Toronto: Communication from City of Toronto staff. Ontario: rounded up to nearest 1,000.
10 At Home Chez Soi reports and Ontario news release.
* Unknown

Phase 1 was announced in 1999 and created 962 units in the province's three largest urban areas: approximately 800 in Toronto and 100 each in Ottawa and Hamilton. The announced expenditure was $24 million. Of this about $19 million was in Toronto, approximately half capital and half operating, the latter annualized.[25] Funding included a 100-bed expansion of the Habitat Services boarding home program in Toronto.

The evaluation of Phase 1 documented that about 85 percent of those served had a diagnosis of schizophrenia[26] and that 40 to 53 percent (varying by provider or area) had been homeless (including hospital and jail/prison) before being housed. Of the 17 programs funded, 5 had high supports, 4 moderate, and 8 low.[27] Headlease rent supp projects included apartments clustered in particular buildings and apartments scattered in various locations; acquisition projects included converted houses and quasi-institutional "residential facilities."[28]

Phase 2 of the initiative was announced in November 2000. The announced expenditure was $37.9 million in capital funding plus $29.7 million annual funding for housing operating costs and support services.[29] In Toronto the announced expenditure was $9.1 million in capital plus $3.5 million annual operating, the latter annualized. Also announced at the time were other funds for community mental health. There was flexibility for different providers to offer different support service models. A staff-to-client ratio of 1:10 was the norm.[30]

Housing was funded in two ways. The first option, which covered the majority of units, was operating funding for headleases and referral agreements whereby the housing provider leased a property or set of units and sublet them to tenants in need. The second option was capital funding for property acquisitions, usually involving renovation and/or conversion from non-residential use. Headleases were the policy priority but purchase was permitted in markets where vacancy rates were low and affordable units scarce.

Mental Health and Justice Initiative

The *Mental Health and Justice Initiative* was announced in January 2005,[31] and included expansion of supportive housing along with intensive case management, safe beds and other mental health services. It was part of a broader range of mental health funding announced in 2004 to 2005, with the creation at the time of provincial and regional Human Services and Justice Coordinating Committees.

The population served was people with mental illness and criminal justice involvement (courts, prisons, probation, etc.). The housing component involved rent supplement and relatively high supports, at respectively $6,000 per and $10,500 (total $16,500) per client annually.

Total funding in the Mental Health and Justice initiative was $27.5 million annualized. In the City of Toronto the total was $10.6 million including $6.5 million for supportive housing; four agencies[32] were

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25   Agencies in Toronto funded under Phase 1 included AIS, LOFT, CMHA Toronto, Cota, Eden House, Gerstein Centre, Good Shepherd, House-link (in partnership with other agencies), Progress Place, Regeneration House, St. Stephen's Community Services, and Woodgreen Community Housing. Agencies funded in the '905' GTA included Supportive Housing in Peel. (Source: Ministry of Health and Long Term Care news releases.)

26   Sylvestre et al. (2004), *Evaluation of Phase I of the Mental Health Homelessness Initiative,* p. 10.

27   ibid., p. 10.

28   ibid., pp. 20-21.

29   George et al (2005), p. 7, cite $25 million for housing and $60 million for supports in fiscal 2001/02, but this appears incomplete.

30   Agencies in Toronto funded under Phase 2 included AIS, CAMH, LOFT, CMHA Toronto, Cota, Rouge Valley Health System, Hong Fook, Good Shepherd, Mainstay, and St. Jude. Agencies funded in the '905' GTA included Supportive Housing in Peel, Summit House (Halton), LOFT (York Region), and Colborne Community Services (Whitby).

31   Ontario, news release Jan 12, 2005, "McGuinty Government Helping People with Mental Illness Stay Out of Jail."

32   LOFT as coordinator plus: Cota, Houselink, and CMHA Toronto.

each allocated about 100 units, some of them implemented in partnership with other providers having a specialized expertise or client base. In the "905" GTA, dollars allocated were allocated to mental health services but not to supportive housing.

Mental Health Initiative of 2006

In May 2006 the government announced an expansion of mental health funding and services, with several components. These included Assertive Community Treatment (ACT) teams, crisis response and early psychosis intervention as well as funding for courts and jail/prison-related initiatives. The announcement included $16 million for rent supplement and supports for 1,250 additional units. Unlike the Phase I and II initiative, there was no capital funding.[33]

People with Problematic Substance Use Program (Addictions)

The *People with Problematic Substance Use Program* was initiated in March 2008 and is also referred to as Addiction Supportive Housing (ASH). It was targeted to serve people with active and severe addictions. The main objectives included reduced use of hospital emergency services, and reduced re-admission to withdrawal management or other addiction programs impacts.[34]

The program involved $16 million for 1,000 rent supplement supportive housing units across Ontario. This Funding covered rent supplement costs as well as Intensive Case Management support staff.

In the City of Toronto, 304 rent supplement units were funded – 272 by TC-LHIN and 32 by CE-LHIN. There were 64 in the "905" GTA – half in Durham and half in Peel and Halton. Like the Phase 2 mental health homelessness initiative, this program flowed relatively more resources to communities outside the GTA. Due to the planning time required, most rent supplement units first housed clients in 2011.

Regional/local priorities and delivery plans were developed by the various LHINS, within MOHLTC guidelines. The funded client/staff ratio was not more than 8:1. In order to make best use of expertise, funded agencies were mostly ones with experience; partnerships among them were encouraged, accounting for three-quarters of the funded programs. Many partnerships reflected the strength of mental health housing agencies in housing but not in addictions, and the reverse expertise for addictions agencies.

Although the program was premised on *housing first* principles, about 60 percent of units involved permanent tenancies, 20 percent temporary (with tenancies under 1 years) and the remainder variable depending on client needs. Most units were in the private-rental sector (accounting for 80 percent of funded providers), with the rest in clusters in municipal or other social housing. Independent leases and headleases each accounted for just under 40 percent of providers, the remainder via other arrangements. In three-quarters of providers, client engagement with support services was a condition of rent supplement; both abstinence and harm reduction approaches were used.

A 2013 program evaluation documented considerable success of numerous providers, as measured by four health service usage indicators.[35]

At Home / Chez Soi Remaining Units

At Home / Chez Soi was a demonstration project of a *housing first* approach on the model used by Pathways to Housing in New York. It was carried out under the auspices of the Mental Health Commission

33   Ontario, Ministry of Health and Long Term Care, news release May 19, 2006, "McGuinty Government Expanding Community Mental Health Services."

34   Johnston Consulting (2013), *Addiction Supportive Housing Implementation Review: Program Snapshot*. As of this report, 996 rent supplement units had been funded.

35   Johnston Consulting (2013), *Addiction Supportive Housing Implementation Review: Evolving Practices – Interim Report*.

of Canada (MHCC) in 2010-2013 and Toronto was one of five sites across Canada, with 301 clients. [36]

When the federally funded pilot project ended in 2013, the government of Ontario continued the rent supplement and support funding for the clients then remaining in the program on a permanent basis. The population served has serious mental illness and has experienced chronic homelessness. The initiative provides rent supplement (RGI rents) and flexible supports – Assertive Community Treatment (ACT) and/or Intensive Case Management (ICM). These units are counted in the other recent MOHLTC initiatives.

Phase 2 of the Mental Health & Addictions Strategy

A part of Phase 2 of the Mental Health and Addictions Strategy adopted in 2011,[37] the province allocated funding for 1,000 new rent supplements with supports. This was implemented in stages over the three fiscal years 2014/15 through 2016/17 (the largest share in 2015/16) and with various unit counts allocated by LHIN in each year. The target group was people with active addiction and mental health issues, using *housing first* principles for those who are homeless. The annualized cost once fully implemented is $16.2 million; the funded client/staff ratio was 8:1, consistent with most other post-1999 initiatives.[38]

This included 127 units allocated in the City of Toronto. Some of these were delivered by experienced mental health supportive housing agencies, in partnership with addiction service providers, using headleases; other units were delivered by an experienced provider that is both health-funded and *alternative*, using individual tenant leases.

2.3.2 Strong Communities Rent Supplement Program

In 1999 Ontario initiated what became the Strong Communities Rent Supplement Program (SCRSP), from savings related to the annual transfer under the CMHC-Ontario Social Housing Agreement.[39] Originally funded for five years, it was extended in 2004 for a 20-year period ending in 2023. It was implemented by Service Managers with allocations by and accountability to the Ministry of Municipal Affairs and Housing.[40] Units were delivered in a mix of private rental, social housing, and new housing projects funded under the Canada-Ontario Affordable Housing Program (AHP, the predecessor of IAH – see subsection 2.3.3).

One-fifth of all units in the program (1,296 of about 6,500) were supportive housing, where the rent supplement was paired with support funding from MCSS or MOHLTC. Mental health and addictions, with support funding from MOHLTC, was one of five types of supportive categories within that total. Current data are not available on the number of mental health and addictions units. Because some units were stacked onto AHP projects, unit counts partly overlap between that program and SCRSP.

About 1,841 total SCRSP units were allocated to the City of Toronto,[41] a proportionate share of these

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36   Goering et al. (2014), *National At Home/Chez Soi Final Report* (Mental Health Commission of Canada); Stergiopoulos et al. (2014), *At Home/Chez Soi Project: Toronto Site Final Report* (Mental Health Commission of Canada).

37   Ontario (2011), *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. The first phase of action under the strategy, in 2011-2014, had focused on children and youth mental health.

38   Information from MOHLTC staff. See also "Ontario Investing in 1,000 Supportive Housing Units" (Ministry of Health and Long Term Care news release, December 18, 2015).

39   This was the 1999 agreement between Canada Mortgage and Housing Corporation and Ontario (parallel to agreements in other provinces) that devolved all social housing program administration responsibility to the province, aggregating all related federal funding into an annual transfer to the province, phasing out over 34 years.

40   See Ministry of Municipal Affairs and Housing (2004), *Strong Communities Rent Supplement Program* [program guidelines]. SCRSP was at first called the Homelessness Rent Supplement program then the New Tomorrow Rent Supplement program, renamed *Strong Communities* in 2003.

41   "Long-Term Funding Guarantee for the Provincially Funded New Tomorrow Rent Supplement Program" (report by the Community and Neighbourhood Services Department to the Community Services Committee of Toronto City Council, July 2003).

being supportive.

2.3.3 New Supply Initiatives 1999-2015

Since 1999, a significant number of supportive units targeted to people who are homeless or have mental illness or addictions have been created in new buildings funded under affordable housing and homeless programs since 1999. These are:

- Investment in Affordable Housing (IAH), whose predecessor until 2011 was the Canada-Ontario Affordable Housing Program (AHP).
- Homeless Partnering Strategy (HPS), whose predecessor until 2007 was the Supporting Communities Partnership Initiative (SCPI).
- A few unilateral municipal projects.

IAH/AHP is an affordable housing program which is distinct from the pre-1996 social housing programs. HPS/SCPI is a homelessness program that also funded a significant number of added transitional and supportive housing units. In Ontario, the post-1990s programs, unlike earlier social housing, do not involve financing (mortgages etc.) as an integral part of program design, ongoing operating subsidies, or RGI rents for a high proportion of units. HPS and variations of IAH exist in all provinces.

There is no direct connection between AHP/IAH and Ontario's Long Term Affordable Housing Strategy. AHP/IAH exists in all provinces whether or not they have a housing strategy; it predates the Ontario strategy and most of the goals in the strategy are not systematically linked to program implementation measures.

Investment in Affordable Housing (IAH)

AHP/IAH has existed in Ontario since 2003,[42] and is administered by Service Manager municipalities (DSSABs in Northern Ontario), within provincial guidelines. The main priority until 2014 has been new affordable rental; AHP/IAH also funds housing allowances and a small amount of subsidized repairs and affordable homeownership.

AHP/IAH provides federal-provincial capital grants. Since 2004 (except DOOR), grants have averaged no more than $100,000 per unit, sometimes higher for particular projects. Funding is a mix of federal and provincial funds (typically about 40 percent each) and municipal funds, tax exemptions, or land (typically about 20 percent). The funding typically covers half to two-thirds of project capital costs, the remainder coming from a mortgage, with much variation by project, local community, and phases of the program. The capital grant enables the mortgage to be small, which enables low ongoing costs and thereby low rents, subject to monitoring under an agreement.

The Service Manager municipality (or DSSAB) sets local priorities, selects the projects to be funded, and oversees adherence to conditions of funding once the project is operating. Two-thirds of units funded under IAH and related programs have been non-profit (including municipal) and one-third assisted private rental.

Homelessness Partnering Strategy (HPS)

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42   Nationally, AHP was known as the *Affordable Housing Initiative* (AHI). It was rebranded in 2011 at the federal and Ontario levels as *Investment in Affordable Housing* (IAH), with more flexible allocation between capital needs and rent subsidies. AHI in Ontario in 2003-04 was called the *Community Rental Housing Program*, later renamed the *AHP Pilot*. Closely related programs include funding for new affordable rental housing within the 2006-07 federal housing 'Trust Fund'; within the 2009-11 housing stimulus program (Canada's Economic Action Plan – CAEP); in an Aboriginal housing program under the AHP/IAH umbrella; and within special funding for the Pan-Am Village in Toronto. Ontario designated part of its 'Trust Fund' monies as capital in the *Delivering Opportunities for Ontario Renters* (DOOR) program, allocated these to service manager municipalities with few restrictions other than a requirement to use it for affordable housing; some municipalities used this in a program model similar to AHP. Municipalities including the City of Toronto and Peel had also initiated a few projects with unilateral municipal funding in 1999-2001 before the advent of AHP and SCPI.

SCPI/HPS has existed since 2000. It is administered by "community entities" approved by the federal government. In the GTA, the community entities have been the City of Toronto, the two regional municipalities of Peel and Halton, United Way York Region, and United Way Durham. The community entity sets local priorities, subject to stakeholder input and federal approval, and it selects specific projects to fund.

From 2000 to 2011 in the City of Toronto, approximately 20 percent of federal funding was allocated to capital for transitional and supportive housing.[43] This was the pattern nationwide in early rounds of SCPI, where one-quarter of funds went to that priority.[44] Since then, federal program rules have mandated a focus on Pathway-style *housing first* models although without provision of housing subsidies as an integral part of the program.

Selected Program Data and Characteristics

Rent levels: In AHP/IAH the maximum permitted rent is 80 percent of local average market rent – for example, for a one-bedroom apartment in Toronto, 80 percent of an average $1,103 monthly rent (2015)[45] is $882. This is high for low-income tenants. The SCPI/HPS program did not specify a rent level and this was left to the community entity and the proponent/provider to work out.

Low-income rents: Rents affordable to low-income tenants have been achieved in AHP/IAH and SCPI/HPS projects in several ways. These include larger capital grants for some projects, especially in SCPI/HPS; stacking Strong Communities Rent Supplement in early rounds of AHP; unilateral municipal RGI subsidies (not found in the City of Toronto); and transferring existing RGI rent supplement to these projects. In early rounds of AHP about one-third of units had RGI rents.[46]

It also appears that some health-funded providers have used a combination of AHP/IAH and SCPI/HPS capital funding in certain of the projects noted in Table 2.3. Such "stacking" is explicitly permitted since December 2014,[47] but some cases apparently predated this in practice.

Production volumes in Ontario: AHP/IAH production has averaged about 1,400 new units annually in the period 2003-2014, with significant year-to-year variation.[48] Average annual volumes have been about 500 in the City of Toronto and 300 in the "905" GTA.[49] Since 2011 and especially 2014, IAH has been funded at lower levels, and approximately half of IAH funding is now being allocating to housing allowances, resulting in lower average production (no data available). No tally exists of units created through SCPI/HPS.

Production volumes in the City of Toronto: Table 2.3 provides a tally of AHP/IAH and SCPI/HPS projects and units in the City of Toronto that are supportive housing for people with mental health or addictions or experiencing chronic homelessness. These 1,400 units over approximately 15 years comprise about one-fifth of all units AHP/IAH and SCPI/HPS funded in the city over the period. (Not to be confused with the province-wide average of 1,400 annually). The prominence of mental health and addictions providers in the post-1999 new supply reflects partly a municipal priority to respond to homelessness, and partly

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43   Toronto Community and Neighbourhood Services Department (2000), *Community Plan for Homelessness in Toronto*; Toronto Shelter Housing and Support Division (2003), *Building on Successes: The Community Plan for the Supporting Communities Partnership Initiative in Toronto 2003–2006*.

44   Canada, HRSDC (2004), *National Homelessness Initiative: 1999-2003 Progress Report* (Ottawa: HRSDC), p. 13-17.

45   CMHC, *Rental Market Report: Greater Toronto Area* (fall 2015).

46   Ontario, Ministry of Municipal Affairs and Housing (2006), *Projects in Profile* (Toronto: MMAH).

47   Ministry of Health and Long Term Care (2014), "Subject: Co-ordination of MOHLTC Rent Supplements with Other Housing Programs" (Program Directive, MOHLTC Provincial Programs Branch)

48   The Ministry of Municipal Affairs and Housing website (http://www.mah.gov.on.ca/Page10663.aspx#) cites 16,722 to September 2014.

49   Estimated from reports to municipal councils, and MMAH data reported in Ontario Non-Profit Housing Association, *Where's Home? 2013*.

the fact that supportive providers have been among the more active, entrepreneurial, and higher-capacity proponents.

Production volumes across Ontario: The share of AHP/IAH and SCPI/HPS units that are targeted to people with mental health or addictions or experiencing chronic homelessness is unknown at the Ontario level. Nevertheless, projects of this type have been a significant priority in almost all main urban centres.

In the absence of specific information, Table 2.2 incorporates an assumption that about one-fifth of all AHP/IAH units funded across Ontario have been targeted to this population. This reflects the proportion found in the City of Toronto across AHP/IAH and SCPI/HPS. The province-wide numbers for SCPI/HPS-funded units is unknown. If SCPI/HPS units were added to both the numerator and denominator in the ratio of {supportive units / total units} this would raise the resulting one-fifth figure. Ministry of Municipal Affairs and Housing data[50] show that up to December 31, 2015, 18,279 units of new affordable housing were funded under AHP/IAH. One-fifth of this (rounded down to the nearest 1,000) is 3,000 units.

Funding of support services: Support services in AHP/IAH and SCPI/HPS have been funded in various ways, unrelated to the housing funding through those programs. In various cases, supports have been provided by LHIN-funded support agencies.

Table 2.3
New Municipal Homeless or Mental Health Units, City of Toronto, 2000-2014
Homelessness and mental health units funded through Federal-Provincial new affordable housing programs (AHP/IAH) or the Federal homelessness program (SCPI/HPS)

Provider	Units	Date Completed	Provider	Units	Date Completed
St. Clare's Multifaith Housing	51	2001	Alternate Living Solutions	25	2007
St. Vincent de Paul Society	28	2001	Houselink Community Homes	14	2007
Visiting Homemakers Assoc. with Cota	27	2002	Rouge Valley Health System	30	2008
Na Me Res	3	2002	Wellesley Central Residences	112	2008
Dixon Neighbourhood Homes	12	2003	Houses Opening Today Toronto	8	2008
House of Compassion	11	2003	Salvation Army	98	2009
Houselink Community Homes	26	2004	Na Me Res	22	2009
St. Jude	28	2005	Native Child and Family Services	6	2010
Mahogany with Houselink	19	2005	Alternative Living Solutions	29	2011
St. Clare's Multifaith Housing	84	2005	WoodGreen Community Housing	28	2011
Toronto Community Housing with Deep Quong	86	2005	Parkdale Activity-Recreation Centre	29	2011
Salvation Army	18	2005	St. Clair West Affordable Housing	20	2011
Evangel Hall	84	2006	St. Clare's Multifaith Housing	190	2011
St. Clare's Multifaith Housing	26	2006	Christian Resource Centre	87	2012
Mahogany with Regeneration House	30	2006	Fred Victor & Wigwamen	100	2014
Fred Victor Homes	48	2007	**Total**	**1,379**	

Source: Tallied from municipal reports to City Council.

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50   MMAH website at http://www.mah.gov.on.ca/Page10663.aspx#, accessed February 2016.

3. How and Why the Different Models Emerged

Existing program models reflect policy decisions and providers' initiatives that occurred at specific times and then were entrenched as programs models. Because housing involves physical structures and real property, the interests of third parties (mortgage lenders, municipal regulation, etc.), and an asset with rising replacement costs over time, housing programs and the built assets they create and sustain are less readily altered than programs that consist mostly of staffing.

This section deals with the evolution of housing models, and of support models only as they relate to these.

The evolution has had four main influences that have interacted with and influenced each other:
- Concepts and principles in community mental health (in Canada and internationally)
- Affordable housing policy and programs in Canada and Ontario
- Housing market contexts, changing through different periods
- Policy and program decisions in supportive housing, reflecting these other influences.

3.1 Transitional and Long-term Shelters

For many years, local homelessness programs have included not just emergency shelter, but also services to help people move out of chronic homelessness and into longer-term accommodation. Local shelter systems expanded in ad hoc and planned ways to include support services and specialized facilities to those ends. These have included longer-term supportive units as well as transitional housing, both paid for via shelter system funding.

This arose through a mix of deliberate decisions, evolving user needs, and shortfalls in supportive housing. In the Toronto area this was especially notable in the period of 1995 to 2005, i.e. from the end of large-scale social housing production until the new emphasis on *housing first* in Streets to Homes. Until 2011 when shelter funding became part of the Community Homelessness Prevention Initiative (CHPI) and its capped envelope, shelter funding was an available, uncapped, and cost-shared resource to provide short-term accommodation to people experiencing homelessness.

There are ambiguities in the extent to which various cases should be considered as "housing," in terms of criteria such as whether residents pay rent or residency charges, and the length and conditions of tenure. Examples of shelter funding used for transitional and supportive units include the following, in Toronto:
- *Fort York Residence – transitional units:* This facility was built in 2003 to serve men making a transition from homelessness to stable employment. Clients initially use one of the 74 dormitory shelter beds, and as their lives stabilize and they become more steadily employed, they may move to one of the 24 mini-bachelor units, which are transitional housing where they pay rent.[51]
- *Seaton House Residence:* The large Seaton House men's shelter provides not only emergency accommodation but longer-term accommodation for people with histories of chronic homelessness and related chronic conditions of mental illness or addictions, with provision for rent payment by long-term residents. "The Seaton House facility, inadequate as it is, has become de facto long term and/or supportive housing or long-term care for many of its residents."[52]

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51   Canada Mortgage and Housing Corporation (2011), *Project Profile: Fort York Residence*; City of Toronto, http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=66ccd4b4920c0410VgnVCM10000071d60f89RCRD

52   Toronto Shelter Support and Housing Administration Division (2013), *Update and Next Steps of Proposed Redevelopment of Seaton House and Revitalization of George Street* (June 2013 report to the Executive Committee of City Council), p. 10.

- *Strachan House:* This is a large building of collective dwellings with flexible supports, intended as a first stage of housing for people with histories of chronic homelessness and in many cases mental illness or addiction. It is operated by the Homes First Society with provides supports on a harm reduction basis. It opened in 2003 as a successor to the famous Street City. It is an award-winning conversion of a warehouse, and has 76 rooms in 12 congregate houses.[53]
- *Beatrice House:* Until it closed in 2015, this facility operated by the YWCA was a transitional residence for homeless women with children, or those at high risk, providing stays of up to two years with high supports.[54]

These examples illustrate the significant presence of transitional and longer-term supportive accommodation in the shelter system, which exists in varying degree across Ontario.

3.2 Congregate High-support Housing

Congregate housing with high supports, provided as an integrated bundle, was the dominant model of supportive housing in the 1970s and into the early 1980s, alongside subsidized boarding homes. These were commonly referred to as group homes or residential care facilities. In community mental health policy and practice across North America, this was the model by which people with mental illness could live in the community rather than institutions – as it was for other populations with disabilities or chronic conditions. (As noted, "congregate" in this report does not refer to self-contained apartments clustered in a building.)

Congregate high-support housing was part of a "linear residential continuum" approach to housing with supports, which conceived of various levels of housing, defined by the type, frequency and duration of support services. The premise was that a resident's needs were in transition, and that he or she would move on from one housing situation to another, with successively lower bundled support services.

There were three main reasons for this model of congregate high-support housing: in costs and funding, prevailing ideas of integration, and ideas about support needs.

Congregate housing was most feasible because of its lower capital costs compared to apartments or institutions, and its use of existing available properties. In the 1970s the social housing programs did not yet serve populations other than families and seniors. A group home offered cost-efficiencies in terms of capital or amortization costs: in many older neighbourhoods, a house to accommodate about 4 to 10 people could be bought for the price of a couple of apartments. Housing operating costs were far lower per resident than they would be of people lived in separate apartments. Given that clients were believed to require daily support and perhaps supervision, the congregate model also facilitated efficient staffing.

This model was a means of social integration into the community. It could be implemented in ordinary neighbourhoods in readily available housing stock: in a converted large older house, and sometimes in an average suburban house. In the late 1970s and early 1980s there was strong advocacy to facilitate integration by permitting "group homes" in low-density neighbourhoods without special urban planning approvals, and this was implemented in urban planning policy and zoning law across Ontario.[55]

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53   http://www.homesfirst.on.ca/properties.

54   http://www.sharedlearnings.org/index.cfm?fuseaction=Dir.dspOrg&orgsid=4333bfbd-c404-41f2-8574-7bc177cad8b3

55   See for example, Metropolitan Toronto (1979), *The Establishment of Group Homes in Metropolitan Toronto: Report of the Staff Technical Committee on Group Homes*; Toronto (1977), *Report of the Working Committee on Group Homes*; also Trainor et al. (1987), "The Supportive Housing Coalition: A Model for Advocacy and Program Development" *Canadian Journal of Community Mental Health* 6(2), 101-102.

High supports in supervised, structured environments were believed by many to be needed by people with serious mental illness leaving a psychiatric institution. This was essentially a replication "in the community" of the supervised living that had long existed in psychiatric hospitals. For people whose skills of daily living were assumed to be insufficient for independent living, this offered a way to live in the community, with structured daily routines, and with meals, housekeeping and medications supplied by the provider.

Capital costs of such housing in the 1970s and 80s were either covered directly by the Ministry of Health[56] or else by mortgages arranged through social housing programs. From 1975 to 1985, the latter programs[57] in many cases provided the mortgage, without necessarily funding Rent Geared to Income (RGI); in these cases the Ministry of Health typically covered the operating and amortization costs.

Congregate high-support housing was the model against which the 1980s reformers reacted, with new ideas of normal living environments and flexible supports, discussed below. In the three-part 1980s typology of custodial housing, supportive housing, and supported housing, "supportive housing" originally meant congregate high-support housing. In the early 1990s various providers converted such facilities into shared houses with flexible supports (section 3.4), a form of *dedicated* supportive housing.

Although congregate high-support housing is not a preferred model of supportive housing for most people, it remains a valid option for some. Congregate housing entails more social connection and interaction, which is helpful for some people living with mental illness or addiction. Its suitability to specific property opportunities that sometimes arise, will mean that congregate housing comes up as a practical option.

But the main reasons for congregate housing are in costs and operational needs. Its lower capital costs per resident will remain a powerful consideration. The range of supportive housing must include residential facilities where staff is on site 24 hours a day, every day, because residents' needs require that. Research[58] as well as providers[59] have identified a need for more high-support housing, some of which would require 24/7 or all-day staffing. For the significant minority of supportive housing residents who require meals to be provided, cost considerations necessitate either congregate housing or clustered apartments. High-support models can also be provided in other built forms, including apartments, or quasi-institutional settings analogous to retirement homes, but congregate housing offers efficiencies in capital and operating costs.

3.3 Subsidized Boarding Homes

General Context – Boarding Homes

A room in a boarding home was historically a main urban housing option for single working or retired people with low incomes. Until about the 1970s, very few single persons rented their own apartment unless they had middle or upper incomes; instead they rented a room. A boarding home was a rooming house

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56   Communication from CAMH staff.
57   15.1 and 56.1 programs, i.e. s. 27 and 95 today. Author's knowledge of section 95 non-profit programs and of City administrative data. The CMHC evaluation of the latter documented the widespread use of the program for social program purposes, in addiction to independent dwelling units: Canada Mortgage and Housing Corporation, Section 56.1 Non-Profit and Cooperative Housing Program Evaluation.
58   See Butterill et al. *(2009) From Hospital to Home*, p 29.
59   Addictions and Mental Health Ontario (2014), *Time for Concerted Action on Affordable Housing*, p. 6; Wellesley Institute (2015), *Coming Together on Supported Housing for Mental Health and Addictions in Ontario*.

where housekeeping and meals were provided, often with a considerable element of social control as well.

In postwar Canada as living standards rose, more single persons came to form their own household and rent an apartment. The boarding home sector then became home to many people with very low incomes, including many unable to live independently without some daily assistance. In the 1950s, social housing was very rare; after 1964 that sector expanded rapidly but subsidized apartments for non-senior singles were unknown until the 1980s and they were not eligible for Rent Geared to Income (RGI). Room renting remained dominant for this population.

A large supply of rented rooms was available. Having a 'boarder' had been normal for lower-income homeowners, who were still numerous in 1950s or 60s Ontario. Although OAS arrived in 1952 and CPP in 1966, far fewer people had pensions and renting out rooms was a way to for older homeowners to keep their house. Meanwhile, rapid suburbanization moved most middle-income housing demand out of the central city, and this freed up other houses to be converted into flats or rooms for low-income renters.

As deinstitutionalization gathered force in the 1970s, boarding homes emerged as a main model of supported or supervised living in the community, alongside group homes. Ontario followed a pattern seen across Canada, the US and other affluent countries in that period. The population involved was large enough to have a big impact in the rental market. In 1965, on the eve of deinstitutionalization there were a reported 69,000 people in psychiatric hospitals in Canada, dropping to 20,000 by 1981.[60] This 50,000 difference equates to about 30,000 households:[61] 2,000 in an average year and close to 3,000 a year in the 1970s when most of it occurred. In that period the annual increment in rental demand in the first (lowest) income quintile in Canada averaged approximately 36,000 annually.[62] So in round terms deinstitutionalization added 10 percent to potential low-income renter demand and added a much higher share – probably about one-third – to the subset which was non-senior singles.[63] With very low incomes and facing discrimination, they were not able to rent apartments, and boarding homes met their demand.

But for deinstitutionalized low-income single people, the extent of disadvantage and constrained choice in the market, the poor quality of daily life in the boarding home, and the imbalance of power between landlord and tenant, were more extreme than for ordinary room renters. There were grave risks and many examples of exploitation and abuse, poor food, housing quality, fire risk, and overcrowding.

This invited a response and intervention by municipalities, psychiatric hospitals and community agencies. One approach was to pay a private operator to house people with mental illness. The target population was living there anyway, and the carrot of subsidy could secure more acceptable standards. Another approach was to purchase and operate such a property and provide housing directly. In either case, the lack of social housing subsidies for singles dictated a rooming/boarding house financial model where rents could cover operating and amortization costs – not apartments where low-income rents could not possibly cover costs.

Boarding homes are also referred to as custodial housing, and are criticized as not reflecting recovery principles or fostering personal development.

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60   Nelson (2010), "Housing for People with Serious Mental Illness," p. 124

61   Based on a 60 percent household formation rate. See the accompanying Wellesley Institute background paper on population-based estimates of need for housing with support.

62   Calculated from census microdata. The count of first-quintile renters was 580,000 in 1971, rising to 1,290,000 by 1991. This was 18 percent of total increase in households in the period.

63   3,000 is 9 percent of (35,500 – 3,000); 5,000 is 16 percent of (35,500 – 5,000), but not all the 3,000-5,000 average annual deinstitutionalization formed households. The net change in non-senior renters is not known but they comprised 30 percent of Ontario's single-person households in 1971 and 45 percent in 1974. See John Miron (1980), *The Rise of the One-Person Household: The Ontario Experience*.

In most cases, though not all, rooms are shared and privacy limited. Staff in custodial care facilities are not trained to provide specialized mental health support. Residents are generally provided with a fixed range of services, including laundry, meals, and housekeeping. Their lives are fixed to routines such as set meal times. The predetermined basket of services often limits recovery strategies that may include people cooking for themselves, and can result in some residents receiving services that they do not need.

Custodial care models are guided by many of the same assumptions that underlie older institutional models. These assumptions focus on the limitations of people living with mental illness, rather than their capacities; and they presuppose that people with mental illness are a relatively homogeneous group who have similar needs and limitations, and therefore will benefit from identical levels of care. People are presumed to live in a static state of illness from which recovery is not anticipated. It is assumed that people with mental illness must be taken care of, that they cannot develop independent living skills, play a role in their own caretaking, make decisions for themselves, or set goals for the future. Furthermore, people living in custodial housing are expected to be there for an indefinite period, quite possibly the rest of their lives.[64]

It should be noted, however, that there is much variation within the custodial sector in the nature and quality of supports and application of *recovery* principles, and there is considerable involvement of support agencies in some of the models.

The boarding home funding envelopes are now being incrementally redeployed, on a property by property bases as opportunities arise, to forms of supportive housing that are not boarding homes or to versions of these that are more recovery-based. This is occurring in all three categories – Homes for Special Care, CHPI housing with support (Dom Hostels), and Habitat Services.

CHPI Housing with Related Support (Domiciliary Hostel):

Ontario municipalities in the 1950s began providing some financial support to boarding home operators and regulating housing standards. The term domiciliary hostel (Dom Hostel)[65] dates from that period. Regulation was municipal partly because boarding homes presented issues of neighbourhood impacts and property standards, and secondly because this predated the 1960s when reliance on residual municipal social programs was supplanted by federal-provincial programs cost-shared under the Canada Assistance Plan.[66]

In 1972 the Ontario *Nursing Homes* Act set in place a funding regime for nursing homes, and dealt with the residual sector by empowering municipalities to license and fund operators of boarding homes for residents needing more than 1.5 hours of nursing care daily, also providing 80 percent provincial cost-sharing. The context was the expanding social programs of the period. Funding and regulatory authority was later transferred to other Acts but the model was little altered. This was a Ministry of Community and

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64   Centre for Addiction and Mental Health (2012), *From this Point Forward: Ending Custodial Housing*, p. 1-2.
65   "Hostel" was the prevailing Ontario usage for emergency, short-term, or supported accommodation in rooms or dormitories, and did not connote budget travellers; domicile implies a home and not temporary accommodation.
66   For context on the latter point, see Haddow (2002), "Municipal Social Security in Canada."

Social Services program, administered locally through a municipal social services department.[67]

In 2011 the Domiciliary Hostel program became part of the *Community Homelessness Prevention Initiative* (CHPI) and transferred to the Ministry of Municipal Affairs and Housing, now under the *Housing Services Act*. Within CHPI, domiciliary hostels were officially renamed *Housing with Related Support*, although the former term remains in widespread use.[68]

The resident population historically included a mix of elderly people who needed help with activities of daily living but not nursing home care, and other adults with disabilities or chronic conditions. Many individual Dom Hostels have residents with quite diverse conditions and support needs. During the 1980s, deinstitutionalization resulted in many people with long-term mental illness seeking accommodation in this sector, and since then that population has been the predominant one. The prevalence of adults with high needs was reinforced by rising homelessness in the 1980s and 90s.

Growth of this sector apparently stopped, for the most part, by the 1980s. However, it has remained an available funding pool that municipalities could deploy to fund housing supports.

Evolution toward better models of supported housing is occurring in this sector, in uneven ways across Ontario. Since the advent of CHPI in 2011, Service Manager municipalities (DSSABs in Northern Ontario) have the power to restructure this program, and some are doing so. Some have initiated program reviews or reform in the context of the statutory municipal role as system manager for affordable housing and homelessness under the *Housing Services Act,* 2011. In certain cases, stronger access by support agencies has been arranged, or operations have been shifted to non-profit providers. Most notably, the Region of Waterloo has undertaken a comprehensive restructuring of this sector to more it toward non-profit operations and best practices in supported housing.[69]

Home for Special Care:

This program is a sibling of Dom Hostels but its origins and evolution are different. The program was established in 1964, early in the era of deinstitutionalization, and equivalent programs exist in several provinces.[70] Its explicit purpose was to enable and oversee supervised accommodation in boarding homes for people with serious mental illness, with procedures for access, standards for living conditions and services, and funding.

The ongoing role in program administration by the specialized mental health hospitals partly reflects their former status as units within the Ontario Ministry of Health, prior to being divested as independent institutions over a decade ago. Homes for Special Care have higher turnover and availability than most supportive housing, enabling those hospitals to refer patients with high needs who are being discharged.

It is significant that operators of homes for special care, unlike Dom Hostels, own a license under the Act, which is *de facto* a significant asset and property right. Owners of HSCs are represented by the Ontario

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67 In 1990 the funding authority was transferred to the General Welfare Assistance Act, administered by the Ministry of Community and Social Services, and in 1997 to its successor the Ontario Works Act. At the time of devolution and "Local Service Realignment" in 1997-98, 80/20 provincial/municipal cost-sharing and municipal administration were reaffirmed. In the wake of the Lightman *Community of Interest* report (1994), tenancy rights were extended to residents in this sector but no steps were taken on ensuring more adequate care or standards. See Ontario, Commission of Inquiry (1992), *A Community of Interests: The Report of the Commission of Inquiry into Unregulated Residential Accommodation* [Lightman report].

68 For the origins and history, see brief account in Waterloo (2012), *Exploring Promising Practices*, p. 6.

69 Waterloo Regional Municipality, Community Services and Corporate Services Departments (2015), "Request for Proposal 2015-01 Community Homelessness Prevention Initiative Supportive Housing Program" (report to Community Services Committee of Regional Council, December).

70 Centre for Addiction and Mental Health (2012), *From this Point Forward: Ending Custodial Housing*.

Homes for Special Needs Association, whereas Dom Hostel owners are more disparate.

Although the majority population in Dom hostels is now similar to Homes for Special Care, the differences between the programs have widened, as HSC remain part of the MOHLTC-funded system while Dom hostels have become more municipally and less provincially program-managed, outside the Health funding system.

Evolution toward better models of supported housing is occurring in this sector, in uneven ways across Ontario. The Ministry and the mental health hospitals have supported reallocation of funding to non-profit models, with recovery orientations and flexible supports, in cases where licences are relinquished or funding becomes available to be reallocated.

The Ontario government in March 2016 announced that it would develop a plan to 'modernize' the Homes for Special Care program, moving toward best practice and recovery principles.

Habitat Boarding Home:

The Habitat Services program, established in 1986, is specific to the City of Toronto.[71] It was a response to the spread of boarding homes accommodating people with mental illness, in the context of rapid deinstitutionalization. Among the Ontario communities most affected was Toronto's Parkdale district, near the (then) Queen Street Psychiatric Hospital and Lakeshore Psychiatric Hospital. Many large older houses were converted to rooming and boarding homes, the rooms rented to people with mental illness, with issues of poor quality, inadequate support, neighbourhood stresses, and exploitation of residents. After much outcry, a Mayor's Task Force was formed, chaired by psychologist Reva Gerstein.[72] A main recommendation was the formation of Habitat Services,[73] immediately implemented through a collaboration of the City of Toronto, Metropolitan Toronto, the Ministry of Health, and Queen Street Psychiatric Hospital.

Habitat has distinguishing features vis-à-vis other subsidized boarding home programs. Program administration is by a community-based agency, Habitat Services, accountable to the Ministry of Health and Long Term Care and the municipality. Funding flows from the Ministry (80 percent) to the City under an agreement, thence to Habitat Services which funds the boarding home operator under a contract. The latter governs housing standards, care standards, inspections, and access by workers from the support agency, Cota. As a regulatory mechanism, the contract is an effective one in requiring that standards are met.[74]

Funding was set on the same basis as Dom hostels (80 percent provincial from the Ministry of Community and Social Services, 20 percent municipal) but it has evolved quite differently. In the latter 1990s the provincial program and funding responsibility was transferred to the Ministry of Health, which already funded high-support congregate housing for mental health and from 1998 onwards also funded the *dedicated* supportive housing (see section 3.5). For Dom hostels, by contrast, MCSS continued as the main funder and municipal administration remained accountable to it, this provincial role being later transferred to MMAH. Habitat Services does not have the mental health hospitals and the Ministry involved in detailed program administration role as is the case for HSC. LHIN funding covers the costs of administration.

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71   The program is unrelated to Habitat for Humanity and predates its arrival in Ontario by a decade. The term habitat had wide currency in the 1960s-1980s (e.g. UN Habitat conference; Habitat at Expo 67).

72   Toronto, Mayor's Action Task Force (1984), *Final Report of the Mayor's Action Task Force on Discharged Psychiatric Patients*.

73   The agency was originally called Mental Health Program Services, later taking the name of the program it ran.

74   Communication, supportive housing manager and MOHLTC staff.

3.4 Shared Houses, Rooming Houses, and Congregate Apartments

Shared Houses and Rooming Houses

A wide range of supportive housing is provided by non-profit agencies that own and operate supportive shared houses, rooming houses, and congregate apartments.

- A rooming house provides rented rooms, usually in a large house converted from its earlier use as a single dwelling. Each tenant rents a room, and usually bathrooms are shared. Non-profit rooming houses more often have a shared lounge areas and/or kitchen than do private rooming houses.
- 'Shared houses' refers to (typically) 4 to 6 people, each with their own bedroom, sharing a house. The residents have separate tenancies but they manage household matters collectively and they share lounge areas, bathrooms and kitchen. In many models, residents have a voice or veto in who gets housed with them.
- A congregate apartment applies the shared house model to an apartment, often a large custom-designed one, in a social/supportive housing apartment building. Each resident has his or her bedroom and share lounge areas, bathrooms and kitchen within the shared dwelling unit.

Various properties can fall on a spectrum from a shared house or congregate apartment that functions as genuine household, to a classic rooming house with little shared living or mutual support.

The shared-house model is quite distinct from high-support congregate living as there is normally no daily on-site staff and there is no mandatory programming or supervision; each resident has personal autonomy in daily life and a normal residential tenancy. The small scale of a shared house means that there is no difference from other family houses in terms of planning and land use law, although *de facto* there often is a difference when it comes to Fire Code and building standards enforcement.

These models arose from four types of factors. First, many date from the 1970s and early 80s, when governments did not offer much if any funding for independent supported apartments for single people. Shared houses, congregate apartments, or rooming houses were a cheaper model that could be implemented with limited capital funding or amortization subsidies. Houselink Community Homes was founded in 1977, initially renting homes but soon purchasing them with mortgages from the social housing programs, and within a decade it has 20 such "co-op" (i.e. shared house) properties. The Christian Resource Centre (CRC) operated rooming houses from 1975 onwards with some resident self-management.[75] Initially there was no RGI (rent geared to income) subsidy and residents' incomes covered operating and amortization costs, but RGI became more common as acquisition costs rose and the Ontario government in the early 1980s widened RGI eligibility to various types of disability including mental illness.

Second, buying and operating a rooming house was a way for social agencies to intervene directly and with little delay to improve conditions in the housing where their clients or target group were living anyway. In the early days of supportive housing in Toronto, much of the activity was focused on rooming houses, boarding homes, and congregate supportive housing. This reflected the nature of the new Supportive Housing Coalition that was formed to advocate and take action on these issues. As a coalition of mental health professionals, social service providers, active community leaders, and consumers, its priorities necessarily ranged across boarding home regulation, changes to land use laws to facilitate the congregate

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75   See Single Displaced Persons Project (1987), "From Homelessness to Home: A Case for Facilitative Management".

supportive housing then being put in place, and funding for better housing options.[76] Many social housing rooming houses were acquired by church-sponsored organizations under a short-lived 1986 program[77] which provided capital grants for that purpose but no operating subsidies.

Third, a congregate model was believed by some people to be more familiar and socially comfortable for people who had long experience living in them and were unaccustomed to running their own apartment.

Finally, the shared house or congregate apartment model sought to foster mutual support in an *intentional community*. These models were the first housing in the Ontario context to implement the concepts of recovery and autonomous community living. Shared living was seen as a way to overcome the isolation that so often results from mental illness, and to support personal development. The spirit of the 1970s was sympathetic to intentional communities, from student co-ops to hippie communes to therapeutic collectives. The emphasis in Houselink, CRC, or other agencies was social and practical supports rather than programmatic mental health supports. As described in the mid-1980s, "Residents share responsibility for rent, household expenses, and chores" ... "In 'shared living' arrangements, individuals choose to live with three or four others with whom they co-operate in the handling of day-to-day affairs (food and meal preparation, cleaning and maintenance, problem-solving, interpersonal skills)." ... "Current residents participate in setting criteria about who is to be housed, and have final say in deciding with whom they will live."[78] Unlike high-support congregate housing, supports were provided by a separate agency (de-linked) in SHC; they were flexible in Houselink and CRC.

As the 1980s progressed and low-rent housing stock shrank while deinstitutionalization continued, more community-based social agencies became interested in housing for those they served. Some decided to form non-profit housing corporations, taking advantage of the active social housing programs. Other agencies entered arrangements with specialist housing agencies. In Toronto the largest of these was SHC, but the municipal housing company, Cityhome, also leased several dozen properties to agencies providing supportive housing under its Singles Housing Opportunity Program (SHOP) initiated in 1989.[79]

Over time, various agencies that originally operated high-support congregate housing shifted to a shared living program model in the same properties. This responded to ideas of autonomous and less supervised living, to the successful example of other providers and their residents, and to evolving needs as residents needed less support over time. This shift is documented in the community mental health literature in regard to Madison Community Services and Regeneration House in Toronto as well as Waterloo Regional Homes for Mental Health.[80] "Some of the principles of supported housing (e.g. permanency of housing, individualized support) have infiltrated congregate supportive housing programs."[81] But this shift by these providers in the 1990s directly adopted a model by then established for almost two decades in Houselink, CRC, and SHC.

This model of shared houses with flexible supports was also adapted, with mixed success, to congregate

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76   See Trainor et al. (1987), "The Supportive Housing Coalition: A Model for Advocacy and Program Development" *Canadian Journal of Community Mental Health*, 6(2): 93-106.

77   The Capital for Permanent Housing for the Homeless program.

78   Single Displaced Persons Project (1987), "From Homelessness to Home: A Case for Facilitative Management," quotes from pp. 11, 16, and 23 respectively.

79   Cityhome is one of the three public-sector social housing agencies amalgamated to become Toronto Community Housing Corporation by 2002.

80   See George et al. (2005), *Strengthening the Housing System for People who have Experienced Serious Mental Illness*.

81   See also Nelson, (2010), "Housing for People with Serious Mental Illness" Approaches, Evidence, and Transformative Change" *Journal of Sociology and Social Welfare*, 37 (4): p. 131-132.

apartments in new supportive housing development. The earliest social housing projects targeting clients who had histories of chronic homelessness used congregate apartment design.[82] In the pioneering 90 Shuter Street project of 1984, each floor of a high-rise was a congregate dwelling with several residents, and the building was described as a "vertical rooming house."

Although independent apartments became the preferred model from the mid-1980s onwards, certain providers continued to purchase and operate shared houses, congregate apartments, or rooming houses as supportive housing. This continued to serve various goals: faster implementation, lower capital costs, replicating a familiar rooming house social model, integration in neighbourhoods, creating intentional communities, intervening directly to improve conditions in specific properties, using available surplus municipal properties, and receiving transfers of church properties and bequests.

Due to this weave of historical factors, in which high-support congregate housing is one strand, a very large share of *dedicated* supportive housing stock is in the form of shared houses. In the mid-1990s an estimated one-half of Ontario supportive housing was in this form; the fact that few of the people housed there required such a supervised model was documented at the time and again in 2005.[83] In the City of Toronto today the shared house and other congregate share of supportive housing is estimated at 40 percent.

Shared living can be challenging even for people with high social skills and no mental health crises. By the latter 1980s, a consensus emerged that independent apartments were preferable not only in offering more personal autonomy, but in presenting fewer household management issues and interpersonal conflicts, lesser demands on staff time, and less risk of social dysfunction and lack of safety in larger buildings with congregate designs.

But while shared or congregate living requires higher support than independent apartments, it usually has lower costs per resident to amortize and operate. Many of the agencies that have shared or congregate houses would like to redeploy that asset, selling the house and building or buying apartments with the proceeds. But that housing option would require either capital funding or augmented operating funding.

3.5 Supported Independent Apartments

In the mid-1980s, independent supported apartments became the preferred model of supportive housing, identified as best practice in the community mental health literature. This trend across North America reflected more ambitious principles, advocacy by people living with mental illness, and evolving program experience. Activist professionals collaborated with a consumer-survivor movement that emerged within a broader disability rights movement[84] in that period, and persuaded governments to fund such housing.

The premises and social consequences of the group home model were sharply criticized when it came to people with mental illness: "…if consumer-survivors were successful in the group home program, they graduated; but if they were unsuccessful, they were evicted. In both cases they were relegated again to being homeless, relying on inadequate rooming and boarding homes, hostels, or the street. Inherent in

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82   Most notably, Homes First Society's 90 Shuter St., Fred Victor's Keith Whitney Homes, and part of Houselink's Channan Court, all developed in the mid-1980s. See Fagan (1993), *The Fred Victor Mission Story*; Alan Etherington & Associates (1987), *Evaluation of 90 Shuter Street*.

83   George et al. (2005), *Strengthening the Housing System for People who have Experienced Serious Mental Illness*, p. 14.

84   George et al. (2005), *Strengthening the Housing System for People who have Experienced Serious Mental Illness*; Trainor et al. (1987), "The Supportive Housing Coalition: A Model for Advocacy and Program Development" *Canadian Journal of Community Mental Health*, 6(2): 93-106.

this system was the assumption that consumer-survivors needed rehabilitation more than housing."[85]

The new 1980s idea was that people with mental illness did not need to live in collective settings, but could be tenants in their own rented apartment, with legal rights and secure tenure like anyone else. This involved choice of housing for the person living with mental illness, flexible supports rather than a supervised and programmatic approach, supports de-linked from the tenancy and housing provision, and of course subsidized rents.[86]

> "In a new paradigm in mental health, the person with a mental health struggle is viewed as a tenant in his or her housing, a person with rights and the potential to contribute to society, not as a patient or client to be supervised or managed. As well, there is a focus on strengths and the potential for recovery, not on the person's deficits or illness."[87]

> "At the individual level, there is a transformation from patients or clients of housing to tenants with rights; ... helping relationships are transformed from on-site staff supervision to individualized, consumer-directed supports; at the organizational level, housing and support are de-linked, thus taking mental health professionals out of the landlord role; at the community level, there is a transformation from stigma and exclusion in specialized, segregated housing to integration into normal housing and communities..."[88]

Researchers and practitioners in Toronto were active and even prominent in this new paradigm in community mental health, and the continent-wide research networks contributing to it. Emerging at the same were parallel approaches to housing chronically homeless people – a population distinct from those with diagnosed mental illness, but overlapping. This led to the emergence of the *alternative* housing model, discussed in section 3.6. In supportive and *alternative* housing, the new ideas helped propel program changes and the latter made it possible to implement the ideas.

The new model of independent apartments with flexible supports was implemented in the 1980s and early 1990s primarily in subsidized private-sector apartments in the USA, and in new social housing in Ontario. This difference was not about models of housing and support. The emphasis on rent supp in the US and social housing in Canada arose from the different housing policy regimes at the time. There was also a difference in the extent to which *stages* versus *housing first* ideas were entrenched in policy frameworks.

Canada in the 1980s and early 90s gave much stronger priority to subsidized rental than the US did, and implemented it mostly through new social housing and less by way of rent supplement in private rental. From 1981 through 1994, the average annual addition of section 8 rent supplement (project-based and vouchers combined) in the USA was per 27 annually per 100,000 population.[89] Average annual social housing

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85   Novac et al. (1996), *Borderlands of Homelessness*, p. 4, referring to singles displaced persons project critique

86   Ridgway and Zipple (1990), "The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches" *Psychosocial Rehabilitation Journal* 13 (4): 11-31.

87   Nelson, (2010), "Housing for People with Serious Mental Illness" Approaches, Evidence, and Transformative Change" *Journal of Sociology and Social Welfare*, 37 (4): 136.

88   ibid., 137.

89   Calculated from Schwartz (2010), *Housing Policy in the United States*, data at pages 161-162 and 181. Added project-based s.8 averaged 44,700 annually (1975-1983) while added vouchers averaged 55,386 annually (1981-1994), for a combined annual average of 64,964 (1981-1994). This equals 27 per 100,000 on US 1985 population of 237.9 million. From 1987 onwards the USA was also supporting income-targeted production under the Low Income Housing Tax Credit program, but the income-targeted RGI rents in these projects were achieved through the section 8 program.

production with RGI rents targeted to low incomes was 60 annually per 100,000 population in Canada,[90] and higher in Ontario at 77 per 100,000, three times the US level.[91] In the 1980s, half of the ongoing annual increase of Canada's low-income renters was being housed in RGI social housing versus a small fraction in the USA. Applying the language of community mental health at the time, social housing was "normal housing" in Canada – or in Europe or Australia – to a far larger extent than in the US.

This reflected different political environments, social policy trends and housing market conditions. In the US, slower economic growth and political change in the 1970s had curtailed social program expansion, while Canada experienced strong growth and rising social spending. US housing policy shifted away from public housing and income-targeted new private rental, to emphasize rent supplement in private rental.[92] Different housing market conditions also shaped this. Postwar Canada had more rapid urban growth and far more rental demand relatively than the US, and responded with large subsidies to public and private rental production. Large Canadian cities (except Montreal and Winnipeg) by the 1970s had limited and diminishing supplies of cheap older rental, while most US cities had extensive, expanding inner-city neighbourhoods of cheap rented houses and older apartments. Canada's larger relative social housing supply reflected a stronger agenda of housing choice, affordability and quality for people with low incomes; building most of it outside older downmarket areas reflected an agenda of neighbourhood social and income mix.

The stages model became entrenched in US housing and homelessness policy and practice of the decade from the latter 1980s through the mid-1990s, as a function of the *Stewart B. McKinney Homeless Assistance Act* of 1987. The term "supportive housing" became widespread in the US in 1987, within the framework of that Act, when the US Department of Housing and Urban Development (HUD) collaborated with the US National Institute of Mental Health to create the Supportive Housing Demonstration Program. This provided funds to develop and operate transitional and permanent housing for homeless populations, initially in four states and later extended more broadly.[93] The demonstration program provided strong evidence for effectiveness of permanent supportive housing.[94] The McKinney Act provided a framework for more systematic responses to homelessness than yet existed in Canada, but it mandated local plans involving a structured array of programs, progressing from emergency shelter to long-term solutions. That array entrenched permanent supportive housing in a stages model. This positioning was explicitly set out in HUD guidelines.[95]

In Ontario by then, policy and practice had moved to permanent housing with flexible supports. As noted above, this started with mostly "house" properties rented or acquired by supportive and *alternative* housing providers, then expanded strongly in 1986-1995 in apartments. By the time the Supportive Housing

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90   Canadian social housing production averaged 19,300 units annually, 1981-1994, of which approximately 80 percent were low-income targeted RGI units (about 15,500 annually); calculated from CMHC, *Canadian Housing Statistics*, supplemented by Ontario unilateral data. This equals 60 per 100,000 on Canadian 1985 population of 25.8 million.

91   Ontario social housing production averaged 8,600 units, 1981-1994, of which approximately 80 percent were low-income targeted RGI units (about 6,900 annually). This equals 77 per 100,000 on Ontario 1985 population of 9.0 million.

92   See Schwartz (2010), *Housing Policy in the United States*, chapter 8. Rent supp and vouchers were referred to as Section 8, after the relevant section of the 1975 Housing and Community Development Act. In the 1990s, section 8 vouchers were rebranded as 'Housing Choice Vouchers' (HCV).

93   Hurlburt et al (1996), "Providing Independent Housing for the Homeless Mentally Ill: A Novel Approach to Evaluating Long-term Longitudinal Housing Patterns" *Journal of Community Psychology* 24(3): 291-310; Glauber (1996) "The Evolution of Supportive Housing."

94   Hurlburt et al (1996).

95   See U.S. Department of Housing and Urban Development (1997), *1997 Homeless Programs: Continuum of Care* (Washington DC: U.S. Government Printing Office, HUD Publication No. HUD–40076).

Coalition's advocacy was rewarded in 1985 with funding allocations from the non-profit housing programs, its development agenda included both congregate facilities and independent apartments.[96] In 1986 Ontario funded a Singles Housing Demonstration program, for subsidized independent social housing apartments with supports. This embodied official recognition that people who had histories of homelessness or mental illness needed housing, whatever the support they might need.[97] In 1987 the provincial government initiated a social housing program, *Project 3000*, targeted at these populations, versions of which were an integral part of the social housing programs until 1995. In 1988 Ontario made low-income single persons eligible for RGI (rent geared to income) – previously available only for families, seniors, and a few disabled people.[98] Through these programs, many social housing projects were developed to house people who had experienced chronic homelessness, serious mental illness, and/or addictions. (Other supportive projects served needs such as frail elderly, young single mothers, people with severe physical disabilities, or acquired brain injury.) The approximately 2,000 units of homeless-focused *alternative* housing, and the majority of the *dedicated* housing, was developed in that 1986-1995 decade, averaging about 500 units a years a year.

Homeless-serving agencies that developed housing in this manner – either independent apartments or shared houses or apartments with flexible supports – soon included All Saints, Fred Victor, and Woodgreen in Toronto as well as Options Bytown and Ottawa Salus in Ottawa, House of Friendship in Kitchener-Waterloo, and Cornerstone in Oshawa.[99] SHC (today's Mainstay) shifted away from the old model of high-support congregate housing with bundled supports, to give priority to self-contained apartments in small apartment buildings with supports provided by separate agencies.[100] Houselink was now providing independent apartments in small buildings it owned,[101] with secure housing tenure regardless of the flexible supports a given tenant would receive. By the time production ended and devolution arrived in the latter 1990s, 37 percent (902 of 2,451) of *dedicated* supportive housing in the amalgamated City of Toronto was independent apartments, mostly with flexible supports, and most *alternative* housing was also of this type.[102]

Thus the shared idea of independent supported apartments for people experiencing serious mental illness or chronic homelessness was implemented differently in countries with somewhat different housing systems and policies at the time. US agencies such as Pathways implemented independent supported apartments with flexible supports by way of rent supplement in the private sector, reflecting the US housing policy context. Ontario's community agencies implemented independent supported apartments with flexible supports by way of social housing development, reflecting the Canadian housing policy context.

Meanwhile in the community mental health literature, there was thinking on what was 'normal housing' when it came to implementing the new model of independent apartments, flexible supports, and neighbourhood integration. One landmark article set out criteria which included housing chosen by the consumer, neighbourhood contexts that would facilitate integration and support, minority shares of

96   See Trainor et al. (1987), "The Supportive Housing Coalition: A Model for Advocacy and Program Development" *Canadian Journal of Community Mental Health*, 6(2): 93-106.
97   Novac et al. (1996), *Borderlands of Homelessness: Women's Views on Alternative Housing*, p. 5
98   Ontario, Ministry of Housing, *Annual Report 1987/1988*, p. 22.
99   ibid.; See Novac and Quance (1998), *Back to Community: An Assessment of Supportive Housing in Toronto*.
100   ibid, p. 6.
101   Single Displaced Persons Project (1987), *From Homelessness to Home*, pp. 11-12.
102   Novac and Quance (1998), *Back to Community: An Assessment of Supportive Housing in Toronto*, Table 2.

diagnosed mentally ill people in a building, normal appearance of the housing, and permanent tenure.[103] In 1999 the three-part typology of *custodial* housing, *supportive* housing, and *supported* housing was articulated in the Canadian context. The article noted that 'supported' apartments were "typically apartments, housing co-ops, or other government funded social housing for low-income people."[104]

But the place of clustered social housing apartments with flexible supports – the mainstream of the sector in Ontario – was ambiguous or viewed negatively in the community mental health literature. Some confusion arose between the use of "supportive" in that literature to mean congregate housing with supervised housing and bundled supports, and the same term used in the world of Ontario practitioners, programs, and providers to refer to the full range of models of housing with supports. The preferred type of the 1980s and early 1990s, independent social housing apartments with flexible supports, was sometimes missed as typologies jumped from high-support congregate housing to dispersed private rental; it was sometimes viewed unfavourably as inherently *un*integrated, clustering people with mental illness, and at other times it was recognized as similar to supported apartments in private rental.[105]

Providers and the residents they served have noted that while scattered units best avoid stigmatization, clustered apartments often provide a supportive community of peers, with social activities and a sense of belonging that are an important part of recovery for many people.[106] Others have found that de-linking supports from the specific housing provider and housing site facilitates more flexibility in scaling back supports if the resident no longer needs them, or transferring the same supports to a new location if the person chooses to move.

In the early 1990s the Ontario government adopted formal policies that incorporated such principles and practice. These included integration of people with disabilities or chronic conditions or needing supports with other people and housing; de-linking of housing provision and support services; fostering personal autonomy; reasonable portability, such that a person would not lose services if they move; flexibility, so that services adjust to meet the individual's changing needs; and control by the client/resident. This policy reinforced a practice whereby the Ministry of Housing was responsible for the housing component and other ministries, especially Health and Community and Social Services, were responsible for the supports.[107]

Supportive housing in Ontario and in other jurisdictions has been implemented through a wide range of models. A recent US review found "considerable overlap in the distributions of ratings between these two program types and considerable variability within the two program types. Thus, rather than a clear distinction between what is supported housing and what is not, the results indicated that there is more of a continuum of supported housing."[108] This conclusion was from comparing delinked 'supported housing' and other supportive housing in terms of how well each met criteria such as housing choice, client choice on support services, and separation of housing tenure from support services. The need for

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103 Hogan and Carling (1992), "Normal Housing: A Key Element of a Supported Housing Approach for People with Psychiatric Disabilities" *Community Mental Health Journal* 28 (3): 215-226.

104 Parkinson et al. (1999), "From Housing to Homes: A Review of the Literature on Housing Approaches for Psychiatric Consumer/Survivors" *Canadian Journal of Community Mental Health* 18 (1): 145-164.

105 For the latter case, see Parkinson et al. (1999), p. 159.

106 Kirsh et al. (2009), *Critical Characteristics of Supported Housing: Findings from the Literature, Residents and Service Providers*, p 23; Wellesley Institute (2015), *Coming Together on Supported Housing for Mental Health and Addictions in Ontario*. See also Taylor Newbury Consulting (2014), *Mental Health and Addictions Supportive Housing in Waterloo-Wellington*, p. 42.

107 Ontario, Interministerial Committee (1992), *Directions for Supportive Housing: A Housing Framework for Ontario*, p. 11-13; Novac et al., 1996, *Borderlands of Homelessness,* p. 6;

108 See for example, Rog et al. (2014) "Permanent Supportive Housing: Assessing the Evidence" *Psychiatric Services* 65 (3), 132.

high-support and transitional models was also noted in earlier sections. US policy and programs in fact use a mix of housing approaches: of the two most renowned, Pathways uses rent supplement while the Corporation for Supportive Housing and Breaking Ground (formerly Common Ground) use purchase and renovation, or development.[109]

In recent mental health literature, the three-part typology of custodial housing, supportive housing, and supported housing is still sometimes invoked.[110] This entails categorizing supported independent apartments as *supported* housing if are in the private sector, and as *supportive* housing if in social housing – with an implication that private-rental fosters better autonomy and recovery for the resident. While there is strong evidence of the benefits of independent housing with flexible supports, there is no evidence for distinctions based on market versus non-market funding and operation of the housing. Either rent supplements in private rental or subsidized social housing – with flexible supports – can be forms of independent housing in the community.

3.6 Dedicated, Alternative, and Regular Social Housing

Supportive and Alternative housing: 1985-1995

The model of independent supported apartments with flexible supports arose in Ontario in two closely related sectors that nevertheless had differences in their origins and guiding ideas. One sector of housing providers had origins in community mental health, where the movement toward independent housing and flexible supports reflected the continent-wide evolution of ideas and practice discussed above. The other sector of housing providers had its roots in homeless-serving agencies and the idea of a right to housing.[111]

> "The new supportive housing model was promoted by community-based mental health agencies... A desire to improve the inadequate and exploitive housing circumstances of discharged psychiatric patients, and a commitment to the linking of shelter and support services motivated the formation of a coalition of mental health agencies and activist 'consumer-survivors' of psychiatric services [SHC – Mainstay] in 1981... At the same time, community- and church-based agencies and women's services viewed housing as a vehicle for community development, to enable residents to get more control over their lives and deal with issues in a non-clinical way. This was the basis for the *alternative* housing model. The *alternative* housing sector emphasized tenants' rights and stressed the importance of distinguishing housing provision and security of tenure from service programming, i.e., de-linking housing and support services."[112]

As a response to big-city homelessness, *alternative* housing was especially a Toronto-based movement and sector, although there were also networks across the country[113] and parallels in other North American cities. It had creative and articulate leadership, it was part of policy networks that included municipal

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109   On CSH, see Houghton, *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individuals* (New York: Corporation for Supportive Housing).

110   For example, Yip (2014), *Housing Models in the Ontario Mental Health and Addictions System*.

111   'Alternative' providers also included mandates and resident populations other than homeless people, such as frail elderly, young single mothers, or abused women.

112   Novac and Quance (1998), *Back to Community" An Assessment of Supportive Housing in Toronto*, p. 5

113   Novac et al., (1996), p. 5; Novac and Quance (1998), *Back to Community*, p. 7.

and provincial officials, and by 1986 it could tap abundant social housing funding to implement its ideas.

The key players formed the Singles Displaced Persons Project, a movement advocating and soon developing permanent housing rather than shelters as the response to homelessness – "homes not hostels." SDP also led the critique of group homes, with their tightly paired housing and services, as creating "mini-institutions" – "residents are labelled with a diagnosis, the homes are highly structured, interaction with staff is non-optional, and day to day choices are limited;" "eligibility for residency and length of tenure get defined according to the programme goals rather than a persons' need for a home… Housing or shelter which is tied to service delivery is not a real housing alternative for many people experiencing homelessness."[114]

The SDP principles explicitly set out the right of homeless people to housing, with secure tenure, and no obligation to participate in a support program as a condition of getting or retaining housing. "We believe that …security of tenure in one's home must not be based on participation in a programme: housing management must become a separate function from the delivery of support services."[115] Participants founded the Homes First Society on such ideas in 1983, its name expressing directly the same idea as today's phase *housing first*. However, the guiding ideas were not primarily from community mental health but were concepts of social rights, remedying structural inequality and (in today's terms) social exclusion, and empowering people who are marginalized.[116]

The homeless people being housed included many had histories of mental illness and/or heavy drug/alcohol use, but the issue was framed as one of people needing housing, not as mental health clients needing support services. The movement did not view eligibility or need for supportive housing through the lens of specific diagnoses. Rather, the thinking was that "All persons who are homeless share with those who have been institutionalized a loss of freedom and self-determination…This makes the provision of stable housing and the requirement of housing subsidies a primary goal of supportive housing".[117] Providers and residents experienced and recorded – although not in academic journals – many of the benefits of secure supported housing which are the focus of *housing first* research today, in matters including residential stability, autonomous personal decision-making, returning to education, and lesser use of psychiatric services.[118]

There were some differences between providers emphasizing suitable supports and those emphasizing personal autonomy and housing rights, but all were part of a broader supportive housing sector in dialogue about these issues of "integration, stability, independence, and consumer choice and control," and with movement toward "somewhat greater agreement" over time.[119] The emphasis in *alternative* housing on community development, social supports and practical assistance in daily living, rather than mental health supports, was a direction in which mental health supportive housing was evolving in the same period.

From the mid-1980s onward, very little of the thinking or activity in this broader supportive housing sector was in terms of the classic model of 'supportive' housing, i.e. group homes, and very little of it was in terms of a "stages" model with bundled housing and supports. It was mostly about permanent, independent housing with flexible supports. By the latter 1980s this sector was providing a mix of shared

114   Single Displaced Persons Project, *Homelessness to Home*, pp. 9-10.
115   ibid., various quotes from pp. 5-8; also Novac et al., 1996, *Borderlands of Homelessness,* p. 4.
116   See also Falvo (2009), *Homelessness, Program Responses, and an Assessment of Toronto's Streets to Homes Program*, 16-17.
117   Novac and Quance (1998), *Back to Community*, p. 4.
118   Single Displaced Persons Project (1987), *Homelessness to Home*, p. 13.
119   Novac et al. (1996), *Borderlands of Homelessness,* p. 6.

living, rooming house, and independent apartments, with support staff off-site in most cases.[120] The supportive and *alternative* sectors shared common purposes and values, formed interrelated networks, and used the same housing programs.

Dedicated and Alternative Housing After 1995:

The 1986-1995 evolution created some providers with mandates and program models focused on people with serious mental illness, with MOHLTC support funding; and others that focused on people who had experienced chronic homelessness and often addictions, more often with MCSS support funding. Broadly speaking, the first group became today's *dedicated* supportive housing, with programs funded and administered by MOHLTC, while the second group became today's *alternative* housing, funded and administered in the devolved municipal system.[121] But the distinction between these two categories in their origins and today is far from clear-cut.

The entwined evolution of mental health supportive housing and *alternative* housing abruptly changed course in the mid-1990s. The Conservative government that took office in Ontario in 1995 immediately ended social housing production and soon decided to devolve funding and program administration responsibility to the upper-tier and unitary municipalities. When this was implemented in 1998-2001, the *alternative* housing providers and stock were also devolved. But 550 projects with 5,400 units of *dedicated* supportive housing were instead 'transferred' in 1999 to be funded and program-managed by MOHLTC or MCSS. This included the 3,032 units of housing targeted to people living with mental illness,[122] other categories transferred to MOHLTC, and others going to MCSS. This decision not to devolve responded to a lobby by supportive providers concerned about their future in a devolved system.[123] Thus the government of the day, whose policy was to "get out of the housing business," was persuaded to categorize *dedicated* supportive housing preferentially as a health matter for high-need populations, not a housing matter.

The term *dedicated* referred to these projects being entirely targeted to the population receiving supports. The criterion for being transferred to MOHLTC rather than devolved was being a Health transfer agency with a very large majority of residents receiving health-funded supports. But the line thus drawn was somewhat arbitrary. Devolved projects included many that served homeless populations with a high prevalence of mental illness or addictions, and various people receiving similar supports as in *dedicated* housing.

The distinction between *dedicated* and *alternative* partly reflected the state of thinking in 1998, before addictions became fully integrated with mental health in policy paradigms and institutional mandates. It also predated today's renewed emphasis on mental health supports as part of the solution to homelessness.

The *dedicated* and *alternative* sectors differ in the approach to support services and population served. *Alternative* housing retains an emphasis on housing-related stability and related support services, while *dedicated* housing pairs this with mental health supports. *Alternative* providers vary in their support model, staffing ratios, and sources of support funding for this. *Alternative* providers variously either operate their own individual access system or are part of the Service Manager's coordinated access system,

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120   Single Displaced Persons Project, *Homelessness to Home*, pp. 16, 23.

121   The largest Alternative providers in Toronto are Homes First Society, Fred Victor Centre, Ecuhome, and Woodgreen Community Housing.

122   Ontario, News Release, "Province assumes responsibility for special needs housing", June 12, 1998. An alternative count of 2,659 is given in George et al. (2005), *Strengthening the Housing System for People who have Experienced Serious Mental Illness*, p. 7.

123   See Ontario Federation of Community Mental Health and Addiction Programs, letter to Ron Sapsford, Assistant Deputy Minster for Institutional and Community Health, November 25, 1997.

whereas MOHLTC and LHIN policy, and *dedicated* providers' own initiatives, have moved in the direction of coordinated access[124] for health-funded mental health and addictions supportive housing.

Nevertheless the *dedicated* and *alternative* sectors intersect considerably, in terms of population served, some direct health-sector funding to *alternative* providers, and ongoing partnerships between *alternative* providers and health-funded support agencies.

For *dedicated* supportive housing, the mortgage financing, RGI, and funding frameworks remain quite parallel to devolved social housing. Ontario has the same obligations to the federal government in the latter's role as co-funder, mortgage guarantor, and party to the CMHC-Ontario Social Housing Agreement. *Dedicated* and devolved housing has the same range of older projects with CMHC-insured mortgages and rent supplement contracts, and newer ones with an all-in operating subsidy. *Dedicated* housing faces a parallel issues of expiring federal funding, stepping down project by project over the next decade and beyond, with resulting pressure on the province (for *dedicated* housing) or the municipality (for *alternative*) to make up the difference.

The main MCSS support funding used by *alternative* providers, *Supports to Daily Living* (SDL), was also devolved to municipalities to administer, and later in 2011 became part of the Community Homelessness Prevention Initiative (CHPI). The latter is the general envelope of homelessness and housing stability programs funded by the province and administered by Service Manager municipalities (DSSABs in Northern Ontario). Until the advent of CHPI, Service Managers also contributed 20 percent of the funding, and this municipal cost-sharing ratio carries over as CHPI practice in many regions of Ontario. In some cases, Service Mangers have increased their SDL funding in recent years.[125]

Apartment in Mixed Social Housing:

Residents needing support in regard to mental health or addictions comprise a rising share of tenants in regular social housing. This refers to the over 90 percent of public, non-profit and co-operative housing which is neither *dedicated* nor *alternative* housing, and which is funded and program-administered at the municipal level. While Toronto Community Housing has received media attention in this regard, it applies to much social housing across Ontario. The population in high-needs singles public housing projects is now regarded as similar to that in *alternative* housing. This has been well described in the 2015 ONPHA report, *Strengthening Social Housing Communities*, and the reasons for it explained.[126]The converging causal factors are of two types: policy governing access to social housing, and broader changes in the socio-economic and housing system context.

In access and targeting policy and practice, five main factors have contributed. As far back as the 1980s a few municipal non-profit projects were targeted all or partly to people coming out of chronic homelessness or with diagnosed serious mental illness (as a "disabled" category), before universal eligibility for RGI started in 1988. Examples in Toronto include certain units in the municipal projects (former Cityhome) in St. Lawrence and the East Downtown. Second, various providers entered referral agreements (see also section 2.2.2) whereby a support agency would have the right to place clients in particular units when

124 See Brian Rush (2016), *Review of Coordinated/Centralized Access Mechanisms: Evidence, Current State, and Implications* (Ontario Ministry of Health and Long-Term Care).

125 In the City of Toronto, the budget for SDL has risen from $3.2 million in 2012 to $4.9 million in 2015/16. Calculated from Shelter Support and Housing Administration Division reports to City Council.

126 Ontario Non-Profit Housing Association (2015), *Strengthening Social Housing Communities*.

they became available (bypassing the waiting list), with an obligation to support the person. In Toronto, a significant number of Streets to Homes placements into housing have been into devolved social housing.[127] Third, rising homelessness led to a local access priority for such applicants from the mid-1990s onward in various communities, including Toronto. In the latter case, applicants housed under the homeless priority category, many of them with support needs, were 20 percent of total placements (turnover) in 2007-2011,[128] and probably close to double that share of turnover in the bachelor and one-bedroom unit sizes. Finally, support agencies learned that people applying to high-turnover locations would get housed sooner, and so they have assisted or encouraged their clients in urgent housing need to do so.

When Ontario made singles eligible for RGI in 1988, this reflected rising concern about homelessness and loss of low-rent market options as gentrification proceeded. Seniors social housing demand was tapering off, because applicants then were 1930-1945 baby bust hitting retirement – a smaller cohort than those born in the 1910s and 1920s and with fewer renters and higher pension income. The Ministry of Housing in 1988 required its housing authorities to convert seniors buildings (i.e. those with small rather than family-sized units) into all-ages housing. Codified human rights law was coming into play and at the time did not clearly protect the right to run a seniors-targeted building. With more non-seniors applying, many seniors buildings quickly evolved into 'singles' buildings.[129] Conversion of a few seniors public housing units to singles occupancy in 1988-1995, when new production was expanding the social housing stock by an average 8,100 units annually, was a modest change by Ontario governments that paid careful attention to social housing operating policy. Cumulative conversion of possibly 20,000 or so units[130] in 1996 onwards, in a flatlined social housing stock, was a large systemic change occurring with little regard to outcomes.

More broadly, Canadian social housing has become *residualized* in terms of social profile as well as policy priority.[131] Social housing is a legacy system, under increasing fiscal and social stress today. The most active production was from 1965 to 1995, with volumes averaging about 6,000 across Ontario compared to an average 1,400 new affordable a year since 2003.[132] The 210,000 RGI units were 5.3 percent of total housing in 1996 but 4.3 percent by 2011. At the low end, among the 1 in 8 households (12 percent) who are renters in the lowest income quintile,[133] RGI accounted for 45 percent in 1996 but only 36 percent today.

A flat social housing system in the context of rapidly growing population and housing system will

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127 See Falvo reference above: circa 2010, approximately 20 percent of Streets to Homes placements were in social housing other than Health-funded and/or 'Alternative' housing; most of the 20 percent was in municipal housing.

128 Average 826 homeless out of 4,227 annual placements. Calculated from Housing Connections, *Annual Statistical Monitoring Report*, 2007, 2008, 2011.

129 ONPHA also notes two other factors in addiction to the mental health, addictions, and chronic homelessness discussed here. One is rising numbers of 'old elderly' with related support needs. Another is the provincial Special Priority Policy (SPP) which gives women fleeing domestic violence priority access to social housing, soon comprising about one-third of placements into social housing. ONPHA notes that these contribute to higher support needs in social housing, but they are less relevant to this paper's focus on mental health support.

130 At the end of social housing production in 1995-96, Ontario's units targeted to seniors were 49,495 in the public sector (OHC and MTHCL) plus 19,725 in the non-profit sector, total 69,220 (Ontario Ministry of Housing, data report CHPR118, mimeo). A reasonable estimate is that about one quarter or more (20,000 or so) were converted to singles occupancy over the years. However, an alternative estimate is that there remain about 60,000 to 70,000 seniors social housing units: see Margie Carlson (2014), *A Slice of Affordable Housing for Seniors in Ontario May be Diminishing*, 46; the latter was cited in Ontario Non-Profit Housing Corporation (2015), *Strengthening Social Housing Communities*, 11.

131 See Suttor (2015), *Rental Housing Dynamics and Lower-Income Neighbourhoods in Canada*. Residualization was a term coined in the UK and then widely adopted across Europe to describe the declining social profile and policy priority in social housing.

132 Pre-1996 figures calculated from Canada Mortgage and Housing Corporation, *Canadian Housing Statistics*, and Ontario Ministry of Housing data; post-2001 from Ontario Ministry of Housing data.

133 Calculated from census microdata.

tend inexorably to become a higher-need sector unless purposeful steps are taken to counter that. The households with lowest incomes, who get prioritized for social housing, will also tend to be those with the highest social needs. The specific access policies and practices contribute, but there is also an unmanaged systemic dynamic at play that is seen in flatlined social housing around the world. In a context of high turnover in projects with high-needs population and related social problems, it is people with urgent need who get placed in such projects when applying, while people in lesser need pass up that housing option.

The flatlined and relatively shrinking social housing system is most pronounced in Greater Toronto, where growth is much higher than in most parts of Ontario:

- The GTA population in 1996 was 4.6 million and it is an estimated 6.7 million in 2016.[134]
- On a scenario where 3 percent of population has serious mental illness and this group's household formation rate is 60 percent,[135] there were 83,000 such households in 1996 but 121,000 today.
- If one-fifth of households with serious mental illness or addictions were housed in the 100,000 RGI units, they comprised 17 percent of RGI tenants in 1996 (1 in 6) but 24 percent today (1 in 4).

These points paint a scenario and we do not know the actual percent of RGI tenants that have serious mental illness or addictions. But given population growth, a flat RGI system, and access policies favourable to this group, these points accurately portray the general dynamic that is operating. The result is higher support needs in regular social housing.

Recently, municipal housing providers have entered agreements with LHINs or the community mental health agencies they fund, to have support provided in projects with high-need populations. This is most prominent in the case of Toronto Community Housing and community agencies funded by an arrangement with Toronto Central LHIN. But parallel needs are found across the Ontario social housing sector.

3.7 Dispersed Housing First

Dispersed rent supplement with supports in private rental:

In recent years rent supplement, dispersed in the private rental sector and paired with flexible supports, has come to the fore in Ontario. This approach was taken in most of the successive rounds of additional supportive housing which the Ontario government has funded and delivered since 1999, described in subsection 2.3.1. The partial exception was the initial, 1999-2002 round which offered both this approach and a capital funding option. The rent supp approach is also seen in the At Home / Chez Soi demonstration program and in Toronto's Streets to Homes program and similar ones in other communities. Thus rent supplement with support in dispersed private rental has been implemented in explicit *housing first* program models, and in more generic ways.

The term "dispersed housing first" is used here to refer to models involving direct access from homelessness, independent tenancies, de-linking supports from housing, and no preconditions or housing stages, and units that are dispersed either in private rental housing or in a mix of private rental and social housing. Such principles have also been implemented for many years in supportive social housing. Some researchers have drawn a distinction in this vein, between "housing first" as a principle or paradigm that

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134   1996 from census data; 2016 estimated from Ontario, Ministry of Finance, population projections.
135   These are reasonable scenarios. See the accompanying Wellesley Institute report on population-based estimates of need for supportive housing.

may apply in different programs, and *housing first* as a specific program model.[136] European practitioners and researchers have been very interested in the model but have also, more than in Canada, given thought to how it maps onto their systems, with homelessness programs quite different from the US and most low-income renters living in social housing.[137]

Ontario's emphasis on rent supplement in 1999-2015 corresponds to large changes in prevailing ideas, and in the housing policy and program context, aided by different housing market conditions. Ontario housing policy in the latter 1990s entered a new period in these terms, as Canada's high priority to social housing ended. In 2003-2011, Ontario's production of 12 new affordable units annually per 100,000 was less than half the US rate of 27 new units per 100,000 population.[138] Where governments are concerned about spending constraint, or give higher priority to needs other than to housing, rent supplement is attractive because it has lower short to medium-run costs than social housing supply. With program delivery scaled back and system expansion occurring in periodic initiatives rather than an annual cycle, rent supplement has appeal because it can be more quickly implemented. Compared to property development it requires less program delivery infrastructure, involves simpler accountability, and offers quickly measurable results.

The emphasis on rent supplement also accords with broader influences since the 1990s, especially the *housing first* concept and program model. The Pathways model using rent supplement[139] became very influential in Canada and internationally over the past decade or more. In this country, rent supplement was reinforced by the At Home / Chez Soi demonstration program which offered powerful research evidence of the benefits of housing with supports. It was entrenched as a requirement in the post-2011 phase of the federal Homelessness Partnering Strategy, reflecting the 2006-2015 government's market-oriented policy. Various Ontario communities have implemented various models of *housing first*, in the specific meaning of sense of rent supplement dispersed or *scattered*[140] in private rental.

This approach was also favoured by changes in the Ontario rental market. The low-demand rental market of 2002-2007, with vacancies above 3 percent in Ontario's big cities for the first time since 1970, meant far more willing landlords and available units, for providers with rent supp funding in hand, and with clients who were not always easy tenants. Those market conditions reflected the 1996-2006 homeownership boom, when the number of renters shrank absolutely for the first time ever in Canada, Ontario, and Greater Toronto.[141] But a broader, longer-term shift has also been occurring: most added low-income renter demand – part of the spectrum of rapid ongoing growth – is now met in existing private rental.[142] Where at one time either social housing or private rental was 'normal housing' for Canada's low-income

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136   Waegemakers Schiff and Schiff (2014), "Housing First: Paradigm or Program?" *Journal of Social Distress and the Homeless* 23 (2): 80-104.

137   For example, see Pleace and Bretherton (2013), "The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness" *European Journal of Homelessness* 7 (2): 21-41; Tsai and Rosenheck (2012), "Considering Alternatives to the Housing First Model" *European Journal of Homelessness* 6 (2): 201-208; Johnsen and Teixeira, "'Doing it Already?': Stakeholder Perceptions of Housing First in the UK" *International Journal of Housing Policy* 12 (2): 183-203.

138   Total Low Income Housing Tax Credit Units targeted to low incomes (2003-2011) were 732,230, summed from online HUD LIHTC data at http://www.huduser.org/portal/datasets/lihtc.html#data. Ontario data calculated from project reports for GTA service manager municipalities and occasional MMAH data releases (see Wellesley Institute (2015), *Submission to the Province of Ontario: Long Term Affordable Housing Strategy Update*. Population (2006) 298 M (USA), 12.2 M (Ontario). The difference between Ontario and the USA is greater than indicated, because not all Ontario AHI-IAH units have been low-income targeted.

139   Tsemberis (1999), "From Streets to Homes: An Innovative Approach to Supported Housing for Homeless Adults with Psychiatric Disabilities" *Journal of Community Psychology* 27 (2): 225-241.

140   Scattered rent supplement as a housing program tool in Canada dates to the 1970s. Recent Canadian *housing first* literature has tended to adopt the US HUD (Department of Housing and Urban Development) term 'scattered site'.

141   Ontario Non-Profit Housing Association, *Where's Home? 2013*.

142   ibid.; also Suttor (2015), *Rental Housing Dynamics and Lower-Income Neighbourhoods in Canada*.

renters, in the past two decades it is overwhelmingly market rental in terms of net change or added renters. The existing numbers of low-income market renters with affordability problems now far exceeds growth in that segment, and policy increasingly focuses on them. In sum, both our housing policy context and housing market context have moved closer to the US experience and approach.

At Home / Chez Soi:

In 2008 the federal ministry Health Canada provided $110 million to the Mental Health Commission of Canada (MHCC) for a five-year demonstration project on *housing first*. At Home / Chez Soi (AHCS) implemented supported housing on the model used by Pathways to Housing in the USA, for people with serious mentally illness experiencing chronic homelessness. It used rapid access to housing, RGI rent supplement scattered in market rental, and flexible supports (Intensive Case Management or Assertive Community Treatment). The initiative arose in the context of strong interest in Canada and internationally in *housing first* approaches, particularly the Pathways model, and interest in developing more systematic responses to homelessness that integrate various program elements and are flexible enough to adapt to the particular needs of each person. The project was designed as health research: a randomized controlled trial with a rigorous evaluation component comparing outcomes for those housed with supports under the program to those of a control group of people who continued homeless or got housed (as the case may be) without intervention by AHCS. It has provided the strongest available evidence for the positive housing, health and other outcomes of providing subsidized housing with flexible supports to this population.[143]

Toronto was one of five sites across Canada, along with Moncton, Montreal, Winnipeg and Vancouver. Intake commenced in 2010 and the project was carried out over 24 months in 2011-2013. Of the Toronto participants, 301 were assigned to housing and supports through the program and 274 to 'treatment as usual', the latter including an unplanned range of evolving situations of homelessness as well as housing and/or supports outside the At Home / Chez Soi project.

At the conclusion of the demonstration project, Ontario continued the rent supplement and support funding on a permanent basis, for the number of participants remaining in the program.

Streets to Homes Transitional Supports:

The City of Toronto created the Streets to Homes program in 2005. This was in fact a mixed model; as noted in section 2.2.2 about 40 percent of housed clients were in social housing and 60 percent in private rental (as of 2010). It fits in the dispersed private rental category, given its rapid rehousing approach.

The origins relate to evolving experience in Toronto, *housing first* examples in other cities, and political concerns at the time. Street outreach was a developing practice in Toronto in the 1990s onwards, and in the early 2000s the emphasis for the City and some community agencies shifted to "high support street outreach,"[144] supported by a new provincially funded Off the Streets Into Shelter (OSIS) program, later folded into broader provincial homeless funding, and by federal homelessness funding (the Supporting Communities homelessness Initiative). The relocation of the Tent City squatters into housing was a large precedent and opportunity to develop program models, expertise and practice.[145] *Housing first* on the model

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143   Goering et al. (2014), *National At Home/Chez Soi Final Report*; Stergiopoulos et al. (2014), *At Home/Chez Soi Project: Toronto Site Final Report*.
144   See Falvo (2010), "Toronto's Streets to Homes Program", 10-11.
145   Gallant et al. (2004), *From Tent City to Housing: An Evaluation of the City of Toronto's Emergency Homelessness Pilot Project*.

of New York-based Pathways and Common Ground[146] programs was gaining attention internationally and across Canada. In the post-amalgamation years there was intense political concern about the way rising funding was going into homeless services without appearing to make any difference in street homelessness.

The component of the program that used flexible housing allowances for some of the clients was enabled by AHP-IAH (the Canada-Ontario Affordable Housing Program and then the Investment in Affordable Housing program) which funded these from 2005 onwards. This was a departure from the pre-existing RGI model that provided only deep subsidies under contract with the landlord, required that intake be through the coordinated access system, and in recent years has lacked any funding for net new units or beneficiaries.

This model illustrates the complex relation between municipally funded homeless services and Health-funded supportive housing for people with mental illness and addictions. From the point of view of the City and community agencies dealing with street homelessness and people in chronic homelessness, expeditious routes to housing were needed. Many homeless people could achieve stability in various forms of housing, often with only modest forms of housing assistance; not all required long-term supportive housing. They needed quick and direct access, which was rarely possible into Health-funded supportive housing. Available municipal and federal funds, or provincial non-Health homelessness funds, could achieve some of these goals in an expeditious way. Supports could be contracted with a range of agencies included those funded by homelessness funds as well as with provincial health dollars.

Other Ontario communities have implemented various models of dispersed *housing first* with direct access from homelessness, rent supplements, and flexible supports.

3.8 Mixed Models and Sector Linkages in the 1999–2016 Period

One consequence of the initiatives of 1999-2016 has been to created a system with a wider mix of housing tenure and subsidy arrangements, and renewed cross-over between the Health-funded system, devolved social housing (*alternative* and other), and the municipally administered homeless program system.

Although the supportive housing initiatives of MOHLTC in this period were implemented through Health transfer agencies, i.e. supportive housing providers, they fostered cross-sectoral linkages and partnerships across sectors. The Addictions Supportive Housing initiative of 2008 onwards strongly encouraged partnerships between supportive housing providers with their expertise in housing, and addiction support/treatment agencies with their specialist expertise.

The emphasis on homelessness in several of the MOHLTC initiatives encouraged or reinforced partnerships with local homeless-serving agencies. Whereas at the time of transfer from MMAH to MOHLTC in 1998, mental health supportive housing agencies were strongly encouraged to ensure that all tenants had serious mental illness diagnoses, the emphasis on homelessness in the new initiatives meant serving many whose diagnoses and connections to mental health or addictions services were less clear-cut.

The mental health providers, which two decades ago mostly operated "projects" they owned and operated, funded as social housing, today operate a mix of those projects and rent supplement contracts. The overall system, net of boarding homes and high-support congregate facilities, has shifted to a mix which is approximately two-third rents supplement and one-third social housing. Many providers now have

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146   Now re-named Breaking Ground. See http://www.breakingground.org/

extensive experience with the pro and con factors in each of the approaches, and some ability to adapt one approach or the other to different client needs.

Other decisions and initiatives have also contributed to an emerging system of mixed models and more structured relations between the Health-funded system and the devolved housing and homeless system. The Streets to Homes initiative in Toronto tended in this direction. S2H was about housing people experiencing chronic homelessness, regardless of mental illness, addiction, or other chronic condition, and it was not an MOHLTC supportive housing program. But these conditions have a high prevalence among the people served, and although Streets to Homes supports are not LHIN-funded, they are in many cases provided by agencies whose primary service is LHIN-funded mental health supports. In Toronto, one of the largest *alternative* providers, Fred Victor, has been a mental health transfer agency for some years, and having recently merged with a large Health-funded support agency, CRCT, now straddles the *alternative* and Health-funded sectors.[147] Another large *alternative* provider, Homes First Society, is funded by MOHLTC and CAMH respectively for two among its various programs, and operates with partnerships to ensure Health-funded as well as other external support for tenants.[148] The several pilot programs of LHIN-funded support in devolved social housing have been noted above.

Addictions housing also tended toward crossover and intersections. The MOHLTC addictions initiative brought mental health housing providers more strongly into serving that population, in new partnerships with addiction service agencies. Addictions had long had a high prevalence among the residents of devolved *alternative* providers. In such cases, addictions-related support is high,[149] and sometimes comparable to what exists in MOHLTC-funded housing. Fred Victor has also provided transitional housing for homeless people with addictions who then move on to a Health-funded supportive unit.

In addition, the Mental Health and Justice Initiative of 2005 onward built links between the corrections sector and the supportive housing sector. Housing has remained a significant concern of the provincial and regional Human Services and Justice Coordinating Committees established at that time.

In sum, the past 15 years have tended to deepen the experience of providers in varied partnerships, their knowledge of and confidence in a system with diverse models, and the understanding of a need to bridge effectively between various sectors including addictions, mental health housing, devolved social housing, homeless-related services, and corrections.

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147 See Fred Victor Centre and CRCT (2015), *Business Case for the Integration of Community Resource Connections of Toronto with Fred Victor Centre* (Submission to Toronto Central LHIN).

148 See http://homesfirst.on.ca//mental-health-supports; also 2015 Annual report and 2015 financial statements. The specific programs referred to are Savard's and Hospitals to Homes.

149 For example, description of Fred Victor Housing in Region of Waterloo, Social Services Department (2011), *Program Review Resource Guide: Selected Longer Term Housing Stability Programs, pp. 29-31.*

Conclusions

This review of supportive housing suggests some general themes and implications, considered in this section. An overview of findings is provided in the executive summary.

The Ontario system of supportive housing for mental health, addictions, and chronic homelessness includes a range of models and several distinct program categories. These range from boarding homes and high-support congregate facilities, to independent rent-subsidized apartments with flexible supports that are tailored to individual client needs.

The core of the system (12,900 units and somewhat over $200 million annually) is funded by the Ministry of Health and Long Term Care, directly and through the Local Health Integration Networks (LHINs). Separately from that, significant parts of the system are within the programs administered by the 47 Service Manager municipalities (DSSABs in Northern Ontario) and overseen by the Ministry of Housing.

The Service Manager system includes various *alternative* social housing, transitional accommodation funded through the shelter system, dispersed *housing first* programs, more mental health-related boarding home beds than in the Health-funded system, and a significant share of the new affordable housing supply since 2003. The municipal system accounts for an estimated 10,000 units.

The system has shifted over the past forty years in ways that reflect evolving thinking and best practice in the mental health and addictions sector, and a changing housing policy regime and market context. The subsidized boarding homes and residential care facilities of the 1960s and 70s involved a fixed, often mandatory package of supports that was bundled and integral with residency. In the 1980s and early 1990s the dominant approach was *dedicated* supportive social housing – small apartment buildings or shared houses with flexible supports coming either from 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 endures today, reflecting what each period created in terms of provider mandates, real property, and program frameworks, budgets, and practices.

While independent apartments with flexible supports are best at implementing recovery principles for most people, other people benefit from congregate (collective) living arrangements and higher levels of support, sometimes bundled with the housing. There is robustness in a system with a diversity of housing and program models, and the part 15 years have tended strongly toward mixed program models. Yet the combination of programs and models that exists today is a product of history rather than of systematic planning. There is a need to manage more strategically how this mix evolves.

The system has expanded significantly in 1999-2016. About two-thirds of the units in the Health-funded system date from this recent period. But these years have also seen significant expansion in the municipally (Service Manger) administered programs, reflecting the local/regional responsibility for homelessness programs and corresponding priorities to address such issues. The links between such Service Manager programs and priorities and the Health-funded system are relatively weak.

Municipally administered social housing has also become a main sector housing people with unmet mental health and addiction needs, as a function of access policies and overall residualization of this sector. There is little information on what de-linked LHIN-funded housing-related supports, and pilot LHIN-municipal collaborations in this area, may add up to across Ontario within the social housing sector. The scale of this population and its needs suggests that responses are required on a larger scale.

The dual significance of the Health-funded and municipally managed programs in terms of stock, recent expansion, and unmet needs, suggests a need for better coordination between the two systems. Policy and program planning for mental health and addictions supportive housing in relation to homelessness should consider the full range of sectors involved, and not only Health-funded supportive housing.

The three-part typology of supportive housing used in some mental health housing literature – *custodial, supportive, and supported* – does not capture effectively the range of existing program models described in this report. The typology does not achieve internally consistent and well-differentiated categories. This conclusion supports the earlier suggestion[150] that the typology has outlived its usefulness.

Private rent supplement and social housing are both part of the system. *Housing first*, in the sense of scattered rent supplement in private-sector rental with flexible supports, is part of a spectrum of successful approaches. Its recent salience has been shaped by its real achievements, and also by fiscal concerns and weak social housing policy. Seeking and using options in private-sector rental is essential in a housing system where that sector provides most of the moderate-cost rental supply. But private rental stock offers few options in many communities. Supportive housing has comprised about one-fifth of new units funded in Toronto, and all likelihood across Ontario, under the new affordable housing supply programs since 2003. Scattered rent supplement and *dedicated* supportive housing have different and complementary merits and shortcomings, and Ontario supportive housing policy should be informed by analysis and understanding of these.

Boarding homes are part of the program mix, and constitute almost one-quarter of the system. These are typically not as recovery-oriented as most other supportive housing, and they are no more cost-efficient. The move toward more non-profit, recovery-based models is important to pursue. Nevertheless, this sector provides rapid access to housing, and for Service Managers the CHPI "Housing with related support" funding is a flexible tool to respond to needs and opportunities in the housing market. It will be a challenge to replace the more than 5,000 subsidized boarding home beds, in a system where accommodation in rented rooms is a main market response to the housing demand of people with very low incomes. Working with the down-market rental sector, and supporting clients living in it, will need to remain part of supportive housing policy.

The ideal of flexible supports with de-linked housing subsidy faces hurdles in a market-based housing system where subsidized rents are many fewer than people in need. Many others besides mental health and addictions clients compete for such units. Giving more priority to this specific population will therefore continue to require the provision of housing and supports in tandem, with access also handled in that way.

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150   Nelson and Peddle (2005), *Housing and Support for People Who Have Experienced Serious Mental Illness*, pp. 4, 7.

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