BACK TO COMMUNITY

AN ASSESSMENT OF SUPPORTIVE HOUSING IN TORONTO

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Final Report

Prepared for the Mayor's Homelessness Action Task Force
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EXECUTIVE SUMMARY

Our focus in this report is to provide an overview and assessment of supportive housing in Toronto, a sub-sector of the housing system that provides both housing and support services to special needs groups and to the most marginalized who are at risk of becoming or remaining homeless due to their particular circumstances and vulnerabilities. Supportive housing lies on a continuum between institutions and independent living; it includes various forms of shared and self-contained housing, e.g., group homes with on-site staff, supervised apartments, and portable support services.

Supportive Housing and Homelessness

The supportive housing model emerged as an alternative to institutions, and the newest application is to assist the visibly homeless and most marginalized. It is a model of housing provision designed to accommodate individuals and families who require extra services to both obtain and maintain their housing and their well-being. Particular projects range from therapeutic programs of rehabilitation with intensive service provision of daily personal care to an explicit insistence that residents are foremost tenants who retain choice regarding the level and type of support service use required to promote their independence.

Most people would agree that emergency shelters are not the answer to homelessness, partially because they can make matters worse. Prolonged homelessness requires adaptations for survival, and extended hostel living may result in a certain degree of institutionalization. Shelters are also costly. Thus, well-targeted supportive housing programs are a better strategy, especially for chronically homeless people who disproportionately consume the resources of emergency shelter and hospital services. A recent review of Toronto hostel records found that 17 per cent of hostels users are chronically homeless and occupy 46 per cent of bed nights. For these people, hostels function as a form of institutional or 'quasi-supportive' housing.

Evaluative Research

While supportive housing projects have been found to be effective with various populations, most of the research applies to people with psychiatric disabilities. Except for a small minority, this group, like most others, prefers to live in self-contained units. Both community integration and quality of life are improved when residents are able to influence decision-making in their living environment. Research conducted by local supportive housing agencies demonstrates that their residents are generally satisfied with their housing. Some agencies have established a pattern of incorporating evaluative research in their planning and management decisions to improve their services, a practice that should be promoted.

Profile of Supportive Housing in Toronto

In total, there are 8,566 supportive housing units in Toronto. Excluding those for frail elderly people and those with developmental disabilities (groups that may not be well-housed, but are unlikely to be among the visibly homeless), there are ***5,295 units***.

- almost half of the units, 2,483, are self-contained
- a majority of the units are dedicated, and a high proportion are linked
- about two-thirds of the residents are psychiatrically disabled or homeless and hard to house
- funding for the development and operation of most supportive housing projects has been, and is, provided by both federal and provincial governments; some have been funded solely by one senior government

Needs and Issues

Access to supportive housing is uneven and highly dependent on social service sector contacts. This reflects the absence of a co-ordinated infrastructure. Our assessment outlines a serious gap between the need and availability of supportive housing units in Toronto. Applicants have been waiting for up to four years for a self-contained unit. At least another 5,000 units are required to meet existing need. The design and planning for new supportive housing projects should take into account some of the particular needs and issues of certain groups: Aboriginal persons, substance abusers (especially those with psychiatric disabilities), youth, women, and those considered hard to house. There are several sector-wide issues that require attention, for example, improved policies to deal with the additional management costs inherent in dealing with a troubled and difficult tenant population, and methods to allow for very fast evictions in situations that threaten serious harm to tenants or staff.

Policy Directions and Implications

Most of the supportive housing units listed in our inventory will be transferred to the Province — up to 55 per cent to the Ministry of Health and up to 26 per cent to the Ministry of Social and Community Services. The status of integrated supportive housing units, which do not meet support ministerial criteria, is unclear. Also, about a fifth of the stock (over 1,000 units) is subject to devolution to the municipality. These changes are causing local agencies to focus on how they will be affected; and they raise a great many questions. While a portion of the current stock may lose funding, there is no funding mechanism in place to develop the additional stock direly needed to prevent an increase in the number of those who are chronically homeless.

Conclusions

It is critical that all three levels of government co-operate to develop a new supply funding mechanism for the supportive housing required. We suggest a model which combines federal funding for housing with provincial support service funding. The municipal government also has a critical role to play in co-ordination and planning with funding and sponsoring agencies.

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SECTION 1: INTRODUCTION

"*First, homelessness is a result of economic restructuring and the collapse of the welfare state.... Second, homelessness is a housing problem. ... And finally, homelessness is a personal crisis. Individuals react differently to economic hardship and housing shortages; what may be a temporary setback for one individual could be the start of a dizzying descent into homelessness for another*" (Wolch and Dear 1993: xx).

Clearly, the problem of homelessness encompasses a complex array of structural and psychosocial factors. Those with insufficient social supports to tide them over periods of crisis, those with low-paying jobs, and those least able to obtain public assistance are more likely to become or remain homeless (Wolch and Dear 1993). Individuals with health problems, disabilities, or other vulnerabilities are also more likely to become homeless and require assistance that goes beyond basic housing provision.

Our focus in this report, one of several commissioned by the Mayor's Task Force on Homelessness Action chaired by Dr. Anne Golden, is to provide an overview and assessment of supportive housing in Toronto, a sub-sector of the housing system that provides both housing and support services to special needs groups and to the most marginalized who are at risk of becoming or remaining homeless due to their particular circumstances and vulnerabilities, especially in highly competitive urban housing markets with low vacancy rates. They include people with mental illness, HIV/AIDS, developmental disabilities, teen mothers, women and youth leaving violent or unstable family relationships, frail elderly, and those discharged from institutions such as psychiatric hospitals and jails. In short, they are people who have been institutionalized, or would have been in the past, as well as those who lose their housing due to family breakdown, abuse, and poverty.

In order to determine the role of supportive housing as a program for dealing with homelessness, this report attempts to provide a general assessment of the current state of supportive housing in Toronto and contains the following:

- a brief introduction to the supportive housing sector
- a review of research findings on supportive housing
- an inventory of supportive housing in Toronto
- an estimation of need and overview of issues
- policy directions and implications, and
- conclusions

1.1 What is Supportive Housing?

The integration of social and other services with housing is not an unusual concept; we all look for places to live that will be accessible to the services we need, and we rely on support from family, friends, and community. For those who are homeless or at risk of homelessness, have special needs, or who otherwise lack a support system, supportive housing purposefully provides the links required to live with self-determination (Glauber 1998).

Supportive housing is a model of housing provision designed to accommodate individuals and families who require extra services to both obtain and maintain their housing and their well-being. Supportive housing providers develop or manage a 'bundle' of subsidized housing with extra services to accommodate various and diverse individual and group needs. These include group homes, supervised apartments, housing with independent supports, and portable community supports.

The types and levels of support required by tenants vary considerably. They include assistance with housekeeping, cooking and meal preparation, banking, life skills, medical care, counselling, recreation, service referrals, employment assistance, and drop-in programs. Some tenants

who have been recently deinstitutionalized, or who would otherwise be in institutions, need higher levels of support in order to assist them carry on with day to day living and to move to a higher level of independence, to the extent that is feasible. Others need relatively little assistance or support and their needs are very similar to those of the rest of the population, however, their living arrangements, especially to the degree living space is shared, may require assistance in problem-solving and conflict resolution.

There is generally not a clear demarcation between residential and support services (Pomeroy and Dunning 1998). As property managers, supportive housing providers commonly invest greater efforts to maintain both buildings and tenancies. They also tend to foster positive community relations among tenants, and even in some cases promote community economic development projects that re-establish employment relations. Significant efforts are made to prevent evictions through extensive problem-solving and conflict resolution. This frequently requires a careful, and sometimes difficult, balancing of tenants' individual and collective interests, against a backdrop of financial costs. Some providers also retain residents' beds, rooms, or apartments during absences due to hospitalization or other causes.

The philosophies and program models range from therapeutic programs of rehabilitation with intensive service provision of daily personal care, to an explicit insistence that residents are tenants foremost, who retain choice regarding the level and type of support service use required to promote their independence.

1.2 Supportive Housing as a Response to Homelessness

For various reasons, a great deal of attention has been directed to the situation of the visibly homeless who have an alcohol, drug, or mental disorder (ADM), and research on homeless people almost invariably attempts to estimate the prevalence of mental illness among them (Rossi 1989). The high number of visibly homeless people with a psychiatric disability is generally viewed as an indicator that the mental health system is failing to provide appropriate and adequate community assistance as deinstitutionalization policies have proceeded (Lipton, Nutt, and Sabatini 1988).

From another starting point, many housing activists have criticized the representations of homeless people as vagrant, deviant, sick, or victim. In the words of one researcher, "the [housing] advocates focus on economic distress and the service providers focus on social or physical distress" (Hoch 1986: 228).

Regardless of approach, most people would agree that emergency shelters are not the answer to homelessness, partially because they can make matters worse. A British study has elaborated the theory of the "three-week-rule" which describes the period during which people rapidly adapt to homelessness in order to survive, and after which it is more difficult to re-integrate into mainstream society (Grenier 1996). The lack of housing for the very poor is therefore increasing the necessity for support services to counteract the harm inflicted by extended homelessness.

Prolonged homelessness requires adaptations for survival, and extended hostel living may result in a certain degree of institutionalization or 'shelterization,' a term Kozol (1988:21) uses to refer to processes that "make healthy people ill, normal people clinically depressed, and those who may already be unwell a great deal worse." The documented effectiveness of "critical time intervention programs," which direct intensive service as quickly as possible to homeless adults with serious mental illness, underscores the harm and costs of homelessness (see work of E. Susser).

Many researchers have argued that well-targeted supportive housing programs are an effective strategy, especially in dealing with chronically homeless people. Research on hostel use in the United States reveals that chronically homeless people generally have special needs related to mental health or substance abuse, and while they constitute only about ten per cent of shelter users, they consume half of the shelter system days.

Since their circumstances do not constitute an emergency, it is inappropriate that half of the emergency shelter system's resources are devoted to providing what is essentially permanent housing for this relatively small sub-group (Culhane 1997).

There are ongoing debates in research and policy circles regarding the prevalence of alcohol, drug, and mental disorders among the visibly homeless population. Definitional and methodological issues abound in the literature on homelessness and its measurement; these are compounded by similar debates regarding the assessment and prevalence of alcohol, drug, and mental disorders (Springer, Mars, and Dennison 1998). Most research findings are based on U.S. studies and vary widely in their assessments of these disorders, however, the important point is that *chronic hostel users especially require assistance in acquiring and maintaining appropriate permanent housing through related support services*.

All persons who are homeless share with those who have been institutionalized a loss of freedom and self-determination to a degree which is harmful in itself. This makes the provision of stable housing and the requirement of housing subsidies a primary goal of supportive housing (Howie the Harp 1990).

The other shared characteristic is the loss of social networks and community.

> The hallmark of homelessness is extreme dissatisfaction and disconnection from supportive relationships and traditional systems that are designed to help (Bassuk et al. 1984: 1549).

It is also the case that increased homelessness reflects the weaknesses of current systems that are designed to help. One partial solution to this problem is supportive housing.

In his review of innovative programs designed to address homelessness, Daly (1996) used several criteria to direct his selection: *participant involvement*; *comprehensiveness* (e.g., addressing several problems simultaneously by providing services to help people manage housing and a job); *adaptability* (to deal with people's changing needs over time); and *prevention* (or alternatives to temporary measures such as emergency shelters). Permanent supportive housing meets all these criteria.

1.3 Mental Health and other Needs among the Visibly Homeless

It appears that the proportion of mentally ill people among hostel and shelter users in Toronto has increased over time, although systematic attempts to measure the incidence have begun only recently. A 1985 internal report highlighted the need for better co-ordination of services for the sizeable number of people in Metro Toronto hostels with mental health problems (Metropolitan Toronto Community Services Department 1985). A decade later, an internal memo noted the increasing proportion of hostel residents with mental illness and the lack of resources to deal with their needs (Hoy 1996). Another report notes that many homeless people have substance abuse problems and that women are often homeless because of prior abuse in the home (Metropolitan Toronto District Health Council 1996).

While it is clear that people with serious mental illness are disproportionately found among the visibly homeless, determinations of how many varies. The results of a recent major study of Toronto hostel users (known as the Pathways to Homelessness study) form the basis for the following profile of hostel users (see Mental Health Policy Research Group 1998).

About 11 per cent of hostel users have severe mental illness (six per cent have psychoses, mainly schizophrenia, and five per cent have mania).[1] When other categories of serious disorders such as major depression are included, about two-thirds of hostel users and people on the street have lifetime diagnoses of mental illness.

[1] This does not include two common diagnoses among visibly homeless populations: substance abuse and severe personality disorders (see Geyer Szadkowski Consulting 1998). Compared to other similar studies conducted in cities in the United States, Germany, Spain, and Australia, however, it is a middle-range definition.

Many of those with a lifetime diagnosis of mental illness also have a diagnosis of substance abuse. The prevalence rate of substance abuse among hostel users is 66 per cent. This is noteworthy because substance abuse is an important factor in housing loss and maintaining homelessness, a conclusion supported by several studies. When the prevalence of substance abuse is combined with that of mental illness, the overall lifetime prevalence rate rises to 86 per cent.

A recent analysis of Toronto hostel records found that 17 per cent of hostels users are chronically homeless (i.e., they stay or are repeat users for one year) and they occupy 46 per cent of bed nights. Some of them have used the hostel system for up to six years (Springer, Mars and Dennison 1998). For these people, hostels function as a form of institutional or 'quasi-supportive' housing (Emanuel and Suttor 1998).

More than a third of Toronto hostel users are women, however, it is estimated that up to 80 per cent of adult single women have serious mental illness, especially older women. These women are more likely to be chronically homeless.

In general, chronic hostel users tend to be single, male, and to have come from the corrections system and hospital or treatment programs (Springer, Mars, and Dennison 1998).

1.4 Emergence of Supportive Housing in Toronto

There are several antecedents to the supportive housing model as an alternative to institutional care. One predecessor was established by the Homes for Special Care Act, passed by the provincial government in 1964 to provide long term and permanent residential care to patients discharged from psychiatric hospitals. Although the objective initially sounded promising – "to provide residential care for the severely disabled patient with relatively stable and socially acceptable behaviour and to establish the individual as a person rather than a patient" – it was developed primarily to reduce health care costs (Trainor 1996:2). A contemporary review of the program reveals some weaknesses and inflexibility in terms of incorporating advances in knowledge. Most of the housing is quasi-institutional, consisting of large commercial boarding homes with a custodial model of care. This model represents the traditional approach to supportive housing and is now criticized by advocates of more 'normal' models.

Over the past two decades, various Toronto agencies responded to the mounting housing crisis for low income and vulnerable groups by developing non-profit housing funded by the federal and provincial governments. Much of it was funded by Ontario programs, such as P3000, that were available from 1987 to 1995. And while federal programs continue to provide rental subsidies, programs for new social housing development have not been available since 1993. Among the developers of non-profit housing, a sub-sector of self-identified supportive and alternative housing providers evolved, with different philosophical positions regarding the provision of housing and support services, positions that have merged somewhat over time (Novac et al. 1996).

The new supportive housing model was promoted by community-based mental health agencies that saw housing as a therapeutic vehicle. 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 in 1981. This is the origin of the Supportive Housing Coalition.

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.

1.5 Models of Supportive Housing

One way to distinguish projects is by their eligibility criteria for residents. For example, some projects are strictly targeted and require medical diagnoses of specified categories, while others are restricted simply to applicants who are homeless and very poor. Another dimension is revealed in the management model and the relative emphasis on resident participation and influence or community development.

The most distinctive characteristic of supportive housing is that it offers an alternative to institutional settings, yet the predominant health, physical, and social needs of its residents have fostered a strong connection between housing and service provision.

Supportive housing refers to subsidized housing-plus-support service bundles that have been designed primarily for people with disabilities (psychiatric, physical, and developmental disabilities, as well as frail elderly). It covers a wide range of non-institutional models that includes some residential programs, board-and-care homes, group homes, supervised apartments, and rental agreements with non-profit or private landlords that include case management services. The support services are commonly coupled with the housing provision and are frequently offered by the same organization.

There has been a more recent shift in the mental health field toward offering individualized and flexible treatment services to residents who live in community settings. The model of *supported* housing emphasizes the provision of conventional housing that is integrated within communities (scattered sites), flexible accommodation of individual support needs, and the de-coupling of support services from housing provision (Ridgway and Zipple 1990a; Ridgway et al. 1994). It is contrasted with supportive housing projects that are located on clustered sites, including apartment houses and single room occupancy (SRO) hotels that have a specialized program of services, or case management linked to the setting.

The distinction between these models and terms is not firmly established, and some argue that the origins of supported housing retain some grounding in a therapeutic approach, for instance by incorporating housing 'goals' (Brown et al. 1991).

Supported housing refers to subsidized housing with arrangements for support services that are provided by agencies other than the housing provider or landlord (i.e., de-linked). It is commonly designed for people with psychiatric or other disabilities, as well as homeless people, and adheres (or aspires) to the following characteristics and principles[2]:

1) housing is dispersed in the community (buildings are not inhabited exclusively by the same special needs group);
2) residents have housing choices and are assisted in locating, choosing, and maintaining housing;
3) no imposed restrictions on length of stay in housing;
4) participation in program activities is not a requirement of the housing arrangement;
5) services are flexibly provided at varying levels of intensity when and where needed; and
6) services are available to help prevent loss of housing during hospitalization.

The shift in emphasis from support to housing needs has also grown out of the experience of practitioners who have demonstrated that intensive treatment and rehabilitation can be delivered in normal settings such as clients' homes, or wherever people feel comfortable.

Models for more 'normalized' living from other fields such as mental retardation, the independent living movement for people with physical disabilities, and the assisted living models for elderly persons all showed that people with severe impairments in functioning could live in normal housing if provided with adequate supports and services (Zipple and Ridgway 1990a).

[2] Adapted from Carling (1990) and Ridgway and Zipple (1990b)..

The emphasis has coalesced around the general need for housing among those with mental illness and those who are homeless or relegated to substandard, dangerous or inappropriate settings, or unnecessarily institutionalized. Thus, the supported housing model is premised on the right to a home in the community for people with severe disabilities, along with recognition that a stable home is a prerequisite for effective treatment and psychosocial rehabilitation (Ibid.).

The *alternative* housing model appears to be unique, at least in name, to Toronto developers, notably Homes First. Its philosophy is similar to the approach of housing activist and theorist John Turner who viewed housing as both 'a noun and a verb.' An emphasis on empowerment and self-help underscores the approach which is grounded in community development practices and is quite likely to incorporate community economic development schemes as well.

Alternative housing refers to subsidized housing projects for the most marginalized – those who have been homeless, who may have mental and physical health problems, who suffer from severe economic disadvantage, long-term unemployment, violence and abuse, and profound social isolation. The primary concern of alternative housing providers is the provision and maintenance of stable housing and community development support, more than the provision of medical or psychosocial services or programs. This includes an emphasis on involving future residents in the planning and development of housing projects.

In this report, supportive housing is a generic term that encompasses supportive, supported, and alternative housing, not because the distinctions are unimportant, but because there is in essence more in common than not among the approaches, and because dealing with the varied issues and needs of those who are homeless and at risk of homelessness requires a broad range of housing and support options.

However reasonable the premise for supportive housing appears, what do we know about how and whether it works, and for whom? In the next section of this report, we will review some of the research on supportive housing projects.

SECTION 2: RESEARCH ON SUPPORTIVE HOUSING

This section reviews selected research on the applicability and effectiveness of supportive housing projects for various special needs groups, the effects of certain project characteristics on residents, and the results of evaluation research.

2.1 Applicability of Supportive Housing

While the majority of published research on supportive housing is found in the mental health literature and refers to projects that serve only people with psychiatric disabilities, there is evidence that the supportive housing model is also used for other homeless and vulnerable sub-groups.

Youth

For 2.5 per cent of Toronto hostel users, parental abuse is reported to be the main reason for their homelessness (Springer, Mars, and Dennison 1998). Family abuse and dissolution, as well as homelessness at an early age, have been identified as high risk factors for later homelessness among adults. One study of homeless adults found that prior to age eighteen, over 41 per cent of them had been physically assaulted at home, 29 per cent had out-of-home placement, and 23 per cent had been homeless (Susser et al. 1991).

Familial abuse and neglect is a fairly common part of the experience of runaways, 'throwaways,' and street kids. Many of them fall 'between the cracks' because they are outside the jurisdiction for children's services yet ineligible for adult services, especially income support programs (Breakey and Fischer 1990).

Local street workers have confirmed reports of homeless youth setting up illegal 'squats' and forming 'street families' of up to 50 individuals. These youth are highly suspicious of adult assistance and unlikely to use general hostel services. Their histories of abusive treatment are perpetuated by the rejection they face by adult society and are also played out amongst themselves. Young women are at particular risk of sexual abuse, exploitation, and pregnancy.

Birmingham, MacLeod, and Farthing (1990) studied a supportive housing pilot project for young people (aged 16 to 19 years) with emotional or behavioural difficulties who were placed in sex-segregated apartment in groups of three and received weekly and on-call supports to help them deal with the demands of independent living, including financial responsibilities. Because the challenges of shared living led to repeated conflict, the residents were eventually re-assigned, first to live with only one other youth, then to live alone. The program was more successful with female and older youth for whom it was an effective resource for respite from home and bridging the transition from unstable home lives to independent living.

At least one local agency working with youth (Pape Adolescent Resource Centre) appears to have developed a successful model of matching youth living in rooming houses with slightly older 'graduates' as mentors who provide on-call support in exchange for a free room.

People with Developmental Disabilities

People with development disabilities are frequently placed in group home settings with high levels of supports. A supported housing model involving shared apartments integrated in community settings, along with a mid-level of support services (weekly visits by professional staff) has also been found to be effective with this group, especially those with mild or no functional impairment (Campanelli et al. 1992).

Women

Relatively few studies of homelessness or supportive housing have addressed gender differences or women's issues. One local study, however, explored the concerns of women living in supportive housing projects, most of whom had previously been homeless (Novac et al. 1996a). The respondents reported a very high level of satisfaction with the design and features of their housing units, especially those with self-contained units. Most of the women living in shared units (generally consisting of four or five residents, with common facilities) said they preferred self-contained apartments, or at least women-only shared units. Lack of privacy and the necessity to accommodate the needs, desires, and choices of others were the reasons given for disliking shared housing.

Several studies have shown that homeless women and women with disabilities report higher rates of previous abuse, especially sexual abuse, than their male counterparts, housed women, or women without disabilities. Women's experiences of domestic violence, combined with their gender roles as homemakers and mothers, have been related to women's particular experiences of home and homelessness (Watson and Austerberry 1986). In fact, the relationship between violence against women and their housing is complex; it both drives women toward and away from housing situations and living arrangements with men, depending on individual assessments of specific situations (Novac et al. 1996b).

When previously homeless women and men are housed together, it appears that the prevalence of sexual harassment and abuse escalates. Women with mental illness, along with those who live in shared accommodation, are more vulnerable. Over a third of the respondents in one study indicated that they had experienced an incident of sexual harassment by male tenants. This is a much higher prevalence rate than for female tenants at large. Moreover, very few of these incidents are reported to staff, or appropriately handled when they are reported (Novac et al. 1996a).

Both homeless women and men express a strong preference for independent rather than shared living space, however, women express more concerns related to personal safety. They stress adequate living space, appropriate facilities for children, and safety features (Goering et al. 1990).

There are very few women-only supportive housing projects or buildings available, although it appears that those who live in them report higher levels of satisfaction and fewer problems than those living in sex-segregated projects (Novac et al. 1996a).

Racial Minority Groups

Racial minority people are over-represented among the visibly homeless, yet issues of racism or discrimination and supportive housing have not been the subject of any published research to date.

Data from Novac et al. (1996a) suggests that racial problems are a significant issue within local supportive housing projects. Anti-racism awareness and explicit anti-discrimination policies have been promoted by some local agencies, and at least one supportive housing provider has begun to implement "anti-discrimination change" throughout its operations (Locke 1997: 2).

People with Psychiatric Disabilities

Since the research on supportive housing has focused on the situation of people with psychiatric disabilities, this knowledge base is more developed; the main substantive findings are summarized here.

First, better quality, affordable housing improves the health of individuals with chronic mental illness. Several studies have found that the provision of affordable housing is associated with shorter hospital stays (e.g., Newman 1994).

Second, the socio-emotional characteristics of the environment, i.e., social support and interpersonal stress, together are strong predictors of mental health for chronic psychiatric patients in the community (Goldstein and Caton 1983).

Third, the superiority of smaller facilities is the most widely cited finding in the literature, and resident involvement in planning within the housing facility has been shown to enhance adaptation to the setting (Trainor et al. 1993). Fourth, people with mental illness want to live in regular housing like everyone else. A meta-analysis of 26 studies found that mentally ill clients "consistently reported that they would prefer to live in their own house or apartment, to live alone or with a spouse or romantic partner, and not to live with other mental health consumers. Consumers reported a strong preference for outreach staff support that is available on call; few respondents wanted to live with staff. Consumers also emphasized the importance of material supports such as money, rent subsidies, telephones, and transportation for successful community living" (Tanzman 1993).

Fifth, even homeless people with severe mental illnesses are able to stabilize their lives with supportive housing. A major U.S. study of 900 homeless adults with mental illness in three cities found that nearly all participants in supportive housing projects remained housed and increased their use of community-based mental health treatment and other services (Center for Mental Health Services 1994).

Sixth, the type of housing form and service provision affects a variety of outcome indicators. As outlined below, residents in shared apartment settings generally fared better than those living in group homes, and residents in either of these settings generally fared better than those living in board-and-care homes (Nelson, Hall, and Walsh-Bowers 1998, Nelson, Hall, and Walsh-Bowers 1995, Nelson, Wiltshire, Hall, Peirson, and Walsh-Bowers 1995, and McCarthy and Nelson 1993).

While pre-post evaluations of both group home and shared apartment supportive housing projects have revealed improvements for residents in terms of rates of hospitalization, independent functioning, instrumental role involvement, and personal growth, comparisons across various models reveal more specific results:

Resident Control: Those living in shared apartments exhibited the highest level of resident control, followed by those living in group homes. Those living in board-and-care homes exhibited the lowest level.

Privacy, Stigma: Group home residents reported more problems with lack of privacy, stigma, and lack of employment opportunities, while shared housing residents reported conflict with living companions as a problem. And, more residents in shared apartments and group homes had their own room than in board-and-care homes.

Affordability: board-and-care home residents spent the most of their income on housing, group home residents spend the next highest proportion of their income, and residents of shared apartment spent the least.

Neighbourhood Relations: the likelihood of developing social relationships with neighbours, and being located in a suburban area, was greatest for shared apartment residents, next highest for group home residents, and lowest for board-and-care home residents.

Social Networks: residents of group homes and shared apartments reported higher levels of positive emotional support and positive problem-solving support, and lower levels of emotional abuse.

Staff Support: Residents of both group homes and board-and-care homes reported that they received more staff support than those living in shared apartments.

Based on their findings, Nelson and his colleagues have made several suggestions for supportive housing providers:

- involve residents in all decisions, including the selection of new residents.
- provide every resident with their own room and a secure lock.
- develop ways of increasing stimulating activity in the community.
- develop peer supports and friendships.
- use conflict resolution workshops for dealing with interpersonal conflicts

The importance of promoting relationships with peers rather than with staff and professionals is also stressed by other researchers (Ridgway et al. 1994, Goering et al.1992). Based on an evaluation of a local group home project, Goering et al. (1992) suggest that there may be iatrogenic effects of environments with levels of involvement and support that are higher than typically provided for adults in our society. This may inadvertently

create undue dependency and other unintended negative consequences.

We still need to experiment with models for particular groups of homeless people. For example, a new model of low-demand, respite residences that serve noncompliant, treatment-resistant chronically homeless women has been found to be effective in a Philadelphia program. Aggressive outreach, combined with an open door policy, few rules, and no treatment requirements have eventually led to the successful placement of most residents in independent housing, while others moved to moderately or highly structured housing. Only 14 per cent have returned to the street (Culhane 1992).

A local project, Savard's, is based on the low-demand, respite model. While the results of its evaluation are not yet available, there are obvious and remarkable signs of greater stability for the residents; virtually all of them have stopped their constant moving from place to place and very quickly 'settled.' And the residents shifted their sleep patterns from day to nighttime, another reflection of the greater sense of safety provided by the project.

2.2 Resident Influence and Control

There has been almost no research to investigate the effects of resident influence or control on decision-making in supportive housing. Other studies, however, have found that opportunities for choice and control are positively related to well-being for older people in nursing homes (McCarthy and Nelson 1993) and single mothers in co-operative, non-profit, and private rental housing (Doyle, Burnside and Scott 1996).

Doyle, Burnside, and Scott (1996) found that the social structure of the housing environment has a major effect on well-being, with the significant factor being resident influence. They concluded that:

- social housing settings can ameliorate the marginalizing effects of low socioeconomic status through opportunities for residents to expand personal networks, develop instrumental roles, and create a respected social identity, and
- residents' well-being is improved by opportunities to participate in decisions within the housing development that affect their lives

Many local alternative and supportive housing projects apply a model of community development and management that fosters tenant participation. A study of female residents housed by various local providers found that two out of five residents were involved in social and management activities. In some cases this included input in building and project development; more often it involved decisions about rules and social activities. Some residents said that their opinions were invited but not followed by staff (Novac et al. 1996b).

2.3 Community Integration and Quality of Life

Disabled and low income groups want to avoid transforming housing into service settings (Carling 1993). The development of separate or special housing is more likely to meet with community resistance and less likely to facilitate resident participation in community life than integrated and conventional housing (Carling and Ridgway 1987). Several studies have found that residents want to be more involved in their wider communities (Carling 1993).

According to an Ottawa study, people with psychiatric disabilities living in large board-and-care home settings reported lower levels of social contact with neighbours and general life satisfaction than a marched sample of nearby community residents, although both groups reported similar levels of physical presence and sense of community in the neighbourhood. One consequence of such congregate living is that it identifies its residents as having a psychiatric disability. The stigma may serve to exclude residents from the regular social exchanges that occur among community residents (Aubry and Myner 1996).

Segregating a group of people with the same type of problem in one building may have other negative outcomes. One study found that

congregating a large number of residents with psychiatric problems in one apartment complex contributed to a stressful living environment because of exposure to various kinds of disturbing behaviour on the part of some fellow residents, including attempted suicide, violence, and drug or alcohol abuse (Hodgins, Cyr, and Gaston 1990).

While integrated, conventional housing settings are promoted by some researchers, developing such housing is a challenge: an emphasis on economy of scale can conflict with the need to keep households small and dispersed. Also, agency commitments to serving persons with specific disabilities may conflict with the goal of developing housing that promotes social integration and avoids stigma-engendering settings (Ridgway and Zipple 1990).

Integrated (or supported) housing is increasingly being adopted as a model in the United States and has been the focus of a major evaluation in a five-state demonstration program (Carling 1993). The findings of that evaluation include the following:

- within three years, nearly all residents were living successfully in integrated apartments.
- housing quality was generally good.
- some sites were more scattered than others.
- most of the housing was privately owned, some by mental health agencies.
- all the projects provided assistance with housing searches and moves and helped residents to keep their housing; most provided financial assistance with rent.
- projects provided a broad range of community support services and low case management caseloads.

The evaluation showed that the projects fell short of the principles of supported housing in several respects. They were not as focused on self-determination as the conceptual model suggests: most programs picked a housemate whom the participant could accept or reject. Few programs offered more than one or two housing choices. Most programs expected that clients who received housing would also participate in services.

The degree of residents' satisfaction and well-being was affected by both personal factors (such as feelings of control, self-understanding, and mental health) and social-environmental factors (social support, housing quality, financial resources, and meaningful community integration) (Ibid.).

Shared Living / Shared Rooms

Regardless of housing form (e.g., group homes or apartments), residents in shared or collective living arrangements generally prefer to have more privacy and to live alone (Nelson et al. 1995). The absence of a private room, combined with the overall number of living companions and other housing concerns, all significantly predict various dimensions of community adaptation. This has led some researchers to conclude that two or more residents per bedroom, even in small, well-kept supportive residences, must be regarded as unsatisfactory (Nelson et al. 1998).

Satisfaction with shared living also depends on the degree of choice over new housemates and the ability to match for lifestyle behaviours (Novac et al. 1996a). Forced groupings diminish the capacity for peer-based communities to be effective, yet there are no accepted standards in the field for the extent to which projects should offer choice (Ridgway et al. 1994).

2.4 U.S. Supportive Housing Program

Based on data from over 500 projects, a recent national evaluation of the U.S. Supportive Housing Programs for Persons with Disabilities[3] found that most projects serve residents with developmental disabilities or chronic mental illness, a growing portion of residents have multiple disabilities, and a decreasing number have mobility impairments (Applied Real Estate Analysis 1996).

[3] Over the past three decades, a supportive housing program has evolved in the United States (administered by the U. S. Department of Housing and Urban Development), beginning in 1959 as a direct loan program that financed rental housing for elderly and physically disabled persons. The concept later changed into a grant program serving very low income persons with a broad range of disabilities. The definition of disability was expanded in 1974 to include developmental disabilities, and in 1982 to include psychiatric disabilities.

Other findings include the following:

- most units are apartments, some without on-site services; the rest are group homes with on-site services.
- most apartment residents (84 per cent) were satisfied with their current living conditions, rated them better than former residences, and rated the availability of on-site services as important in their ability to live independently.
- more than three-quarters of residents said their quality of life improved, either dramatically or somewhat; very few reported the move had a negative effect.
- more than 90 per cent were satisfied with their living space.
- residents' dissatisfaction focused on a desire for more living space, better amenities (access to transport, social, and recreational services), and concerns about personal safety.
- due to increasing demand and decreasing funding, most of the projects have high occupancy levels, low turnover, and lengthy wait lists.
- development of a new project typically take over three years, depending on the sponsor's experience.
- a key strength of the program is the expertise of sponsors who are well-informed regarding the characteristics and needs of tenants they serve (Ibid.).

In Ohio, a partnership to develop supportive housing projects has formed between state substance abuse and mental health services and a separate non-profit housing corporation that provides scattered apartments. Their efforts have graduated from reliance on piecemeal funding programs to program development activities and legislative mandates to facilitate local implementation (Knisley and Fleming 1993). State and local staff have discovered that "treatment and support services could not be effective if they were provided as a condition of housing or without involving clients in the decisions being made on their behalf. Similarly, if clients had to live in specified housing to receive services, their choices were narrowed, and service delivery was often viewed as coercive; the development of housing was also slowed down" (Ibid.: 458).

The following recommendations were made to improve the program or replicate its successes:

- a partnership with housing authorities is required.
- recognize that the cost of providing support services is high.
- it is important to measure client outcomes.
- listen to consumers and case managers to maximize client choice.
- service systems must continue to change and offer more flexible services.

2.5 Changes in Support Level

The lack of longitudinal research on supportive housing limits our ability to assess its long term impact on residents, but there are some indications that the level of support services required for mentally ill homeless persons may decrease after an initial period of stabilization. For instance, Boydell and Everett (1992) found that psychiatrically disabled residents who lived in bachelor apartments in a supported housing project located in Toronto needed less and less support and staff assistance over a one year period. The researchers concluded that supported housing projects eventually 'stabilize' when tenants become comfortable with their independence, potentially allowing staff to be reassigned to new projects (Ibid.).

A larger study conducted in the United States tested this tendency by evaluating two models of housing provision for mentally ill homeless people: traditionally managed housing and consumer-assumed housing (Goldfinger et al. 1996). Over a hundred participants who had case managers and passed a 'safety screen' (about half were substance abusers) were drawn from shelters and randomly assigned to one of the housing settings: either to group home-style shared houses with 24 hour staff whose services could be gradually withdrawn according to the residents wishes, or to scattered apartments and single room occupancy (SRO) units in public housing, with an offer of clinical referrals and nearby weekly group meetings.

Both models achieved a good degree of success in stabilizing the housing of participants; overall, only 19 per cent returned to living in shelter within a year and a half.

Those assigned to the group home, shared living model (which the researchers called an evolving household or EH model) were less satisfied with the degree of privacy, however they developed more liking for group living over time, except for the substance abusers who were also the most likely to lose their housing. The EH residents eventually lessened their reliance on on-site staff and took responsibility for many of the requisite daily tasks.

Goldfinger et al. concluded that homeless people with psychiatric disabilities are willing to accept both individual housing and group living situations, despite initial resistance to group living, provided the system is responsive to their needs and willing to incorporate their ideas. Moreover, even severely impaired individuals can develop the ability to work together and acquire the skills necessary to handle most of the tasks generally performed by residential staff.

2.6 State of Evaluation Research on Supportive Housing

Not surprisingly, given the recency of supportive housing development, the literature reflects an emphasis on description; a focus on housing with on-site services, such as sheltered care or board-and-care; short-term assessments; and relatively unspecified analyses. Few investigators have examined which housing programs actually work in ending homelessness among people with mental illness or the range of housing that has proven necessary; and fewer still have detailed how an effective program is developed (Culhane 1992).

One indicator of the early stage of evaluation research on supportive housing is the 'black box' phenomenon, the fact that program characteristics that produce positive outcomes in participants are neither specified nor studied so that it is not clear how processes are related to change in participants (McCarthy and Nelson 1993). For example, there is evidence that housing concerns and lack of privacy are correlated with residents' negative affect; quasi-experimental design methods are necessary to clarify causality (Nelson et al. 1998).

A few studies of supportive housing have used a combination of quantitative and qualitative research methods to good advantage (e.g., Boydell and Everett 1992). Such studies have recommended the examination of residents' subjective experiences, thoughts, and feelings; tangible changes in residents' work history and community tenure; negative and positive interactions with staff (McCarthy and Nelson 1993); and the use of ethnographic research techniques to learn about changes in social identity, health status, and self-esteem (Goering et al. 1990).

While research on supportive housing for people who have been hospitalized in psychiatric facilities has repeatedly found that such programs are successful in reducing rates of rehospitalization and in increasing rates of employment, such criteria are, by themselves, inadequate outcome indicators. Other criteria and additional outcome measures such as individuals' level of independent functioning and perceived quality of life should be used (McCarthy and Nelson 1993), along with measures of safety and resident control (Goering et al. 1990).

Several researchers have called for implementation of ongoing research and program evaluation in supportive housing projects to clarify their effectiveness, especially with the homeless (Trainor et al. 1993, Goering et al. 1990). Moreover, innovative projects are beginning to test the limits of who can be served through a supported/alternative housing approach and to determine the resources and strategies required to house those with multiple problems or severe disabilities (Ridgway and Zipple 1990b).

Many suggestions have been made for inclusion in future evaluative studies:

- routine data collection on residents and those who refuse to participate; surveys of resident

satisfaction; and evaluations of staff (Goering et al. 1990).
- measures of sense of community (Aubrey and Myner 1996).
- measures of housing characteristics, such as management practices and social climate (Nelson and Smith-Fowler (1987).
- measures of quality of life, physical and material well-being, relationships, community activities, personal development and fulfillment, and recreation (Ridgway et al. 1994).
- more attention to independent apartment models (Newman 1994).
- assess the role of peer support in community success and how particular housing strategies contribute to success, including different living arrangements (Carling 1993).
- hire residents as interviewers, the benefits of which include: diminished potential for bias, increased involvement, opportunities for employment and skill development, and promoting peoples' abilities rather than their disabilities (Tanzman 1993).

2.7 Local Evaluation Research

Limited resources made it impossible for us to canvas all local supportive housing providers for agency reports on their housing and programs, nevertheless we were able to review some such reports. Not unexpectedly, study topics vary from assessing organizational objectives and development to evaluating resident satisfaction and particular program goals (see Alan Etherington and Associates 1987, Berkeley Consulting Group 1989, Locke 1997, Phillips Group of Companies 1991, Piedalue et al. 1994, and Quance and Novac 1996).

The findings are generally quite positive and reveal an admirable willingness to allow arm's length scrutiny and to investigate potential problem areas with a view to improvement. Some of the resident satisfaction data goes well beyond what is available in the published literature and warrants a wider audience in order to foster improved planning for housing and support service development. Those agencies who have commissioned such research also demonstrate efforts to integrate recommendations in their subsequent planning.

At least one agency (i.e., Houselink) has sought expert advice in the planning and design of its future research. The resultant report provides a very useful guide on the determination of evaluation topics and questions, appropriate and effective research techniques, and the integration of evaluation findings into planning for change (see Clarke Consulting Group 1995).

Some of the findings from agency studies can be found in Section 3 of this report as part of the description of particular supportive housing projects.

With no intention to compare housing providers, one study attempted to evaluate certain aspects of supportive housing from the perspective of women residents (Novac et al. 1996b). The findings indicate a high level of tenant satisfaction overall:

- most respondents were well satisfied with the design and layout of their units, and only slightly less so with their neighbourhoods.
- most respondents said they had developed social and organizational skills or mastery in their lives; improved their ability to cope with a wider social network and relationships; and acquired practical life skills, as well as knowledge about social or political issues.
- respondents were most appreciative of the opportunities for social involvement and support from other tenants and staff.
- most respondents had a favourable view of staff, found them responsive and helpful in providing support, advice, and problem-solving assistance.

Certain issues were identified that require further attention from supportive housing providers:

- although some of the respondents who lived in shared housing appreciated its sociability, about a third of them were dissatisfied with the lack of privacy and inadequate space; having to share a kitchen and bathroom; and the irresponsible, annoying, or frightening behaviour of other tenants.
- sexual harassment of female tenants by male tenants was a significant problem, and staff handling of such situations was generally poor.
- most frequently reported problems were loitering, racial problems, and alcohol-related and drug-related activities.

- tenants have a strong interest in tenant selection, and there is considerable concern about screening processes and troublesome or dangerous tenants.

A systematic and thorough review of all the studies conducted by local supportive housing agencies could provide a superior base of knowledge to clarify not only what works well, but *how* it works to improve the capabilities of individuals and communities.

There are many questions that could be explored within the sector. For example, it appears that a sizeable group of residents believes, mistakenly in this case, that their security of tenure is dependent on maintaining client status with their current support agency or that assistance from their support agency is dependent on their specific tenancy (Quance and Novac 1996). It is important that residents clearly understand their options regarding such matters. Another example is suggested by studies showing that as many as a quarter of residents would prefer to live in sex-segregated buildings and that very few sex-segregated housing options are available in the city (Quance and Novac 1996, Novac et al. 1996a, Novac et al. 1998).

The best context for evaluative research is one in which the results are used for progressive development within an iterative process. It is unclear to what extent local supportive housing providers have the necessary funding and organizational stability and support to conduct such research. The diversity of supportive housing approaches and projects within the Toronto area could provide an excellent opportunity for cross-agency research to explore specific, substantive questions. On the other hand, this same diversity, the large number of agencies involved, combined with a lack of co-ordination and infrastructure, may make such an effort difficult.

SECTION 3: INVENTORY OF SUPPORTIVE HOUSING

There is no central directory or listing service for supportive housing *per se* in Toronto. Our inventory was compiled from several sources (listed below), most notably data from a member survey conducted by the Ontario Non-Profit Housing Association (ONPHA).

3.1 ONPHA Survey

A 1997 member survey conducted by ONPHA provided the base data for building our inventory. Of the approximately 240 ONPHA members in Ontario, 78 per cent (N=188) who responded to the survey provide supportive housing. This was the best data source on a sub-sector involving a wide range of non-profit agencies, most of whom are small organizations who serve particular target groups.

Forty-five agencies from the Toronto area responded to the ONPHA survey, the majority of whom provide supportive housing exclusively. (Some have units in their housing portfolios that are not designated supportive housing, although the residents are low income.)

According to the ONPHA data, out of a total of 3,638 supportive housing units in Toronto, 27 per cent (N = 970) are beds or rooms in shared houses or boarding houses, and 73 per cent (N = 2,643) are apartments. A third of the residents live in shared living arrangements, and two-thirds live on their own. Most of the units (70 per cent) are linked, i.e., the same agency provides the housing and the support services.

The vast majority of this housing (94 per cent) was funded by federal/provincial cost-shared programs or unilateral Ontario programs (notably the Special Housing Initiative 3,000 or P-3000 program); the remainder by federal programs.

3.2 Inventory of Supportive Housing in Toronto

As noted above, the definition of supportive housing was initially framed as a community-based alternative to institutional residences and treatment centres and primarily served frail elderly and those with developmental and psychiatric disabilities. The predominant housing forms were nursing homes, group homes, and board and care homes. Over time, supportive housing agencies have expanded the special needs groups they serve to include people with other disabilities, as well as those who are most marginalized: the homeless and hard to house. The housing forms expanded to include rooming houses and self-contained units, sometimes with innovative design features. The subsequent elaboration of supported housing and alternative housing principles further pushed the model toward normal housing that is integrated in communities, promotes individual choice, and provides flexible and individualized support services.

Due to this variation, it is not always easy to classify the various forms of supportive housing. Previous researchers have had similar difficulty identifying supportive housing projects, largely because government ministries and agencies do not freely release information on the projects they fund and do not have databases with common definitions for supportive housing (see Starr et al. 1991, Lightman 1992). Although we obtained a list of long term care supportive housing from the Ministry of Health, we were unable to obtain data from the inter-ministerial committee which recently compiled a comprehensive list of provincially funded supportive housing.

We began with self-identified supportive housing providers and included other agencies who met our criteria of providing permanent (not transitional or emergency) housing with some form of rental assistance or subsidy and clear arrangements for the provision of support services, either by the same or another agency. This includes agencies that own or manage their own housing as well as those who have contractual agreements to secure housing from private or non-profit owners (e.g., public housing, co-operative housing, and municipal or private non-profits). Where the housing is not owned or managed by the supportive housing agency (i.e., integrated housing), the criterion for inclusion was a formal referral agreement that commits certain units or number of units for referrals that are made by the supportive housing agency.

Our emphasis was on secure, affordable housing matched with supports. This excludes agencies that provide solely support services, even services that prevent housing instability and evictions.

We made one exception to this approach. While only one of the Aboriginal housing providers in our inventory self-identifies their project as supportive housing, we included two additional agencies because of the culturally-specific residential settings they provide for a group that is disproportionately found among hostel users and the visibly homeless.

The inventory was built upon the database provided by the ONPHA member survey and augmented by data from several other sources:

1) *The Blue Book, Directory of Community Services in Toronto*. Community Information Toronto. 1998,

2) *Making Choices, 1996-1997.* Community Resource Consultants of Toronto. 1996,

3) *Report on Supportive Housing Survey.* Ontario Federation of Community Mental Health and Addiction Programs. April 1998,

4) *Directory of Attendant Services for Persons with a Physical Disability and Outreach Projects.* Centre for Independent Living in Toronto (CILT) Inc., Project Information Centre. 1998,

5) *Affordable Housing Directory: A Service Directory of Non-Profit, Co-op and Special Needs Housing in the City of Toronto, including Community Agencies, Shelters, Housing and Legal Resources.* City of Toronto. 1997, and

6) Ministry of Health listing of funded supportive housing in Toronto area.

Where supportive housing agencies also have housing stock which does not qualify as supportive housing, these units were excluded. And while projects that serve the frail elderly and those with development delays were included in the initial count, they are not listed in Table 2 (because these groups are quite unlikely to be among the visibly homeless).

All reasonable efforts were made to ensure there was no double counting of units that are listed in multiple sources. Rather, there is a slight undercount of supportive housing units that are integrated in non-profit and co-operative housing. For example, supported units located within the co-operative housing sector are not included in this inventory, except for those with attendant care services for people with physical disabilities. From 1988 to 1995, the Ministry of Housing encouraged new co-operative housing projects to target a proportion (usually 5-10 per cent) of housing units for special needs groups. Some housing co- operatives have been receptive to such arrangements, however, each co-operative is autonomous in such decisions. There is no compilation of how many formal agreements exist or how many supportive housing units there are within the co-operative housing sector. There are also supportive housing units integrated in other non-profit projects, such as Metro Toronto Housing Company, CityHome, and various private non-profit housing projects, but again, no overall registry.

3.3 Inventory Characteristics

There are several variables in the inventory that distinguish the housing stock of various supportive housing providers in Toronto (see Table 2 below). In fact, the inventory is sub-divided into parts by one characteristic: living arrangements. Part A of the table consists of agencies that provide self-contained housing only; Part B consists of agencies that provide shared housing only; and Part C consists of agencies that provide both self-contained and shared housing. The summary table is based on these sub-table totals plus that of additional long-term care units funded by the Ministry of Health.

Descriptions of the variables used in the inventory follow:

Shared vs. Self-contained Housing

The first three sub-tables distinguish agencies that provide self-contained housing only, shared housing only, or both. The self-contained units are typically bachelor or one-bedroom units, occasionally townhouses. The shared housing is accommodation in which cooking or bathroom facilities are shared and is counted 'per bed.' Private bedrooms are almost always provided, except in boarding homes (e.g., Habitat Services). A classic form of shared accommodation is a single detached house in which unrelated people each have their own bedroom or bed and share the kitchen and bathroom/s. Some newer mid- or high-rise developments have apartments that contain multiple bedrooms (4 to 8) whose residents share a bathroom, kitchen, and social area. These buildings also have general common areas for all residents.

Level of Support Services

The inventory describes the support levels in terms of the frequency or duration of staff presence or supervision. In descending order, the categories are: continuous, daily, weekly, and on-call. This is only one criterion for support provision, and it may not reflect the intensity of service. For example, another criterion is the nature of the support service, e.g., mental health support worker, attendant for physical care or personal care provider, individual counselling, community development facilitation, or monitoring. Other criteria include the staff-to-client ratio, hours of contracted services, and staff costs and qualifications.

Dedicated vs. Non-dedicated Units

While we have included the distinction 'dedicated' in the inventory, it is important to note that its definition differs by provincial ministry and was recently changed for the Ministry of Health. Since the compilation of our inventory is based on the ONPHA survey data, we assumed that respondents followed the then-current definition of 'dedicated' used in operating agreements with the Ministry of Municipal Affairs and Housing — that at least 85 per cent of the units within the project and portfolio were targeted for people having special needs. We attempted to extend this criterion for all projects, however, knowledgeable readers will undoubtedly question the validity of some of our designations. We believe that the variable, nevertheless, contributes usefully to a portrayal of the sector.

Linked vs. De-linked Units

The designation of linked and de-linked housing units refers to the relationship between the provider of housing and the provider of support services. In linked housing, the agency that is the landlord (owner and/or property manager) also provides the support services.

In linked projects, the tenants has a lease with the landlord that virtually includes an agreement to receive support services; these range from 24 hour supervision to infrequent monitoring to assistance 'on-call.' In the case of de-linked housing units, the provider of housing is a separate (legal) entity from the provider of support services, and the individual tenant enters into a support service agreement totally separate

from the lease agreement with the landlord. Commonly, in de-linked, dedicated housing the support service provider has sole right to refer clients to certain housing units and has agreed to provide support to the people it refers. The lease agreement between the individual and the housing provider, however, does not reference the support agency and is independent of that agency. The individual, thereby, has the right to terminate the support service without jeopardizing their right to tenancy.

Special Need Type or Target Group

This refers to the special need characteristics that have been acknowledged by the three provincial funding ministries. Most of the terms are self-evident.

Funding Source

Canada Mortgage and Housing Corporation (CMHC) and the Ministry of Municipal Affairs and Housing (MMAH) have provided funds for the development and operation of social housing (including the Metro Toronto Housing Authority or public housing, municipal non-profits, i.e., Cityhome and Metro Toronto Housing Company, private non-profits, and housing co-operatives).

The vast majority of supportive housing projects developed over the past two decades were funded under the private non-profit housing program with federal-provincial cost-sharing.

The annual operating budgets for social housing are approved by their funders and permit rents to be subsidized to just below 30 per cent of low income tenants' incomes. In addition, MMAH has acknowledged the additional management and operating costs required to accommodate the hard to house and provides 'enhanced management' costs for this purpose.
The Ministry of Health funds support service operations through various programs, each targeted to a population with a medically defined health problem: *Community Mental Health* for people diagnosed with chronic mental illness; *Long Term Care* for frail elderly persons, those who are HIV+, and those with a physical disability; and *Homes for Special Care* which are predominantly quasi-institutional, large-scale board and care homes for persons with severe and chronic mental illness.

The Ministry of Community and Social Services also funds support service operations through several programs: *Developmental Services* for people with developmental disabilities; *Community Services* for special needs such as homeless, hard to house, and ex-offenders; and *Youth Services* for youth requiring assistance.

3.4 Inventory in Summary

There are 8,566 supportive housing units in Toronto. Excluding those for frail elderly people and those with developmental disabilities (groups that may not be well-housed, but are unlikely to be among the visibly homeless), there are ***5,295 units***. Of these,

- almost half, 2,483, are self- contained,
- a majority, 4,311, are 'dedicated' (generally meaning that at least 85 per cent of the units within the housing project and portfolio are targeted for people with special needs),
- a majority, 3,194, are 'linked' (meaning that the landlord also provides the support services),
- about two-thirds of the residents are psychiatrically disabled or homeless and hard to house, and
- almost all the housing units are funded by federal and provincial governments — usually a combination of housing and support ministry programs that cover development and operating costs.

3.5 Special Needs

We have estimated the distribution of supportive housing by type of special need in Table 1. For the small number of agencies (12) who identified two or more special needs groups without specifying the number of units for each, we systematically attributed the units by dividing the total number evenly among the special needs types. This introduces an error factor for the housing units affected (about 15 per cent of the total), but allows for a fairly close approximation of the comparative distribution.

Over a third of the residents of supportive housing projects in Toronto have a psychiatric disability; the next largest group is homeless or hard to house.[4] These two categories combined account for two-thirds of the special needs types in supportive housing. In descending order, the remaining categories are: people with physical disabilities, Aboriginal people, women or families, people with multiple needs, those who are HIV+, those who abuse substances, youth, ex-offenders, those with acquired brain injury, and refugees.

Table 1: Number of Supportive Housing Units in Toronto by Special Need

Special Need	# of Units	% of Units
psychiatric disability	1,926	36.4
homeless / hard-to-house	1,517	28.6
physical disability	470	8.8
Aboriginal	362	6.8
women/mothers	323	6.1
multiple needs	180	3.4
HIV+	157	3.0
substance abuse	151	2.9
youth	82	1.6
ex-offenders	72	1.4
acquired brain injury	37	0.7
refugees	18	0.3
Total	**5,295**	**100**

It is interesting that housing form was not included as a distinguishing element, since tenants are very concerned about whether their housing is shared or self-contained and there are obvious implications for residential privacy and control.

3.6 Case Studies

The inventory describes the array of projects according to selected criteria, however it gives little sense of how the differences are realized. We have chosen some examples to illustrate the range and diversity of projects.

A recent document produced by a group of local supportive housing providers identifies three elements by which projects may be distinguished:
a) role, skills, and availability of staff,
b) type of services offered, and
c) property management approach (*Housing Solutions* April 20, 1998).

To illustrate some of the differences in housing and support service provision, a description of selected supportive housing agencies and projects follows.

Regulated Private Board and Care Home (supportive, linked, high level of support)

In 1987 Habitat Services began funding privately- owned and managed boarding house operators who undertook contractual obligations to comply with physical structure, facility, staffing, and service standards, to accept (most) applicants supplied by the agency, and to co-operate with other providers of support services. Habitat Services offers permanent 'board and care' housing for people with psychiatric disabilities. A high proportion of its residents also have behavioural and physical problems. In total, it offers about 700 beds, with an expansion of 100 beds underway.

[4] Frail elderly people constitute the largest resident group in supportive housing, however, they are excluded from our listed inventory, as are people with developmental disabilities.

Bed and board is offered in a traditional housing form in residential neighbourhoods. Many of the houses offer a comfortable and 'homey' atmosphere. The total number of residents in a house varies from 9 to 35, and most of the residents share a bedroom. There is a common room for socializing or watching television. Habitat Services offers housing support workers to deal with operator-tenant and tenant-tenant conflict resolution and assist with eviction prevention, and to monitor contract compliance.

The operators provides on-site staff twenty-four hours a day to provide meals, clean the house, encourage personal care by the tenants, and ensure basic security in the buildings. While staff have basic training in relevant skills, they are not expected to provide crisis intervention or community development. There is an agreement with Community Occupational Therapists and Associates (COTA) to provide support services for all residents.

An early evaluation study conducted in 1989 concluded that Habitat Services was filling a significant service gap, and demonstrated a successful program model and a well-managed agency. A high proportion of the residents was then, and continues to be, male, and it was recommended that the high demand for single rooms and requests for female-only and ethno-specific houses be addressed. Since then, one house has been designated female-only, and the agency recently commissioned a study to assess how it might now proceed to accommodate more women and homeless people.

Harbord Mews (supportive, linked, moderate level of support)

Houselink, which was established in 1976, owns and manages a range of buildings, housing primarily people with psychiatric disabilities. One of its projects, Harbord Mews, was built in 1987. This mid-rise building, located in a desirable neighbourhood, houses a diverse group of residents in shared units for singles as well as family units. Some of the residents were involved in the early development of the project. Staff provide individual support and facilitate community development (Piedalue 1994). The level of support service varies according to each resident's wishes and needs, however, it never falls below occasional checking-in by staff.

Houselink has conducted evaluation research since the early 1980s and integrated evaluation findings into its subsequent planning and organizational change processes (Locke 1997). Most of its residents rate the quality of housing and staff support as good, and they are satisfied with repairs and maintenance.

Houselink adopts a community development model and refers to its residents as members. There are a variety of programs designed to involve residents with each other and the community, as well as the organization. This includes some opportunities for residents to undertake part-time employment. A recent evaluation showed that residents value this option; they reported a desire for more skill and job training (Locke 1997).

90 Shuter St. (alternative, dedicated, linked, moderate level of support)

Designed as a 'stack of rooming houses', Homes First opened its 90 Shuter St. building in 1986 to accommodate homeless single men and women. It consists of 17 apartments, two per floor, each with two or three bathrooms, one kitchen and living room, and four or five bedrooms, for a total of 77 bedrooms. Common spaces on each floor are used for socializing and meetings. Keys are required to operate the elevators and residents can exit only at their floor.

There are four housing support workers in the building who facilitate community development, problem-solving, and conflict resolution. Referrals and support services are provided off-site by as many as ten agencies who work with a variety of client groups: ex-psychiatric patients, pregnant teens, homeless women, persons with physical disabilities, seniors, and Aboriginals who are experiencing adjustment problems. Homes First pioneered the concept of facilitative management, a style of management that goes

well beyond conventional property management to develop a community among the residents and encourage resident participation in decisions that affect their lives.

An array of non-complementary funding programs from three levels of government was patched together through a slow and complicated process to develop this project, partially because this was the first time that housing subsidies were made available to single adults with 100 per cent rent-geared-to-income funding, but mostly because the traditional housing and support service funding programs ill-suited a supported housing model that stressed resident independence and control rather than a therapeutic model of assistance. It is notable that Homes First's philosophy is to resist stereotyping, labelling, and categorizing its residents in terms of their support service needs.

An early evaluation of the project concluded that it had met its objectives at a cost comparable with alternative forms of accommodation for its residents. It also showed that residents had a high degree of input into decision-making, and their problems and service needs decreased after moving into the building. Residents improved their personal networks and ability to cope with problems, stabilized their lives, and felt more independent.

Esperance (supported, dedicated, de-linked, low level of support)

Esperance consists of a single apartment building with 111 self-contained units for women and their families who are victims of violence. Housing staff are present during weekday hours and provide on-call response to emergencies and safety issues after hours. The staff and landlord involve tenants in building management, using 'enhanced management' funding to engage in community development work with tenants.

Safety is a major concern for the tenants who, with staff support, have engaged in thoughtful debate to develop policies and practices intended to promote personal and community safety while maximizing personal autonomy.

Table 2: Inventory of Supportive Housing in Toronto

Part A: Agencies with Self-contained Housing Units

Agency	Units	Support	Dedicated	Non-dedicated	Linked	De-linked	Special Needs	Funders
Adjustment into Society	28	weekly on-call	28	0	28	0	psychiatric disability	Housing Health (cmh)
Aldebrain Attendant Care	27	continuous	0	27	0	27	acquired brain injury psychiatric disability	Housing Health (ltc)
·All Saints' Church Homes for Tomorrow	75	continuous	75	0	75	0	homeless / hard-to-house	Housing charity
Canrise Non-Profit Housing	77	weekly	0	77	77	0	homeless / hard-to-house multiple	Housing ComSoc (com)
Cheshire - Rotary Homes	16	continuous	16	0	16	0	deaf blind	Housing ComSoc (com) charity
Dixon Neighbourhood Homes	7	on-call	7	0	7	0	homeless / hard-to-house	Housing ComSoc (com)
·Esperance	111	on-call	111	0	0	111	victims of violence (women / families)	Housing
Evangel Hall Non-Profit	46	*	46	0	46	0	homeless / hard-to-house	Housing ComSoc (com)
·Gabriel Dumont	86	on-call	86	0	86	0	Aboriginal	Housing
Good Sheppard Non-Profit Homes	41	daily	41	0	0	41	homeless / hard-to-house ex-offenders psychiatric disability	Housing ComSoc charity
·Interchurch Community Housing	32	on-call	32	0	0	32	homeless / hard-to-house	Housing charity
·Jessie's Non-profit Homes	16	continuous	16	0	16	0	adolescent parents	Housing charity
Les Centres d'Accueil Heritage	30	daily	0	30	30	0	HIV+	Housing Health (ltc)
Mary Lambert Swale Non-profit Homes	75	*	75	0	75	0	homeless / hard-to-house	ComSoc (com)
·Massey Centre for Women	27	on-call	27	0	27	0	young mothers	Housing
·Parkdale United Church Foundation	20	on-call	0	20	0	20	homeless / hard-to-house	Housing charity
St. Jude's Community Homes	37	daily	37	0	37	0	psychiatric disability	Housing Health (cmh)
Tobias House	40	continuous	0	40	0	40	physically disabled	Health (ltc)
Walton Place	12	continuous	0	12	0	12	physically disabled	Health (ltc)
·Wigwamen	215	on-call	215	0	0	215	Aboriginal	Housing
Woodgreen Community Centre	241	on-call	64	177	241	0	homeless / hard-to-house multiple	Housing (177) ComSoc (64)
YSM Genesis Place	26	on-call	26	0	26	0	homeless / hard-to-house	ComSoc (com)
TOTAL	1,285		902	383	787	498		

Part B: Agencies with Shared Housing Units

Agency	Beds	Support	Dedicated	Non-dedicated	Linked	De-linked	Special Needs	Funders
Beverley Lodge	24	continuous	24	0	24	0	youth	ComSoc
·Christian Resource Centre Self Help	177	continuous	177	0	0	177	psychiatric disability	Housing charity
Community Head Injury Resource Centre	6	continuous	6	0	6	0	acquired brain injury	Housing Health (ltc)
·Cornerstone Women's Residence	18	continuous	18	0	18	0	homeless / hard-to-house	Housing charity
·Deep Quong Non-profit Homes	45	daily	0	45	45	0	homeless / hard-to-house	Housing
Fife House	5	*	5	0	5	0	HIV+	Housing Health (ltc)
Fred Victor / Keith Whitney	194	continuous	194	0	194	0	homeless / hard-to-house ex-offenders psychiatric disability substance abuse	Housing Health (ltc) charity
Habitat Services	707	continuous	707	0	707	0	psychiatric disability	Health (cmh)
Homes First Society	251	continuous daily	251	0	251	0	homeless / hard-to-house	Housing (16) ComSoc (235)
·House of Compassion	10	continuous	10	0	10	0	homeless / hard to house psychiatric disability	Housing
·Isabella	20	continuous	20	0	20	0	HIV+	Housing
Margaret Fraser House	10	continuous	10	0	10	0	psychiatric disability (women)	Health (ltc)
My Brothers' Place	8	daily	8	0	8	0	psychiatric disability ex-offenders	Housing ComSoc
Nellie's Housing	5	daily	5	0	5	0	homeless women / women with children	ComSoc
North Yorkers for Disabled Persons	10	continuous	10	0	10	0	physically disabled	Health (ltc)
Pilot Place	20	continuous	20	0	20	0	psychiatric disability	Health (cmh)
Poverella Charities	26	continuous weekly	26	0	26	0	psychiatric disability	Health
Regeneration House	35	continuous	35	0	35	0	psychiatric disability	Health (cmh)
Salvation Army / Dufferin Residence	23	continuous	*	*	*	*	psychiatric disability	Health (cmh) charity
·St John's Non-profit Housing	5	weekly	5	0	0	5	homeless women	Housing charity
·Toronto Refugee Community Non-profit Homes	18	daily	18	0	18	0	refugees	Housing
Youthlink	15	continuous	*	*	*	*	youth	ComSoc
TOTAL	1,632		1,549	45	1,412	182		

Part C: Agencies with both Self-Contained and Shared Housing Units

Agency	Beds	Support	Self-contained	Support	Dedicated	Non-dedicated	Linked	De-linked	Special Needs	Funders
Anglican Houses	112	continuous daily	52	on-call	112	52	164	0	psychiatric disability homeless substance abuse youth HIV+	Housing (5) Health (45 cmh) (89 ltc) ComSoc (30) charity
Arrabon House	15	continuous	4	daily	15	4	15	0	youth women	*
Bellwoods Centres for Community Living	24	continuous	32	continuous daily	32	24	32	24	physical disability / attendant care	Housing Health (ltc)
Cheshire Homes / McLeod Home Morrison Residence	7	continuous	16	continuous	7	16	7	16	physical disability / attendant care	Health charity
Ecuhome	228	weekly	80	on-call	228	80	228	80	psychiatric disability substance abuse homeless hard-to-house multiple	Housing (80) ComSoc (228 com) charity
Houselink Community Homes	58	daily	171	on-call	229	0	229	0	psychiatric disability	Housing Health (cmh)
Houses Opening Today	25	daily	41	on-call	25	41	25	41	homeless low income	Housing ComSoc
Madison Avenue Housing & Support	41	continuous daily	1	weekly	41	1	41	0	psychiatric disability	Health (cmh)
·Nishnawbe Homes	49	weekly	12	*	61	0	49	12	Aboriginal	Housing
Riverdale Housing Action Group	6	weekly	38	on-call	44	0	44	0	psychiatric disability women with children	ComSoc (com)
·Start 103 Non-profit Homes	5	weekly	7	weekly	5	7	12	0	homeless hard-to-house	Housing
Street Haven at the Crossroads	16	*	15	*	31	0	31	0	psychiatric disability substance abuse hard-to-house ex-offenders	ComSoc (20 com)
Supportive Housing Coalition	172	continuous daily weekly	652	weekly on-call	824	0	0	824	psychiatric disability hard-to-house	Health (cmh)
YWCA	41	continuous weekly	77	on-call	118	0	118	0	multiple (77) homeless women	ComSoc
TOTAL	799		1,198		1,772	225	995	997		

· The agencies flagged in the above tables currently receive provincial funding from the Ministry of Municipal Affairs and Housing and Canada Mortgage and Housing Corporation only. They are not among the supportive housing agencies whose funding has been transferred to the ministries of Health or Community and Social Services and are subject to devolution to the municipality along with other social housing projects. The total number of supportive housing units involved is 1,028 (19 per cent).

Part D: Summary Statistics of Supportive Housing

Sub-totals	# of Units	# Dedicated	# Non-dedicated	# Linked	# De-linked
Self-contained Units (Part A totals)	1,285	902	383	787	498
Shared Housing (Part B totals)	1,632	1,549†	45	1,412	182
Combined Portfolios (Part C totals)	1,997	1,772	220	995	997
Long Term Care Facilities***	381	88	293	*	*
GRAND TOTAL	5,295	4,311‡	941	3,194†	1,677†

* information unavailable
† missing data
‡ Additional data on long-term care facilities funded by the Ministry of Health (331 of these units are for people with physical disabilities, 70 for those who are HIV+, and 18 for those with acquired brain injury)

SECTION 4: SERVICE NEEDS AND ISSUES

To assess service gaps, we first attempted to estimate the unmet need for supportive housing by reviewing wait list information. The difficulty of locating this information highlights the issue of access and co-ordination of services. We also considered particular issues for several user sub-groups which should be considered in the management and development of supportive housing projects. Finally, we reviewed some sector issues.

4.1 Access and Co-ordination

Given the historic development of supportive housing projects by a large number of relatively small agencies, and the diversity of special needs groups, it is understandable that there is no centralized wait list. This means, however, that awareness of supportive housing options, and access to them is not equitable for all potential users. For instance, those who are more involved with the social service sector are also more likely to have access to supportive housing. Novac et al. (1996a) found that most of the female residents living in various local supportive housing projects were referred by a social service agency, especially shelter and hostels. A small number learned about supportive housing projects from 'word of mouth' and their own intensive search efforts.

It is critical that improved, equitable access to supportive housing be developed via a co-ordinated access mechanism.

4.2 Wait List Data

Not all supportive housing agencies have individual wait lists. Some keep only a few names ready for when an opening comes available. For some categories of prospective residents, wait lists are not a suitable mechanism. For these reasons, the wait list data should be considered only a crude indicator, not a good reflection, of the need for supportive housing.

Since applicants may submit to more than one housing provider concurrently, a combination of agency wait lists is likely to include some duplicates. On the other hand, many people who require supportive housing will not place an application once they discover how long the lists are and how long they will have to wait for a unit. Even some service providers believe it is futile to submit additional applications.

We contacted some supportive housing providers who serve fairly distinct sub-groups to diminish the likelihood of overlap or double-counting applicants. While the wait list for shared housing was expressed in terms of weeks and months, that for self-contained housing was in terms of years. These are some wait list results:

- Houselink has a total of *266 applicants* on its wait list: 63 families, 116 single men, and 87 single women. Self-contained units are being allocated to applicants who have been waiting for *four years*. The largest provider of supportive housing to people with psychiatric disabilities, the Supportive Housing Coalition, also reports a *five year* wait for self-contained units.

- Ecuhome reported a wait period of *four to six weeks* for shared housing and *three to five years* for self-contained units.

- Nishnawbe reported a wait list total of *812 applicants* for their twelve self- contained units (with a turnover rate of about one unit per year) and *100 names* for shared housing. Current vacancies are being filled by people who have been on the wait list for about *four years* for self-contained units and about *four months* for shared housing (for which turnover is nine per cent per month).

- Project Information Centre, a central referral office for supportive housing for people with physical disabilities, reported that vacancies in housing with attendant care services are being filled by people who have been waiting *four to five years*. There are 664 applications for attendant care housing units within Metro (and only 350 such units).

The number of applicants is a less telling indicator of need than the wait time — for some supportive housing agencies, units are being allocated to people who applied up to five years ago. And three supportive housing agencies that serve distinct groups (Houselink, Nishnawbe, and Project Information Centre) have a total of 1,842 applicants on their wait lists.

4.3 Unmet Need for Supportive Housing

A 1991 report estimated that there were twice as many people on wait lists for supportive housing as units available (Starr Group et al. 1991). At that time, various providers said the demand was 'bottomless' and increasing rapidly, and there was recognition that emergency beds were being used by people for whom supportive housing was required but not available. Then, as now, the lack of centralized or co-ordinated data on the supportive housing sector made a firm determination of need difficult.

Even the wait list data we collected requires careful interpretation. Some of the current applications for supportive housing are several years old; it is not clear how many are actually waiting. We consider it a conservative estimate to deem a third of the reported applicants, about 600, to be in immediate need of supportive housing.

The data on Toronto hostel use showed that 17 per cent of the approximately 26,000 different individuals who use the system every year are considered chronically homeless. There is a high level of consensus that these 4,400 chronically homeless hostel users require supportive housing.

Among the mentally ill poor, the lack of appropriate supports and housing is leading to their incarceration in another institution — jails. It is estimated that as many as one out of five inmates in Ontario's jails (1,600 out of 8,000) are suffering from a mental illness (Boyle 1998). While new programs have been developed to address this problem (a special court for the mentally ill and local programs to divert mentally ill people), many of those released from jail require supportive housing.

If less than a third of the incarcerated mentally ill are to be released in the Toronto area, i.e., 500, we suggest that this group will also require supportive housing over the next couple of years.

By adding the estimates given above, 600 on wait lists for supportive housing, 4,400 chronically homeless in hostels, and 500 mentally ill being released from jails, we estimate that approximately 5,500 people require supportive housing, either immediately or in the near future.

There is no government program in place for the development of new supportive housing at this time. And it takes about five years for a non-profit agency to develop a new housing project from scratch.

Without a considerable, planned effort to substantially increase the supply of supportive housing, we are facing a mounting crisis for more and more vulnerable people with nowhere to live.

4.4 Sub-Group Needs and Issues

Some additional information on service issues for various sub-groups is provided below. This is followed by an overview of issues faced by the supportive housing sector at large.

Substance Abusers and Dual Diagnosis

According to the preliminary findings of a study by the Parkdale Community Health Centre, low income people who are substance abusers are in a catch-22 situation: on the one hand, they are at very high risk of losing their housing due to substance abuse, and on the other hand, without a stable home, they face overwhelming barriers to obtaining and benefiting from treatment services. This is because treatment regimes cannot be followed properly, the available treatment programs tend to be inflexible regarding the circumstances of the homeless, and their survival needs are paramount. The fact that most shelters bar residents who use drugs or alcohol compounds the difficulties. So, too, does the current reduction in social assistance benefit levels.

Recent provincial changes to eligibility for income support for people with disabilities will now exclude those who with substance abuse problems. And substance abusers who were previously eligible for this financial support will receive a lower benefit level, increasing the likelihood of their becoming and remaining homeless.

This group is also quite likely to be screened out of supportive housing projects due to their difficult behaviour and the risks they pose to other tenants.

Application of exclusionary criteria frequently leads to the ineligibility of residents with dual diagnosis (i.e., people with mental illness who are addicted to drugs or alcohol) who are likely to end up in custodial boarding homes, with their families, on the street, or even in jail (Trainor et al. 1993).

Psychiatrically disabled substance abusers probably face the highest risk of impaired health and death due to the interaction of prescribed and non-prescribed drugs and homelessness. They are unable to properly store and self-administer prescribed drugs without a stable home, and treatment programs are not available for substance abusers who are mentally ill. This group requires carefully planned supportive housing, such as projects with harm reduction programs. There is almost none of this sort of supportive housing in Toronto. Apparently effective projects have been developed in Vancouver and San Francisco which could be used as models or to give direction to local planning (Novac et al. 1998).

Aboriginal People

A disproportionate number of hostel users and people living on the street is Aboriginal. Past experience has demonstrated that cultural specificity in program design and delivery is critical to successfully meet the needs of Aboriginal homeless people.

Many of the Aboriginal-specific supportive housing units are designed for families, and all of them offer only low levels of support service. There is virtually no culturally appropriate supportive housing for homeless single people who need higher levels of support.

Youth

Youth make up 28 per cent of hostel users and are one of the fastest growing populations using hostels (Springer, Mars, and Dennison 1998). Only one per cent of supportive housing units are targeted for youth, yet mixing them with adults in supportive housing projects may be problematic.

For instance, McCarthy and Nelson (1993) found that youth with psychiatric disabilities living in dedicated supportive housing projects with adults are more deeply affected by the negative effects of labelling and the stigma of living in housing that identifies them as different. It prevented them from meeting new people and establishing or maintaining close relationships, thereby impeding their struggle for acceptance.

Local agency experience with this sub-group should be tapped to develop appropriate projects.

Women

While they have much in common, there are also discernible differences between women and men who are homeless. According to U.S. research, homeless women are younger in age than homeless men, more likely to retain social connection; more likely to suffer from a mental illness; less likely to suffer from substance abuse; and much more likely to have dependent children (see Novac et al. 1996b for overview).

Women are much more likely than men to be among the ‘hidden homeless’ (precariously housed with family or friends, or living in insecure housing) who are virtually impossible to enumerate (Watson and Austerberry 1986). The predominant tendency to focus on visible homelessness detracts from our understanding of these gender differences. Among hostel users, women constitute about 30 per cent of the homeless in Toronto (Springer, Mars, and Dennison 1998).

One of the reasons for homelessness among women is domestic violence. Eight per cent of

hostel intakes list spousal abuse as the primary reason service is needed (Ibid.). The prevalence of previous physical abuse is higher for female than male hostel users (51 versus 38 per cent), as is the prevalence of childhood sexual abuse (49 versus 16 per cent) (Mental Health Policy Research Group 1998).

There has not been a great deal of research on the effects of childhood sexual abuse on men, but for women, there is a tendency toward re-victimization, especially without appropriate counselling (Wyatt et al. 1993). Histories of abuse and the high level of violence among homeless people play out in gendered patterns that should be understood and dealt with by supportive housing providers to prevent re-victimization (Novac et al. 1996b).

The women's shelter movement has long recognized that abused women, and their children, require an array of supports to re-establish their security and independence, however the demand for permanent supportive housing that is designed to meet needs of women with histories of abuse continues to be largely unmet.

Families

The second largest growing group of hostel users is families, comprising 31 per cent of hostel users and using 41 per cent of 'bed nights' (Springer et al. 1998). Yet, very few supportive housing projects are designed to accommodate homeless families (or those in whom a member has special needs).

Further, the average family size among hostel users is increasing (from 2.97 children in 1988 to 3.37 children in 1996), and the vast majority of self-contained supportive housing units are very small. The larger family size may reflect the influx of refugee groups who tend to have more children, such as Somalis. Large families have greater difficulty obtaining affordable units in both the private and social housing sector. Research from the U. S. suggests that homeless families are less likely to have mental health or substance abuse problems, but that the children are at high risk of developmental difficulties and health problems (see Novac et al. 1996b for overview of research).

There is evidence that some unsuitably housed children are removed from their parents' care (Cohen-Schlanger et al. 1995). This presents a catch-22 situation for parents when social assistance payments are reduced on the withdrawal of dependent children, making it more difficult for parents to obtain appropriate housing and regain custody of their children.

Without additional information on the particular needs of local, homeless families, including refugee families, it is not clear whether they require supportive housing or simply improved income supports and subsidized housing.

People with Developmental Disabilities

A total of nineteen agencies serve people with developmental disabilities in the Toronto area, of which the Metropolitan Toronto Association for Community Living (MTACL) is the largest.

Besides its supportive housing units, the agency has an adult protective service for about 300 clients who are living in boarding houses and apartments in the private rental sector and receive support services on a weekly or bi-weekly basis. These individuals tend to require or request a low level of support and are not interested in more structured living arrangements. Some of them have a psychiatric as well as developmental disability.

People with Mental Illness

The need for supportive housing for people with severe mental illness is particularly acute. A survey of local case management and individual support organizations who serve people with psychiatric disabilities found that it has been harder to find decent housing for their clients over the past year (CRCT 1998). Respondents also noted that there is a five year wait list for public housing, and so many names on wait lists for supportive housing that "it makes no sense to keep the lists"; that the most disabled are accepted only by boarding homes, most of which is shared

accommodation; and that private sector housing is less safe for residents than supportive housing.

Staff from a local assertive outreach and support program for homeless women with mental illness report that most of their clients lose their housing due to their own difficult and inappropriate behaviours, which are often violent or threatening; the second most common reason is rent arrears. They estimate that over a third of their clients live in substandard housing (Ibid.).

Most hospitals that serve psychiatric consumers report that it has become more difficult over the past year to find housing for their discharged patients. In fact, most of them say they have kept patients in hospital longer than is clinically necessary for this reason. And there has been an increase in the number of patients who are discharged to a shelter or hostel due to the lack of housing. Overall, shorter hospital stays are resulting in increased use of shelter and hostels as the only housing option available (Ibid.)

These results match those of the Mental Health Research Group (1998) who found that six per cent of hostel users had received treatment in a psychiatric facility during the previous year, suggesting that a small but critical number of patients are being discharged to shelters or quickly lose whatever housing arrangements are made for them.

Hard to House

The phrase "hard-to-house" generally refers to people living in poverty who are anti-social and have severe difficulty getting along with other tenants; engage in disruptive, violent, or drunken behaviour; exhibit an inability to cope alone; work in the sex trade; are unable to manage a budget and household; accumulate rent arrears; and break terms of contracts.

They are most likely to include those who live from hostel to hostel, with periods of time on the street; those who have used up their time at hostels, or are barred; those who have been evicted from conventional housing; and people leaving institutions (Phillips Group of Companies 1991). Among the chronically homeless, there is a very high incidence of people in these circumstances who exhibit such behaviours. Supportive housing providers are generally the only landlords willing to accept the high risks and costs involved of housing these people.

4.5 Sector Issues

There are a number of issues that affect virtually the entire supportive housing sector. Those that have come to our attention during this research are outlined below.

Needs Assessment

The supportive housing sector in Toronto has little infrastructure to mobilize for cross-agency communication, consultation, planning, and development. The limited data on overall community needs, as well as sub-group needs, suggests that a general needs assessment would be useful to guide future planning of service provision and project development.

Additional Management Costs

There is a cost premium involved in managing supportive housing due to the extra demands of a more difficult tenant population who have minimal resources. Through the designation of "manageable costs" within operating budgets, the Ministry of Municipal Affairs and Housing has allowed for additional expenditures to compensate for the extra management resources required to house people with special needs, especially those who are considered "hard-to-house", as long as this does not duplicate funding from another Ministry (i.e., Health or Community and Social Services). This is sometimes made more complicated because it has been difficult to distinguish the service functions funded by the support service ministries from the additional management functions funded by the Ministry of Municipal Affairs and Housing.

Alternative housing providers accommodate very high ratios of the "homeless/hard-to-house" in their projects. They currently receive funding for the enhanced management tasks associated with this resident group, and have recently requested an

increase in these funds. The special needs of people with physical and developmental disabilities and the frail elderly impose relatively modest extra management costs compared to many of those in alternative housing projects who have personal issues and behavioural problems that stem from severe poverty, drug and alcohol dependency, the aftermath of physical and sexual abuse, and severe mental illness.

The extra funding is required to pay for staff activities that begin prior to occupancy, with tenant selection processes, and include more intensive efforts related to tracking and processing applications; conflict resolution; move-outs and evictions; dealing with destructive behaviour, violence, and illness; prevention; education; as well as higher costs for security, elevator maintenance, pest control, insurance premiums, and bad debts (*Request for a special manageable cost range* 1998).

Discrimination and NIMBY

"The homeless are not just people who cannot find housing they can afford. They are also people who are refused housing and denied choice" (Porter 1989: 6). Part of the housing 'grid-lock' for homeless people, and especially those with special needs, is exacerbated by 'creaming' for 'more desirable' tenants, especially in the private sector.

For example, people with severe mental illness have worse housing and neighbourhood circumstances than the overall population, even those with similar incomes and housing tenure. This suggests that discrimination by housing gatekeepers is a factor. Probably due to their poor housing and neighbourhood conditions, people with severe mental illness also move more often, thereby limiting their ability to establish neighbourhood and social ties (Newman 1994).

Discrimination also occurs at the neighbourhood level, commonly referred to as NIMBY (Not In My Backyard) and directed at social housing projects. Although studies have repeatedly demonstrated that special housing projects do not decrease property values, the problem of neighbourhood resistance continues.

In relation to group homes, Cook (1997) found that neighbours' expectations of negative effects were much greater than what was actually experienced.

There is a discernible hierarchy to the resistance expressed by conventional neighbourhood groups, as shown in Table 3. The proportion of people resistant to residential facilities that accommodate people with various disabilities or special needs is lowest for people with physical disabilities and highest for substance abusers.

Table 3: Neighbour Opposition by Group[5]

Resident Group	Opposed
elderly	4%
physically disabled	6%
terminally ill	12%
developmentally disabled	21%
mentally ill	39%
parolees	48%
troubled adolescents	51%
alcoholics	55%
drug addicts	78%

A concerted public relations campaign that informs the public about the successes of supportive housing projects could serve to allay some of the fear and mistrust that exists. Another benefit could be to residents of supportive housing projects who see positive images of their lives and situations.

Evictions

Among the challenges or issues identified by supportive housing providers, one of the most difficult is that of evictions (Witkowski 1998). Managers must balance several competing interests: that of difficult individual tenants, that of the other tenants, as well as that of other service agencies who sometimes want immediate eviction of troublesome tenants.

Occasionally, case management or support service agencies are reluctant to disclose the implications of their client's illness and thereby create a liability for the supportive housing landlord, e.g.,

[5] Wolch and Dear (1993): 186.

in cases where there is a history of setting fires, violence, or sexual abuse.

The sector's overall goal is to prevent evictions because options are even fewer for evicted tenants. When evictions are necessary, however, the law is clumsy. Landlord and tenant courts have been reluctant to grant evictions; they tend to see supportive housing as an institutional setting and ignore the rights of other tenants. While the new landlord and tenant legislation allows for quicker evictions, it may still not be fast enough, particularly where accommodation is shared and living is communal.

The risks include severe disruption of the residence and even physical danger to other residents and staff. This problem has been evident for some time, but still awaits a practical solution (see Lightman 1992). An option is necessary when delay is likely to cause serious harm to the person or property of operators or other residents.

While these sectoral issues are important, broad policy concerns that affect the future of supportive housing are the focus of the next section of this report.

SECTION 5: POLICY DIRECTIONS AND IMPLICATIONS

The current policy context is forcing the supportive housing sector to focus on significant shifts in funding arrangements which may affect its practice. In conjunction with a lack of strong local infrastructure, this weakens the sector's ability to develop long-term plans for its increased development, both in terms of expansion and adaptation to the requirements of homeless people.

5.1 Devolution and Transfer Issues

Current provincial and federal policies have a tremendous impact on the supportive housing sector. The initiated devolution of social housing from the provincial to municipal governments is the source of great uncertainty. A substantial portion of the supportive housing stock, however, will not be devolved, but transferred to either of two provincial ministries, the Ministry of Health and the Ministry of Community and Social Services.

On June 12th, 1998 the Ministry of Municipal Affairs and Housing publicly announced that, as a result of an inter-ministerial committee's determinations, supportive housing units that are provided by agencies currently funded by either the ministries of Health or Community and Social Services and that meet ministerial definitions for 'core business' would not be devolved to municipalities along with other social housing. Instead, these projects will be transferred to the support ministry from which they have been receiving funding.

This decision creates three status categories for Toronto's supportive housing stock:

1) projects that receive support ministry funding and meet the criteria for provincial transfer,

2) integrated units that currently receive support ministry funding but do not meet the criteria for transfer, and

3) projects that do not receive support ministry funding and will be devolved to the City of Toronto.

Most of the supportive housing units listed in our inventory will be transferred — up to 55 per cent to the Ministry of Health and up to 26 per cent to the Ministry of Social and Community Services. The status of integrated supportive housing units, which do not meet support ministerial criteria, is unclear. Finally, about a fifth of the stock (more than 1,000 units) is subject to devolution to the municipality.

5.2 Transferred Supportive Housing Stock

The supportive housing stock that is transferred to a support ministry must meet these criteria:

1) the building must be 'dedicated' supportive housing — it must receive support services funded directly by a support ministry or through a non-profit agency funded by a support ministry,

2) the definition of special need must meet the 'core business plan' of the funding support ministry, and

3) for transfers to the Ministry of Health, 100 per cent of the residents must fit the definition of special need (the previous requirement was 85 per cent).

The benefit of this transfer is purportedly to streamline the planning, monitoring, and administration of dedicated supportive housing by providing single-source funding. Since supportive housing projects are being allocated to different and separate support ministries, however, there will be distinct and separate administration of projects within the sector.

Supportive housing agencies transferred to different provincial funders may be subject to varying administrative policies in future, weakening their ability to co-ordinate their services and flexibly accommodate homeless people with varying support needs. For example, the Ministry of Health has been moving toward stronger reliance on medical diagnoses as eligibility criteria. And it has increased the proportion of residents who must meet the criteria of special need (or core business) from 85 to 100 per cent. Both these changes could result in greater rigidity in the selection of residents, as well as contribute to institutionalization of projects.

Definitions of Special Needs

It appears that ministerial definitions of special need are being narrowed. Canada Mortgage and Housing Corporation's definition of 'special needs housing' is broad. It includes housing for the following groups: battered women, immigrants, single adolescent mothers, the homeless, chronically mentally ill, refugees, physically disabled, mentally handicapped, offenders and ex-offenders, frail elderly, young adolescents who cannot go home" (Starr et al. 1991: 11-12).

The Province of Ontario, in 1987, began to establish policies and programs that accepted community-based living for people requiring special supports (including health, social, and corrections services). The goal was the provision of housing that most closely resembled the housing arrangements available to the general public. There was express acknowledgement that special need should not be the primary factor defining the choice of residence.

> They should not be required to live together with others who share their disability if they are capable of more independent living; and like most people, they should be able to live in their accommodation knowing that they can remain as long as they choose to do so. (from *More than shelter* 1987: 12-13 cited in Starr Group et al. 1991: 5)

Key principles of normalized housing – resident choice, and security of tenure that is unconditional (on tied or linked services) – are incorporated in this statement. Now, however, it appears likely that changing provincial policies will erode such principles. This is problematic since eligibility criteria must be broad to allow for mixed sub-groups and integrated housing and to promote flexibility in planning for the homeless and accommodate their varied needs.

A Policy of Linkage

Both research findings and new initiatives in project models favour delinking (or separating) accommodation from the provision of care. Yet, without any open discussion, and a focus on budgetary rather than public policy issues, the ministries that fund supportive services are moving to enforce a policy of linkage between service and accommodation.

This could mean that services are non-portable for tenants: if they leave their supportive housing unit, the support services do not follow them. And if they decline the particular services attached to the housing, they may be unable to stay in their supportive housing unit. There is a renewed risk that supportive housing projects may evolve into new mini-institutions when services are tied to housing rather than to people.

5.3 Integrated Supportive Housing Stock

It is unfortunate that we cannot state how many integrated supportive housing units fail to meet the criteria set out above for transfer. The new, stricter provincial criteria for 'dedicated' units have not been applied to our inventory description, so it does not provide a clear reading of which projects and which units will not be transferred. Further, our inventory undercounts integrated or scattered units which by definition do not qualify for transfer. Generally, when the housing and service is delinked, i.e., provided by separate agencies, the unit does not qualify. There are such units provided by the Metro Toronto Housing Authority, Cityhome, co-operative housing projects, and non-profit housing projects. Will these units remain as supportive housing?

How will the support service funding continue to be covered?

With the financial pressures imposed by devolution of the social housing stock, housing subsidies may be reduced. Any threat to the continued support service provision or housing subsidies for these units will likely cause the tenants to become homeless.

5.4 Devolved Supportive Housing Stock

The Province has announced that it has plans to develop standards for supportive housing units that are part of portfolios being devolved to municipalities. It is unclear, though, how the province will administer standards for housing projects that it has already devolved to the municipality.

The devolved supportive housing projects are those who are most likely to accommodate the homeless and hard to house. These groups are not part of any ministry's business plan. The Province reports that its transfer scheme will leave municipalities with a more homogeneous social housing portfolio to administer. This suggests there is no commitment to the devolved supportive housing, and no recognition of its unique qualities or funding requirements.

Full responsibility for social housing is a new task for municipal government and politicians. How will the unique aspects and additional costs of supportive housing projects be understood? There is good reason to question whether, in a context of extreme financial constraint, adequate management funds will continue to be available. The devolved supportive housing projects are at great risk of loss unless their current housing and support service funding can be protected from severe municipal fiscal constraints.

These projects are predominantly managed by alternative housing providers who are more likely to adopt principles that the evaluative research suggests is more effective for residents — integrated housing, resident mix, support services de-linked from the landlord agency, and resident participation and influence. Along with the homeless and hard to house, they are accommodating victims of violence, families, youth, Aboriginal persons, and refugees. How will the supportive housing sector maintain and develop its integrity and accountability when it is split according to divorced funding bodies and levels of government administration? It is critical that a co-ordinating mechanism be developed between the relevant ministries and the City of Toronto to address this question. Some form of local infrastructure is also required to assist the sector to maintain a capacity to develop and plan. The City should undertake a role in developing a planning context for the supportive housing sector that is integrated with the wider social housing sector.

5.5 Need for More Supportive Housing

Unfortunately, the immediate concern is to protect the supportive housing sector from losses when it should be to investigate ways to increase its stock and develop the model's strengths.

Both the U.S. and Canadian research shows that supportive housing is an appropriate and effective response to the problem of chronic homelessness. There is every indication from the available research that supportive housing programs keep vulnerable people housed, reduce the inappropriate use of emergency services such as shelters and hospitals, and re-establish residents' social networks and their ability to re-join and contribute to communities.

There is a considerable disjuncture between the availability and need for supportive housing in Toronto. We estimate that an additional 5,500 units are required in the very near future. It is not sufficient to simply target vulnerable populations and 'move them to the head of the line' for subsidized housing. New housing development is the critical factor. Yet, there is currently no policy mechanism to fund the development of supportive housing.

5.6 Mental Health Reform

A major overhaul of the mental health system is being planned that will involve moving more patients out of hospitals. Since the early 1960s, a total of 10,700 psychiatric beds have been closed in Ontario. There is currently a moratorium on further closures, however, the plan is to eliminate almost half of the remaining hospital beds and close five out of the ten provincial psychiatric hospitals after 2003, when it is assumed that adequate supports will be available in the community or general hospitals (Boyle 1998).

Since it takes about five years to develop new supportive housing, preparations have to be made quickly to prevent more deinstitutionalized people becoming homeless and without adequate support services. While an investment fund of $10 to $15 million is promised for community treatment in Ontario, the provincial advisory committee on mental health has estimated $400 million is needed for community supports before more beds are closed. How much of the community mental health funding will be available for housing development?

If the Ministry of Health plans to assume the responsibility of developing housing projects to meet the projected need, it will require the addition of staff with expertise in non-profit housing development.

5.7 Federal, Provincial, and Municipal Responsibility

The Government of Canada has signed international agreements in support of the right to housing, along with other fundamental human rights. It has played a substantial role in improving the housing conditions of its citizenry. The growing rate of visible homelessness in urban areas, however, is a strong indicator that such efforts must be renewed. Those homeless people who require supportive housing are the least able to meet their needs in the private sector. A well-targeted new program that involves the federal, provincial, and municipal governments is required.

Moreover, there are two groups over-represented among the visibly homeless in Toronto for whom the federal government has additional responsibility: refugees and Aboriginal persons. Immigration policy is a federal responsibility. The fact that Toronto is the major reception centre for more than a third of the 200,000 immigrants and refugees that Canada admits each year is not within municipal control. Federal funding reductions for agencies serving immigrants and refugees have limited their ability to assist, and refugees and immigrants are showing up in shelters in discernible migration waves. The federal government also has jurisdictional responsibility to address the needs of Aboriginal persons. The high number of Aboriginal persons among the visibly homeless is an unacceptable reflection of the historically inequitable situation faced by First Nations peoples in Canadian society.

The federal government should re-establish and improve funding for settlement work, including affordable housing and supportive housing, for immigrants and refugees (especially those who have experienced war trauma) and for Aboriginal persons coming to cities who do not find employment.

Although the problem of homelessness is not new to Canada, the current form of it is. There have never been so many people without any form of shelter at all in Canadian cities. This warrants policy and program innovation, especially for those who require more than simply housing. The U.S. experience with a major supportive housing program has been successful. And there is evidence that local supportive housing projects are effective for residents with a range of problems and service needs. Specifically, supportive housing is an effective strategy to eliminate homelessness among the vulnerable.

The concerted assistance of all three levels of government will be required to develop a co-ordinated funding envelope that matches federal funds for housing with provincial funds for support services, with municipal planning assistance and local service agency programming.

The federal government should ensure that the program is effective across the country by making provisions for provinces that choose to opt out. The municipal government has an important role to play in co-ordination and planning with funding and sponsoring agencies.

Service providers require more resources and latitude in designing projects to meet diverse needs of proposed tenant groups. The inventory of supportive housing available in Toronto reveals its diversity in terms of housing forms and level and intensity of support service provision. This variety should be encouraged to promote a range of choice for residents and provide for best-fit matching.

Research and Evaluation

The provision of specific funding for evaluation research should be promoted as a crucial tool for the improvement of supportive housing models. Supportive housing is still a new field that requires opportunities for experimentation and creativity. There is much to be learned yet about effective program and management models. Evaluative research can assist in better planning and implementation. And although several local providers have conducted studies for just that purpose, it is unclear whether sufficient funds are available to all supportive housing providers to allow them to conduct such research.

SECTION 6: CONCLUSIONS

The focus of this report has been to map the supportive housing available in Toronto, assess its applicability as a partial solution to homelessness, and determine the service gaps, especially in terms of how much additional supportive housing is needed. The results of these efforts can be summarized as follows:

Supportive housing is an alternative to institutional living (and to independent living) for people who require some level of extra assistance to obtain and maintain stable housing arrangements.

There is a substantial supportive housing sector in Toronto comprised of a large number of mostly small service providers. These agencies have developed a range of approaches and models of housing and support provision. In brief,

- there are about 5,300 units of supportive housing in Toronto (excluding those for frail elderly and people with developmental disabilities),
- about half of the units are self-contained, and
- the majority are funded by both the federal and provincial governments.

A growing body of research demonstrates that supportive housing is effective for a variety of special needs groups, especially those with psychiatric disabilities. More particularly, supportive housing is an appropriate intervention for the 17 per cent of hostel users in Toronto who consume close to half of the system's resources. A high proportion of these chronically homeless people have a psychiatric or other disability and they require more than simply housing to re-establish themselves in the community.

There is a clear need for an additional 5,500 supportive housing units in the near future.

The policy context determined by senior governments is forcing the supportive housing sector and the municipal government to deal with changes and threats to current stock. Specifically,

- about three-quarters of the units are being transferred to provincial ministries,
- an unknown, small proportion of the units are integrated and therefore ineligible for transfer, and
- about a fifth of the units are subject to devolution to the municipality.

Recent changes to provincial policy, such as more restrictive definitions of special need and a commitment to projects that link housing and services, suggest a re-trenching of old models of supportive housing.

It will be necessary to develop a new funding mechanism that involves all three levels of government to develop more supportive housing and promote development of progressive models of housing and support services.

Appendices

1. List of Key Informants

- Kathleen Blinkhorn, Ministry of Municipal Affairs and Housing
- W. Clarke, Ministry of Health
- Stephanie Zelinkski, Ministry of Health
- Minnie DeJong, Ministry of Health
- Kathleen Blinkhorn, Ministry of Housing
- John Trainor, Director, Community Support and Research Unit, QSMHC
- George Tolomiczenko, Research Psychologist, Clarke Institute of Psychiatry
- Paul Dowling, Executive Director, Homes First
- Angie Haines, Executive Director, Metro Toronto Association for Community Living
- Alison Guyton, Executive Director, Community Mental Health Program
- Peggy Birnberg, Executive Director, Houselink
- Susan Bacque, old City of Toronto Housing Department
- Sheryl Pollock, old City of Toronto Housing Department
- Joyce Brown, Consultant (formerly with Savard's and Nellie's)
- Jennifer Pyke, Community Resource Consultants of Toronto
- Leslie Gash, Ontario Non-Profit Housing Association
- Calvin Kangara, Research Project Director, Parkdale Community Health Centre
- Tom Clement, Co-operative Housing Association of Ontario
- Mary Menzies, Metropolitan Toronto Housing Company (wait list database)
- Brian Berstein, Manager, Toronto Social Housing Connections
- John O'Bourne, Turning Point Youth Services
- Lee Vittetow, Central Toronto Youth Services
- Susan Forrester, Community Independent Living Toronto
- Nora McAuliffe, Community Occupational Therapists Association
- Nancy Sidle, Community Occupational Therapists Association
- Rene Post, Houselink
- Joe Hester, Anishnawbe Health Centre

2. List of Self-Identified Alternative Housing Providers in Toronto

CRC - Self Help
Deep Quong Non-Profit Homes
Ecuhome
Fred Victor Centre / Keith Whitney Homes
Homes First Society
Houselink Community Homes
Houses Opening Today Toronto
Interchurch Community Housing
Habitat Services
My Brothers' Place
Portland Place
Project Esperance
Regeneration House
Riverdale Housing Action Group
Supportive Housing Coalition
Start 103 Non-Profit Homes
Woodgreen Community Centre
YSM Genesis Place
YWCA of Metropolitan Toronto

3. Statement on Alternative Housing

There is virtually no documentation of the alternative housing philosophy in the published literature. The following excerpt provides a general sense of the alternative housing viewpoint as it evolved from the work of the Displaced Single Persons Project and was adopted by those who participated in the development of 90 Shuter St., a Homes First project built in 1986 (Alan Etherington and Associates 1987: 33-34):

> Shuter Street was developed for and with homeless people who come from the streets. There are a number of stereotypes about who these people are. Primarily we think of them as people with problems (alcoholics, psychiatric patients), or people who cause problems (drug users, criminals). However, these characteristics must be understood in the context of the social and economic dynamics which work on homeless people. Homeless people are primarily poor.
>
> These are the men and women who have been displaced from the cheap accommodation in rooming houses and residential hotels taken over by urban redevelopment and the gentrification of formerly working class downtown neighbourhoods. While those neighbourhoods offered affordable housing, many of these people used hostels infrequently: during periods of unemployment or because of lack of funds. However, as the stock of rooms to which they normally returned were taken off the market in significant numbers, the hostels more and more became their 'permanent housing.' Hostels have limits on the length of stay, so people had to move from hostel to hostel. But they were 'permanently housed' in hostels. At the same time, these people gradually became more and more dependent on social services to meet their needs as economic shifts removed their traditional jobs. Inflation further eroded their already limited purchasing power as costs of food, shelter and clothing escalated at a greater rate than did incomes from low and minimum wage jobs and social assistance.
>
> As these people increasingly turned to, and became dependent on, social services, the social service system responded in two ways. Increasingly, treatment programs for low-income single men and women from the streets became residential programs, and the length of the residential portion kept increasing. The typical pattern is the development of the alcohol treatment system — the detox, 28 day program, halfway-house, 3/4 way house, and in one case a 7/8 way house. After one's 'recovery,' the agency people correctly saw recidivism as a result of the person having no option but to return to the streets or to the bad housing settings in which he or she had previously resided.
>
> The people themselves had also to adapt and they learned they had to present themselves as having needs to which available programs could respond. In some cases people would actually become an alcoholic, commit crimes and get caught, or exaggerate mental health problems/symptoms so they could get housing.
>
> As a result of having and losing housing over a period of months or years, the homeless become 'transient.' They lose personal property that is hard to move with them and begin to limit their belongings to those that they can carry. Their social and familial relationships become strained or broken. They have no effective legal protection of tenure. They are more vulnerable to rape and other forms of violence, to harassment by police, shopkeepers, and the general public. They are exposed to special laws (against 'vagrancy,' loitering, and drinking in public) and they become prone to the abrogation of due legal process. They experience blockages when they attempt to vote, set up a bank account, get credit, get a job, get general welfare assistance, get health insurance coverage, take care of health problems, keep clean, mate, and build friendships.

This flow of events traces the development of individuals' characteristics as well as the worsening situation for the whole group. The result is that individuals become caricatures of their problems in order to get their basic needs met. Service providers continually have more and more difficult situations to deal with. People with these characteristics can be described in two ways which generate different responses to the problem. If we think of them in terms of their disabilities we develop therapeutic programs which do things for the people. If we think of them in terms of their abilities we develop programs in partnership which do things with the people. It is a hard point to keep in mind, but they are the same people. What is different is the way society and the social service system treats them.

The people in Shuter Street are the people who came off the streets through the system. The people who developed Shuter Street are the people in agencies which provided the inadequate responses. Shuter Street represents a new partnership in which both parties – housing provide and consumer – are learning new roles and relationships.

4. Supportive Housing Resource Group

Created in 1991, the Corporation for Supportive Housing provides advocacy and educational materials on the development and operation of supportive housing projects in the United States. These materials are available from: Corporation of Supportive Housing, 342 Madison Ave., Suite 505, New York, NY 10173, (212) 986-2966. A brief description of the organization's work can be found at http://www.fcny.org/olivia/csh.html and research reports commissioned by the Corporation are listed on the web site for the National Resource Center on Homelessness and Mental Illness: http://www.prainc.com/nrc/index.html

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