

Housing and Health: Unlocking Opportunity

October 2016



Reference:

Toronto Public Health. *Housing and Health: Unlocking Opportunity*. October, 2016.

Author:

Linda Wood

Acknowledgments:

I appreciate and acknowledge the expertise and assistance provided by the following Toronto Public Health staff: Jan Fordham (Manager Lead), Dr. Monica Campbell, Dr. Barbara Yaffe, Jann Houston, John Bugailiskis, Susan Shepherd, Alice Gorman, Marco Vittiglio, Dr. Herveen Sachdeva, Dia Mamatis, Jill Maclachlan, Rita Paul Sengupta, Charles Yim, Andi Stover, and Cathy Canonizado.

Thank you to those who provided support for the lived experience interviews. Thank you to Rosie Mishaiel, Toronto Public Health, who played an integral role in coordinating the recruitment of interview participants. Thank you to Dean Simikic, Gary Baker, and Ashraf Ali, Toronto Public Health, for providing technical assistance for the interviews. Finally, a special thank you to staff at Toronto Public Health and community agencies who assisted in recruiting interview participants. To protect the identities of participants, staff names and organizations have not been listed.

Thank you to the following individuals for their review and input on this report: Erik Hunter, Affordable Housing Office, City of Toronto; Dr. Stephen Hwang, Centre for Urban Health Solutions; Laural Raine, Shelter, Support and Housing Administration, City of Toronto; John Stapleton, Open Policy Ontario; Greg Suttor, Wellesley Institute; and Noah Zon, Maytree Foundation.

A special thanks to Dr. David McKeown, former Toronto Medical Officer of Health, for his idea for the project and his belief in the power of stories from people with lived experience.

Most importantly, I am especially grateful to all the people who courageously shared their stories. Your willingness to share what are deeply emotional and distressing experiences is a testament to your desire to be heard and see change.

Distribution:

This report and the staff report that was presented to the Toronto Board of Health on October 31, 2016 are available on the Toronto Public Health website at:

<http://www.toronto.ca/health>

For more information:

Phone: 416-338-7600

TTY: 416-392-0658

Email: publichealth@toronto.ca

Table of Contents

Introduction	1
Toronto Housing Context	3
At-Risk Populations	7
Indigenous people	7
Newcomers and immigrants	7
Children and families	8
Youth	8
Seniors	8
Lesbian, gay, bisexual, trans, queer, and two-spirited (LGBTQ2S) people	9
People affected by violence	9
People with mental health and/or substance use issues	10
People with chronic illnesses and/or physical disabilities	10
Marie's Story	11
Quill's Story	13
Housing and Health	16
Housing Affordability	19
High Shelter Cost Burdens	19
Food Insecurity	20
Energy Insecurity	22
Julie's story	23
John's Story	24
Housing and Neighbourhood Quality	26
Housing Conditions	26
Neighbourhood Conditions	28
Ashley's Story	30
Housing Stability and Security	32
Housing Tenure	32
Overcrowding	35
Residential Mobility	36
Bindu's Story	37
Evictions	38
Renel's Story	39
Homelessness	40
Julio's Story	42
Brother Nicholas's Story	43
Conclusion	45
Appendix A	47
References	49

List of Figures

Figure 1: How are Housing and Health Related?	16
Figure 2: Percent of Monthly Income Required for Average Market Rent and for a Nutritious Food Basket, and Monthly Income Remaining, Toronto, 2016	21
Figure 3: Household Food Insecurity by Housing Tenure, Toronto, 2005-2014	33

*“It is homes we must give our people,
not merely shelter.”*

- Dr. Charles Hastings,
Toronto Medical Officer of Health, 1918

Introduction

Affordable, good quality, and stable housing is a key prerequisite for promoting health and preventing illness. It is also a key determinant for building healthy and inclusive communities. The current Toronto housing context, which is increasingly unaffordable and has a limited supply of affordable housing, is resulting in inequities in access to housing that is affordable, good quality, and stable, which has significant implications for health and health equity in Toronto. Research and lived experience in Toronto demonstrates that housing unaffordability, poor quality housing and neighbourhoods, and housing instability, including homelessness, are associated with a range of poor mental and physical health outcomes, risk factors for poor health, health care non-adherence and follow-up, and significant costs to the health care system.

The link between housing and health policy has been recognized since the Industrial Revolution. In 1911, Toronto's Medical Officer of Health Dr. Charles Hastings released a seminal report on the "slum conditions" in Toronto.¹ The report used statistics and powerful photographic evidence to illustrate the pervasiveness of poor housing conditions such as inadequate and unsanitary housing, overcrowding, and poor ventilation and called these conditions a "menace to public health." Hastings's commitment and leadership on the issue resulted in widespread housing reforms such as demolishing substandard housing, stricter housing standards, and social housing projects.²

In the context of national, provincial, and local policy efforts to address housing issues, it is important for policy makers, elected officials, and the public to understand the implications of the current housing context in Toronto for health and health equity. This report highlights housing need in Toronto, including populations most at risk, and reviews the international, Canadian, and local research on the three key dimensions of housing that are important for health and health equity – affordability, quality, and stability. While it is recognized that housing issues can affect people across the socioeconomic spectrum, this report focuses on people experiencing homelessness or at risk of homelessness.

Included throughout this report are personal stories by Toronto residents with lived experience of homelessness and housing instability who represent diverse living situations, household types, housing concerns, and at risk populations.¹ Their stories provide powerful and compelling accounts of the impacts that housing unaffordability, poor quality housing and neighbourhoods, and housing instability and insecurity have on their lives, health, and well-being. Their stories not only illustrate the immediate connections between housing and health, but also speak to the broader role of the insufficient supply of good quality affordable housing and social and economic inequities such as poverty, precarious employment, violence, lack of supports, and discrimination in Toronto in producing and exacerbating homelessness and housing instability and, in turn, health inequities.

¹ Participants were recruited through Toronto Public Health and community agencies. All participants were fully informed of the project and signed a consent form. Participants were given the choice to share their written story or their story captured through an audio or video-recorded interview; most chose an audio-recorded interview. Some participants cited reasons such as embarrassment of their housing issues, concerns about their safety, and concerns about retribution from landlords for not wanting to participate in video-interviews. Interviews were conducted between March and August, 2016 in either participants' homes or community agencies. To protect their identity, participants were asked to choose pseudonyms, and certain details of their story have been omitted. All participants were given a \$40 grocery voucher for their participation. We thank them for their willingness to share their stories.



Toronto Housing Context

Toronto has one of the least affordable housing markets in Canada.^{3,4} A recent (2015) report *Renewing Canada's Social Architecture* notes that this housing need is at risk of worsening as a result of four pressures on the social and affordable housing system: 1) economic pressures on low-income households, including increasing income inequality, inadequate social assistance rates, and incomes failing to keep pace with the rising cost of living; 2) challenges to the sustainability of social housing assets as a result of insufficient investment in repairs and maintenance costs and withdrawal of federal funding as operating agreements expire; 3) decreased federal spending on affordable housing since the early 1990s and less generous levels of subsidies for households in need; and 4) trends in the housing market such as limited purpose-built rental housing construction, which has contributed to increasing rents and low vacancy rates and made it challenging for low income people to find housing in the private market.⁵

Housing Need

The Toronto census metropolitan area has the second highest incidence of core housing need in Canada, next to Vancouver.ⁱⁱ In 2010, the incidence of core housing need in Toronto was 21%⁶, which is higher than in Ontario and across Canada (13.4% and 12.5%, respectively).⁷ Affordability is the most common reason for households being in core housing need.⁶ Households spending 30% or more of their before-tax income on shelter costsⁱⁱⁱ are considered to have affordability issues. In 2010, renters, who made up almost half (45%) of all private households in Toronto, were almost three times more likely than owners to experience core housing need (32.9% versus 11.5%) and are one and a half times more likely than owners to experience affordability issues (43.5% versus 27.6%).⁸ One reason for this difference is the higher average and median household income of homeowners, which is more than double that of renters.⁸ Almost one quarter (22%) of renter households in Toronto spend more than 50% of their income on shelter⁹, which indicates severe housing need and can put them at risk of homelessness.

Although housing issues affect people across the socioeconomic spectrum, they are more challenging for low income people who have less financial means to compete in the private market and may have less control and autonomy over their living environment. Low income is a key determinant of core housing need and affordability problems. On average, low income households have higher shelter cost burdens and are more likely to exceed the 30% affordability benchmark.¹⁰ For example, in 2010, renter households in Toronto who earned less than \$20,654 spent an average of 82% of their monthly income on rent compared with those earning \$67,543 or more who spent an average of 13% of their monthly income

ⁱⁱ According to the Canada Mortgage and Housing Corporation (CMHC), a household is in core housing need if its housing fails to meet one or more of the adequacy (i.e., not requiring any major repairs), affordability (i.e., costs less than 30% of total before-tax household income), and suitability (i.e., enough bedrooms for the size and composition of the household according to National Occupancy Standards) standards and it would have to spend 30% or more of its before-tax income to pay the median rent of alternative local housing that meets all standards.

ⁱⁱⁱ Shelter costs include: for renters, rent and payments for electricity, fuel, water and other municipal services; and for owners, mortgage payments, property taxes, condominium fees, and payments for electricity, fuel, water and other municipal services.

on rent.⁹ In addition, income security programs such as Ontario Works (OW) and Ontario Disability Support Program (ODSP) are inadequate to afford Toronto rents, with rates falling below the poverty line and not indexed to the cost of living in Toronto.

The high cost of housing and increasing poverty in Toronto has led to an increased demand for subsidized housing. As of June 30, 2016, there were 98,323 Toronto households on the waiting list for social housing¹¹, with an average wait time of 8.4 years.¹² As a result, low income and working poor households are being pushed out of the downtown core to the peripheries of Toronto in search of more affordable housing. The *Vertical Poverty* (2011) and *The Three Cities within Toronto* (2010) reports demonstrated that from 1970 to 2005 Toronto has experienced income polarization resulting in a significant decline in middle-income neighbourhoods and increase in low income neighbourhoods concentrated in the inner suburbs of Toronto.¹³ Similarly, the *Working Poor* (2015) report demonstrated that from 2006 to 2012 working poverty in Toronto has moved from the downtown core northward towards the outer suburbs of the Toronto region to York, Durham, and Peel regions.¹⁴ The Daily Bread's *Who's Hungry* (2016) report notes that this geographic shift in poverty has led to a 48% increase in food bank visits in the inner suburbs and a 16% decrease in the city core since 2008.¹⁵

While demand continues to grow for affordable housing, Toronto's private and social housing stock is aging; by 2020, approximately 60% of rental apartments will be 50 or more years old. Toronto's largest social housing provider, Toronto Community Housing Corporation (TCHC) is facing significant pressures with a \$2.6 billion capital repair backlog. Without significant investment in these repairs over the next ten years, tenants will be living in conditions that are unsafe and unhealthy and many of these units will be forced to close.

Social housing is also becoming home to an increasingly vulnerable population with mental health issues. A recent report by the Ontario Non-Profit Housing Association *Strengthening Social Housing Communities* (2015) notes that economic trends and a series of policy decisions by the Ontario government (e.g., deinstitutionalization, priority status for groups such as victims of domestic violence, and loss of affordable housing) have resulted in social housing as the "housing of last resort" for vulnerable populations, despite the lack of sustained funding for support services.¹⁶ The report estimates that at least 23,000 adults with a serious and persistent mental illness live (with or without supports) in social housing in Ontario. A recent staff report examining recommendations from the final report of the Mayor's Task Force on TCHC estimated that approximately 7% of tenants (8,900 adults) in TCHC have a mental illness serious enough to make them eligible for supportive housing.¹⁷ In Toronto, the number of people on the waiting list for supportive housing has almost doubled in the last two years – from 5,696 to 10,814 between 2013/14 to 2015/16, with average wait times of approximately 5 to 7 years.¹⁸

Homelessness remains a significant issue in Toronto, with an estimated 5,253 people who were homeless^{iv} on the night of April 17, 2013¹⁹ and more than 16,000 unique individuals using the City of Toronto's shelter system in 2014.²⁰ It was also estimated that 9% of the total homeless population (447 individuals) were sleeping rough outdoors and 39% reported sleeping outdoors at least once in the previous six months. The high cost of rent, insufficient supply of affordable and supportive housing, and inadequate income are major factors in homelessness. The 2013 Toronto Street Needs Assessment found that almost three-quarters of homeless respondents identified a need for services to help address housing affordability either directly or indirectly such as more money from OW/ODSP, subsidized housing or a housing allowance, help finding affordable housing, or help finding employment or job training to increase income.¹⁹ This was echoed in the 2007 Street Health report, in which homeless respondents overwhelmingly cited the high cost of rent and inadequate income as the main factors leading to homelessness and keeping them homeless.²¹

^{iv} The 2013 Street Needs Assessment counts people who are sleeping outdoors as well as staying in emergency or transitional shelters, health and treatment facilities, and in correctional facilities. It does not include the 'hidden homeless' (e.g., couch-surfers).

HOMELESS
I AM WHO I AM IF
YOU DONT LIKE IT IM
SORRY CAN YOU SPARE
A PLACE



At-Risk Populations

Certain populations such as Indigenous people, newcomers and immigrants, children and families, youth, seniors, LGBTQ2S people, people affected by violence, people with mental health and/or substance use issues, and people with chronic illnesses and/or physical disabilities are more likely to experience social and economic inequities such as poverty and, as a result, are at greater risk of experiencing homelessness and housing instability and related health impacts. While these groups are categorized as separate below, it is recognized that their identities often intersect which can result in compounded and distinct housing and health issues experienced. This is illustrated in the stories from people with lived experience included throughout this report.

Indigenous people

Colonization, structural and institutional racism, and government policies and practices including the Indian Act, residential school system, reserve system, and the systematic removal of children from their families and communities have all contributed to higher rates of social, economic, and health issues among Indigenous people in Canada. Indigenous people have a higher incidence of core housing need compared to non-Indigenous people in Toronto (27.9% versus 20.9% in 2010).⁶ Indigenous people are also overrepresented in the Toronto homeless population and, especially, the outdoor homeless population.^{19,22} The 2013 Street Needs Assessment found that one-third of the outdoor homeless population in Toronto self-identified as Aboriginal^v. The 2008 Toronto Aboriginal Research Project found that serious social problems such as unstable housing and lack of employment, and poor physical and mental health were particularly acute among homeless Aboriginal^v men in Toronto.²² Addressing racism by landlords and influencing supportive housing policy for the benefit of Indigenous youth, seniors, two spirit, pregnant women, and women involved with the child welfare system were identified as key strategic priorities in Toronto's First Indigenous Health Strategy report.²³

Newcomers and immigrants

Immigrants had a higher incidence of core housing need compared to non-immigrants in Toronto in 2010 (25.1% versus 15.1%), with recent immigrants having the highest incidence of all immigrant groups (40.1%).⁶ Non-permanent residents also had a high incidence of core housing need (33.6%).⁶ A recent study on refugees, asylum seekers, and immigrants in the Toronto Metropolitan Area found affordability to be the main housing issue faced by newcomers.²⁴ While asylum seekers and refugees reported the most severe housing problems, affordability and housing difficulties were persistent issues for immigrants who lived in Canada for 5 to 10 years. Precarious housing, poor housing conditions, overcrowding, and hidden homelessness were also common issues reported in the study. Newcomers also face discrimination in trying to find housing, may be unaware of their rights as tenants, and may be reluctant to report housing issues to landlords for fear of retribution.^{25,26}

^v The term 'Aboriginal' is used here to remain consistent with the original source.

Children and families

Lone-parent households, particularly female-led, had the highest incidence of core housing need of all household types in Toronto in 2010.⁶ Female lone-parents had almost twice the incidence of core housing need compared to all household types (40.8% versus 21%). Low income families often face significant challenges finding affordable housing that is suitable in size in areas where they feel safe and comfortable raising their children. They may be forced to live in poor quality, unsuitable, and/or illegal housing that is unsafe and unhealthy for their children. Low income families who struggle to pay their rent are at risk of housing instability such as frequent moves, evictions, and homelessness. Homelessness experienced during the pre-natal, post-natal, and early childhood period is harmful to children's healthy growth and development.²⁷

Youth

Youth homelessness in Canada has been identified as a pressing and distinct problem requiring distinct solutions.^{28,29} Youth are overrepresented, making up approximately 20% of the homeless population in Canada.²⁸ Based on the 2013 Toronto Street Needs Assessment, it was estimated that there are approximately 850 homeless youth in Toronto on any given night and 3,300 over a one year period.³⁰ Dr. Stephen Gaetz, a leading expert in the area, notes that youth homelessness is different from adult homelessness in that youth are often fleeing households where they have been dependent on adult caregivers. Moreover, for youth, homelessness involves not just the loss of housing but may involve family breakdown, loss of friends and supports, disruption or withdrawal from school, and premature independence.³¹ A recent international systematic review of the causes of child and youth homelessness found that in North America, family conflict was the most commonly reported reason for street involvement, followed by poverty, abuse, and psychosocial health.³² Delinquency, which is often assumed to be a reason for child and youth homelessness, was the least frequently cited reason.

Seniors

Seniors, especially those with chronic health conditions, age-related issues, physical disabilities, and/or mental health issues, are at risk of housing instability, including eviction and homelessness. They may also be living on a low and fixed income, socially isolated with limited or no social supports, living in unhealthy or unsafe living conditions (e.g., bed bugs and hoarding situations), and may be resistant and non-receptive to services. In 2010, female seniors (65 years and older) living alone had the second highest incidence of core housing need (38.1%) of all household types in Toronto.⁶ The proportion of seniors (over 60 years of age) in the homeless population has doubled from 5% to 10% between 2009 and 2013.¹⁹

Lesbian, gay, bisexual, trans, queer, and two-spirited (LGBTQ2S) people

People from LGBTQ2S communities face significant housing-related barriers, including homelessness as a result of family rejection and conflict.³³ Transphobia, homophobia, discrimination, harassment, violence, and threats of violence within the housing and shelter system can lead to unstable and unsafe living situations including couch surfing and sleeping rough on the streets. Dr. Alex Abramovich, a leading expert in the area, notes that the minimal research on LGBTQ2S homelessness has largely focused on youth compared to adults for a number of reasons.³⁴ Specifically, youth are more likely to be “out” compared to adults, family rejection resulting from coming out is a major factor in youth homelessness, and youth have distinct needs compared to adults.³⁴ The 2013 Toronto Street Needs Assessment found that twice as many respondents in youth shelters identified as LGBTQ2S compared to respondents in the total population surveyed (21% versus 9%). Homeless youth from the LGBTQ2S community are at a greater risk for substance use, risky sexual behaviour, and mental health issues, which are made worse by a lack of specialized social and health supports.³³ Abramovich notes that there are few specialized support services and there were no specialized shelters for LGBTQ2S homeless youth until recently (February 2016), with the opening of the first transitional house for LGBTQ2S youth in Toronto.³³

People affected by violence

Violence within the home and neighbourhood can have major impacts on housing stability and increase the risk of homelessness. Violence and poverty can impact a person’s ability to access safe housing, which can in turn affect their health and wellbeing. The physical, psychological, social, and economic impacts of violence can make it more difficult to maintain employment and access housing. Lack of affordable housing, adequate income, employment, and other supports often forces people experiencing violence to remain or return to abusive homes and can contribute to housing instability after leaving home.³⁵ People from the LGBTQ2S community may remain in abusive living situations and avoid shelters because of additional barriers such as discrimination, transphobia and homophobia, risks to physical safety, and a lack of specialized supports and housing.³⁶ A recent report by Toronto Public Health on intimate partner violence (IPV) identified shelter and housing as a significant issue for women experiencing IPV in Toronto.³⁷ The report noted that on a single day in Toronto the occupancy of provincially-administered shelters was at capacity (185 women and 238 children) and, as a result, these shelters had to turn away 20 women and 15 children on that day.

People with mental health and/or substance use issues

Stable, supportive housing has a key role to play in reducing health risks and improving the quality of life of people with substance use issues.³⁸ However, many people with mental health and/or substance use issues live in poverty and precarious or unstable housing conditions, including shelters, motels, rooming houses, staying with friends or relatives, which may increase their risk of eviction and homelessness. They may also face multiple barriers in trying to find and maintain housing including a lack of harm reduction and supportive housing options, stigma and discrimination by landlords, housing providers, and communities, and eviction from housing due to substance use and discrimination.

People with chronic illnesses and/or physical disabilities

People with disabilities are more likely to experience poverty and hence may be more likely to experience housing instability. ODSP rates that do not reflect the cost of living in Toronto make it challenging for people with disabilities to afford food and other expenses. For example, the Daily Bread's 2016 annual report on hunger in Toronto found 59% of the food bank clients surveyed reported having a disability (physical or mental illness) or serious illness, compared with 49% in 2006.¹⁵ They may also face discrimination and barriers in trying to access housing or get essential modifications made to their housing.³⁹ People with chronic illnesses and/or physical disabilities may require various health and social supports and assistance with daily living in their homes. An emerging body of research has found housing stability to be associated with increased adherence to medication and treatment regimes, utilization of health and social services, and decreased risk behaviours for individuals living with chronic diseases such as HIV, diabetes and hypertension.^{40, 41}

Marie's Story

Marie is a Métis woman in her early twenties who is living at ENAGB Saswaanhs (“The Nest”) transitional housing. Marie has experienced housing instability for most of her life. She was a Crown ward and lived with a number of guardians over the years but always ended up running away – the last time to live with her mother who she hoped would take care of her. Her guardians “didn’t have any participation in whether or not I was housed after they dropped me on my face ... I pretty much relied solely on my birth mother, who didn’t raise me at all ... and didn’t exactly have the means to support me.”

Although she doesn’t describe herself as homeless, there have been many times when Marie didn’t have permanent housing and had to stay with friends, at a shelter, or in transitional housing. She has moved about ten times in the past five years. The places Marie lived in over the years were “not that great” and introduced her to many of the people she was getting into trouble with. She has also experienced racism from neighbouring tenants and landlords. “I’ve had a lot of, like, landlords, like as soon as they find out I’m Native, like they assume that I’m an alcoholic; they assume that, like, I’ve had all these issues and stuff.”

When she first moved out, she reached out many times for help with housing but got no support so she ended up staying with friends. She was about 17 years old and unaware at the time that she was pregnant. A week after learning of her pregnancy, Marie gave birth to her daughter. She was interrogated by the police at the hospital about whether she was trying to murder her daughter. “It was really kind of heartbreaking,” she said. Her daughter was taken away and placed in foster care. Marie believes it was because of racism and ageism. She was accused of using drugs and causing her preterm birth but, in fact, she had gestational diabetes. She worries about her daughter’s future. “... In my heart and my soul, I know that they’re just going to fail her just like they did me,” she said.

She lived with her mother for a bit and then with a partner but the experiences were very stressful as they were hanging around with people who were “doing things they shouldn’t be doing.” She moved into the transitional housing program where she stayed for about 5 months. She tried moving out on her own again but she experienced similar problems with her partner. “It’s really stressful, because it was starting to affect, like me wanting to go out and do things.” Marie’s chronic housing instability caused her major stress and caused her to lose a significant amount of weight. She couldn’t handle living on her own so she moved back into the transitional house, where she has lived for the past three months.

Marie’s experience at the transitional housing program has been very positive and supportive. She describes it as a “family environment” with someone there every day who is “like a mother” and “helps us in ways that I can’t really explain” by supporting

and guiding them in the right direction. Having her own room is “awesome” and being surrounded by people trying to better their lives is helpful. “Having people that I can talk to ... it’s pretty empowering.” Marie is also learning a lot about her culture through various workshops such as beading circles. She has had various opportunities to volunteer to gain more experience so she can get a better job in the community. “It helps me find my voice,” she said of the program.

Marie feels that if she had stable and permanent housing and other supports she wouldn’t be in the situation she is in today and her daughter would be with her. She strongly believes that youth need to be made a greater priority. “I know a lot of, like, 13, 14, 15, 16-year-olds who have moved out of their places and they’re like, ‘I can’t deal with home life and I need my own place.’ Like, I was one of them ... if they were supported at that age, I’m pretty sure that they wouldn’t have to go through half of the things that I’ve even seen or gone through.” Marie is on the wait list for social housing with her mother, who is currently living in a shelter. She is hoping to get custody of her daughter.

Quill's Story

Quill is a transgender man in his early twenties who has experienced homelessness and housing instability since he was an adolescent. His father passed away when he was 12. After his mother passed away when he was 17, Quill left Toronto to live with his godmother in a small Ontario community.

Quill described his godmother's place as a "very bad" living environment where he experienced abuse. His godmother drank heavily and smoked marijuana and repeatedly called him a "bad child." "I basically lived in the barn in the middle of winter time," he said. Shortly after moving in, Quill came out as a transgender man. His godmother denied his identity. Quill ran away two weeks later because of the abuse and because he felt the community was not safe for a transgender person. After staying in a few shelters, Quill moved to Toronto. He wanted to move back as it was closer to where he grew up, his social network, and was "a more supportive environment."

Quill spent his first night in Toronto on the street because he had no means of contacting anyone. He stayed with a family friend for about a month before moving to a "predominantly male" rooming house in the area that was within his budget. Despite being open about being transgender, Quill was 'misgendered' a lot by his roommates. He ended up leaving the rooming house after he woke one day to his landlord praying over him to "cleanse this child of their sins of transgenderism." He then rented a room from friends, who he thought would be safe and supportive. After Quill refused their sexual advances on multiple occasions, they began denigrating him for being transgender. He left and stayed in a few shelters over the next year.

Quill described his shelter experiences as "horrible" and said he "tried to avoid the shelter system for as long as I could." Many of the staff were good at using his preferred name and pronouns, but a few staff refused. There were no single rooms or safety for transgender people. He was in the section of the shelter with women, which made him uncomfortable. One of the first days there, a shelter resident said to him 'Are you a boy or are you a girl?' and repeatedly called him 'he/she', threatening to harm him if they saw him on the street. Staff threatened to kick Quill out after he yelled at the person to stop. Because of his concerns for his safety, Quill refused to leave the shelter without being accompanied.

He then stayed with friends for two months, sleeping in the living room of their one bedroom apartment. He stayed at two more shelters after this. The last shelter he stayed in he was welcomed onto the male floor but was told a day later that he had to share a room with three other cis men. When he refused, "they magically made a single room available" for him and he felt safe again.

Quill's homelessness and housing instability has significantly impacted him and his health. Quill used alcohol and marijuana to cope with his traumatic experiences and was always drunk and high while at the shelters. Although he eventually returned to

school, he was failing most of his classes. He couldn't find a doctor to prescribe him hormones until he was stably housed which significantly affected his mental health. "Being on hormones made me stable ... It made my mental health so much better ... It was not a good experience having someone say you can't be on hormones because of where you are living."

Quill feels there needs to be more mental health supports in shelters because many shelter residents have had traumatic lived experiences. He thinks there needs to be both shelters specific for LGBTQ2S people, but that existing shelters should be made safe for LGBTQ2S people "so they feel comfortable sharing the space." He would like to see an LGBTQ2S advisory group that could meet regularly to discuss their experiences and provide input to the shelter system.

Quill now lives with a roommate in private market rent. He posted an online ad for a place that was "LGBT friendly specifically with LGBT people living in the space." He describes his current living situation as stable and positive but at the same time "it's different" and "I'm not used to it" because of his previous experiences. Although he spends over half of his income from ODSP and casual employment on rent, he's "doing pretty good for the most part" and feels more stable and socially active.

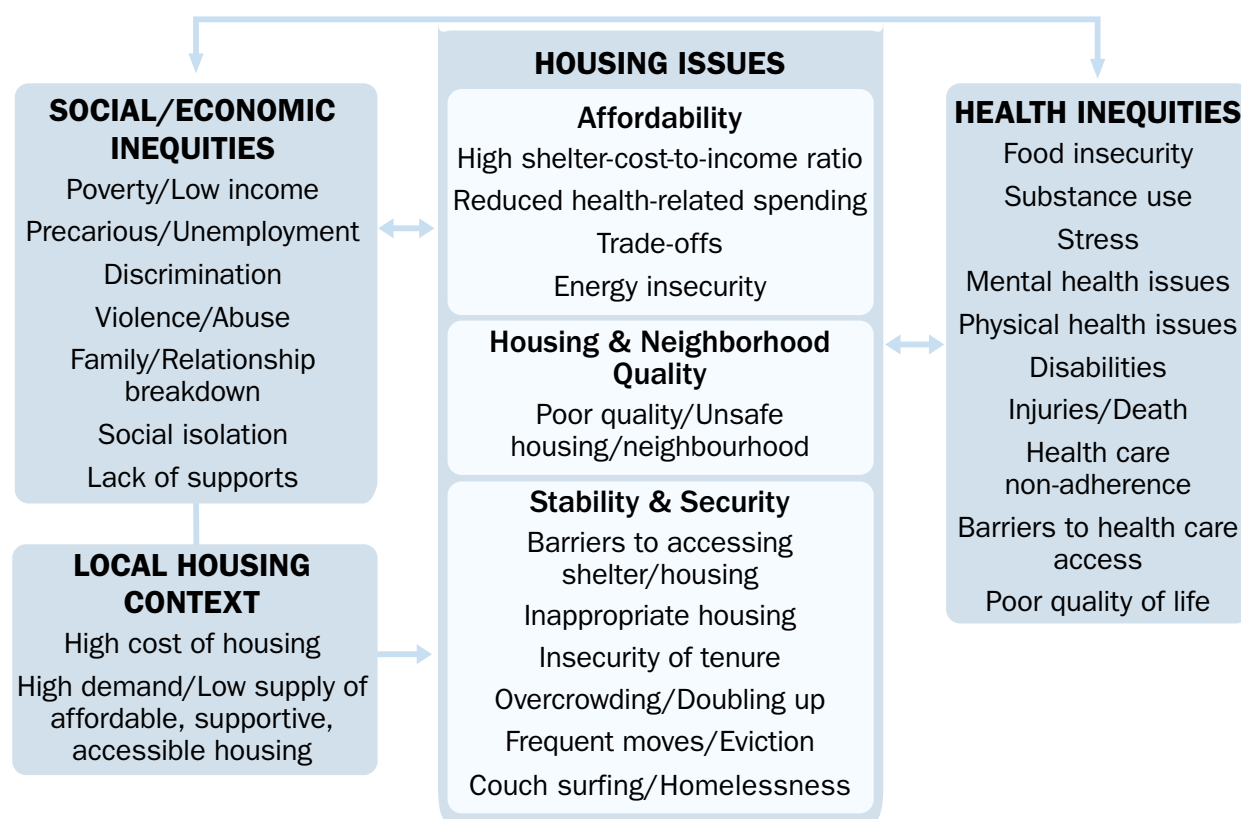


Housing and Health

Housing is a social determinant of health. It is one of the mechanisms through which social and economic inequities translate into health inequities.⁴² Upstream policies outside the sphere of health in the area of housing and related areas such as income security and employment play a paramount role in shaping the social and economic context in which people live. Differential access and exposure to social determinants of health such as housing can, in turn, create or worsen health inequities.⁴³

Figure 1 illustrates the more immediate relationship between housing and health which involves a complex interplay of factors such as the local housing context and social and economic inequities (shaped by social, economic, and housing policies), which influence people's living conditions and, in turn, impact health and health equity. Research and lived experience demonstrates that housing affordability, quality (of the dwelling and neighbourhood), and stability and security are key dimensions that are important for health and health equity. These dimensions are not entirely congruent with Canada Mortgage and Housing Corporation's (CMHC) core housing need measure. Specifically, 'core housing need' misses key dimensions of the neighbourhood (i.e. constrained choice and poor conditions) and housing instability that are central to the housing issues faced by low income people and important determinants of health.

Figure 1: How are Housing and Health Related?¹



¹ The figure attempts to simplify a complex relationship; however, it is recognized that: 1) many of the factors within each of the boxes are interrelated (e.g., violence can lead to family breakdown which can lead to poverty); 2) the list of health inequities are a mix of health-related behaviours and health outcomes; and 3) different housing dimensions are associated with different health-related behaviours and outcomes.

The relationship between housing and health is multi-directional and involves a number of direct and indirect pathways:

- The high cost of housing and insufficient supply of good quality affordable, supportive, and accessible housing in combination with social and economic inequities such as poverty can result in people living in poorer quality housing or neighbourhoods with less access to factors important for health;
- The high cost of housing and low supply of affordable housing can lead to affordability issues which can lead to reduced expenditures on food, food insecurity, and food bank usage which can impact health;
- Social and economic inequities such as discrimination and violence/abuse can lead to housing instability such as couch surfing, overcrowding, doubling up, and homelessness which can in turn affect health;
- Substance use can lead to evictions and homelessness either directly or indirectly through poverty and unemployment. This can either amplify existing mental and/or physical health issues or lead to other health issues;
- Physical disabilities or chronic illnesses can lead to social and economic inequities such as unemployment and poverty, which in combination with an insufficient supply of accessible, affordable housing can amplify these health issues, make their treatment and management more challenging, or lead to further health issues.

Although not depicted in the figure, housing issues are experienced within the context of multiple intersecting identities, social contexts, and life events and the interplay of these factors may create compounded disadvantage that can worsen the impact on health. For example, transgender youth who are fleeing a violent home may face multiple issues such as lack of income, barriers to employment, lack of specialized supports, lack of safe housing, and discrimination and transphobia, which in combination, can increase their likelihood of homelessness or housing-related issues and negatively impact their health.

The following section outlines international, Canadian, and local research on the three key dimensions of housing that are important for health: affordability, quality, and stability and security. Although these are treated as distinct for the purposes of this report, they are interrelated. For example, the amount a household is able or willing to pay for housing affects not only the quality of the housing but also the choice of neighbourhood. The high cost of housing relative to income can result in inability to pay the rent, which can result in housing instability. Stories shared with us by Toronto residents with lived experience provide compelling illustrations of the complex relationship between housing and health, particularly for groups who are at risk of homelessness and housing instability.



Housing Affordability

Housing is a non-negotiable expense. Some households who are able may choose to spend a large part of their income on housing that is a suitable size, better quality, and in a desirable neighbourhood. For low income households, the high cost of housing and related expenses create hardship and leave little money left over for essentials such as food and medication and personal investments such as extracurricular activities, all of which are important for health and well-being. As a result, households face dilemmas such as “pay the rent or feed the kids”, “heat or eat”, or “cool or eat.”⁴⁴ The United Way’s *Vertical Poverty* study found that close to half of the Toronto tenants interviewed reported that they worry about paying the rent each month, one-quarter reported that they do without necessities every month in order to pay rent, and another one-third reported they do without necessities some months of the year.⁴⁵

“So we kind of figured out we could not afford both gas and electricity, we had to choose one or the other. Because we use electricity for other things like lighting, we chose electricity.”

John, speaking about the difficult decision to forego using gas as a result of affordability issues.

High Shelter Cost Burdens

Despite housing affordability being a major concern, research on its connection to health is less developed, particularly in Canada.^{46,47,48} An emerging body of evidence in the United States (US) has found a link between housing affordability and poor self-rated health and reduced health care utilization and follow-up.

For example, a 2008 survey of more than 10,000 Philadelphia residents found that individuals, particularly renters, experiencing housing affordability issues were more likely than those without these issues to report fair or poor self-rated health, not seeking health care/prescription medications due to cost (i.e., health care non-adherence), and certain health conditions (i.e. hypertension and arthritis).⁴⁹ Similarly, a study of more than 11,000 renter households from the 2011 New York City Housing Vacancy Survey found that higher rent burdens (i.e., the ratio of rent to total household income) were associated with worse self-rated health and an increased likelihood to postpone health care services (i.e. dental, preventive care/checkup, mental health, treatment/diagnosis of health condition/illness, or prescription drugs) for financial reasons.⁵⁰ The study also found that the relationship was stronger for those with severe rent burdens (i.e. spending more than 50% of their income on housing). These studies provide support for the argument that unaffordable housing is associated with financial trade-offs, reduced spending on health-related expenses, and health care non-adherence.

A study of 650 households in Vancouver found that gross monthly housing expenses and housing expenses as a percentage of monthly income were significantly associated with self-reported health and mental health.⁵¹ Specifically, households with lower gross monthly housing expenses and those spending a smaller proportion of their income on housing reported better self-rated health and a lower likelihood of poor mental health.

Studies have also found that subsidized housing and rental assistance programs such as housing vouchers, which address housing affordability, can have a positive impact on health. For example, the *Affordable Housing for Families* study of 85 low income families in Metro Vancouver and the Okanagan examined changes in shelter and non-shelter outcomes after moving into social housing.⁵² The study found that most households reported more suitable, better maintained, and better quality housing as a result of the move. Families also reported less financial stress, more privacy, less crowding, and more secure tenancy. Families also reported improvements in physical and mental health (e.g. due to reduced stress) and determinants of health such as improved academic performance by their children, increased access to services and amenities, and increased community involvement. Further, families reported that many of the positive changes were directly linked to the change in their housing circumstances.

The Housing Choice Voucher Program is the US federal government's program to assist low income families, seniors, and individuals with disabilities to afford housing in the private market. A systematic review found sufficient evidence that rental voucher programs have positive impacts on determinants of health, including improving household and neighbourhood safety such as reducing exposure to personal and property crimes.⁵³ A more recent systematic review found evidence that housing vouchers improved reported physical and mental health and health service use (i.e. decreased hospitalizations, institutional stays, and emergency room visits) among both low income and homeless adult and child populations in the US.⁵⁴

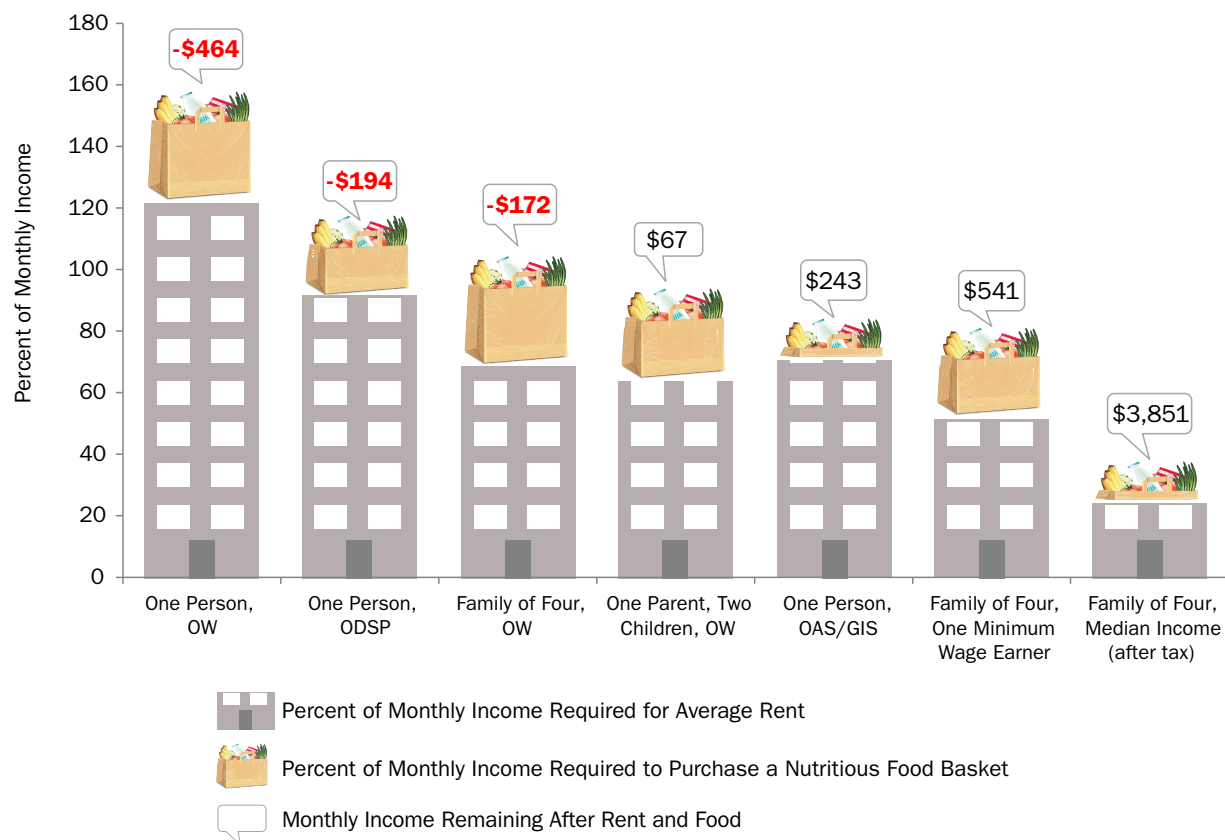
Food Insecurity

In Toronto, research has examined housing circumstances in relation to food bank usage and household food insecurity. Food insecurity is a significant public health issue in Canada that is associated with a range of poor physical and mental health outcomes and increased health care utilization and health care costs.^{55, 56} The Daily Bread's 2016 annual report on hunger in Toronto found that over half (56%) of food bank clients surveyed reported skipping meals to pay for something else, with rent being the most frequently reported reason.¹⁵ The majority of food bank clients surveyed were living in market rent housing and spending on average 71% of their income on rent and utilities.

A study of 473 families in market rental and subsidized housing in high poverty neighbourhoods in Toronto found household food insecurity increased with decreasing income and after-shelter income.⁵⁷ The study also found that families who were in rent arrears were more likely to be food insecure. While there was no difference in food insecurity between families in market rental versus subsidized housing, families on the waiting list for subsidized housing were more likely to be food insecure than those living in subsidized housing. For families in market rental, housing affordability was related to food insecurity, with families spending more than 30% of their income on rent more likely to be food insecure compared to those spending 30% or less. Further, for families in market rental, as the amount of income spent on housing increased, expenditures on food decreased.

The Nutritious Food Basket survey is a tool used by public health units across Ontario to estimate the minimum cost of a healthy diet (a 'nutritious food basket'). The income/expense scenarios in Figure 2 illustrate the cost of healthy eating in relation to other major household expenses for various household sizes, unit sizes, and levels of income. The figure depicts the percent of monthly income required to pay for average market rent and for a nutritious food basket, including the monthly income remaining (after paying these expenses) for Toronto in 2016.⁵⁸

Figure 2: Percent of Monthly Income¹ Required for Average Market Rent and for a Nutritious Food Basket, and Monthly Income Remaining, Toronto, 2016²



¹ Depending on the scenario, monthly income may include: Income from Employment, Ontario Works (OW)/Ontario Disability Support Program (ODSP) Basic Needs Allowance, OW/ODSP Maximum Shelter Allowance, Old Age Security/Guaranteed Income Supplement/Guaranteed Annual Income System (OAS/GIS/GAINS), Canada Child Tax Benefit, GST/HST Credit, Ontario Trillium Benefit, Working Income Tax Benefit, Employment Insurance paid, and/or Canada Pension Plan paid.

² See Appendix A for scenario references.

Source: Adapted from the May 2016 Nutritious Food Basket Scenarios, Toronto
Prepared by: Toronto Public Health

The scenarios illustrate that all of the households, with the exception of a family of four making median after-tax income, would have to spend more than 50% of their monthly income on market rent (ranging from 52% to 123%), which indicates severe housing need

and can put them at risk of homelessness. Many households do not even have enough income to cover market rent alone or to cover market rent and healthy food. For example, a single person on OW would have to spend 123% of their income on market rent alone and a single person on ODSP and a family of four on OW would have to spend over 100% of their income on rent and healthy food (specifically 116% and 108%, respectively). For other households, little money is left over for other basic expenses. For example, a single parent with two children on OW has \$67 left over after paying for rent and healthy food.

Energy Insecurity

The impact of household energy insecurity on health is an emerging concern given rising energy costs and the potential for more frequent episodes of extreme temperatures as a result of a changing climate. The Low-Income Energy Network of Ontario uses the term “energy poverty” to describe the disproportionate burden of electricity, natural gas and other utility costs on low income households which reduces funds for food, clothing, medicine and other necessities.⁵⁹ Energy insecurity can be the result of poverty but also the quality of the dwelling (e.g., inefficient appliances and drafts), and can result in extreme (hot and cold) home temperatures, hazardous heating alternatives, threat of utility disconnection, and utility arrears.⁶⁰ A US study found that young children living in energy-insecure^{vi} households (compared to children in energy-secure households) had a greater likelihood of food insecurity, reported fair/poor health, hospitalizations since birth, and developmental concerns.⁴⁴ A more recent evidence review examined fuel poverty^{vii} and health, including various interventions such as home heating retrofits, a home insulation program, and a winter heating subsidy for low income families.⁶¹ The review found significant adverse effects of fuel poverty on the physical health of infants, particularly on weight gain and susceptibility to illness, and the mental health of both adolescents and adults.

“So we had to heat our home through portable space heaters. There was no hot water, so we would boil our water on a portable hot plate and that’s how we do our cooking, cleaning, and bathing... The house became cold during the winter, but with the use of space heaters, only the places where we slept were kept warm.”

John, speaking about the impact of having to choose electricity over gas.

^{vi} “Energy insecurity” was defined in the study as experiencing at least one of four conditions in the past year: a threatened utility shut-off or refusal to deliver heating fuel; an actual utility shut-off or refusal to deliver heating fuel; an unheated or uncooled day because of inability to pay utility bills; or use of a cooking stove as a source of heat.

^{vii} The term “fuel poverty” is used in United Kingdom to describe the cost of heating a home in relation to household income, the cost of fuel, and the energy efficiency of a home.

Julie's story

Julie is a retired woman in her late sixties who moved to Canada 25 years ago. She lives alone in an 'affordable' seniors building, which means she pays slightly less than market rent. Julie moved into her apartment because she needed a place that was affordable and accessible as she uses a walker. Julie lives on a fixed and low income from government pensions. Before retiring, she was making a good salary. After she retired, her income dropped significantly and she started to experience severe affordability challenges, spending more than half of her pension on rent.

For Julie, her rent and health are her two biggest worries. She has a number of chronic health conditions, including diabetes, high blood pressure, and high cholesterol requiring numerous prescription medications and assistive devices. She also had surgery recently. Although she receives some assistance with the cost of her medications, paying the deductible each time adds up because of her multiple prescriptions. She has had to pay for certain modifications in her apartment. "That's everything extra, extra money, each one," she said. She's also had to forego getting a blood pressure monitor recommended by her doctor and a scooter because she was unable to pay for it. She cannot afford to buy the healthier foods that have been recommended for her health conditions.

Julie has no car and relies on Wheel Trans to get around, which is helpful but the cost adds up. "Every day \$4, \$4, \$4," she said. She has very little support around her home and has to rely on friends or people in her building to do her grocery shopping, take her to medical appointments, and help with laundry and cleaning, which is challenging given her health issues and recent surgery.

Julie loves her place but is afraid she cannot afford to live there much longer. She has been on the waiting list for an accessible subsidized unit for the past nine years. She worries that she may not live long enough to get into the housing. "Everybody say 'Oh, you supposed to wait more'. I say 'Wait for what? Cemetery?' How long I live? I don't feel well. How long? When I 80, 75?" Julie's situation is causing her major stress and anxiety and is affecting her quality of life. "That's my panic attack. Where I go? What I supposed to do?" she said in tears.

Julie feels that having some assistance to pay her rent and having someone to help her a bit around the house would be very helpful: "It'd be much better. You no have worries."

John's Story

John is a single man in his fifties who lives with his brother in their childhood home. John has received ODSP for most of his adult life due to cognitive impairments. His brother was laid off over a decade ago and hasn't been able to get another job. Despite having no mortgage, John spends more than 50% of his income on housing expenses such as property taxes, electricity, water, and garbage. After their mother passed away, his brother used all of his savings to maintain the house. John and his brother are now in a situation where they are forced to sell their home because they cannot afford the expenses or to improve the condition of their home, which is "dilapidated and crumbling." For John, the chronic poverty combined with the loss of pooled income as a result of a series of negative life events, including his parents' separation, deaths, and brother's unemployment, are the main reasons for the situation they face today.

After his father passed away, it was increasingly difficult to afford their housing. After their gas was shut off due to arrears, they had to make the difficult choice of electricity over gas. In the winter, they heated only the places where they slept and did their cooking and bathing using water they boiled on a portable hot plate. This was a stressful time, which affected their family's relationships and mental health: "We were at each other's throats. There were times we said we wanted to kill each other, either through suicide or basically one attacking the other." For John, "no matter how hard we worked, we were not getting anywhere, no matter how much effort we put into our work, we were not getting anywhere, we were going backwards and backwards."

Their current situation is causing conflict and emotional stress because his brother wants to sell but John wants to stay. "I stayed in the house and the neighborhood since I was two years old...That was my home, it's not just the house, it was home with a capital H-O-M-E. That was my home. That was everything. So very sentimentally, very emotionally attached," he said.

For John, everything comes down to having enough income. He can't afford a telephone, has to rely on drop-ins for meals, and his health and social life have deteriorated. His brother and he are now "full of hate" and have lost hope at the prospect of improving their situation. "You're trying to push away all those obstacles, you spend all your energy...doing that and you have nothing left over. And that's why people have suicidal thoughts, because eventually they say 'It's all too much and I don't see anything'." If he had enough income he would "be able to afford food, there would be more happiness, less stress, more calmness...There would be more income to save, and invest." John said it would be "10,000% different."

John fears the only place he will be able to afford when they sell the house will be "in shambles, will be filled with pests and the fellow tenants will be violent" as he has heard these experiences from visiting the drop-in centres. For John, his greatest fear is that he will end up homeless.



Housing and Neighbourhood Quality

When housing costs are high, incomes are inadequate, or affordable housing is in limited supply, the housing and neighbourhood choices available to individuals are limited. As a result, people may end up living in poorer quality housing, exposing them to factors that are associated with poor health, or neighbourhoods with less access to factors important for health (e.g., safety, social cohesion, green space, access to employment and education, and access to services).

Housing Conditions

There is strong and well-established evidence that various biological, chemical, and physical exposures in the home have adverse health effects.^{47,48} A comprehensive review of existing research on housing and health⁴⁸ found the strongest evidence of health effects for the following physical/chemical exposures: lead, which is harmful to the brain, nervous system, blood system, and kidneys; asbestos, which can cause various cancers; and radon, which can cause lung cancer. The review also found strong evidence supporting a causal relationship between allergens, specifically dust mites and cockroaches, and asthma.⁴⁸ In addition, the review found strong evidence of the health effects of physical characteristics of the home related to: home safety/stairways, which are associated with falls and injuries; smoke detectors, which can prevent burns and smoke inhalation; heating systems, which can cause burns, smoke inhalation, and carbon monoxide poisoning; second-hand smoke, which can cause or exacerbate respiratory conditions, including lung cancer; and cold and heat, which can cause or be associated with heat stroke, respiratory infections, cardiac events, and mortality.⁴⁸ A more recent systematic review found strong evidence that home dampness and mould significantly increase the risk of developing asthma.⁶²

The *Poverty by Postal Code 2* report by the United Way documents the “vertical concentration of poverty” whereby close to half of Toronto’s low income families are housed in aging privately owned high-rise buildings. The report also highlighted the insufficient supply of affordable housing and poor housing conditions such as infestation, disrepair, and safety concerns of Toronto residents living in these high rise-buildings in areas of high poverty.⁴⁵ Approximately 80% of tenants were unable to control the temperature in their unit, and 50% reported that their unit was sometimes or always too hot in the summer. Tenants were forced to break window locks to let air into their apartment creating an unsafe environment for children. Other factors identified that had potential negative health impacts were the frequent occurrence of mould or mildew, excess cold, dampness or heat, and pests such as cockroaches and bed bugs and vermin in the building, reported by 50% of the tenants.

A Toronto study of 295 adult rooming house residents in 1998 found that the physical attractiveness of the rooming house (based on interview ratings of building, noise levels, odours, and cleanliness) was significantly associated with eight of ten health measures (overall physical health, general health perceptions, physical functioning, bodily pain, physical and emotional role functioning, energy and vitality, and mental health).⁶³ Rooming house residents suffered from a higher prevalence of 10 of 13 chronic conditions compared to the general Canadian population and a higher prevalence of 6 of 13 chronic conditions compared to the Canadian low income population, suggesting that their worse health could not be attributed solely to the lower income of rooming house residents. Given the cross-

sectional design of the study, it was not possible to determine whether rooming house conditions had a direct effect on residents' health or whether people with poor health (who often have lower incomes) tend to live in rooming houses because they are an affordable housing option.

Housing quality is particularly important for families with children, as children are at greater risk than adults because of differences in their proportion, physiology, behaviour, and developmental stage.⁶⁴ Poor housing quality has been linked with emotional and behavioural problems in children and youth. An analysis of a longitudinal sample of 2,437 low income children and adolescents from low income urban US neighbourhoods found that poor housing quality (relative to housing stability, type, and cost) was the most consistent and strongest predictor of emotional and behavioural problems in low-income children and youth.⁶⁵ Children exposed to homes with leaking roofs, broken windows, rodents, non-functioning heaters or stoves, or peeling paint or exposed wiring, or unsafe or unclean environments experienced greater emotional and behavioural problems than children in higher quality homes. The study also found that when children's housing problems increased over time, their emotional behavioural problems also increased. Housing quality was also related to school performance for older children, with adolescents in poorer quality homes showing lower reading and math skills in standardized achievement tests.

A qualitative study by Toronto Public Health in 2010 on the impact of poverty on parenting in Toronto found that inadequate housing conditions increased children's risk of injuries due to disrepair. Pests reduced opportunities for children's floor play and broken or no elevators limited opportunities for outings, which are important for healthy child development.⁶⁶

There is strong evidence that improvements to housing conditions improve health, particularly interventions targeted to people with poor health and people living in inadequate housing conditions, especially inadequate warmth.⁶⁷ A systematic review of housing improvements for health found that improvements in energy efficiency and provision of affordable warmth may allow households to heat more rooms in the house, thereby increasing the amount of usable space in the home. This may increase privacy and reduce stressful relationships in the home. The authors of this review concluded that housing which promotes health should be an appropriate size to meet household needs and affordable to maintain a comfortable indoor temperature.⁶⁷

A systematic review of green building interventions that incorporate health and environmental quality goals found evidence of reductions in health risks and improvements in health.⁶⁸ The studies that examined these interventions in public housing buildings found improvements in resident reports of health and well-being, asthma and allergy symptoms, and respiratory symptoms. It also found a reduction in cockroach and mouse allergens and an improvement in air quality and ventilation. A recent study found that low income housing residents who live in "green" buildings had fewer "sick building" symptoms than residents of traditionally constructed low income housing.⁶⁹ Asthma outcomes involving hospitalizations, asthma attacks, and missed school days were also significantly lower for children living in the green buildings.

A recent report commissioned by TCHC analyzed the economic, social, health, and energy/environmental impacts of investing in (or not investing in) TCHC's \$2.6 billion 10-year capital repair plan.⁷⁰ The study predicted that without investment by all three levels of government, by 2030, TCHC can expect over 90% of its units to be in poor or critical condition or forced to close for being in an unsafe state of repair. This would lead to a predicted 1.1 million additional health care visits and \$1.55 billion in health care costs over the next thirty years. Conversely, full investment in capital repairs was predicted to reduce health care system use by 2.1 million visits and health care costs by \$3.8 billion.

Neighbourhood Conditions

Opportunities and constraints presented in communities with different social and economic conditions can shape the educational attainment, employment prospects, and income level of individuals, which in turn, can influence health.⁷¹ Features of the physical, service, and social neighbourhood, over and above the individual socio-economic characteristics of residents, can also play a role in shaping health.^{72,73}

Social, economic, and physical features of neighbourhoods have been linked with mortality, self-rated health, disability, chronic conditions and their risk factors, mental health, injuries, and violence.⁷¹ There is evidence that neighbourhoods with high poverty, inadequate and unaffordable housing, and lack of public and private goods and services are associated with poor quality of life and negative short and long-term health consequences. A Canadian study found that residents of Toronto neighbourhoods with higher-than-average median income and greater proportion of postsecondary graduates are more likely to report better health than residents of less affluent neighbourhoods.⁷⁴

The level of violence, safety, and social cohesiveness of a neighbourhood can influence health and well-being in numerous ways. Unsafe neighbourhoods as a result of high crime and/or hazardous conditions can affect health directly through bodily harm and injuries. Concerns about violence and crime in communities can affect health by increasing stress, limiting movement and social interaction, preventing the health-promoting practice of walking, cycling, playing in parks, and access to services essential for health.⁷⁵ A report by the United Way documented the geographic concentration of poverty in high-rise buildings in high poverty neighbourhoods of Toronto.⁴⁵ The report

"It stresses me out. Like a lot of people in this area, they drink all day and they're known for doing drugs. And they harass me every time I go out, especially when I'm with my son ... He can walk perfectly fine by himself, but I don't want him walking in this area ... And so that makes me have really bad anxiety and it just makes me uncomfortable. There's always like people fighting outside. There's been shootings in the area, and just like ... great place for a kid to grow up."

Ashley, speaking about how neighbourhood conditions impact her and her son.

notes that the concentration of poverty in these areas makes it increasingly difficult for individuals to escape poverty, threatens social and community cohesion, and can lead to a cycle of neighbourhood deterioration and disinvestment.

Interventions aimed at addressing area characteristics either by relocating people from high to low poverty areas or through revitalization have the potential to improve health and its determinants.⁷⁶ Overall, the evidence from a number of systematic reviews suggests that relocation interventions are associated with improved mental health, reduced obesity, and impact positively on broader determinants of health.⁷⁶ An expert panel review of healthy housing intervention research found that these interventions are promising, however they need additional field testing, particularly their impact on specific subgroups such as adolescent boys.⁷⁷ Another systematic review examining area-based urban regeneration/revitalization interventions in the United Kingdom found small positive health impacts of revitalization interventions, but noted that adverse impacts can also result from these interventions.⁷⁸

The Toronto Social Housing and Health Study interviewed residents of Toronto's Regent Park before and one year after revitalization efforts. The study found improvements in resident perceptions of their home, neighbourhood, and community as well as feeling less distressed.⁷⁹ There were no changes for a number of health measures (e.g., self-rated health, depression, anxiety) and an increase in reports of physician-diagnosed heart disease and high blood pressure. The researchers concluded that this increase may be related to age, better access to medical care after moving into their new unit, or that residents were simply diagnosed with conditions they had previously.

Ashley's Story

Ashley is a 19 year old, single mother of a toddler who lives in subsidized housing. She used to live with her mom but left because her grandparents were abusive and “the place was like a shack...it was really bad living conditions.” Ashley has moved at least sixteen times in the past five years, mostly staying with friends. She stayed in a shelter but hated being there.

Ashley was able to get on the priority list for subsidized housing for victims of abuse. She was pregnant at the time. She chose her place because she knew the area and it was close to friends, grocery stores, child care, school, and her hospital. Ashley describes her place as “better and safer” than the last and she feels her mental health has improved now that she is living on her own away from the abuse. “When I was younger, especially when I was living at my parents, I was really depressed and I tried to kill myself. I didn’t want to live there ... I just wanted to die whenever I was there.” Ashley finds subsidized housing and ODSP to be helpful because she doesn’t have to worry about affording rent, especially since she is unable to work. When she was on OW, she often had to choose between paying her rent and spending money on other things. “So it was like should I even bother paying my rent and just like wait an extra few days until I can ask someone for money? That way I can buy something.”

Ashley has had a number of issues with disrepair, black mould, and pest infestations in her place. She reported them to the management but said they don’t take her seriously due to her age or are slow in responding. When she first moved in, she didn’t have a fridge for over a week and her stove was broken and would catch fire. There was a hole under her sink which allowed cockroaches to enter from neighbouring units. Her place also became infested with bed bugs after doing laundry in the building. She stayed with her mom because she didn’t want her son to be bitten by bed bugs. Ashley had to spend a lot of money to purchase the spray and powder, new mattresses, box springs, and bedbug covers, and launder clothes and clean the couch. This was challenging living on social assistance. She had to wash her son’s toys multiple times because she was concerned he would ingest the chemicals.

Ashley describes where she lives as a “bad neighbourhood” and has concerns about her son’s safety. She also avoids going out with her son or letting him walk in the area, often grocery shopping while he is at day care or travelling long distances to take him to parks in neighbourhoods she feels safer. If she had a choice, Ashley would move to a “nicer neighbourhood but like with all the conveniences of having everything downtown” but the cost of housing and lack of choice in social housing prevents her from moving. She feels this would have a positive impact on her mental health and well-being as she wouldn’t have to worry about her son as much: “I’d be less stressed. I think I’d have less anxiety.”



Housing Stability and Security

Housing that is unaffordable, poor quality, insecure, or unsuitable can threaten housing stability and lead to overcrowding, frequent moves, eviction, and homelessness, which can be detrimental for health. Violence and abuse in the home, mental health and/or substance use issues can also impact on housing stability and ultimately lead to homelessness. Research has found that stable housing along with other supports can have positive impacts for particular groups such as people with mental health and/or substance use issues^{38, 80} and people with chronic health conditions such as HIV.^{40, 41}

Housing Tenure

Housing tenure, particularly home ownership, may have benefits for health because it gives people a sense of security, stability, and control over their living environment. In the United Kingdom, housing tenure has been consistently found to be associated with various measures of health including longevity, with people in owner occupied dwellings living longer and healthier than those who live in the public rental sector.⁸¹

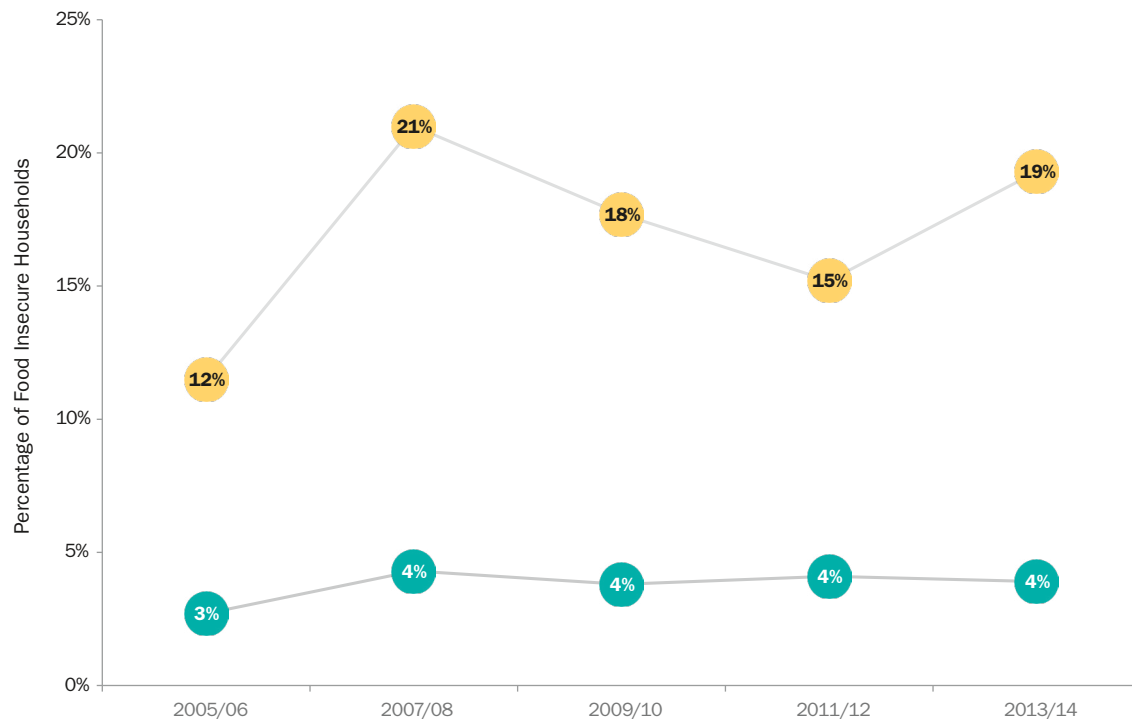
A Canadian survey of families who purchased a home through *Habitat for Humanity* found that over three-quarters (78%) of homebuyers reported their health as 'better now' than in their previous housing. Over 70% of the homebuyers reported improvements on a range of indicators such as reduced colds and flu, allergies, asthma symptoms and stress. Almost one third reported less frequent visits to the doctor, and about one-quarter reported fewer days of work missed due to illness. Homebuyers also reported improvements in their children's well-being and school performance and increased participation in activities outside school. Homebuyers also reported improvements in housing-related dimensions that are important for health such as better housing quality, less overcrowding, and increased stability and security. The study was not able to ascertain which aspects of the new homes (e.g., security of tenure or quality of dwelling and neighbourhood) may be related to reports of improved health.

In Toronto housing tenure is significantly associated with food insecurity, with renters being 4 to 5 times more likely than home owners to experience household food insecurity (Figure 3). This trend has remained relatively consistent over the past 10 years.

"I wouldn't have met the people that I met. I wouldn't have dropped out of school. I wouldn't have, like, done half of the things that I did. I would have been self-sufficient and I would ...not have to worry and not have to live with friends, not have to do certain things, like, I'd pretty much just be okay."

Marie, speaking about what her life would have been like if she was in stable housing and had access to supports.

Figure 3: Household Food Insecurity by Housing Tenure, Toronto, 2005-2014



Source: Canadian Community Health Survey, Cycles 2005/06, 2007/08, 2009/10, 2011/12, and 2013/14
Prepared by: Toronto Public Health

It is thought that housing tenure is related to health because it is a marker for socioeconomic status, such as income, which is a powerful predictor of health. Home owners tend to have higher incomes and people with higher incomes tend to have better health, which is the case in Toronto. However, some studies have found a link between housing tenure and health even after controlling for income, suggesting that there may be features of housing tenure such as a sense of security, stability or control, or the quality of the dwelling and/or neighbourhood that impact health.⁸² Dunn refers to the sense of security, stability, and control which may have important health benefits as the 'meaningful dimensions' of the 'home'.⁸³ The absence of a sense of control and stability may result in emotional and physiological stress which can negatively affect health.

"Nowhere else for me is home, that is my home ... When I identify myself I identify myself with my address that I've lived in since I was two years old ... I'll always feel stranger in another place, always. To the last breath I take, I'll always feel that is my home and it's being taken away from me. I can't do anything about it."

John speaking about being forced to sell his childhood home due to poverty.

A Canadian study examined the link between housing tenure and psychological distress.⁸⁴ The study found a gradient between housing tenure and psychological distress, with decreasing levels of distress as one moves from renter, to homeowner with a mortgage, to homeowner without a mortgage. This relationship could not be explained by differences in demographic and socioeconomic factors (such as income) or stress, suggesting the home ownership may have a protective effect against stress. Due to the cross-sectional nature of the study, it was not possible to assess the causal direction of the housing tenure and mental health relationship.

While the health status of homeowners tends to be better than that of renters, the financial and emotional strain of high debt-to-income ratios, mortgage defaults, and foreclosures could potentially undermine the benefits of homeownership. Higher debt loads may increase stress, decrease investment in health promoting items like food and medications, create further stress from increased workloads in an attempt to alleviate debt, or lead to unhealthy coping mechanisms such as alcohol or substance misuse. In addition, the stress that results may exacerbate existing physical and/or mental health issues.⁸⁵ An emerging body of research, prompted by the mortgage default and home foreclosure crisis in the US, has examined the impacts of home ownership on health. A systematic review of various sources of household indebtedness found that mortgage debt was associated with poorer mental and physical health, including depression and generalized anxiety.⁸⁵ A more recent review on the health impacts of foreclosures found that experiencing a foreclosure and living near foreclosures were related to poor psychological and behavioural morbidities, particularly anxiety and violent behaviour, and declining health care utilization.⁸⁶

This evidence is important in light of concerns in Canada about the overheated housing market and high mortgage-debt-to-income ratios. A recent report by the Canadian Centre for Policy Alternatives, *The Young and the Leveraged* (2015), identified the significant financial impacts (i.e., decreases in net worth, owing more than they own) of a housing market correction, particularly for young families.⁸⁷ The evidence in the US suggests that there may be health impacts in addition to the financial impacts for homeowners of high mortgage debt-to-income ratios.

Overcrowding

When housing is not affordable, families may be forced to live in unsuitable and overcrowded living conditions. They may rent smaller but cheaper apartments, use the living and dining rooms as bedrooms, or share bedrooms with their children. They may have no other choice but to 'double up' with other family members or friends to share the cost of rent or 'couch surf' to avoid homelessness which can result in crowded living conditions.

Overcrowding, according to the CMHC, is defined as housing which does not meet the National Occupancy Standards. These standards require one bedroom for each person in the household, unless they are an adult couple, two children of the same gender under 18 years old, or two opposite-gender children under 5 years old. In 2010, 13.8% of Toronto households were living in overcrowded conditions, which is higher than the Ontario proportion of 7.2%.⁸⁸ Renters were 2.5 times more likely than owners to live in overcrowded conditions (20.5% versus 8.2%). As demonstrated in the United Way's *Vertical Poverty* report, overcrowding in the high-rise rental stock in Toronto doubled from 8% to 17% between 1981 and 2006.⁴⁵

"I feel he will not be independent. It will affect his self-confidence, self-esteem. Because, the principal and the teacher ask me to keep him separate, but I have no choice."

Bindu worries about the impact on her 8 year old son of having to share a bedroom with her.

Overcrowding is a particular issue for low income families with children. An analysis of a subsample from the United Way's *Vertical Poverty* survey found that half of the low income families with children in the inner-suburban neighbourhoods and downtown neighbourhood of Parkdale, Toronto were living in overcrowded conditions.⁸⁹ A study by Toronto Public Health (2011) found that small spaces and crowded living conditions limit children's opportunity for play and exploration and contributed to insufficient sleep, which is important for healthy growth and development.⁶⁶

Early public health interventions in the 19th century recognized the link between overcrowding and the spread of infectious diseases such as tuberculosis. More recent research has found possible relationships between overcrowding and a range of health outcomes in children and adults such as psychological distress, general physical health, mortality, haemophilus influenza type b infection, tuberculosis, helicobacter pylori infection, hepatitis B infection, type 1 diabetes mellitus, meningitis, and respiratory conditions.^{48,90} There is also emerging evidence of a link between overcrowding and children's mental health.⁹⁰

Living in close proximity, congregate, poorly ventilated and closed conditions in shelters, rooming houses, and institutional settings increases the risk of transmission and outbreaks of communicable diseases such as tuberculosis and group A streptococcus. Individuals in these settings are often highly vulnerable, with mental and/or physical health comorbidities which can increase their susceptibility to infection and related complications.

A review of the evidence on housing interventions that improve health found sufficient evidence of the positive impacts of rental vouchers.⁷⁷ In particular, voucher holders were less likely to suffer from homelessness, overcrowding, and malnutrition due to food insecurity than non-voucher holders. Further, voucher holders were less likely than public housing residents to reside in high-poverty neighbourhoods.

Residential Mobility

People may choose to move in order to improve their circumstances. For example, families with children may move in search of housing that is of a suitable size, good quality, and in a good neighbourhood with access to schools, child care, grocery stores, and recreational facilities. Low income households may have no other choice but to move frequently or may be forcibly relocated (e.g., evicted) as a result of economic and social circumstances. Residential mobility and forced relocations such as evictions have a major impact on families, particularly on the health of children. It may lead to further instability and homelessness, ‘doubling up’ with others, and/or accepting worse living conditions and neighbourhoods.

“There was a point where I would, like, lay down and, like, I would have my hip bones, like, sticking right out, just because I was so stressed out about everything that was going on.”

Marie, speaking about the weight loss she experienced from the stress of her chronic housing instability.

Adequate, safe, stable, and affordable housing is linked to positive child health and development outcomes. Instability can affect children through negative parenting, poor parental health and well-being, lower quality home environments, and a lack of emotional and material resources for healthy development.⁹¹ A systematic review found strong evidence of a link between residential mobility and behavioural and emotional problems in school age children and increased behavioural disturbance, poorer emotional adjustment, increased teenage pregnancy rates, earlier illicit drug use, drug related problems and teenage depression in school age and adolescents.⁹¹

Similarly, an analysis of a longitudinal sample of 2,437 low income children and adolescents from urban US neighborhoods, found that residential instability was associated with children’s emotional, behavioural, and cognitive functioning.⁶⁵ While children experiencing a single move showed decreases in emotional and behavioural problems and improvements in reading skills, multiple moves over time resulted in greater emotional and behavioural problems. The authors suggest that single moves may involve a chance to improve one’s housing context, to access more affordable housing, or to move from relationship/family issues, which can enhance children’s well-being. However, chronic residential instability involving frequent moves is disruptive for children and families.

“It’s hard not knowing where you’re going to go next or if you’re going to be kicked out onto the street. Kind of living like that, living in fear is not really something you should experience as a kid.”

Bindu’s daughter, 15, speaking about her fear of not knowing where they will live next.

Bindu's Story

Bindu is a single mother in her early forties who works in a part-time, low-wage job. She lives with her three young children in a two-bedroom basement apartment of a house. Bindu has always lived in private market housing since she moved to Canada sixteen years ago. She used to live in a house with her husband but separated because of violence and abuse. Her husband sold the house to repay debts. "Suddenly we lost everything," she said. Bindu didn't tell her caseworker about the abuse because she feared her husband would find out and retaliate. She didn't go to a shelter because her caseworker helped her find housing and the first and last month rent.

Bindu has experienced chronic housing instability, living in six different places in the past five years. She has been on the waiting list for social housing for two years. Bindu struggles to find a place to live as there is always some problem like cockroaches, disrepair, or neighbouring tenants. She always feels at risk and uncertain about what will happen next. "It's quite painful," she said in tears. Her first place was a one-bedroom apartment she shared with her mother and children. Bindu and her mother slept in the living area, separating the dining and living room with a curtain. In her next apartment, her electricity was cut for 4 weeks and she was eventually evicted because she could not afford to pay for utilities.

Bindu has made a lot of sacrifices to pay her rent. She would always pay her rent first and save the rest of the money for food. Most times she had to rely on food banks. She had to skip a lot of school trips and extras like shoes and clothes.

Although her current place is better, it is far from stable or secure. Bindu spends close to 50% of her income on her rent and utilities. She is also uncertain how long her family will be able to live here because the homeowner has plans to move back in. She hasn't even unpacked their suitcases and boxes from the last move. For Bindu's family, the chronic instability and uncertainty of where they will live has had the greatest effect on them. She experienced isolation from her cultural community and loss of her social support network as a result of frequent moves. She feels the instability has negatively affected her children's self-confidence, self-esteem, and trust in her, their performance in school, and has disrupted their routines such as going to the library and gym. Bindu worries about the impact on her children's future. When she asks her children what they will do in the future they say "What are you talking about Mom? There is no future. I don't know if we can live tomorrow even."

All Bindu and her family want is to live in one place. Her young daughter shared: "If I never have to move again and I just have to move again to this one house ... then I would be completely fine. As long as there is enough bedrooms and enough space. For me it is mainly just one place. One place. I'd be fine with that."

Evictions

When people struggle to pay their rent and/or utility bills or are in arrears, they risk having their utilities disconnected or, worse, being evicted. Eviction often leads to homelessness and high rates of residential mobility and subsequent moves, which can have consequences for health.⁹² In the 2007 Toronto Street Health report, eviction or conflict with a landlord was the third most frequently cited reason for becoming homeless.²¹ An analysis of the United Way's *Vertical Poverty* data study found that almost one quarter of the low income families living in inner-suburban neighbourhoods and the downtown neighbourhood of Parkdale in Toronto were at risk of eviction due to rental arrears, causing these families to live in fear.⁸⁹ Further, in the study's focus groups, service providers reported that a history of eviction, especially in a competitive rental market, can make it almost impossible for families to find new housing.

The negative health impacts of eviction is an emerging area of research. An analysis of a subsample of low income urban mothers from a large US longitudinal survey found that eviction had negative effects on mothers' health.⁹³ Specifically, mothers who were evicted in the past year (compared to those who were not evicted) experienced greater material hardship (measured by the degree to which they are able to obtain basic necessities such as food, medicine, and clothing), were more likely to suffer from depression, reported greater parenting stress, and reported worse health for themselves and their children. Further, at least two years after being evicted, mothers still experienced higher rates of depression and material hardship than their peers.

"You asked me how it makes me feel. Not happy. Depressed, always. You have to worry about being sent to the Tenant Board all the time."

Renel said the constant threat of eviction is the cause of his depression and post-traumatic stress disorder.

"The last time ...when they asked me to evict... I was fed up and ... I tried to kill myself, honestly. I was fed up with moving ..."

Bindu, speaking about the impact of chronic housing instability and eviction on her mental health.

Renel's Story

Renel is a young man who has lived alone for the past three years in subsidized housing. The manager of his building has been “threatening and intimidating” and constantly trying to evict him, which is significantly impacting his mental health. He is currently on OW because he is unable to work.

He has been to the Landlord and Tenant Board about five times already. He doesn't understand why the manager is targeting him as he is “not a troublesome person.” He thinks it is because his mom took them to the Landlord and Tenant Board for unresolved repair and maintenance issues. He also questions if it is discrimination because he is Métis and bisexual. “... Some people say [manager] doesn't like Native people. I don't know how true that is. I mean, I'm not full Native. As you can see, I'm Black as well.” He knew as soon as he moved in he would be a target. “...When I first moved in, they said ‘good luck.’”

Renel describes where he lives as a jail. “You have lockdown and there's cameras everywhere ... not in your units, but in the hall ... But, everything you do they're always watching it.” He has even covered his peep hole with duct tape because cameras point at his door. Renel feels powerless. He and other tenants tried to form a tenant association but it never materialized because they were scared of being targeted and evicted. “I mean, I have no power. That's how I feel, I have no power.”

Renel was recently diagnosed with depression and post-traumatic stress disorder. He never had these issues before and attributes them to his current situation. “It's really hard,” he said in tears. “It's just the stress. They just constantly try and try and try to get to me all the time.”

If he had the choice, Renel would like to live downtown as he would feel safer and more comfortable. “... It's nice, go for walks on the beach, buying fruits and stuff.” He feels that people in his neighbourhood are not accepting of his sexuality and he has been the target of homophobic comments. Renel's medical transfer to another subsidized building was recently accepted. He hopes he will move to a better place so he can get back to his previous lifestyle where he was working, eating healthy, and feeling better.

Homelessness

Although homelessness is an extreme form of housing instability, the line between the two is very fluid²⁸ and the health issues experienced are similar. A longitudinal study tracking the health and housing status of 1,200 vulnerably housed and homeless adults in Vancouver, Toronto, and Ottawa found that people who are vulnerably housed (i.e., having a place but moved twice or homeless in past year) face the same severe health problems as people who are homeless (i.e., living in a shelter, street, or place unfit for habitation).⁹⁴

Compared to the general population, homeless people are at increased risk of death and suffer from a wide range of health problems including mental illness and substance use. The 2007 Toronto Street Health report found that homeless people in Toronto were much more likely than the general population to have hepatitis C, epilepsy, heart disease, cancer, asthma, arthritis, rheumatism, and diabetes.²¹ Three quarters of homeless people surveyed had at least one chronic physical health condition, more than half reported extreme fatigue, and one in seven reported living usually in severe pain. They also reported high rates of mental health symptoms, suicidal ideation, and attempted suicide. The most common mental health issues reported were depression and anxiety. Assault and violence, social isolation and lack of social supports, and barriers to accessing health care including discrimination, which can have negative impacts on health, were also prevalent among the homeless respondents. A study of 1169 homeless individuals in Toronto found that one in six homeless people surveyed had an unmet health care need (i.e. being unable to see a doctor or nurse in the past year despite need).⁹⁵ Those who were younger, had been a victim of physical assault in the past year, and had worse mental and physical health were more likely to have unmet health care needs. For transgender people, homelessness and housing instability can also present barriers to gender transition-related health care.

The relationship between homelessness and health involves a complex interplay of a number of factors. The living conditions of homeless people can directly impact their health. Homeless people spend most of the day outside exposed to dampness, cold, extreme heat and pollution which can increase their risk of for arthritis, pneumonia, allergies and asthma.²¹ Long periods of walking and standing can result in prolonged exposure of the feet to moisture and cold, which can lead to cellulitis, venous stasis and fungal infections,

“Sometimes I think there’s no one there ... that’s where the homelessness is really the worst.”

Brother Nicholas, speaking about the social isolation and loneliness of homelessness.

“Being on hormones made me stable ... it made my mental health so much better. It was not a good experience having someone say you can’t be on hormones because of where you are living.”

Quill, speaking about how his homelessness and housing instability were barriers to him accessing hormones for his transition.

which are common among the homeless population.⁹⁶ Living in close proximity in shelters combined with underlying co-morbidities in homeless persons can result in exposure to communicable diseases such as tuberculosis and can lead to outbreaks. Homeless people also suffer from food insecurity, which may contribute to, or make worse, conditions such as diabetes and stomach ulcers.²¹ Many of the risk factors for homelessness, such as poverty and substance use, are also risk factors for poor health.⁹⁶ Health issues such as mental illness and substance use issues can lead to and be worsened by homelessness.

Housing First approaches have been found to be an effective approach for helping homeless people become stably housed. This approach involves providing people experiencing homelessness with access to permanent housing with client-centred treatment and support services without requiring treatment or demonstration of sobriety. The results from the Toronto site of the At Home/Chez Soi demonstration project showed that participants receiving Housing First with supports experienced improvements in housing stability, more consistent quality of housing, more rapid reduction in health care and justice system use, and reduction in costly services compared with participants receiving treatment as usual.⁹⁷ The success of Housing First approaches depends on an adequate supply of safe, secure, quality affordable housing as well as supports.²⁸

Homelessness experienced during early childhood is harmful to children's growth and development. The stress of homelessness during early childhood can lead to potentially permanent damaging changes in brain and body function, in turn causing higher levels of stress-related chronic diseases in later life.²⁷ Recent research in the US illustrates that there is no safe level of homelessness for children.²⁷ Specifically, a study of over 20,000 caregivers of low income children in five US cities found that children who experienced homelessness in either the pre- or post-natal period had an increased risk of being hospitalized, having fair or poor health, and developmental delays compared to children who were never homeless. Moreover, children who experienced homelessness in both periods had the highest risk of poor health compared to children who were never homeless or children who had experienced it during only one of these periods. The research also found that young children (especially infants) who experienced homelessness for greater than six months were at a significantly greater risk of developmental delays, fair or poor health, and hospitalizations compared to children who were never homeless or only homeless for less than six months. The research suggests that the earlier and longer a child experiences homelessness, the greater the cumulative impact of negative health outcomes. Interventions that focus on preventing child and family homelessness in the prenatal period such as rapid re-housing with intensive case management have been shown to be effective in the US.²⁷

Julio's Story

Julio is a Siksika First Nations man in his early thirties who has been living on and off the streets for twenty years. He ended up on the streets after his “super conservative” adoptive parents kicked him out when he was 14 years old for being “a dumbass” and “smoking weed.” “But the weird thing is I finally found out I had grand mal epilepsy ... when I started smoking weed at that age, I stopped having seizures,” he said.

Julio describes himself as “houseless not homeless.” Sometimes he will be housed (usually when he is working) but will get evicted and return to the streets. He attributes this to his fetal alcohol spectrum disorder. “I don’t exactly play by all the rules and then landlords get mad at me. That’s why I always end up back homeless and I always start drinking.”

For Julio, having a job helps him with his alcohol issues. “You just sit there and you just work, work. You sweat it out.” He has tried to get into detox for his alcohol issues but couldn’t afford a cell phone or cell phone minutes to continually check in. He has also been kicked out or prevented from entering some shelters across Canada because of drinking.

With the money he receives from social assistance and panhandling all Julio can afford to live in is a rooming house. “... Give me only like four something for a place, like I swear to God, it’s probably like one quarter of the size of this room, shared bathrooms, shared kitchen... and I’m paying like \$500 or \$400 ... a month. That’s not cool.” Julio would rather sleep on the streets than stay in shelters or rooming houses due to issues with bed bugs, body lice, inability to sleep from the noise, and tenants with mental health issues. Becoming infested with bed bugs and body lice means having to throw away all of his things and spend money on new clothes and a sleeping blanket.

Brother Nicholas's Story

Brother Nicholas is a single man in his late fifties. He describes himself as “homeless in my heart” since he was a child. He used to stay in motel rooms and hostels and lived in a rooming house for twenty years. In the last few years he has been travelling back and forth a few times a week between his father's house and Toronto. Not being forced to stay in one place helps Nicholas to heal from the torment he experiences from being abused by his parents as a child.

When Nicholas comes to Toronto, he sleeps in his van. In the winter he uses a heating blanket to stay warm. He hates staying in shelters because of the fighting, people drinking, staff who are not always trained to help people with mental illness, and noise, which prevents him from sleeping.

Nicholas has challenges affording food, gas, clothing, and housing with the money he receives from ODSP and panhandling. He spends most of the money on cannabis, which he finds helpful for managing his anxiety, schizophrenia, and back pain. “The government gives me enough to pay my little bit ... I'm broke two, three days in the beginning of the month, I'm broke after paying my bills. It's been like for 18, 20 years. You know so they're not about to help me.” He often visits drop-in centres for food, clothing, and books, but goes mostly “for the people, more... to bond with people.”

If he could afford it, Nicholas would like to be living in a condo in a high rise building in a clean environment. “You know a place to go home to ... Everybody wants a place, that's why we're all here begging for you know.”

Conclusion

Housing is an important social determinant of health. Housing is more than just shelter and includes the social and psychological aspects of the home, the physical structure, its design and characteristics; the immediate physical area around the building; and the social characteristics and range of services in a neighbourhood.⁴⁷ Housing is also a health equity issue. Certain groups are more likely to experience social and economic inequities such as poverty, precarious employment, discrimination, and violence/abuse which puts them at a greater risk of experiencing homelessness and housing instability and their inequitable health impacts.

Research and lived experience demonstrate the significant impact of the affordability, quality, and stability of housing on health and well-being. Spending an exceeding amount of income on housing and housing-related expenses limits investments in, and forces trade-offs between, essentials such as food, utilities, prescriptions, and recreational opportunities, which are important for health. Biological, chemical, and physical exposures in the home have adverse health effects and improvements to housing conditions can lead to reductions in health risks and improvements in health, particularly when they are targeted to people with poor health and living in inadequate living conditions. Social, economic, and physical features of the neighbourhood have been linked with health outcomes. Unsafe neighbourhoods can affect health directly through harm and injuries and concerns about violence and crime in communities can affect health by increasing stress, limiting movement and social interaction, preventing the health-promoting practices of walking, cycling, playing in parks, and access to services essential for health. Housing that is unaffordable, insecure, inadequate, and inappropriate can threaten housing stability, leading to evictions, frequent moves, overcrowding, and homelessness, which can have detrimental consequences for child and adult health. Stable and permanent housing with appropriate supports can have positive impacts for homeless people, people with substance use and/or mental health issues, and people with chronic health issues.

The increasing unaffordability of housing in Toronto is a significant public health concern in light of the international, Canadian, and local evidence. Given that the federal government is in the process of developing a National Housing Strategy and housing is a key priority for all three levels of government, it is an opportune time to consider health and health equity as explicit goals in housing policy and program development. Further, given the paramount role of social and economic inequities in shaping the affordability, quality, and stability of people's living environment, addressing housing issues requires addressing the upstream causes of housing inequities and homelessness in the area of affordable housing policy and related public policy areas such as income security, employment, and health care.

To promote the health of Torontonians and reduce health inequities, new policies and program interventions are needed that: increase the supply and support the repair and maintenance of affordable, supportive, and accessible housing; provide adequate income, financial assistance and employment so people are not forced to make difficult choices between their rent, food, utilities and other basic elements of a healthy life; tackle discrimination within the housing system; and prevent homelessness in the early years (during pregnancy, childhood, and adolescence) through investments in mental health promotion and violence prevention.

Appendix A

2016 Nutritious Food Basket Scenario References:

- Scenario 1: 1 adult (male age 31-50); on Ontario Works; bachelor apartment
- Scenario 2: 1 adult (male age 31-50); on Ontario Disability Support Program; 1 bedroom apartment
- Scenario 3: 2 adults (male and female ages 31-50), 2 children (girl age 8, boy age 14); on Ontario Works; 3 bedroom apartment
- Scenario 4: 1 adult (female age 31-50), 2 children (girl age 8, boy age 14); on Ontario Works; 2 bedroom apartment
- Scenario 5: 1 adult (female age 70+); income based on Old Age Security and Guaranteed Income Supplement (OAS/GIS); 1 bedroom apartment
- Scenario 6: 2 adults (male and female ages 31-50), 2 children (girl age 8, boy age 14); income is based on one minimum wage earner, 40hr/wk, \$11.25/hr (minimum wage in May 2016); 3 bedroom apartment
- Scenario 7: 2 adults (male and female ages 31-50), 2 children (girl age 8, boy age 14); 3 bedroom apartment. NOTE: Income from employment is based on Toronto median after-tax income- two-parent families with two children; however, EI and CPP contributions are calculated using median before-tax total income- two-parent families with two children, two earners. Assumption of a dual income family with a split of 65%/35% between partners.

References

- 1 Toronto Department of Health. (1911). *The report of the Medical Officer of Health: dealing with the recent investigation of slum conditions in Toronto, embodying recommendations for the amelioration of the same*. Toronto, ON: Author.
- 2 MacDougall, H. (1990). *Activists and advocates: Toronto's health department 1883-1983*. Toronto, ON: Dundurn Press Limited.
- 3 Demographia. (2015). *12th annual Demographia international housing affordability survey: 2016*. Retrieved from <http://www.demographia.com/dhi.pdf>
- 4 RBC Economics. (2016). Housing trends and affordability report - June 2016. Retrieved from http://www.rbc.com/newsroom/_assets-custom/pdf/20160622-ha.pdf
- 5 Zon, N. (2015). *Renewing Canada's social architecture: Access to affordable housing*. Retrieved from <http://social-architecture.ca/wp-content/uploads/AccessstoAffordableHousing.pdf>
- 6 Canada Mortgage and Housing Corporation (CMHC) (census-based and National Housing Survey-based housing indicators and data). Core housing need (2011) – Toronto (C).
- 7 CMHC (census-based and National Housing Survey-based housing indicators and data). Canada – Housing standards (% of households in core housing need).
- 8 City of Toronto. (2013). *2011 National household survey: Income and shelter costs*. Toronto, ON: Author. Retrieved from <https://www1.toronto.ca/City%20of%20Toronto/Social%20Development,%20Finance%20&%20Administration/Shared%20Content/Demographics/PDFs/Reports/nhs-background-income-shelter.pdf>
- 9 Canadian Rental Housing Index. Community Profile – Affordability and overspending – Toronto (Based on the 2011 National Housing Survey). Retrieved from <http://rentalhousingindex.ca/>
- 10 Rea, W., Yuen, J., Engeland, J., & Figueroa, R. (2008). *The dynamics of housing affordability*. Statistics Canada-Catalogue no. 75-001-X. Retrieved from <http://www.statcan.gc.ca/pub/75-001-x/2008101/pdf/10511-eng.pdf>
- 11 Housing Connections. (2016). *Monthly statistical report – June 2016*. Retrieved from <http://www.housingconnections.ca/pdf/MonthlyReports/2016/Monthly%20Report%20-%20June%202016.pdf>
- 12 Ontario Non-Profit Housing Association (2016). *2016 Waiting lists survey report: ONPHA's final report on waiting lists statistics for Ontario*. Toronto, ON: Author. Retrieved from <http://qc.onpha.on.ca/flipbooks/WaitingListReport/>

- 13 Hulchanski, J. D. (2010). *The three cities within Toronto: Income polarization among Toronto's neighbourhoods, 1970-2005*. Toronto, ON: Cities Centre, University of Toronto. Retrieved from <http://www.urbancentre.utoronto.ca/pdfs/curp/tnrn/Three-Cities-Within-Toronto-2010-Final.pdf>
- 14 Stapleton, J., & Kay, J. (2015). *The working poor in the Toronto region: Mapping working poverty in Canada's richest city*. Toronto, ON: Metcalf Foundation. Retrieved from <http://metcalffoundation.com/stories/publications/the-working-poor-in-the-toronto-region-mapping-working-poverty-in-canadas-richest-city/>
- 15 Daily Bread Food Bank. (2016). *Who's hungry: 2016 profile of hunger in Toronto*. Toronto, ON: Author. Retrieved from <http://www.dailybread.ca/whoshungry/hunger-in-toronto.html>
- 16 Ontario Non-Profit Housing Corporation. (2015). *Strengthening social housing communities: Helping vulnerable tenants maintain successful tenancies*. Retrieved from https://www.onpha.on.ca/onpha/web/Policyandresearch/Other_research/Content/PolicyAndResearch/Other_research_list.aspx?hkey=0742ba26-d027-4c79-92a0-8f4d4606a33a
- 17 City of Toronto. (2016). *Tenants first: A way forward for Toronto Community Housing and social housing in Toronto*. Retrieved from <http://www.toronto.ca/legdocs/mmis/2016/ex/bgrd/backgroundfile-94222.pdf>
- 18 The Access Point. *The Access Point: Our data, July 2013 - March 2016*. Retrieved from <http://theaccesspoint.ca/wp-content/uploads/2016/06/TAP-data-2013-2016-updated.pdf>
- 19 City of Toronto. (2013). *2013 Street needs assessment*. Toronto, ON: Author. Retrieved from www.toronto.ca/legdocs/mmis/2013/cd/bgrd/backgroundfile-61365.pdf
- 20 City of Toronto. *Quick facts about homelessness and social housing in Toronto*. Retrieved from <http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=f59ed4b4920c0410VgnVCM10000071d60f89RCRD>
- 21 Khandor, E., & Mason, K. (2007). *The Street Health report 2007*. Toronto, ON: Street Health. Retrieved from www.streethealth.ca/downloads/the-street-health-report-2007.pdf
- 22 McCaskill, D., FitzMaurice, K., & Cidro, J. (2011). *Toronto Aboriginal research project final report*. Retrieved from <http://www.tassc.ca/assets/tarp-final-report2011.pdf>

- 23 Toronto Indigenous Advisory Circle, Toronto Public Health, & Toronto Central Local Health Integration Network. (2016). *A reclamation of well being: Visioning a thriving and healthy urban community. Toronto's first Indigenous health strategy, 2016-2021*. Retrieved from <http://www.toronto.ca/legdocs/mmis/2016/hl/bgrd/backgroundfile-93077.pdf>
- 24 Preston, V., Murdie, R., D'Addario, S., Sibanda, P., Murnaghan, A., Logan, J., & Ahn, M. (2011). *Precarious housing and hidden homelessness among refugees, asylum seekers, and immigrants in the Toronto Metropolitan area*. (CERIS Working Paper no. 87). Toronto, ON: CERIS, The Ontario Metropolis Centre. Retrieved from <http://www.homelesshub.ca/resource/precarious-housing-and-hidden-homelessness-among-refugees-asylum-seekers-and-immigrants>
- 25 Murdie, R., Preston, V., Ghosh, S., & Chevalier, M. (2006). *Immigrants and housing: A review of Canadian literature from 1990 to 2005*. Ottawa, ON: Canada Mortgage and Housing Corporation. Retrieved from http://homelesshub.ca/sites/default/files/Immigrants%26HousingAReview_of_Canadian_Literature_from.pdf
- 26 Social Planning Toronto, & Neighbourhood Change Research Partnership. (2016). *Private-sector rental housing in Greater Toronto: Towards a research agenda*. Toronto, ON: Neighbourhood Change Research Partnership. Retrieved from <http://neighbourhoodchange.ca/documents/2016/04/private-sector-rental-housing-in-toronto-research-agenda.pdf>
- 27 Sandel, M., Sheward, R., & Sturtevant, L. (2015). *Compounding stress. The timing and duration effects of homelessness on children's health*. The Centre for Housing Policy & Children's Health Watch. Retrieved from http://media.wix.com/ugd/19cfbe_07b13c8e56a14337a316e2e991aa0bf7.pdf
- 28 Gaetz, S., Donaldson, J., Richter, T., & Gulliver, T. (2013). *The state of homelessness in Canada 2013*. Toronto, ON: Canadian Homelessness Research Network Press. Retrieved from <http://homelesshub.ca/sites/default/files/SOHC2103.pdf>
- 29 Government of Ontario. (2015). *A place to call home: Report of the expert advisory panel on homelessness*. Retrieved from <http://www.mah.gov.on.ca/AssetFactory.aspx?did=11038>
- 30 Redman, M., & Gaetz, S. (2015, October). *Youth homelessness in Toronto*. PowerPoint presentation at the Toronto homelessness research symposium: Connecting research to practice, Toronto, ON.
- 31 Gaetz, S., O'Grady, B., Buccieri, K., Karabanow, J., & Marsolais, A. (2013). *Youth homelessness in Canada: Implications for policy and practice*. Toronto, ON: Canadian Homelessness Research Network Press. Retrieved from <http://www.homelesshub.ca/sites/default/files/YouthHomelessnessweb.pdf>

- 32 Embleton, L., Lee, H., Gunn, J., Ayuku, D., & Braitstein, P. (2016). Causes of child and youth homelessness in developed and developing countries. A systematic review and meta-analysis. *JAMA Pediatrics*, 170(5), 435-444.
- 33 Abramovich, A. (Ilona). (2013). No fixed address: Young, queer, and restless. In S. Gaetz, B. O'Grady, K. Buccieri, J. Karabanow, & A. Marsolais (Eds.), *Youth homelessness in Canada: Implications for policy and practice* (pp. 387-403). Toronto: Canadian Homelessness Research Network Press. Retrieved from <http://www.homelesshub.ca/resource/23-no-fixed-address-young-queer-and-restless>
- 34 Abramovich, A. (2016). Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Questioning and 2-Spirited (LGBTQ2). Homeless Hub. Retrieved from <http://homelesshub.ca/about-homelessness/population-specific/lesbian-gay-bisexual-transgender-transsexual-queer>
- 35 Jategaonkar, N., & Ponc, P. (2010). *Unsafe and unacceptable housing: Health and policy implications for women leaving violent relationships*. Toronto, ON: University of Toronto Scarborough Printing Services. Retrieved from http://bcnpha.ca/wp_bcnpha/wp-content/uploads/2014/05/4-jategaonkar_ponc.pdf
- 36 Abramovich, A. (2015, January 28). Homeless LGBT youth face discrimination, violence in shelter system. *Healthy Debate*. Retrieved from <http://healthydebate.ca/opinions/homeless-lgbt-youth>
- 37 Toronto Public Health. 2015. *Action on intimate partner violence against women*. Retrieved from <http://www.toronto.ca/legdocs/mmis/2015/hl/bgrd/backgroundfile-85930.pdf>
- 38 Rogers, E. S., Kash-MacDonald, & M., & Olschewski, A. (2009). *Systematic review of supported housing literature, 1993-2008*. Boston University, Sargent College: Center for Psychiatric Rehabilitation. Retrieved from <http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/supported-housing/>
- 39 Ontario Human Rights Commission. (2008). *Housing discrimination and the individual*. Retrieved from <http://www.ohrc.on.ca/en/right-home-report-consultation-human-rights-and-rental-housing-ontario/housing-discrimination-and-individual>
- 40 Cohen, R. (2007). *Positive impacts of affordable housing on health: A research summary*. Enterprise & The Centre for Housing Policy. Retrieved from <http://www.enterprisecommunity.com/resources/ResourceDetails?ID=65101.pdf>
- 41 Leaver, C. A., Bargh, G., Dunn, J. R., & Hwang, S. W. (2007). The Effects of housing status on health-related outcomes in people living with HIV: A systematic review of the literature. *AIDS and Behavior*, 11(2), 85-100.

- 42 Braubach, M., & Savelsberg, J. (2009). *Social inequalities and their influence on housing risk factors and health: A data report based on WHO LARES database*. Copenhagen: WHO regional Office for Europe. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0013/113260/E92729.pdf
- 43 Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf
- 44 Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M., Chilton, M., ... Cutts, D. B. (2008). A brief indicator of household energy security: Associations with food security, child health, and child development in US infants and toddlers. *Pediatrics*, 122(4), 867-875.
- 45 United Way of Greater Toronto (2011). *Poverty by postal code 2: Vertical poverty-declining income, housing quality and community life in Toronto's inner suburban high-rise apartments*. Toronto, ON: Author. Retrieved from <http://www.unitedwaytyr.com/document.doc?id=89>
- 46 Dunn, J. R., Hayes, M. V., Hulchanski, J. D., Hwang, S. W., & Potvin, L. (2006). Housing as a socio-economic determinant of health: Findings of a national needs, gaps and opportunities assessment. *Canadian Journal of Public Health*, 97(3), 11-15.
- 47 Moloughney, B. (2004). *Housing and population health: The state of current research knowledge*. Ottawa, ON: Canadian Institute for Health Information. Retrieved from https://secure.cihi.ca/free_products/HousingPopHealth_e.pdf
- 48 Hwang, S., Fuller-Thomson, E., Hulchanski, J. D., Bryant, T., Habib, Y., & Regoeczi, W. (1999). *Housing and population health: A review of the literature*. Toronto, ON: Centre for Applied Social Research, University of Toronto. Retrieved from http://www.urbancentre.utoronto.ca/pdfs/researchassociates/1999_Hulchanski-et-al_Hous%20.pdf
- 49 Pollack, C. E., Griffin, B. A., & Lynch, J. (2010). Housing affordability and health among homeowners and renters. *American Journal of Preventive Medicine*, 39(6), 515-521.
- 50 Schwartz, A., & Meltzer, R. (2016). Housing affordability and health: Evidence from New York City. *Housing Policy Debate*, 26(1), 80-104.
- 51 Dunn, J. (2002). Housing and inequalities in health: a study of socioeconomic dimensions of housing and self reported health from a survey of Vancouver residents. *Journal of Epidemiology and Community Health*, 56(9), 671-681.

- 52 CMHC (2010). *Affordable housing for families: Assessing the outcomes*. (Socio-economic Series 10-007). Ottawa, ON: Author. Retrieved from <https://www.cmhc-schl.gc.ca/odpub/pdf/67033.pdf>
- 53 Anderson, L. M., St. Charles, J., Fullilove, M. T., Scrimshaw, S. S., Fielding, J. E., and Norman, J., and the Task Force on Community Preventive Services. (2003). Providing affordable family housing and reducing residential segregation by income: A systematic review. *American Journal of Preventive Medicine*, 24(3S), 47-67.
- 54 Acevedo-Garcia, D., Joshi, P., Ramirez, A. S., Rosenfeld, L., & Geronimo, K. (2012, November 10). *The health impact of subsidized housing: A systematic review of the section 8 voucher program*. Paper presented at the 2012 Association for Public Policy Analysis and Management Fall Research Conference, Baltimore, MD.
- 55 Vozoris, N. T., & Tarasuk, V. S. (2003). Household food insufficiency is associated with poorer health. *Journal of Nutrition*, 133(1), 120-126.
- 56 Tarasuk, V., Cheng, J., de Oliveira, C., Dachner, N., Gundersen, C., & Kurdyak, P. (2015). Association between household food insecurity and annual health care costs. *Canadian Medical Association Journal*, 187(14), 429-436.
- 57 Kirkpatrick, S. I., & Tarasuk, V. (2011). Housing circumstances are associated with household food access among low- income urban families. *Journal of Urban Health*, 88(2), 284-96.
- 58 Toronto Public Health. (2016). *Cost of the Nutritious Food Basket - Toronto 2016*. Retrieved from <http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2016.HL14.3>
- 59 The Low-Income Energy Network (2013). *Working to end energy poverty in Ontario: A tool kit*. Toronto, ON: Author. Retrieved from http://www.lowincomeenergy.ca/assets/sitedocs/2013/02/LIEN-energy-poverty-manual_Jan-2013.pdf
- 60 Hernández, D. (2013). Energy insecurity: A framework for understanding energy, the built environment, and health among vulnerable populations in the context of climate change. *American Journal of Public Health*, 103(4), 103-104.
- 61 Liddell, C., & Morris, C. (2010). Fuel poverty and human health: A review of recent evidence. *Energy Policy*, 38(6), 2987-2997.
- 62 Quansah, R., Jaakkola, M. S., Hugg, T. T., Heikkinen, S. A. M., & Jaakkola, J. J. K. (2012). Residential dampness and molds and the risk of developing asthma: A systematic review and meta-analysis. *PLoS ONE*, 7(11):e47526. Retrieved from <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0047526>

- ⁶³ Hwang, S. W., Martin, R. E., Tolomiczenko, G. S., & Hulchanski, J. D. (2003). The relationship between housing conditions and health status of rooming house residents in Toronto. *Canadian Journal of Public Health*, 94(6), 436-440.
- ⁶⁴ Toronto Public Health. (2005). *Environmental threats to children: Understanding risks, enabling prevention*. Toronto, ON: Author. Retrieved from http://www1.toronto.ca/City%20of%20Toronto/Toronto%20Public%20Health/Healthy%20Public%20Policy/PDF%20Reports%20Repository/boh_environmental_threats_summary_all.pdf
- ⁶⁵ Coley, R. L., Leventhal, T., Lynch, A. D., & Kull, M. (2013). Relations between housing characteristics and the well-being of low-income children and adolescents. *Developmental Psychology*, 49(9), 1775-1789.
- ⁶⁶ Toronto Public Health. (2011). *Perspectives of parenting on a low income in Toronto*. Toronto, ON: Author. Retrieved from https://www1.toronto.ca/city_of_toronto/toronto_public_health/healthy_public_policy/inequalities/files/pdf/lowincome_parent.pdf
- ⁶⁷ Thomson, H., Thomas, S., Sellstrom, E., & Petticrew, M. (2013). Housing improvements for health and associated socioeconomic outcomes. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD008657. DOI: 10.1002/1461858.CD008657.pub2.
- ⁶⁸ Allen, J. G., MacNaughton, P., Laurent, J. G. C., Flanigan, S. S., Eitland, E. S., & Spengler, J. D. (2015). Green buildings and health. *Current Environmental Health Reports*, 2(3), 250–258.
- ⁶⁹ Colton, M. D., Laurent, J. G., MacNaughton, P., Kane, J., Bennett-Fripp, M., Spengler, J., & Adamkiewicz, G. (2015). Health benefits of green public housing: Associations with asthma morbidity and building-related symptoms. *American Journal of Public Health*, 105(12), 2482-2489.
- ⁷⁰ Canadian Centre for Economic Analysis. (2015). *Socio-economic analysis: Value of Toronto Community Housing's 10-year capital investment plan and revitalization*. Retrieved from <http://www.toronto.ca/legdocs/mmis/2015/ah/bgrd/backgroundfile-79525.pdf>
- ⁷¹ Pickett, K. E., & Pearl, M. (2001). Multilevel analyses of neighbourhood socioeconomic context and health outcomes: A critical review. *Journal of Epidemiology and Community Health*, 55(2), 111-122.
- ⁷² Coutts, A., & Kawachi, I. (2006). The urban social environment and its effects on health. In N. Freudenberg, S. Galae, and D. Vlahov (Eds.), *Cities and the health of the public* (pp. 49-60). Nashville, TN: Vanderbilt University Press.

- 73 Robert, S. (1999). Socioeconomic position and health: The independent contribution of community socioeconomic context. *Annual Review of Sociology*, 25, 489–516.
- 74 Canadian Institute for Health Information. (2006). *Improving the health of Canadians: An introduction to health in urban places*. Ottawa, ON: Author. Retrieved from https://secure.cihi.ca/free_products/PH_Full_Report_English.pdf
- 75 Robert Wood Johnson Foundation. (2011). *How social factors shape health: Violence, social disadvantage and health* (Issue Brief Series: Exploring the Social Determinants of Health). Princeton, NJ: Author.
- 76 Gibson, M., Petticrew, M., Bambra, C., Sowden, A. J., Wright, K. E., & Whitehead, M. (2011). Housing and health inequalities: A synthesis of systematic reviews of interventions aimed at different pathways linking housing and health. *Health and Place*, 17(1), 175-184.
- 77 National Center for Healthy Housing. (2008). *Housing interventions and health: A review of the evidence*. Columbia, MD: Author. Retrieved from <http://www.nchh.org/Portals/0/Contents/Housing%20Interventions%20and%20Health.pdf>
- 78 Thomson, H., Atkinson, R., Petticrew, M., & Kearns, A. (2006). Do urban regeneration programmes improve public health and reduce health inequalities? A synthesis of the evidence from UK policy and practice (1980-2004). *Journal of Epidemiology and Community Health*, 60(2), 108-115.
- 79 Dunn, J., Dowbor, T., Gibson-Wood, H., & Smith, P. (2012). *Toronto social housing and health study*. Community report no. 2. St. Michael's Hospital, Toronto & McMaster University. Retrieved from http://www.stmichaelshospital.com/crich/wp-content/uploads/TSHHS_Phase_2_Summary_Feb_14_for_web.pdf
- 80 Addictions & Mental Health Ontario (2013). *Addictions supportive housing literature review*. Retrieved from <http://eenet.ca/wp-content/uploads/2013/12/ASH-Lit-Review-FINAL.pdf>
- 81 Ellaway, A., & Macintyre, S. (1998). Does housing tenure predict health in the UK because it exposes people to different levels of housing related hazards in the home or its surroundings? *Health Place*, 4(2), 141-150.
- 82 Macintyre, S., Ellaway, A., Kearns, A., & Hiscock, R. (2000). *Housing tenure and car ownership: Why do they predict health and longevity?* Glasgow, UK: Economic and Social Research Council. Retrieved from <http://www.lancaster.ac.uk/fass/projects/hvp/pdf/fd7.pdf>
- 83 Dunn, J. (2002). *The population health approach to housing: A framework for research*. Ottawa, ON: Canada Mortgage and Housing Corporation.

- ⁸⁴ Cairney, J., & Boyle, M. (2004). Home ownership, mortgages and psychological distress. *Housing Studies*, 19(2), 161-174.
- ⁸⁵ Turunen, E., & Hiilamo, H. (2014). Health effects of indebtedness: a systematic review. *BMC Public Health*, 14(489), 1471-2458.
- ⁸⁶ Downing, J. (2016). The health effects of the foreclosure crisis and unaffordable housing: A systematic review and explanation of evidence. *Social Science & Medicine*, 162, 88-96.
- ⁸⁷ Macdonald, D. (2015). *The young and the leveraged: Assessing the impact of a housing market correction on Canada's homeowners*. Ottawa, ON: Canadian Centre for Policy Alternatives. Retrieved from <https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2015/11/Young%20and%20the%20Leveraged.pdf>
- ⁸⁸ CMHC (census-based and National Housing Survey-based housing indicators and data). Housing stock (2011) – Toronto (C) and Ontario.
- ⁸⁹ Paradis, E., Wilson, R. M., & Logan, J. 2014. *Nowhere else to go: Inadequate housing and risk of homelessness among families in Toronto's aging rental buildings*. Toronto, ON: Cities Centre, University of Toronto. Retrieved from <http://homelesshub.ca/resource/nowhere-else-go-inadequate-housing-risk-homelessness-among-families-toronto%E2%80%99s-aging-rental>
- ⁹⁰ The United Kingdom Office of the Deputy Prime Minister (2004). *The impact of overcrowding on health & education: A review of evidence and literature*. Great Britain: Office of the Deputy Prime Minister Publications. Retrieved from <http://dera.ioe.ac.uk/5073/>
- ⁹¹ Jelleyman, T., & Spencer, N. (2008). Residential mobility in childhood and health outcomes: A systematic review. *Journal of Epidemiology and Community Health*, 6(7), 584-592.
- ⁹² Desmond, M., An, W., Winkler, R., & Ferriss, T. (2013). Evicting children. *Social Forces*, 92(1), 303-327.
- ⁹³ Desmond, M., & Kimbro, R. T. (2015). Eviction's fallout: Housing, hardship, and health. *Social Forces*, 94(1), 295-394.
- ⁹⁴ Research Alliance for Canadian Homelessness, Housing, and Health (REACH3). (2010). *Housing vulnerability and health: Canada's hidden emergency. A report on the REACH3 health and housing in transition study*. (Homeless Hub Report Series #2). Toronto, ON: Author. Retrieved from <http://www.stmichaelshospital.com/crich/wp-content/uploads/housing-vulnerability-and-health.pdf>

- ⁹⁵ Hwang, S. W., Ueng, J. J. M., Chiu, S., Kiss, A., Tolomiczekno, G., Cowan, L., Levinson, W., & Redelmeier, D. L. 2010. Universal health insurance and health care access for homeless persons. *American Journal of Public Health*, 100(8), 1454-1461.
- ⁹⁶ Frankish, J., Hwang, S., & Quantz, D. (2005). Homelessness and health in Canada. *Canadian Journal of Public Health*, 96, S23-S29.
- ⁹⁷ Stergiopoulos, V., O'Campo, P., Hwang, S., Gozdzik, A., Jeyaratnam, J., Misir, V., ... Kirst, M. (2014). *At Home/Chez Soi project: Toronto site final report*. Calgary, AB: Mental Health Commission of Canada. Retrieved from <http://www.mentalhealthcommission.ca/English/document/33196/toronto-final-report-homechez-soi-project>

