Toronto Supportive Housing Growth Plan: Needs Assessment

Sarah Sanford
Brenda Roche
Irma Molina
Nina Acco Weston
Frank Sirotich

Wellesley Institute
advancing urban health

Canadian Mental Health Association
Toronto

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Executive Summary

Introduction

Many people in Toronto are not able to access the supportive housing services that they need. People who require supportive housing to live independently in the community have a range of needs. These needs connect to experiences such as mental health and substance use issues, physical and developmental disabilities, histories of chronic homelessness, age-related health or cognitive issues, and extended stays in institutional settings such as hospitals or the criminal justice system. There is an urgency to better respond to the challenges faced in meeting the needs of those requiring supportive housing, in order to support mental health and well-being within the population.

The City of Toronto's most recent housing plan calls for the development of 18,000 new supportive housing units by 2030 to meet the diverse needs of residents. In response to these targets, the sector-led Toronto Supportive Housing Growth Plan (SHGP), will help to position key stakeholders to increase the supply of supportive housing. The SHGP is informed by several components, including an Asset Inventory, Funding Analysis and this Needs Assessment. The Asset Inventory quantifies existing housing stock, land and rent supplements. The Funding Analysis analyzes how government funding can be applied more strategically to better meet needs.

This Needs Assessment of mental health and addictions (MHA) supportive housing provides research on key challenges and pathways forward for developing responses to need within the sector, and includes a summary of evidence and best practices on housing and supports. These pieces are intended to inform decision-making and the overall development of the SHGP.

For the purposes of this study, supportive housing includes a broad range of approaches that vary by housing sector (e.g., private or social housing), housing type (e.g., scattered or dedicated sites), support model (e.g., bundled with housing, daily or occasional) and support services (e.g., therapeutic, life skills). A central feature of most supportive housing is the provision of financial supports to subsidize the cost of housing, through different methods, such as rent supplements. Funding for supportive housing is provided through different levels of government, and from different ministries at the provincial level.

Objectives and methods

The Needs Assessment has the following four main objectives:

1. Identify what is working well and the strengths of the existing MHA supportive housing sector in Toronto
2. Examine challenges experienced by supportive housing service users and providers within the MHA supportive housing sector
3. Estimate the number of MHA supportive housing units required over the next 10 years to meet projected need
4. Inform sector- and provider-level strategies to address existing challenges and shortfalls within the supportive housing sector

The Needs Assessment brings together the perspectives of 30 subject matter experts (in research, policy and leadership positions in supportive housing organizations) and 16 individuals with lived experience of supportive housing through in-depth qualitative interviews. In addition to qualitative interviews, the research includes a review of academic literature in peer-reviewed journals and grey literature (e.g., strategic policy reports) on supportive housing. An analysis of waitlist data between FY2014 and FY2019 from The Access Point was also conducted in order to quantify the estimated need for MHA supportive housing over the next 10 years.

Preliminary findings from this work were shared with an Advisory Table composed of supportive housing providers working across the sector in October and November 2020. Feedback from these sessions was incorporated into the final product of the Needs Assessment report. Key findings draw from a synthesis across all sources of evidence.

Summary of what works and challenges within the supportive housing sector

Strengths of existing system
The Needs Assessment highlights considerable sector strength and capacity in supportive housing provision. Organizations are managing to successfully meet the housing and support needs of the majority of people who are currently housed in supportive housing. Key informants described productive collaborations and partnerships between organizations to better meet the needs of clients, including formal and informal arrangements. Considerable alignment also exists within the sector with respect to shared goals and mandates.

Key challenges
The research identifies a range of challenges and needs related to increasing access to supportive housing in Toronto. Some main challenges raised by key informants from the supportive housing include:

- A lack of available supportive housing in Toronto, where projections show that without expansion MHA waitlists could grow to 41,000 by 2030
- Increasing complexity of health and social support needs for people with mental health and substance use challenges in need of supportive housing
- A diverse range of supportive housing typologies (e.g., custodial or shared living arrangements) that do not meet the current needs and preferences of people in Toronto
- A mismatch between supports (types, intensities and frequencies) needed and those available to people with complex needs
- Different definitions of supports, and variations in understandings of how to deliver different support intensities can act a barrier for the sector in advocacy and development efforts
- A lack of access to supportive housing for specific groups (e.g., those with experience of incarceration or severe substance use challenges) whose needs are generally unmet by the current system
- A lack of equitable access to supportive housing, where specific groups, such as racialized, Indigenous and LGBTQ2S people, face greater barriers to housing, based on histories of discrimination and exclusion

Key findings: Pathways forward

This analysis of MHA supportive housing in Toronto has highlighted the following key findings:

1. **Future development should focus on permanent supportive housing options in self-contained units in scattered (dispersed throughout the community) or dedicated (concentrated in one location) sites and apply a Housing First approach.**

Given the misalignment between the types of housing stock developed in the past and current needs and preferences of individuals who require supportive housing, future development of stock should focus on self-contained units scattered throughout the community or in dedicated sites. Most key informants noted the preference for self-contained units and the literature and waitlist analysis support this finding. These options should focus on low barrier access to housing, with an emphasis on Housing First where people are offered housing without first requiring treatment for mental health or substance use issues. Where possible, supports should be delinked from housing as this is a best practice. The development of housing supply would also increase opportunity for people to maintain the same housing location even if they no longer require supports, as it reduces the risk of losing housing linked to supports.

2. Greater flexibility is needed within the system to increase or lower support intensity, and especially to enable the subsequent increase of supports if required.

Flexibility is required to address the lack of flow of people into and out of the supportive housing system when they no longer require supports. Strategies to increase system flexibility and address barriers to flow within the system include increasing the provision of housing allowances (e.g., portable rent supplements) to allow people to move on from supportive housing, delinking supports where feasible (e.g., scattered sites), and programs that support transitions to lower support environments. Specific interventions to facilitate smooth transitions between different support intensities will also promote flexibility.

3. Support is needed for the expansion of multidisciplinary teams using evidence-based interventions to meet complex needs.

Multidisciplinary teams would facilitate the adoption of evidence-based interventions to address complex needs, such as those related to substance use, managing crises, conflict, or self-harm, co-occurring conditions, criminal justice involvement, or significant in-patient or emergency department use. Multidisciplinary teams can also work in flexible arrangements to increase or decrease support intensity based on individual needs, thereby avoiding physically moving residents in order to accommodate a change in service intensity.

4. The sector should consider prioritizing access into supportive housing.

In light of the magnitude of unmet need and the possibility that this need will not be addressed for many years, the sector should consider prioritizing access. In order to do this, criteria and methods for determining priority (e.g., standardized tools for vulnerability or level of need) require consensus and administration through The Access Point which provides coordinated access to MHA supportive housing in Toronto. Other considerations include how prioritization methods align with funder priorities (e.g., through the Provincial priority to reduce hallway medicine by moving people currently occupying hospital beds who are no longer in need of this level of care into supportive housing environments) and whether prioritization should involve an equity focus, where a portion of spaces are reserved for members of specific equity-seeking groups. Further work by the sector is needed to identify a framework for prioritization.

5. The sector should develop a shared typology and definitions to describe housing and supports.

The development of shared definitions to define housing and support types was identified as a strategy to facilitate decision-making, planning and advocacy efforts for the sector. This could draw from existing standardized tools that outline support types and intensities for example and would require agreement within the sector on necessary steps and components of the decision-making process. The SHGP is one step in initiating and actualizing this development.

6. A harm reduction philosophy across the sector is necessary to address the needs of people with substance use challenges and to facilitate choice.

People with substance use challenges have considerable unmet needs within supportive housing. A harm reduction philosophy includes low barrier access to program participation (e.g. with respect to drug use and related activities), access to safe supplies, resources for overdose prevention and response, abstinence-based options for those who choose them, and health promoting resources. Increased crisis support is also needed, including making 24-hour support available in lower intensity support models.

7. Develop rapid-access to interim supportive housing to facilitate bail release and community reintegration for individuals in jails.

People who have experience of incarceration have considerable unmet needs within supportive housing. These unmet needs are highlighted in considerable detail in the recent Justice-focused Mental Health Supportive Housing in Toronto: Needs Assessment (2020). People with MHA challenges who are discharged from custody frequently have

no immediate place to go upon release, increasing the risk of their cycling through jails and homeless shelters. Others in custody are denied bail because they lack an address. Collaboration with the criminal justice sector to improve discharge planning, along with the development of interim rapid-access housing options to address urgency should be considered where permanent supportive housing options are not immediately available.

8. Promote anti-racist/anti-oppressive practice across the sector.

Efforts to better meet the needs of historically marginalized groups (e.g., racialized groups, Indigenous people, women, LGBTQ2S people) within supportive housing was identified as a priority in the research. Tools to implement anti-racist/anti-oppressive supportive housing have been developed and evaluated by researchers, as well as best practices from organizations that serve specific groups. Improved collection of equity-based data (e.g., race-based, gender-based) will also assist in better understanding gaps, and introducing measures to address access barriers and unmet needs.

9. Promote community development and social inclusion through supportive housing programs.

While permanent supportive housing is an effective intervention for achieving housing stability and ending homelessness, further action is needed to address other dimensions of well-being for tenants. Examples of programs to build community and inclusion are community kitchens, support groups, employment support, social programs, language supports, and education programs. Social inclusion is also facilitated by representation in decision-making processes, such as the inclusion of those with lived experience on boards of directors. Continued action and advocacy for broader economic and housing policies (e.g., improved income security, stronger rent control measures) that reduce inequities is also needed.

Conclusion

This research has identified key findings drawing from various sources for consideration by the supportive housing sector and others to contribute to growth and address existing unmet need. Ultimately, for the findings of this work to be taken up and effectively operationalized there is a need for sustained investment in supportive housing beyond what has currently been committed, greater coordination across different levels of government, and support for non-profit organizations to develop affordable housing to meet sector targets.

1. Introduction

Context

To live independently in the community some people require support. People who require supportive housing have a range of needs and experiences, such as mental health and substance use issues, physical and developmental disabilities, histories of chronic homelessness, age-related health or cognitive issues, or extended stays in institutional settings such as hospitals or the criminal justice system.[1,2,3,4] There is a need for a robust supportive housing system with diverse supports to adequately house everybody in Toronto.

Many people in Toronto with mental health and substance use issues are not able to access the supportive housing services that they need. This gap has been well documented in the housing sector and by the municipality, including in the City of Toronto's most recent housing plan that calls for the development of 18,000 new supportive housing units by 2030 to meet the diverse needs of its residents. In response to these projections, the supportive housing sector is developing a Supportive Housing Growth Plan (SHGP) to envision and implement growth goals through effective and sustainable action.

The SHGP is informed by several components, including an Asset Inventory, Funding Analysis and Needs Assessment. The Asset Inventory quantifies existing housing stock, land and rent supplements. The Funding Analysis analyzes how government funding can be applied more strategically to better meet needs. The Needs Assessment of Mental Health and Addictions (MHA) supportive housing, presented in this document, provides research on key challenges and pathways forward for developing responses to need within the sector, and includes a summary of evidence and best practices on housing and supports. The Needs Assessment was conducted by Wellesley Institute and Canadian Mental Health Association-Toronto (CMHA-Toronto), and was designed as one piece among these multiple components intended to inform decision-making and the overall development of the SHGP.

While we know that permanent supportive housing is a central component of mental health and recovery,[5] homelessness and unaffordable, inadequate housing are ongoing experiences in the lives of many people in Canada.[6] Clear strategies and evidence-informed solutions exist to address this problem. At the same time, the need for substantial growth in supportive housing exists within the broader context of a housing crisis, marked by growing economic inequity,[7] a scarcity of affordable housing,[8] and a rise in homelessness throughout the city.[9]

The supportive housing system in Toronto includes housing and supports funded by the Provincial Ministry of Health and the Ontario Health Regions/Local Health Integration Networks, the Ministry of Municipal Affairs and Housing, and the Federal Government. The City of Toronto is the service manager for much of the federally funded programs.[10] Other sectors that provide supportive housing, such as the developmental sector and women-serving organizations, also receive funding from the Ministry of Children, Community and Social Services. The roles and functions of funders are elaborated on in Wellesley Institute's Funding Analysis.

There has been some recent interest by different levels of government to address homelessness and invest in supportive housing. The recent 10-year *National Housing Strategy* by the federal government aims to reduce chronic homelessness by half and increase housing options for people in need.[11] At the provincial level, Ontario has made commitments to address mental health and addictions and invest in supportive housing through its Roadmap to Wellness plan, and has conducted some public consultation around community housing to improve systems.[12] The City of Toronto has recently adopted a new 10-year affordable housing plan, which includes targets for the expansion of supportive housing units.[13]

For the purpose of this study, the definition of supportive housing includes a broad range of approaches to support independent living in the community, and might differ by: housing sector (e.g., private or social housing); housing type (e.g., scattered or dedicated sites); support model (e.g., bundled with housing, daily or occasional); support services (e.g., therapeutic, life skills).[14]

A central feature of supportive housing is the provision of financial supports to subsidize the cost of housing. This can be provided in different forms, including a rent-geared-to-income (RGI) approach where the tenant pays no more than a specific percentage of their income for housing; the City of Toronto's housing subsidy allocates 30 per cent of

the household income through their RGI program.[15] Other forms of subsidies include government Housing Allowances, Rent Supplements and housing benefits provided by Ontario Works or Ontario Disability Support Program.[16,17]

Objectives

Research conducted to-date on supportive housing in Ontario and internationally, has resulted in an impressive range of academic literature and other reports. In addition to informing the SHGP, this Needs Assessment aims to contribute to this body of work through the following four main objectives:

1) Identify what is working well and the strengths of the existing MHA supportive housing sector in Toronto

2) Examine challenges experienced by supportive housing service users and providers within the MHA supportive housing sector

3) Estimate the number of MHA supportive housing units required over the next 10 years to meet projected need

4) Inform sector- and provider-level strategies to address the existing challenges and shortfalls within the supportive housing sector

2. Methods

For this Needs Assessment, supportive housing is defined as affordable, permanent housing linked to supports, so that people with MHA[i] challenges can live as independently as possible in the community. Individuals with mental health and substance use issues represent a key group of people who need supportive housing. While people with severe and persistent mental illness are a relatively small percentage of the population, they are more likely to experience repeated episodes of homelessness and have greater need for mental health and social services than others experiencing homelessness.[18]

This Needs Assessment is informed by 1) a review of the existing literature 2) qualitative research findings and 3) an analysis of data from The Access Point MHA waitlist in Toronto. The literature review involved a review of both academic research in peer-reviewed journals and grey literature on supportive housing. Grey literature describes research and reports from sources outside of traditional academic research, and includes formats such as research or project reports from organizations, government reports and strategies, working papers and evaluations. Review of the literature was initiated prior to the start of qualitative recruitment and data collection and was continued iteratively throughout the project. Existing literature was used to develop the preliminary interview guides, and emerging findings from the qualitative research were compared to, and informed by, the literature review findings as the research developed.

Qualitative research interviews were conducted to explore the perspectives and experiences of key informants, and identify strategies for moving forward to address supportive housing challenges in Toronto. Participants were recruited for interviews through organizations involved in supportive housing provision (either supports or housing or both) for people experiencing mental health or substance use challenges.

Semi-structured interviews were conducted with two categories of key informants: 30 subject matter experts (SMEs) and 16 service user participants. SMEs were recruited via invitations to publicly available email accounts linked to the organizations where they worked. This group consisted of research experts, policy experts or government representatives and people in leadership positions in supportive housing organizations (e.g., executive directors, CEOs). The sample includes five research experts, five policy experts and 20 organizational leaders, with a focus on the third sub-category to try to capture a breadth of perspectives from the field.

The objective of our sampling strategy for SME organizational leader participants was to achieve diversity in terms of representation within MHA supportive housing, based on features such as the organizational focus on supports versus housing, the intensity of need met by the supportive housing organization, and the characteristics of clients served by organization. The sample also includes some representation from people whose work straddles the emergency homelessness shelter system and supportive housing, including those working with people experiencing chronic homelessness.

Service user participants were recruited by the research team through MHA supportive housing networks. Email invitations were disseminated to MHA organizational leaders via networks with requests for service users to contact researchers if they were interested in participating in the study. Interviews were conducted with 16 service users from four different supportive housing organizations, providing a range of intensities and types of supports as well as housing types. Service users had been living in supportive housing for a range of time, from less than one year to more than 20 years in duration. Fourteen participants received targeted supports for mental health or substance use-related needs.

The interviews ranged from 30 minutes to two hours in length and were audio recorded. Audio recordings were transcribed via NVIVO Transcription software. Interviews with SMEs were conducted by a researcher from Wellesley Institute and service user interviews were conducted by researchers from the Peer Program Evaluation Project (PPEP) at CMHA-Toronto. Ethics approval for the research was granted by the Ryerson University Research Ethics Board in August 2020 (REB #2020-252). The research was conducted from August to December 2020.

[i] Within MHA funding there are three streams funded by the Ministry of Health and Long-Term Care – Mental Health, Mental Health and Justice (MHJ), and Supportive Housing for People with Problematic Substance Use (SHPPSU).

Thematic analysis techniques were used to analyze data across both key informant groups.[19] Transcripts were analyzed using an inductive technique where emerging codes were derived in a systematic fashion directly from the data set. As analysis progressed, codes were gathered into broader themes, which were then further organized and refined with ongoing engagement with the data. The findings in this report represent a synthesis across the qualitative research and literature review, where the literature is used to further develop the themes that emerged from the qualitative research, filling in gaps where they exist and describing other relevant work.

The themes in this report were organized according to what works well and key challenges experienced within the sector, and elaborates in greater depth on pathways forward for addressing challenges. Qualitative findings are presented first in each section, and relevant literature is discussed following this to further develop the insights of the qualitative data. Quotes from SME participants are provided in several text boxes to illustrate key themes.

An analysis of waitlist data between 2014 and 2019 from The Access Point was also conducted in order to quantify the estimated need for MHA supportive housing over the next 10 years. The methods and findings from the Waitlist Analysis are discussed in more detail in Section 5 of this report.

Preliminary findings from this work was shared with a planning table and an access and equity working group comprised of representatives from the sector in November and December 2020. Feedback from these sessions was incorporated into the final product of this report.

3. Summary of what works within the supportive housing sector

Interviews with participants uncovered considerable strength within the sector, born out of the necessity to optimize limited resources and innovate to address the considerable need for supportive housing in Toronto. Nonetheless, it is important to recognize that participants also raised a number of challenges along with strategies to address these and expand the sector, drawing from current work within the sector, in addition to other knowledge. While the following section briefly summarizes sector strengths and capacity, these are further detailed throughout Section 5 on pathways forward.

Sector capacity and success with supportive housing provision

Key informants highlighted the considerable strength of the sector with respect to experience, knowledge and expertise, partnerships and innovation. Supportive housing organizations are dedicated to working with diverse populations to address need. Where some organizations have general mandates to work with adults with mental health and substance use challenges to provide housing with supports, others work with specific groups, such as women, youth or racialized groups. These offer good examples of efforts that need to be expanded to address the specific needs of groups who experience greater barriers to accessing supportive housing. Similarly, organizations have diverse histories – some have been around since deinstitutionalization while others are more recent in formation – and offer a wide range of supportive programs for tenants.

Supportive housing organizations are successfully meeting the housing and other needs of their clients. While all SME participants discussed the complex needs of some of their tenants/clients, including unmet needs, it was also evident that many people are successfully housed and supported by organizations. One participant pointed out that a disproportionate amount of time can be taken discussing individuals or groups with high levels of complex needs (relative to the overall population requiring supportive housing) precisely because their needs are not well met. In fact, this is a relatively small group of people and there are viable supportive housing solutions that work for most people.

Many service users expressed a considerable sense of relief at attaining supportive housing, several credited it for saving their lives, and for allowing them greater independence than their previous living arrangements. Numerous benefits of supportive housing were identified by service users, including an increased ability to sustain relationships with others, support to stabilize mental health and gain insight into mental health issues, access to employment services, community kitchens and social programs, being able to socialize with others without stigma, reduced worry and anxiety, and access to food programs.

Leveraging partnerships to address need

Many SME participants described partnerships between organizations to better meet the needs of clients, including formal and informal arrangements between organizations. For example, some described the process of formal integration of operations for organizations with complementary and overlapping mandates, in order to increase their impact and potential for developing housing stock. Others provided examples of informal work across agencies to better meet the needs of clients with complex needs that require support arrangements that include multiple providers. A specific example was the collaboration between two distinct organizations to provide supportive housing through modular housing. This collaboration was described as a particularly agile response from the sector to provide complementary supports to City of Toronto-funded housing.

SME participants also emphasized the shared goals and mandates of organizations, and that alignment among organizations was generally greater than areas of divergence. Examples provided with respect to convergence within the sector included mandates/visions and broad goals of building affordable housing, addressing homelessness, and supporting people to maintain housing stability and to live independently in the community.

Steps towards action to develop the sector

Some key informants pointed out that substantial research, evaluation and policy-related work has been done by different groups (e.g., organizations, research institutes, governments) to identify challenges and best practices for supportive housing in Ontario and Toronto. They conveyed the sentiment that there is sufficient knowledge based

on previous work to move forward with a growth plan for the sector, and for corresponding investment into supportive housing in Toronto. Many key informants described the SHGP as an important tool for leveraging the considerable sector capacity to move forward with advocacy and development activities in order to meet existing need in Toronto.

There are several examples of alignment between the three levels of government to prioritize investment into supportive housing. At the municipal level the City of Toronto's HousingTO 2020-2030 plan outlines realistic goals for supportive housing development in partnership with the Province of Ontario and Federal government. Their recent investment into modular housing is one example of their commitment to implement this plan.[20] It was announced in fall 2020 that the City of Toronto was to receive $203 million (of $1 billion total) through the Federal Rapid Housing Initiative, which is part of the *National Housing Strategy*. The *Strategy* also identifies supportive housing as an area of investment.[21] The funding is expected to create 3,000 new affordable housing units and is a promising first step in government commitment.[22]

The Province of Ontario has previously undertaken considerable work on supportive housing to develop best practice[23] guides and policy frameworks,[24] that recognize many of the challenges described related to coordination and fragmentation of programs and services. More recently, the Ministry of Municipal Affairs and Housing (2019-2021), promised a review of programs and policies to increase coordination based on this fragmentation, including stakeholder engagement to address the issue.[25] In December 2020, the Province announced $47 million investment in the development of supportive housing programs, about a quarter of which targets patients with mental health challenges who are in hospital but do not need acute care.[26]

These policy developments are potential signals of positive development for the sector moving forward over the next 10 years. As mentioned, many of the points summarized here are expanded further in Section 5.

4. Summary of challenges

Several themes emerged that related to challenges faced by the supportive housing sector. While these are complex in nature, a brief overview is provided in this section. Identifying pathways forward for supportive housing development requires that challenges be clearly outlined in order to effectively respond to these in corresponding strategies.

Populations with complex needs

A consistent theme from the qualitative data involves the complex needs of clients in supportive housing. Many provider participants described difficulties addressing the needs of people with complex mental health and substance use challenges. Working with populations with complex needs is further complicated by experiences of barriers to housing stability, chronic homelessness, as well as challenges associated with an aging population.

Although providers explained their experiences differently, some consistencies were evident across the data. SME participants described a lack of adequate support services for people with severe mental health issues, and significant experiences of trauma. Often substance use challenges were described as a barrier for people maintaining housing stability.

Many participants described behaviours that cause difficulties around eviction prevention. These include clients who engage in property damage or behaviours that might result in harm to themselves or others. It was also suggested that some people with complex needs can be disruptive to others who either share housing or are in close proximity in housing environments (e.g., apartment buildings). Participants frequently discussed the challenges that providers face in supporting people to maintain housing, which included efforts to navigate relationships with landlords on behalf of tenants and trying to secure funds to cover damages to property.

> *I guess with the rent supplements, the issue...is that if we're head leasing a unit and a tenant destroys the unit for whatever reason... because of mental health or their friends come in and say they're using lots of drugs, then, you know, the unit ends up requiring lots of repair. Well, then we work with the landlord, because if we don't help repair it, then the landlord may not want us to be their tenant anymore... So there really is another cost... I just spoke with the [funder] the other day and I said 'If you give us rent supplements for 10 units, we won't rent up all 10 units. We will hold some back for damages.' Because if we don't [do that], then it's going to come out of our core budget or we're going to have trouble securing future units. Because the landlords do speak to each other. And... a key important part of our role is eviction prevention.*

Several participants described the experiences of clients who have difficulty maintaining housing in terms of their "housing histories" that follow them in housing applications and result in their exclusion from the supportive housing system. Some participants framed this in terms of supportive housing providers avoidance of tenants they deem "risky" due to behaviour and housing histories. It is important to understand the reluctance to work with specific individuals within the context of under-resourced environments, where providers may not have the resources to work with the most marginalized people or those with more complex needs. At the same time, problematic housing histories are frequently a source of stigma and social exclusion for people who already face substantial barriers to accessing supportive housing.

Most SME participants also raised the challenge of addressing the complex needs of older adults and people experiencing premature aging associated with long-term substance use and prolonged periods of homelessness and impoverished living conditions. While the aging population in need of supportive housing represents a diverse group of individuals, most participants felt that efforts should be made to enable people to age as independently as possible in their homes, as with the broader population. For people who require greater support and can no longer live independently, there can be considerable difficulty accessing long-term care if they have complex mental health and substance use issues, as this system is not equipped to meet these needs.

Generally, the data reflects challenges faced by providers in meeting the complexity of need (with a range of causes) experienced by a certain segment of the population either in or waiting for supportive housing.

> *And so without the proper infrastructure or resources... it's hard to support populations with addictions. I know they have funding for supportive housing for people with addictions, but that's probably something that could be beefed up...And we're all doing trauma informed care. I think that recognizing that everybody has gone through some form of trauma, and just being mindful of that in terms of how we can support people and recognizing that a lot of behaviors are survival mechanisms really...that's how people are able to still be alive today...But, poverty is a constant, that's the thing. Regardless of whatever diagnosis someone might have or if they're a family or if they're individuals, single – poverty is the constant.*

Previous studies have also deemed supportive housing for people with complex needs related to substance use issues, experiences of chronic homelessness, involvement in the justice system, dual diagnoses (i.e. mental illness and intellectual or developmental disability), cognitive issues, and high use of inpatient and emergency department services as a priority. In general, these groups have multiple interconnected needs that traverse health and social issues, and represent a range and intensity specific to the individual.[28] The complexity of needs of clients/tenants of permanent supportive housing also speaks to the role of increasing social and economic disadvantage, including the enduring effects of homelessness.

The homelessness crisis and conceptualizations of homelessness are also complex and have relevance for supportive housing, where an increasing number of people are living on the streets or without a fixed address in the city. There is considerable intricacy in terms of the different states of homelessness (e.g., more visible versus hidden), and the multiple pathways and underlying causes of homelessness, that frame this complexity in terms of understanding and responding to the issue.[29,30]

The population of older adults experiencing homelessness is increasing.[31] The literature also demonstrates that older adults comprise an especially vulnerable subgroup of the homeless population, with greater need due to higher rates of health problems and comorbidities resulting from aging. Homelessness is thought to accelerate aging and the health status of older adults who are homeless is often much poorer compared to their housed counterparts.[32]

The opioid crisis is also underlying discussions about complexity in care provision in Toronto. Injection overdoses from substances disproportionally affects marginalized populations, including people experiencing homelessness, and deaths due to overdoses have been increasing in the city.[33] The co-occurrence of mental health and substance use challenges are common in people who experience chronic homelessness.

This complexity of need, underpinned by social and economic conditions, and the lack of investment into addressing these needs has ultimately led to a situation where providers are overwhelmed and unable to meet the demand for supportive housing in Toronto. As a result, there are many residents in the city who are in desperate need of supportive housing and yet are unable to access this basic necessity.

Housing

Housing related challenges encompass issues with the supply of housing stock, and the types and quality of housing available to people in need of supportive housing.

The main challenge consistently identified by key informants is the lack of available supportive housing in Toronto, along with an array of subsidiary issues related to this challenge. To address this, the housing stock needs to be developed significantly. Participants described many factors related to the supply of housing in the city, including inadequate housing policy over many decades and rising rental rates that do not align with housing allowances from government funders. The loss of existing stock due to insufficient rent supplement amounts, in combination with a decline in the quality of housing was consistently identified as an issue. SME participants described doubling up on rent supplements for one unit to cover rising costs and the upkeep of units. Some service user participants identified the need for maintenance and repair in their building, and ongoing issues with pests in some apartments.

> *Our rent supplements have not been indexed to market rent and... the quality of the units have just been going downhill for the past number of years, so we're actually losing units in the back end... when it comes to the affordability gap... it just keeps getting wider and wider.*

A key related challenge is the considerable diversity in terms of housing types, and corresponding array of supports, which can make planning for effective housing models to meet diverse needs more difficult. As one participant explained, the current situation raises a key question: "How do we shift our housing models for them to be effective in addressing current needs, and promoting housing stability and well-being?"

Several participants explained that the range of housing types that have been developed over many decades since the deinstitutionalization of mental health care does not meet the current needs of people in Toronto.[ii] For example, while much of the available supportive housing is shared, in fact, most individuals prefer self-contained units. Many participants voiced that shared housing is not ideal as a long-term option for permanent housing, as evidenced by the preferences of people on waitlist for mental health and addictions supportive housing,[iii] and this was also supported by the interviews with tenants living in supportive housing.

Several SME participants indicated that scattered units were important for upholding the principle of choice around location of housing, although it was generally agreed that this choice is seriously constrained for most people in the current housing market, due to the lack of affordable housing. Some participants explained that because affordable housing is so scarce and difficult to find, people will often compromise their interests and preferences in order to be able to access any kind of affordable housing. For example, some people will enter into accommodation with inappropriate support types or intensities. As a result, the serious shortage in affordable housing contributes to inefficiency in the system as a whole. SME participants explained that people on the waitlist will also refuse supportive housing options for many reasons, including because the quality of the housing is so poor (independent of housing type). It was pointed out that the fact that people are declining housing in a housing crisis, highights the extent to which these housing options are inadequate.

While the research suggests that most clients prefer living independently, some SME participants noted that there are people who prefer to live in shared accommodation. In particular, some groups such as youth may benefit from higher support congregate settings before progressing to greater independence as they build their skills. Another example is older adults who can require a support level that is more easily delivered in congregate settings, and

[ii] See APPENDIX A TABLE 1 for examples of Housing Stock Options.
[iii] The Waitlist Analysis shows that only six per cent of MHA supportive housing applicants requested shared housing.

benefit from the social aspects of communal living spaces. It should also be noted that these populations are diverse in terms of needs and preferences (e.g., many seniors want to live independently in self-contained units).

Whereas shared spaces within dedicated sites can be very effective in building community and reducing social isolation, several key informants also acknowledged that some individuals have more difficulty with social interaction and communication and therefore do not necessarily thrive in communal spaces. There are also many different models of supportive housing within congregate versus non-congregate settings, whereas debate about the merits of these options can sometimes lose the diversity that exists between the two dichotomies.

The literature supports these findings related to housing stock in Toronto. Declining quality or lack of repair of some of the existing housing, such as in Toronto Community Housing, has been identified by others as an issue.[34] Various sources have also estimated the need for supportive housing in Canada. Suttor's (2017) recent population-based estimate of housing with support for people with serious mental illness or addiction in Ontario sets out a framework for approaching estimates and demonstrates that there are many methodologies that could be used to determine need.[35] In addition to key factors such as population prevalence of mental illness/addictions, percentage of low income, and proportion requiring supports to maintain tenancy, estimates must account for future projections of population growth.

With these factors in mind, Suttor provides a range of 4,000 (conservative)-10,000 units annually for a decade-long period. In HousingTO 2020-2030, the City of Toronto projects the need for 18,000 new units over the decade to account for population growth (an increase in 1 million by 2030) and the fact that the demand for mental health and addiction supportive housing will grow faster than the population.[36,37] The analysis from this *Needs Assessment* shows that an even greater number of units (41,000) is needed over the next decade to address the needs of those on the MHA Access Point waitlist. Furthermore, there are many people who require supportive housing who do not have mental health or substance use issues, and therefore these estimates fall short of the actual need.

Suttor (2016) provides a comprehensive analysis of the history of supportive housing development in Ontario that has resulted in a complex housing typology that does not reflect current knowledge about what works for promoting recovery and independence, and inadequately meets current needs and preferences.[38] Immediately following deinstitutionalization in the 1960s, people from psychiatric institutions were housed in custodial settings, such as group homes or residences, reflecting the idea that people would benefit from shared settings. These arrangements did not promote independent living as we currently understand it, or conceive of people living with mental health and substance use issues as a diverse group, endowed with inherent capacity.[39,40]

Supports

Challenges that relate to support services refer to inappropriate types and intensities of supports, variations in understandings and definitions of support services within the sector, and the need for greater coordination of supports and housing.

As discussed in the above section on complex needs, some providers work with clients who struggle with maintaining housing stability because they are not receiving the right kind or high enough supports. At the same time, people who no longer require supports or could decrease intensity of supports sometimes do not do so because their supports are attached to their housing, or because they perceive that they will lose the housing if they relinquish the supports. SME participants also discussed the lack of after-hours staffing (e.g., no staff past 5 p.m.) as a problem for many clients who faced mental health and other challenges at night and on the weekends.

> *So one of the challenges is most of the folks who are in emergency shelters... would require supportive housing. And there is a need for additional onsite supports. They couldn't necessarily move directly from shelters into independent living... without compromising their housing history. So, someone with severe mental health challenges or experiences with substance use might enter into housing, but if it's not supporting them to the level that they need, then it's much harder for them... When thinking about supports, we would also be talking about off hour support, so not just supportive housing between the hours of Monday to Friday 9 to 5. It tends to not be when crises happen for a lot of the folks... What tends to happen, weekends and in the evenings, that's when they're looking for that additional support. You know, people who live with trauma often have a hard time in the evenings and overnight, so a kind of built in support system overnight.*

At times, participants linked these challenges with broader issues with existing funding arrangements. For example, within MHA, the Mental Health and Justice (MHJ) and Supportive Housing for People with Problematic Substance Use (SHPPSU) programs work on a rent supplement model and correspond with insufficient support levels for some people. This can work against housing those most in need, because some landlords are reluctant to take on what they perceive as higher risk tenants (e.g., in terms of engagement in activities that impact other tenants) with lower levels of support. These programs may need greater investment and reorganizing in order to effectively meet the complex needs of people with experiences of chronic homelessness and other related traumas.

As with housing, there is considerable diversity around the delivery of supports and certain housing types are linked to supports, whereas others are not. Several SMEs indicated that differences in definitions of supports, and variations in understandings of how to deliver different support intensity (e.g., high versus medium) was a barrier for the sector in moving forward with collective advocacy and development efforts. Despite the variation, some types of supports were consistently identified as a higher level of intensity, including meal preparation, 24-hour staffing and medication management (e.g., beyond education and indirect support).

A final sub-theme in the data is around gaps in coordination. Participants routinely identified funding fragmentation between housing and programs targeting homelessness, and the mental health supports funded by the province and administered through the LHINs.[iv] This lack of coordination leads to challenges such as projects that have the capital funding commitment, but lack the money for operation and supports. One example provided was the recent modular housing development in Toronto, where the project had initially been designed by the City of Toronto without consideration for the need for supports. Several participants also described situations where multiple service organizations provide within the same building or neighbourhood without collaboration or consideration of how services could be coordinated across organizations for efficiency and effectiveness. Issues related to the equitable access to supports are discussed below.

[iv] At the time of writing, the LHINs are in transition, with 14 LHINs being transformed into four Ontario Health regions. Frequently, OH regions are referenced in discussions about the LHINs, although the Ontario Health role in supportive housing remains to be determined.

> *What we have to do in the community is try to stitch the opportunities together to optimize them, and often bridge the timing gap [between funding for housing and supports] somehow. What would be helpful would be if the Province and the City worked more closely together to roll things out in such a way that the timing is aligned. Now that can be difficult because part of the challenge of creating affordable housing--as far as housing stock, requires acquisition, renovations or new builds, and those can take from months to years from onset to maturity.*

The literature indicates that these are not new challenges for the supportive housing sector. The mismatch between supports needed (types and intensities), and those available to people with complex needs has been previously identified.[41] A 2013 survey of Canadian service providers' perceptions on barriers to meeting service user needs in housing and mental health, outline numerous challenges, including inadequate levels of funding for additional supports.

The top unmet needs identified by the study were 24-hour onsite support, crisis and respite beds, and integrated mental health and housing services. Gaps were identified in models that meet aging-related and youth needs, and fragmentation in terms of service delivery systems. Overall, the research identified housing supports as a major gap and priority.[42]

Many other sources have also identified coordination issues, such as lack of alignment between housing and support dollars, described above as a mismatch between capital funding and operational and support investment, as a challenge. Coordination has been identified as an ongoing priority in work on supportive housing,[43] by provincial governments[44] and previous work on supportive housing in Ontario, including the Provincial Supportive Housing Working group.[45]

Others have identified the historical fragmentation between housing and mental health sectors as resulting in greater complexity with respect to navigating systems, and contributing to unmet needs among people with mental health challenges and those experiencing homelessness.[46] Service providers are key to helping clients navigate access, but still encounter barriers that could be addressed by better integration at the system-level of community support and supportive housing services, as well as between support service providers.

Recent work by Wellesley Institute (2020) identified several case studies demonstrating collaboration between health and housing in Toronto. The research highlights the need for greater connectivity between system-level and service-delivery collaboration in supportive housing, both between sectors (City's social housing and MHA supportive housing) and within sectors (e.g. MHA supportive housing and MHA community support services), which includes greater funding allocation across sectors.[47] The same report identifies restrictions on intersectoral data sharing (the inability of partners to share data) as a barrier to successful service delivery.

Access

In addition to the general lack of housing stock described in previous sections, other access issues included those related to movement within the system, the need for improved access to supports located within communities, and the fact that some groups face greater barriers in accessing supportive housing.

A consistent issue in the data related to appropriate levels of support is the lack of "flow," where people are prevented from moving into and out of the supportive housing system, in addition to moving to other points within the system. Key informants consistently described a lack of system support for allowing supportive housing providers to take on "risk," and ensure that individuals have a way to return to supportive housing if they no longer need supports, or a higher support level if it is needed. This was discussed by participants in different ways, and generally referred to

the need for greater flexibility to be able to change support levels by moving people from high or low support settings, or provide rent allowances so that people can maintain deeply affordable housing when they are no longer in need of supports.

Some participants described programs that already exist to help clients transition from high support housing to more independent situations, but identified a need for greater investment to expand these programs. Examples include programs for a small group of inpatients (Alternative Level of Care (ALC) patients) who have been hospitalized for psychiatric disorders and remain in hospital far longer than necessary due to lack of other options. Most of these patients require high 24-hour onsite support to be able to move on, ideally in purpose-built housing with individual units, congregate areas, and a place where medication can be stored and supported. Effective models already exist in Toronto that could be expanded with investment.

Improved access to supports for people in the community (outside of their unit or building) was identified by some SMEs as a priority, with the need for greater effort to improve access to services regardless of where people live. This was a particular concern for those accessing more specialized supports (e.g., culturally-specific services) that are not widely available in the city. Because these services are underfunded and not widely available, people may have to travel long distances to access appropriate services. Alternatively, front-line workers who are required to travel long distances to provide supports to clients face barriers to providing adequate service provision under these work conditions (e.g., lack of time). This also links to issues around the equitable access to supports.

SME participants identified issues around equitable access to supportive housing, noting that specific groups, such as racialized and Indigenous people and women, face greater barriers to housing, based on histories of discrimination and exclusion. As well, people may require support in accessing supportive housing, and people with strong advocates were perceived by some participants as having significant advantage in system access. Study participants pointed out that it can require considerable resources for agencies to support individuals who face barriers related to language or culture, in addition to all of the other challenges faced in accessing and navigating systems (e.g., health, income security) and maintaining stable housing (e.g., relationships with landlords).

> *"And authentic anti-oppressive work, anti-black racism, anti-indigenous racism, those sort of pieces, there has to be a base understanding for everybody who works in the field. I don't think it would be morally or ethically responsible to not expect that everybody... would have those instilled values in the work that they do... that's going to be crucial... So I think if you're talking about a supportive housing framework then I would also ask the question, 'Is that supportive housing unit dedicated specifically for certain people?' So, for example... for women or gender diverse people?*

Equitable access to the supportive housing system was identified as a priority in the Mental Health Commission of Canada's *Turning the Key* report on housing and supports for people with mental health problems.[48] These issues require ongoing consideration with respect to increasing access. The fact that specific groups are clearly overrepresented in homeless counts in Toronto,[49] including Indigenous people, racialized individuals, LGBTQ2S youth, highlights broader social and structural barriers to access such as stigma, systemic racism and discrimination.[50]

Work has also identified immigrant and ethno-racial groups' lower use of mental health services and barriers to accessing services. Service access barriers for immigrants and refugees include language barriers, cultural interpretations of mental health, stigma around mental illness and fear of negative outcomes associated with living with mental illness. Community-based services, enhanced collaboration in service delivery and a greater role for interpreters and cultural brokers have been identified as important steps for overcoming barriers.[51]

Other sources have similarly identified a lack of flow within the housing system as a barrier to access.[52] While the issue of flow is generally connected to system capacity, there are specific ways to address this, such as prioritizing specific groups waiting for supportive housing, and better integration between supportive housing and other systems, such as interim/transitional housing, institutional care (e.g., hospitals or jails), and immigration or refugee reception centres from which people can be waiting for permanent supportive housing.[53]

Previous work has been done on access to supportive housing in Toronto which shows that some populations are over-represented on supportive housing waiting lists. For example, the Access Point Waitlist Analysis (2018) identifies two broad groupings of people waiting for supportive housing in Toronto as: 1) people with psychosis diagnoses, higher hospital inpatient use, and functional support needs; and 2) people with problematic substance use, criminal justice involvement, and needs related to managing crises.[54]

COVID-19

Participants described new challenges related to the emergence of COVID-19 and an increase in uncertainty with respect to the impact of the pandemic on areas of supportive housing. For example, some key informants explained that since the pandemic, their organizations had been able to secure housing more easily in the private rental market due to unprecedented vacancies, however, they were unsure about the long-term impact on housing availability. Other issues involved the potential for diminished funding in the face of competing priorities that require investment since COVID-19 (e.g., relief grants for businesses impacted by COVID-19).

SME key informants described greater strain on tenants in supportive housing due to social isolation and the inability to participate in-person social activities. Certain support needs were emphasized in the first stage of the pandemic, such as when retrieving food and other essential supplies was especially difficult. Interviews with service users indicate that social activities have declined since the pandemic began. Participants described restrictions on numbers of people permitted in common spaces (e.g., laundry rooms), closure of common areas (e.g., dining rooms), cancellation of social programs, fewer in-person visits and meetings with workers, and an increase in phone calls as a method of connecting. Some participants described increased feelings of isolation, while others who were able to meet neighbours in building common areas were less negatively impacted.

Several SME participants also raised the impact of the pandemic on frontline workers in supportive housing settings, indicating that work environments had become even more burdensome with requirements to implement new protocols and provide supports safely, while also protecting family members and other close contacts from possible infection. Several participants described an increase in deaths of clients or people closely associated with their organization due to social isolation and drug use.

At the same time, some participants pointed out that there has been unprecedented public discussion and acknowledgment by governments about the inequities highlighted by the pandemic, including systemic racism and housing issues, such as homelessness, which may reflect an openness to addressing these social problems.

> *COVID-19 has obviously highlighted the inequalities of low income racialized communities that should be considered in supportive housing... So, I guess being more targeted in the way we actually provide housing to people in those groups. For instance, in general there aren't too many Black or Black serving housing providers. So, trying to build capacity in the sector where needed and finding opportunities for more racialized, or groups from racialized communities to have access to housing.*

Recent reports have echoed concerns about the pandemic and adequate living conditions. COVID-19 has changed general understandings about living environments, where shared settings are now associated with greater risk for facilitating the spread of disease. Housing and shelter systems have had to contend with the issue of crowding, and marginalized groups have been faced with reduced abililty to self-isolate or social distance to prevent contagion.[55] The pandemic has also highlighted the need for policy responses that address eviction prevention in general, and for people who are unable to keep up with housing expenses.[56] These challenges are relevant to the supportive housing landscape because they have the potential to heighten pressure on an already strapped system, due to changes such as new understandings of what constitutes safe living environments and increases in housing instability.

COVID-19 has also been documented as posing new problems for substance use and overdose prevention.[57] For example, the requirement for social distancing/isolation can greatly increase risk for substance users, especially opioid users, as it contradicts a harm reduction approach such as the use of peer drug use networks.[58]

The pandemic has highlighted the significant impact of inequities (e.g., income, racial, gendered) in terms of who is more likely to contract the virus, and also in terms of capacity to endure the economic impacts of the pandemic. Action to address these inequities are required in efforts to develop supportive housing as with many other sectors. We also know that people in frontline jobs tend to earn lower wages compared to other positions with greater flexibility for remote work, and people in these positions often work in multiple positions at more than one site.[59] These issues have the potential to impact frontline workers in the supportive housing sector as well as their clients, by increasing economic vulnerability and risk of exposure to the pandemic virus.

5. MHA supportive housing growth projections: 2020-2030

An analysis of the MHA supportive housing waitlist is a key element of this Needs Assessment as it provides projections for housing units that are needed in Toronto based on the number of individuals on the waitlist. This analysis was also conducted to inform SHGP decision-making, including setting specific targets for the supportive housing sector.

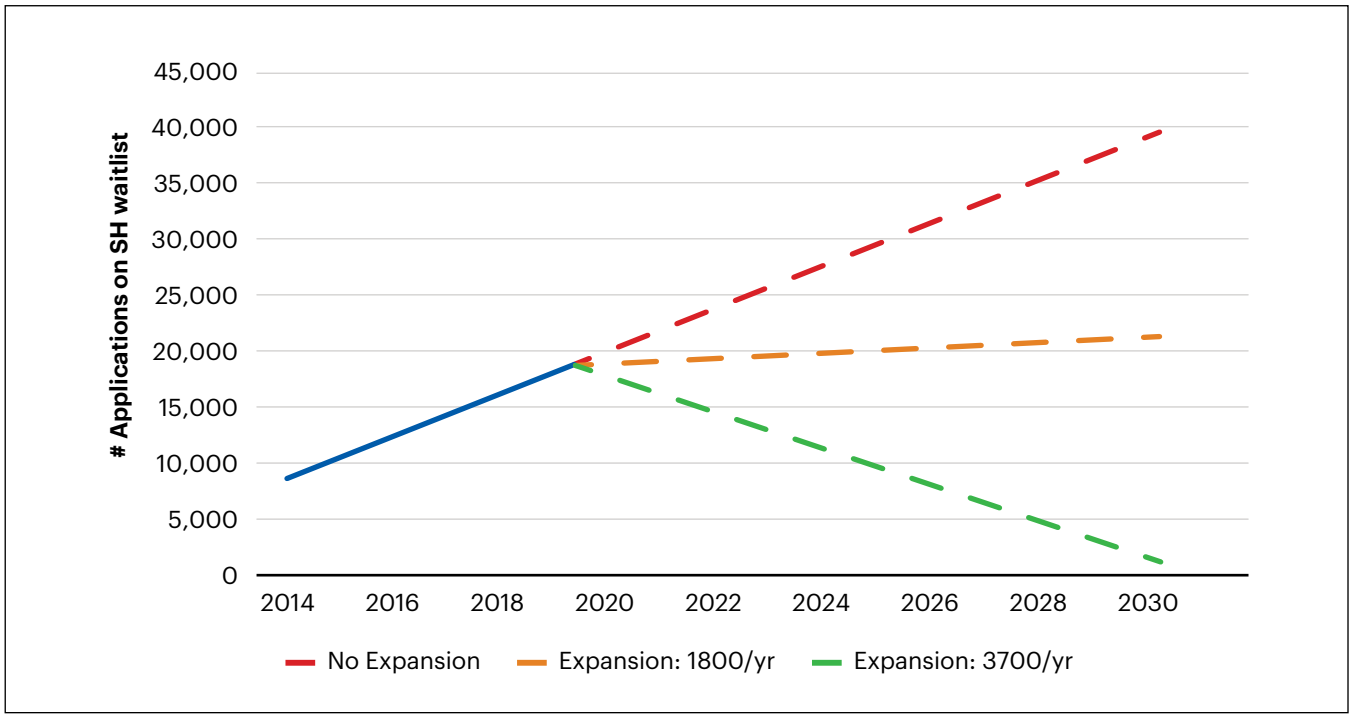
The number of people needing MHA supportive housing in Toronto far exceeds the available housing and support. In FY2019 alone, there were 3,575 new applicants deemed eligible for MHA supportive housing by The Access Point (TAP), the coordinated access service for MHA supportive housing and community support services in Toronto. By comparison, there were 202 vacancies reported to accept applicants from the waitlist during the same period. At the end of FY2019, there were nearly 19,000 individuals waiting for MHA supportive housing.

Estimating growth of supportive housing need

In order to quantify the estimated need for MHA supportive housing over the next 10 years, data from TAP were used to project growth of the MHA supportive housing waitlist. Specifically, the average year-over-year growth of the MHA supportive housing waitlist between FY2014 and FY2019 was used to project the growth of the waitlist to FY2030 and to estimate the number of units need annually to address the need.

Between FY2014 and FY2019, the MHA supportive housing waitlist grew an average of 2,027 applicants each year. Figure 1 below provides the projected growth of the MHA supportive housing waitlist both with and without new investments to expand supply. In the absence of new expansion, the waitlist is projected to grow to over 41,000 by the end of FY 2030. With an investment in 1,800 new supportive housing units each year (18,000 over 10 years), the MHA supportive housing waitlist is projected to grow to over 21,000 by FY2030. In order to eliminate the waitlist for MHA supportive housing in Toronto, 3,700 new units each year (or 37,000 over 10 years) are required.

Figure 1: Projected growth of the MHA supportive housing waitlist to FY2030



A similar analysis was also undertaken to estimate the number of units for three levels of support intensity. TAP maintains waitlist data for three levels of support intensity: 24-hour support, daily support and occasional support. At the end of FY2019, there were 960 individuals waiting for 24-hour support, 2,386 waiting for daily support, and 15,491 waiting for occasional support. Using the average year-over-year increases in the waitlist for each level of support, the annual number of new units needed to eliminate the MHA supportive housing waitlist by FY2030 are as follows:

- 170 (1,700 over 10 years)
- 470 (4,700 over 10 years)
- 3,075 (30,750 over 10 years).

Alternative level of care

Among individuals requesting 24-hour support, a small proportion (approximately 5-6 per cent) are alternative level of care (ALC) inpatients at the Centre for Addiction and Mental Health (CAMH). ALC is the term used to describe patients who occupy a hospital bed but do not require inpatient care. These individuals are held in hospital because there is not an alternative setting available in the community that can meet their support needs. The reduction of ALC stays is a focus of the Ministry of Health, given its priority of reducing hallway medicine. Data from CAMH was used to estimate the number of 24-hour supportive housing units needed to eliminate the existing and projected waitlist of ALC patients from CAMH. Extrapolating from the number of ALC patients currently waiting and the average year-over-year increases in the number of ALC patients waiting for supportive housing, it is estimated that between 82 and 101 24-hour units will be needed over the next 10 years (or 8-10 units per year).

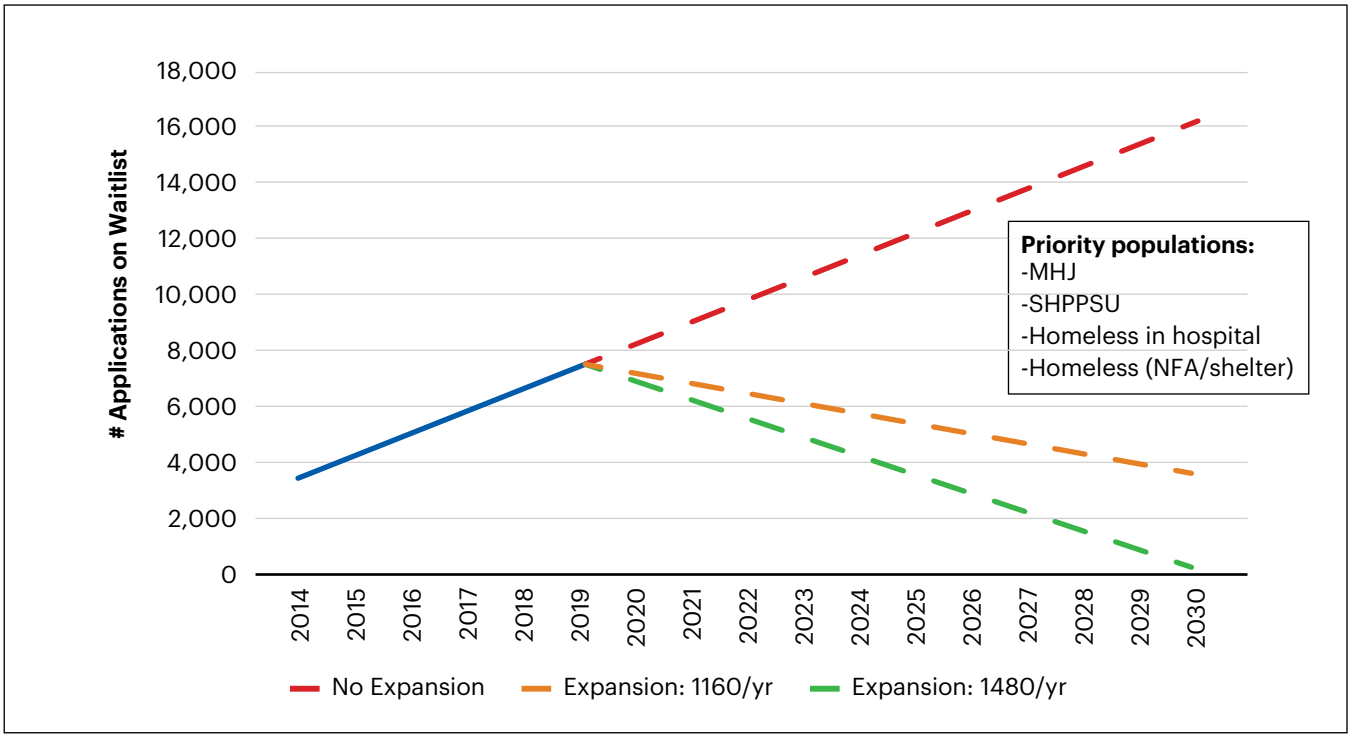
Prioritized access to supportive housing

Based on the above analyses, the City of Toronto's target of creating 18,000 new supportive housing units over 10 years will not be sufficient to meet the estimated need. In light of the magnitude of need, consideration may be given to prioritizing access to supportive housing.

In order to better understand the effect of prioritizing access to supportive housing on the trajectory of growth of the MHA supportive housing waitlist, analyses were undertaken to project growth in need if access were limited to specific populations. In these analyses priority was given to supportive housing applicants requesting 24-hour or daily support on the assumption that these applicants would have the highest needs and would require a high intensity of support to maintain their housing. Next, priority was accorded to applicants requesting occasional support who were applying for MHJ housing or SHPPSU and/or who were homeless and residing in an institution (e.g. hospital, jail) or shelter at time of referral. These latter groups were selected because of the complexity of their needs, their requirement for specialized interventions , their utilization of more costly health and justice services and/or their potential vulnerability.

Applying the above parameters, 6,400 24-hour or daily support units would be needed over 10 years. Figure 2 below illustrates the projected growth of the MHA supportive housing waitlist for occasional support units if referrals were limited to the above-mentioned groups. The waitlist for occasional support for these groups is estimated to grow to over 16,000 by 2030, if no new investments in supportive housing are made. If a growth target of 18,000 new units over 10 years is used, 11,600 units would remain (or 1,160 per year) for the populations noted above applying for occasional support after prioritizing applicants requesting 24-hour or daily support. Allocation of these 11,600 units to the above-noted populations is projected to result in a waitlist of 3,520 by 2030. In order to eliminate the waitlist for MHA supportive housing for the afore-mentioned groups, 14,800 occasional support units are needed along with 1,700 24-hour and 4,700 daily support units over the next 10 years.

Figure 2: Projected growth of select priority populations on SH waitlist for occasional support



The above analyses estimating growth of housing need among some populations afforded priority access to supportive housing are for illustrative purposes only. However, these analyses underscore the need for a systematic process of prioritized access to supportive housing in order to optimize this scare resource.

Other prioritization approaches have been utilized for managing access to supportive housing. One method used in a number of jurisdictions is the application of standardized vulnerability assessment tools (e.g. VAT, SI-SPDAT) to assess an individual's vulnerability to victimization, mortality and/or ill health if left homeless.[62,63] A number of such tools have been employed broadly across Canada.[64,65] A second approach prioritizes people based on greater use of high cost health, justice and social services.[66,67,68] A third strategy employs a blended approach prioritizing access to supportive housing through both the identification of greater vulnerability and higher utilization of health and other public sector services.[69] Another consideration moving forward is how to ensure an equity lens is applied to the allocation of supportive housing spaces, such as reserving some portion of units for equity-seeking groups. The issue of prioritization is further discussed below in the section on addressing equity and inclusion in supportive housing.

6. Pathways forward: Strategies to address challenges

In response to the challenges faced by the sector, the second half of this report focuses on pathways forward that emerged from the qualitative research. Relevant literature is integrated to supplement the analysis and develop an evidence-informed approach to strategies for the SHGP.

Focus on evidence in the development of supportive housing options

In light of considerable diversity in existing models of supportive housing, some participants suggested moving forward with what we know is effective in addressing needs related to supportive housing. This theme reflects the idea that supportive housing options and models already exist and need to be expanded or reorganized to reflect current knowledge of best practices.

One strategy for moving forward in light of the complexity of the supportive housing landscape is to continue to use best practices and evidence to guide decisions. This approach involves balancing urgent pressures and supportive housing options that are currently available in Toronto, with evidence-informed options to guide development. A key objective of this section is to summarize the evidence specific to supportive housing in response to some of the main challenges outlined in Section 4.

Permanent supportive housing is an effective intervention for achieving housing stability

Despite an underinvestment in the development of supportive housing, the evidence shows that there are clear solutions that work for the vast majority of people. There is strong evidence that permanent supportive housing (PSH) results in long-term housing stability for most people who have experiences of homelessness and mental health challenges.

A recent systematic review found that PSH is effective for maintaining stable housing for people in all age groups and with a variety of support needs.[70] The same review found that in order for PSH to be associated with reduced psychiatric symptoms compared to regular services, it must be combined with other services such as case management or assertive community treatment (ACT). The successes of PSH in Canada have been most studied through a combination of mobile or community-based supports with scattered site apartments,[71] and the benefits can be achieved in both the private rental market (single-site or dedicated sites) or social housing.[72,73]

The most widely discussed PSH model, Housing First (HF) provides people experiencing homelessness and mental health challenges, with housing in addition to support services when necessary.[74] There are several core components that are accepted as part of an HF model, including immediate unconditional access to housing (e.g., no "housing readiness" or requirement for treatment), and the prioritization of choice and self-determination with respect to housing and supports. Other HF components include an emphasis on recovery including harm reduction, individualized and client-driven supports, and social and community integration.[75,76] This newer model of housing has also had considerable influence over other types of housing, for example, through the integration of some or all of the core principles into other models.[77]

In the US, the Pathways HF model was introduced in the 1980s, and has been found to be successful for achieving housing stability for people experiencing homelessness.[78] Clients were provided with choice of subsidized, scattered housing in apartments, in addition to mental health supports for people with severe mental illness.[79] A Canadian HF project, At Home/Chez Soi (AH/CS), has been the subject of its own cross-national, randomized-control study.[v] The five sites included one in Toronto, which had a specific intervention to address the needs of racialized communities.[80] Study participants across all sites received one of two interventions – rent supplements in addition to either intensive case management (ICM) or assertive community treatment (ACT).

Participants who received the AH/CS HF intervention were assigned ICM if they were determined to have moderate needs and those with higher needs received ACT supports. The ICM programs consisted of case manager teams who worked with individuals to determine and coordinate necessary health and other supports, and the ACT programs were provided by multidisciplinary teams including a psychiatrist, nurse and peer specialist.[81] The evaluative

[v] The comparison group had access to the housing and support options typically available in their communities.

research found that participants who received the intervention had greater housing stability after two years than those who received standard care.[82] Essential features of ACT were multidisciplinary teams with small caseloads, home-based treatment and out of hours availability.[83] For ICM, case managers support a small group of clients in the community with a focus on everyday issues and advocacy functions, including counselling, facilitating access to community services and life skills training.[84]

A key aspect of PSH and HF is the provision of income supports to maintain affordability in housing. This support can come in different forms (e.g., rent subsidies or income supplements) depending on the nature of the support and the housing model. It is widely acknowledged as one of the most crucial factors in achieving housing stability. The evaluation of fidelity tools to assess whether a housing model can be accurately categorized as HF, has found some support for the idea that programs with higher levels of fidelity result in better housing stability and other outcomes such as decreased substance use.[85] A common fidelity tool developed by Tsemberis & Stefancic in the US,[86] was later adapted by the AHCS team to better reflect the Canadian and local contexts.[87]

Additional interventions are needed to improve quality of life and well-being for people living in supportive housing

Despite the considerable success of PSH and HF in addressing housing instability for people with mental health and substance use challenges, research suggests that additional measures are required to improve overall quality of life and well-being for people living in supportive housing.

The qualitative data suggests that while supportive housing is important for addressing homelessness and housing issues, social and economic contexts continue to act as a barrier to well-being. For example, both SMEs and service users identified food security as an ongoing challenge faced by people living in supportive housing in Toronto, and service user participants also described the fact that many tenants continue to live in poverty, even after they enter supportive housing. The data highlights the structural barriers that consistently limit the health and well-being of individuals (e.g., effects of inequality, gentrification).

While the evidence is particularly strong for the success of permanent supportive housing in achieving housing stability,[88] it is more ambiguous with respect to other outcomes, including the long-term impact of PSH on quality of life, clinical outcomes, service use, and success in community adaptation.[89,90] There is little evidence of the impact of PSH on long-term health outcome indicators,[91] and the AH/CS study found no lasting impact of the intervention on quality of life.[92] The study also found no significant effects of the intervention on substance use problems or criminal justice involvement.[vi]

Research also shows that food insecurity continues to be a major problem in individuals who have transitioned to stable housing,[93] and some work has found that despite leading to better mental health and quality of life outcomes for older adults compared with their younger adult counterparts,[94] PSH is not protective against premature aging for people who have experienced chronic homelessness.[95]

These findings highlight the persistent effects of poverty and inequality on health and well-being even after people achieve housing stability, and the fact that people continue to face significant barriers to economic security in terms of income security and the job market.[96,97] Findings from reviews also speak to the need for adequate and appropriate social and economic supports for people living with mental health and substance use challenges.[98]

While mental health programs such as ACT are well established and known to be effective in treatment,[99,100] it should be acknowledged that other models of support have received comparatively less investment and evaluation, and that more recent, innovative mental health models that are not as well studied also have the potential to address complex needs.

[vi] Research showing improvements in these outcomes has also been limited by design features (e.g., small sample sizes, narrow range of outcomes measured) and a lack of follow-up to examine long-term effects of the program. As well, health impacts of supportive housing interventions take time to establish.

Integrating flexible approaches into Housing First models

The qualitative data also indicates the need to be flexible in approaches to PSH. Several SME key informants who work closely with people directly experiencing homelessness maintained that some people with more complex needs (e.g., dual diagnosis of a developmental disability and a mental health issue, or people with recent, severe experiences of trauma) would benefit from transitional options that bridge to PSH. With this option, individuals can work with providers to determine the right kinds and mix of housing and supports to ensure their tenure in permanent housing is successful.

Participants also suggested that tenants with multiple experiences of evictions may require more resources and time from providers because their housing and support needs are not well served by HF or within the current system. A related challenge discussed by participants in the Needs Assessment was the lack of appropriate support levels, as well as the need for flexibility to move up and down in terms of intensity of support.

Individuals being released from institutions such as jails or inpatient units who require immediate housing but are not able to rapidly access PSH are another group who may benefit from transitional housing. This group often requires housing and people risk being lost to follow-up before PSH can be offered. In some instances, these individuals may cycle repeatedly through shelters, jails and ED services. In this context, short-term transitional housing is used to address urgency of need rather than client readiness for housing and may facilitate earlier release for clients coming from jails or inpatient units, and minimize the use of other systems for housing-related needs.

The need to be flexible and open to other options may be especially true for programs for the small percentage of people (around 13-20 per cent depending on the study) that have difficulty achieving housing stability in the HF model.[101,102] While studies have found that it is impossible to predict who will have difficulty maintaining housing stability in HF in scattered site housing,[103,104] within a range of options leading to permanent housing, the transitional model might be considered more appropriate for some groups, such as youth transitioning from other systems (e.g., child welfare)[105] or in some cases women (e.g., with experiences of intimate partner violence).[106]

Approaches such as flexible assertive community treatment (FACT) allow for greater flexibility in support intensities. This model can take diverse forms across different contexts, but generally has the same multidisciplinary approach as ACT with different levels of care and seamless transition between high and low intensity care; individual case management for most people and full ACT when there is a need for shared caseloads and assertive outreach.[107] FACT also has more lenient admissions criteria, where ACT is generally limited to individuals with specific diagnoses (e.g., psychotic disorder). Studies indicate that using FACT can help to reduce time in hospital and crisis support required by people with mental illness.[108]

Evidence about housing typologies in supportive housing

Research participants described different housing typologies to meet the varying needs of supportive housing tenants, and the data suggests that there are benefits and disadvantages to acknowledge with each. For example, the interpersonal demands of shared housing may not be suited to many needs, and congregate settings were sometimes characterized as more institutional (e.g., rigid timetables for daily activities or relationships of dependency with staff), than scattered options.

At the same time, SME participants pointed out that shared spaces within housing arrangements can facilitate the development of social relationships with other tenants. Various reasons were provided for why supportive housing is declined by those waiting for available units, including type and quality, location (e.g., neighbourhood perceived as unsafe or not near services), or due to participation requirements of the program.

Research has identified important elements of supportive housing for enabling people to maintain successful tenancies. These include the separation of housing and services (i.e., services are not a condition of housing), tenant control over housing (e.g., tenant holds the lease), the integration of housing into the community, and the facilitation of choice over housing options.[109] Greater subjective sense of choice and occupational functioning has been associated with living in independent units versus congregate settings.[110] It has also been established that the same benefits of independent living have been found in the private rental market with rent supplements and in subsidized social housing.[111] Research also shows that better housing quality is linked to improved housing stability outcomes.[112]

Where apartments or other types of independent housing are considered the preferred housing type for most clients because of its connection to control and choice, some people report social isolation and loneliness and receive insufficient support levels in these settings.[113] Dedicated sites may also have greater capacity to provide 24-hour support where needed if there are staff onsite in buildings, whereas people in abstinence based programs may prefer to live in a scattered unit if there is potential for exposure to substance use and related activities in dedicated or clustered sites.[114] As well, scattered-site housing typically involves working with individual landlords to secure rental agreements which can introduce challenges.[115]

Single site, dedicated housing has the potential for significant variation in terms of the amount and kinds of supports provided, as well as the role of tenants in decisions related to housing and supports. Single site housing with onsite support is the most common type of housing in Canada because of its introduction post-deinstitutionalization. Despite its longevity, this type of housing has received less attention in studies than scattered site, and there have been calls for better research given that it comprises a significant portion of Canadian supportive housing stock, there is a segment of people who express preference for this type of housing, and evidence that scattered site housing produces better health and housing outcomes is limited.[116]

Continuum of supportive housing options to meet diverse needs

A prevailing theme from the qualitative study and previous work on supportive housing refers to the need for a continuum of supportive housing that represents a range of combinations of housing and support options for people to choose from. The continuum concept is represented in the grey and academic literature on supportive housing, but it was also reflected in the qualitative research findings, where participants expressed that rather than providing a 'one-size-fits-all' model, diversity in need should be met with an equally diverse range of choices. This approach also recognizes that the needs of people are subject to change in terms of types and intensities of support, where recovery is non-linear and may involve interruptions or setbacks that require changes in support services.

> *So within Housing First...there's lot's of different ways of looking at the core principles... But all of them highlight the importance of choice and no preconditions...And choice is a complicated thing. So if you take a harm reduction approach to supportive housing, that should mean that there's different ways that you can do that. So a harm reduction approach doesn't exclude the possibility of abstinence-only housing. Because if it's truly choice driven, there are some people for whom their ability to manage their substance use means that they need to be away from other users. But others may want something else-- So I think starting from the client outward is the way to think about...what do people need? ...Having said that, there's a huge undersupply [of housing], and so at the same time we have to build up supply. But I think in doing that, [we need] to be thoughtful-- and not just stamp out a one size fits all kinds of approach.*

A continuum approach also accounts for housing and support models outside of PSH that meet individual needs and should be integrated into care models. For example, people in need of supportive housing may access emergency shelter and street outreach or transitional housing services, and there is need for greater planning around how these different service areas can work together to provide permanent supportive housing to those who need it, and greatly reduce the need for emergency-oriented approaches, such as the shelter system.

Guiding sub-themes in the provision of supports

Given the importance of supportive housing for addressing housing stability, as well as the limitations of interventions for improving broader quality of life and social integration, the provision of supports is clearly a key area for consideration. Key informants elaborated on an impressive and diverse catalogue of supports that they either delivered, or maintained should be available to tenants.[vii]

The literature also demonstrates that people housed in and waiting for supportive housing in Toronto have diverse support needs,[117] and previous work has catalogued the wide range of supports that should be available to people with mental health and substance use challenges.[118,119,120] The following sub-themes are derived from the qualitative findings and literature as key considerations to guide thinking about and the provision of support services.[viii]

Flexibility

Findings from the literature and interviews suggest that support needs for some individuals are unmet, and better systems are required to determine the appropriate types or levels of supports, and flexible mechanisms to adjust these. This sub-theme reflects the idea that within a continuum of options, supports should be easily adapted to the changing needs of the individual, in terms of the kinds of supports available and ongoing adjustment of the intensity of the supports. For example, people should be able to access crisis-related supports or increased intensity of supports when needed, and for as long as they are required.

Greater flexibility within the system has also been discussed as a mechanism to enhance flow of people and resources within the system, and consequently increase availability of higher intensity support options when needed. Participants indicated that greater investment by funders into permanent affordable housing options is a crucial mechanism to increase system-wide flexibility. This includes investment into portable rent supplements that could follow tenants no longer in need of supports, and these should match market rates to enable people to pay for accommodation in new settings if necessary. Key informants described the current system as disincentivizing flexibility and change, where individuals are unwilling to take on the risk of losing affordable housing or supports that they may need again in the future.

Other ideas to promote flexibility and flow involved making units in social housing available to organizations to provide housing options for tenants who no longer need supports. There may also be potential for increasing flow by delinking housing from supports where feasible (e.g., non-dedicated sites) so that clients can easily change support intensity (e.g., from ACT to case management) without moving housing. Flexibility of supports is identified as a key best practice in Ontario's 2017 Best Practice Guide on supportive housing.[121]

Individualized

The qualitative data spoke to the individualized support needs of clients, and participants generally resisted describing a prescriptive collection of supports to address the needs of particular groups or populations. Participants frequently expressed that supports should be determined by the individual and their team or advocates on a case-by-case basis. As one key informant summarized, "The extra thing is different for different people." At the same time, participants also discussed specific types of supports to be considered for groups with specific health-related challenges, such as substance use challenges. Specific support options, such as harm reduction approaches, are discussed in more detail below.

Choice & self-determination

The idea of maximizing choice for tenants in terms of the location of supportive housing and determining types of supports is reflected in both the qualitative data and the literature. Study participants conveyed that in addition to choice around types and locations of supportive housing, tenants should have choice in *how* they live, including control over the routines of their lives, such as mealtimes and other daily activities.

[vii] See APPENDIX B TABLE 1 for examples of these supports.
[viii] See APPENDIX B TABLE 2 for a summary of these sub-themes.

These principles recognize that each individual holds their own unique goals and aspirations, and should be supported in an ongoing manner to identify needs and corresponding supports. The importance of choice and control over housing and supports in contributing to quality of life and the ability to adapt to community is central to many supportive housing philosophies.[122] At the same time, the qualitative data and the literature highlight numerous systemic and structural factors that greatly restrict individual choice.

Recovery-oriented and trauma-informed

Key informants emphasized the centrality of recovery-oriented approaches that facilitate well-being in community settings, recognizing that recovery is an ongoing and non-linear process that means different things to different people.

Recovery-oriented approaches in the literature also acknowledge the role of broader structures of marginalization in experiences of mental health, including histories of colonialism, racism, sexism, homophobia, transphobia, among others.[123] People with serious experiences of trauma sometimes have greater difficulty maintaining housing stability.[124] Addressing the effect of trauma stemming from different forms of marginalization, as well as the higher rates of trauma in homeless populations, is also integral to the facilitation of recovery.[125]

Coordination

Coordination of supportive housing has several dimensions in this research. Generally, the sub-theme refers to the coordination of support by service providers as well as the coordination of housing and support services. Participants frequently described the need to better coordinate the funding and delivery of housing with support services in Toronto. An additional idea throughout the data was the need for greater coordination of supports by organizations and funders.

Several SME participants explained that there are sometimes multiple organizations providing supports within the same building or within close geographical proximity. These participants suggested that better tracking of where supports are located (e.g., social housing sites, community clinics or organizations) and who is providing supports could help to initiate steps to coordinate service and thereby increase the impact and efficiency of support provision. Some SME participants indicated the need for better coordination in the response to homelessness across other systems, such as hospitals/health care, jails, shelter systems, including identification of pathways into supportive housing from these systems.

The literature has historically identified better linkages between housing and support services as a priority.[126] The need for better policy and funding coordination in supportive housing provision has been established by other working groups and organizations in Ontario.[127,128,129] A Toronto Alliance to End Homelessness (TAEH) report recently called for better coordination of funding across different levels of government, and a commitment for integration of work on supportive housing across diverse City divisions to facilitate supportive housing development.[130] Coordination across the Ontario LHINs, which have historically determined how supports are funded and delivered, and the local housing service managers has also identified as a priority by advocates.[131]

The literature also refers widely to efforts to reduce the fragmentation of delivery services as a best practice, and coordination of services for diverse populations is known to be important for improving access to care or supports. As well, coordination and information sharing among care providers is key for maintaining continuity of care and consistency in terms of ongoing relationships with specific providers.[132] Coordination across different systems includes elements such as outreach to clients and linkages for individuals between systems, communication across systems, information systems, and policies to address coordination (e.g., around discharge planning and referral services).[133] Better coordination between the criminal justice and supportive housing systems was acknowledged as important to facilitate appropriate housing for people exiting incarceration in a recent report on *Justice-Focused Mental Health Supportive Housing in Ontario*.[134]

Evidence-informed

As discussed previously, the use of evidence-informed approaches is an important component for moving forward with the development of supportive housing. This includes using evidence-informed interventions to address specific support needs (e.g. problem substance use, unemployment, crisis management). Key informants often acknowledged that the topic of supportive housing is well-researched in Toronto and elsewhere, and that there is a need to move forward with existing knowledge to develop supportive housing across the city. This approach would involve the use of best available evidence, while also including diversity in perspectives and knowledge beyond traditional research, such as from those with lived experience of homelessness. This is especially pertinent given the history of excluding marginalized groups and the knowledge that they create.

Ongoing evaluation and performance measurement of supportive housing programs to better understand outcomes and promote best practices, have been identified in the literature as important research and quality improvement objectives.[135]

Social inclusion and community integration

Study participants consistently raised the imperative to facilitate social inclusion and community integration through supportive housing. This sub-theme describes the shared understanding that housing and support services should strive to promote authentic belonging within communities broadly defined. SME key informants described a broad range of supports and programs that are, or should be, available to increase social participation of tenants in supportive housing. These included social programs, community kitchens or support groups, and supports to access employment, volunteering and other occupation-oriented activities. For parents, affordable, accessible childcare was also identified as key to promoting integration through education or social activities.

Several participants suggested that it is sometimes easier to facilitate community development activities in dedicated sites with communal spaces, especially in places where public spaces are more difficult to access. As well, adequate community spaces for socializing and group activities can address social integration needs without necessitating congregate living spaces. Most service users expressed a preference for self-contained units, and many also described the value of shared and communal spaces for socializing as contributing to their quality of life. Many participants also spoke of inadequate levels of income through programs such as the *Ontario Disability Support Program* as a major barrier to social participation.

Research finds that people with mental health challenges who enter into permanent supportive housing (e.g., Housing First) can struggle with experiences of social isolation and loneliness. Furthermore, some people have difficulty with the transition from living in communal settings such as shelters or institutional settings to living alone in HF situations, including achieving social integration and life skills. With this in mind, support services that foster social networks and independent living are particularly important for people in achieving housing stability and positive physical and mental health outcomes.[136] Reseaserch has also raised the need for more work on employment interventions, where tenants receive support accessing pathways to greater economic security.[137]

Important clinical and community supports to address complex needs

The qualitative research and literature review additionally uncovered specific examples of support types and approaches that are important for addressing complex needs of people in supportive housing. These include peer support, harm reduction, tenancy supports/eviction prevention, in combination with other therapeutic and clinical supports.

Peer support

Peer support was identified by SME and service user participants as an important method of contributing to positive mental health and well-being. The embedding of peer support within care models was acknowledged as especially important for people who use substances or similarly experience greater levels of stigma. It was also raised by SME key informants that integration of peers into support models requires careful consideration to avoid tokenism, and to promote the career and personal development of those in peer positions. Peer support services can be embedded into each of the different categories of supports, since insider knowledge is useful in many services, such as harm reduction in clinical services or navigating the criminal justice system.

The literature supports these ideas and the provision of knowledge and guidance by people with shared life experiences has been shown to increase a sense of hope, control and self-efficacy, and the ability to build trusting relationships.[138,139] Findings from the AH/CS Moncton site evaluation suggest that a more structured housing model with peer support can assist individuals who have difficulty with standard HF models to achieve stable housing.[140] In addition to multi-disciplinary teams that include peer support, street outreach systems with peer workers may be necessary for people living on the streets for long periods of time.[141]

The literature also indicates that the use of peer support models for achieving social integration requires consideration of the context, since factors such as the degree of acceptance of peers into provider teams and possibilities for advancement within roles for peers are important to facilitate inclusion for peer workers.[142,143,144] The *RainCity Housing and Support Society* in Vancouver[145] was mentioned by participants as a model that integrates peer support into an HF approach for people not traditionally considered "housing ready" due to substance use challenges and other issues. Other examples of programs that embed peer support services have been identified in Addictions & Mental Health Ontario's (AMHO) *Promising Practices in Supportive Housing* report.[146]

Harm reduction

Harm reduction was consistently raised by key informants as a crucial philosophy and practice for support services for people with substance use challenges or concurrent disorders. This approach emphasizes low barrier settings with minimal housing requirements related to substance use and related activities.

Harm reduction supports involve the provision of safe equipment and supplies for drug use, and environments which are supportive of people in crisis or with severe experiences of trauma, in addition to options for treatment. The importance of access to 24-hour community crisis support was raised by many as key to supporting people to maintain housing stability. From a harm reduction perspective, there is a need to conceive of spaces through the lens of what they look like for safe drug consumption. Several participants pointed out that for a harm reduction philosophy to provide genuine choice, they would also need to have options related to abstinence, although abstinence-based programs may need to be delivered separately for logistical reasons.

Research also finds harm reduction is particularly significant in the context of opioid use and the risks of overdose, and requires an approach that prioritizes the safety of the individual within this context.[147] Harm reduction in low barrier supportive housing settings have included opioid agonist treatment,[148] and recent evidence-based clinical guidelines for homeless and vulnerably housed people include supportive housing, harm reduction and opioid agonist treatment in addition to other interventions.[149]

Eviction prevention and therapeutic supports

Key informants discussed the significance of tenancy support and eviction prevention services for people with complex needs who have difficulty maintaining housing. Eviction prevention can be considered a specific area of support focus, but also an outcome of the appropriate combination and intensity of supports, and appropriate housing conditions for the individual.[150] Organizations that have their own housing stock (i.e., functioned as both the landlord and support provider) tend to have more control over eviction prevention for individuals versus those who had to maintain relationships with private landlords, and navigate issues such as property damage.

The previous section on evidence demonstrates that a multidisciplinary approach provides benefit for addressing complexity in terms of issues such as co-occurring conditions, significant inpatient/ED use, significant behavioural issues related to managing crisis or self-harm. The configuration of a multidisciplinary team means that evidence-based approaches to treatment can be integrated through therapeutic treatments in addition to other kinds of supports.

Specific evidence-based therapeutic supports to address complexity are identified in the recent report on *Justice-focused Mental Health Supportive Housing in Toronto*.[151] These treatments include cognitive behavioural therapy (CBT), integrated dual diagnosis treatment and other behavioural interventions, and have been found to be effective in addressing certain needs, related to substance use, trauma, and concurrent disorders. These treatments are described in more detail in the report, and point to the need for investment in specialized

interventions based on mental health diagnoses, which could include concurrent disorders specialists, behavioural specialists (CBT, DBT, behavioural interventions), or employment specialists (occupation).

In order to facilitate the care of people who are aging, providers need to be able to address psychogeriatric issues (e.g., differences in presentation),[152] and elder care (including ADLs and IADLs) must also be embedded within supportive housing options. Participants also emphasized the importance of primary care for people who have histories of homelessness and have experienced barriers accessing the health care system. This is especially important for people with chronic conditions that require ongoing medical attention.

Partnerships and collaboration for collective impact

A main theme from the qualitative data was the unmet need and urgent pressures facing supportive housing providers, and requiring a systemic response. A key feature of the sector-led response to address these pressures was presented in terms of the role of partnerships within and across sectors to maximize collective impact.

Key principles and values were raised by several participants as important for guiding partnerships. These included the importance of developing authentic partnerships that reflect ongoing transparency about the reasons that organizations have for partnering with each other. As well, it was raised that there may be power disparities within partnerships that require acknowledgment (e.g., with respect to size or funding received), as well as different needs that are fulfilled by partners coming together (e.g., funding requirements, specific agendas).

Key informants described numerous activities that could be undertaken in order to build the collective impact of the sector and address systemic shortcomings in providing supportive housing. Partnerships and collaboration were discussed in terms of strategies to address gaps in resources and experiences, and for advocacy and achieving accountability.

Given the complexity faced in providing housing as part of supportive housing (e.g., lack of affordability or options not meeting current needs and preferences), some participants envisioned developing the housing supply to address needs by pooling existing resources. SME participants suggested that housing providers could pool equity from their existing housing supply and raise capital based on this pooled equity. This capital could then be leveraged in a multi-pronged approach, with short-term and long-term goals, to support refurbishing existing stock and acquiring and/or constructing new buildings.

This approach would address urgency through a strategic, evidence-informed approach to developing housing stock that meets the current needs and preferences of tenants in Toronto, while also remaining flexible to respond to different development opportunities that arise. Cooperation within the sector is an important tool for estimating appropriate targets for housing development and aligning these with necessary support dollars. For example, an understanding of how many rent supplements are held by the sector would enable organizations to pool these tools and leverage them to finance future development. The collective portfolio approach[ix] was often represented as a strategy to increase the control of non-profit organizations and social housing providers over housing, and accordingly address other challenges such as reducing the need to manage difficult relationships with landlords in the private sector.

SME key informants described the common use of partnerships in their work within and across sectors. These partnerships were often described in terms of individual providers working together to meet the needs of clients. For example, several participants suggested that clients with developmental disabilities and mental health or substance use challenges (with or without a diagnosis) may have a particularly high need for supportive housing, with many cycling in and out of other systems. Several participants described addressing the complex unmet needs of this group by bringing together providers with different skills and training to address health and social complexities, which included developing partnerships across organizations and sectors (e.g., MHA and developmental sectors). Although these partnerships already exist within the supportive housing sector in general, it was suggested that mechanisms to further encourage collaborative work would benefit clients with complex needs.

[ix] The step towards a collective portfolio of housing supply had already been inititated by the SHGP at the time of the interviews, through the Asset Inventory, and individual organizations were actively partnering to combine assets to increase impact.

Partnerships were also described as a strategy that would enable the sector to better organize, plan and advocate to governments and other funders. These partnerships already exist within the sector, and include the Toronto Mental Health and Addictions Supportive Housing Network (TMHASHN), which is a group of organizations committed to working collaboratively to improve the quality of life for low income Torontonians with mental health and addictions challenges. A specific advocacy strategy discussed was the development of common language and shared definitions to address fragmentation and represent the work of the sector. Several key informants referred to this as an effort to standardize and self-regulate as a sector, through more formal and common understandings of existing housing types and support models.

A related theme that emerged from the data was the issue of accountability, where participants described a deficit in mechanisms for tracking collective progress and shortfalls in the supportive housing sector. The idea that improved monitoring systems would increase accountability on the part of government funders and also in terms of the work of providers within the sector was linked to the concept of collective impact. Mechanisms for planning and accountability were identified in terms of the development of an inventory of housing and supports in Toronto, with growth targets and a clear quantification of funding (existing and new sources). Monitoring and reporting on investments and shortfalls would allow for advocacy to funders and in relation to equity in access and outcomes for different groups in supportive housing.

The effective development of supportive housing has been described by other sources as requiring partnership and collaboration between providers, governments, and other actors, such as the private sector. A 2019 report from the *TAEH* outlines diverse strategies for the City of Toronto and the supportive housing sector to develop housing.[153] According to this work, governments have a crucial role in supporting providers and reducing barriers to increasing control over the housing stock, through funding and actions such as streamlining municipal planning processes.[154] Other sources that acknowledge the importance of networks and partnerships in supportive housing point out that the development and maintenance of these relationships also require financial support.[155]

Addressing equity and inclusion in supportive housing

Equity and inclusion were consistent themes in the data. The lack of access for people with mental health and substance use issues, those experiencing chronic homelessness, and/or experience of the justice system compared to other groups, was identified as an equity issue because of the considerable stigma and related barriers faced by this group.

SME participants also identified that specific sub-groups within these populations are especially underserved with respect to accessing and maintaining housing. These sub-groups included racialized groups, women, Indigenous people and LGBTQ2S individuals. For example, LGBTQ2S youth experience much higher levels of homelessness than the rest of the population, and within this, trans and racialized youth in particular face considerable barriers to accessing housing. The issue of prioritized access to supportive housing was also raised in terms of the allocation of dedicated units for people experiencing chronic homelessness and for equity-seeking groups. Participants articulated the idea that organizations serving specific populations should be supported in their work, and that mechanisms to build capacity across the sector based on the knowledge and best practices of these agencies should be developed.

The collection of robust data to understand inequities based on factors such as race, age, ethnicity, disability, gender identity, and family composition was also identified as important to ensure equitable access to supportive housing. At the same time, the commitment to act on this data is a necessary mechanism for accountability. This includes leveraging data for continuous quality improvement, evaluating services and identifying models to best serve populations, and investment to reduce existing disparities.

Several key informants cautioned against representing people who experience poverty and homelessness as fundamentally different from the rest of the population. Instead, participants explained that homelessness, poverty and trauma are the result of failing systems and historical factors, rather than inherent features of individuals and groups. Therefore, older adults with experiences of homelessness and mental health challenges may require greater levels of support to maintain health and well-being, they ultimately need the same access to elder care services as everyone else.

Research and policy has identified greater service integration as important for minimizing access barriers for vulnerable populations who face exclusion from systems.[156] Mechanisms to integrate access and assessment processes across systems have been identified as reducing barriers to access for marginalized populations, as they can facilitate shared vision and strengthen the links and relationships between service providers, thus enhancing their ability to meet the needs of underserved groups.[157] Centralized access point for entry or a "no wrong door" policy means that people can enter the system at multiple points without being turned away.[158] AMHO's work on the provision of support services in supportive housing recommends the use of standardized tools for assessment of need.[159] Improved access to services has also been achieved through coordinated care programs, for people with co-occurring substance use and mental or physical health issues.[160,161]

Systematic methods to prioritize access to supportive housing for those who most need it, is also presented by researchers as a method for equitable access,[162] and especially in the context of scarce resources.[163] Prioritization includes dedicated units for specific populations that face increased barriers to care.[x] If prioritization is a goal of coordinated services, then agreement and transparency about how priority is determined and shared standardized tools for assessing priority are needed. Standardized tools such as assessment scales have also been identified as valuable for supporting prioritization decisions in the context of limited resources.[164,165,166]

There is also an increasing acknowledgment of bias within standardized tools, which challenges the role of these tools as objective methods to determine priority and access. The author of a recent critical appraisal of vulnerability tools suggests that "a robust and comprehensive measure of vulnerability among individuals experiencing homelessness ought to contain items related to discrimination or stigma."[167] The study found that the Vulnerability Index, Service Prioritization Decision Assistance Tool (VI-SPDAT), which is used to prioritize access to care based on need, consistently scores White women as having greater vulnerability and need than Black women, despite both groups reporting similar experiences of trauma and abuse. The research indicates the need for applying an anti-oppression lens to the design and application of assessment tools.

The literature also identifies cultural and linguistic exclusion as a major barrier to accessing mental health services.[168] Practice of culturally safe and responsive approaches involves awareness about how specific treatments are taken up, as a lack of cultural competence in the therapeutic setting can lead to greater harm to the individual requiring mental health supports.[169] The engagement of communities to identify appropriate programming is another important part of reducing harm, as is adopting diverse approaches to recovery and healing, and the inclusion of people with diverse identities and lived experience in decision-making processes and governance of supportive housing.[170]

The AH/CS intervention in Winnipeg recognized the complex intergenerational trauma resulting from colonialism as a significant barrier to housing and mental health and wellness. The intervention included a locally specific arm, led by Aboriginal agencies, to meet the needs of Aboriginal tenants. Study documents indicate that without this culturally-specific intervention, the project would have been unsuccessful.[171,172] At the Toronto site, the intervention was adapted to meet the needs of ethno-racial and racialized groups. This program used an anti-racism/anti-oppressive framework to mental health service provision in the delivery of ICM to improve housing stability and community functioning of diverse homeless adults.[173,174] These examples demonstrate the need to be flexible and adaptive to local environments and different worldviews or cultural contexts in the use of Housing First models.

The AH/CS researchers developed a Fidelity Tool for the anti-racism/anti-oppression framework to direct supportive housing work.[175,176] Targets for the tool include: the agency's formalized commitment to anti-racism and in frontline philosophy and practice; the human resource environment (e.g., hiring and retention); the influence of staff and participants in sector and organizational direction-setting; social justice, advocacy, and community building; and commitment to alternative healing strategies and holistic treatment. There are numerous other tools and resources available for guiding the integration of anti-racist and anti-oppressive approaches into supportive housing and mental health services.[177,178]

[x] The federal government has mandated that all designated communities (urban centres) have a coordinated system in place for prioritizing access to homelessness services by 2022. In response, the City of Toronto is developing a coordinated access system that uses a community-wide approach to assessing, prioritizing and connecting people experiencing homelessness to housing and supports.

It has been posited that research and policy generally neglects the deep and enduring effects of poverty in mental health recovery, due to the difficulty in addressing the way that individual and broader structural factors interact to influence experiences.[179] Understanding the complexity of recovery would benefit from approaches such as intersectionality theory that brings together experiences of race and racialization, class, and gender among many others, to understand how multiple intersecting influences frame individual experiences.[180] In addition to the individualization of supports, approaches are required that address the social and structural inequalities that people face. This includes addressing severe and multiple traumas, lack of trust in systems due to historical relationships (e.g., colonialism), and the impact of gender inequities on experiences of recovery (e.g., women experience greater sexual violence).[181]

7. Study limitations

Study limitations involve restrictions related to the lack of representation of supportive housing sectors beyond the MHA sector, along with some gaps in representation of specific populations within both the service provider and service user sub-groups in the sample.

The research sampling strategy originally included frontline workers in supportive housing, however, due to considerable difficulties with remote engagement via existing networks, this perspective is not included in the analysis. One reason this group may have been more difficult to reach is because of increased responsibilities during the COVID-19 pandemic. Their perspective would have added another dimension around work conditions, as well as a unique and grounded perspective about need in the context of MHA supportive housing.

There were also some difficulties recruiting service users during COVID-19. A limitation in this group, is the absence of youth (the sample was all adult), and LGBTQ2S identified participants and the underrepresentation of participants who did not identify as white (11 of 16 participants identified as white). This means that experiences corresponding to specific communities were either absent or underrepresented in the data. Future research could focus on the perspectives of specific groups with unmet needs, and who are underrepresented, to ensure that supportive housing developed is addressing all needs upstream.

For organizational leaders in the SME participant group, the sample included people from organizations working with women (i.e., sites dedicated to women and their families including trans women) and seniors. Representation from an organization solely focused on criminal justice was not included because of the recent needs assessment on mental health and justice, although several participants mentioned the considerable unmet need of this group with respect to supportive housing.

Although no representatives from organizations that served only youth were interviewed, several participants (including those from the research expert group) spoke to the needs of youth experiencing homelessness. Several key informants raised the need to strengthen work with Indigenous partners to increase access and culturally safe and relevant supports across the sector, and provide adequate, affordable, and appropriate housing as part of the ongoing work of Truth and Reconciliation. The sample did not include Indigenous-led organizations due to their unique and autonomous role in providing supportive housing. Despite this, the SHGP has engaged with this group throughout its development, and several key informants stressed the importance of supporting Indigenous providers in their work.

While there was some overlap with other sectors (e.g., developmental, alternative housing) in the sample, the main focus of the research was on MHA supportive housing. As such, while some of the findings may be relevant, others may not be transferrable to these other sectors. This includes waitlist projections for individuals who are waiting for supportive housing outside of the MHA sector.

A limitation of The Access Point waitlist analyses is that some portion of individuals currently on the waitlist may have found the housing and supports they need and not reported their change in need status to The Access Point. This limitation notwithstanding, the existing City of Toronto growth target is not likely to meet demand given that the average year-over-year growth of the MHA support housing waitlist is over 2,000 individuals.

8. Conclusion

This Needs Assessment has outlined some key challenges facing the supportive housing sector, along with strategies for moving forward with developing supportive housing to sufficiently meet need for people with mental health and substance use challenges in Toronto.

The number of people in need of supportive housing in Toronto far exceeds the available housing and support. The waitlist analysis in this report demonstrates that in order to address need and eliminate the waitlist for MHA supportive housing in Toronto, 37,000 new units are required over the next 10 years. These projections are greater than other targets for the city, and demonstrate the urgent need for supportive housing development.

Supportive housing providers are currently initiating important mechanisms to propel development forward, such as pooling resources to increase access to supportive housing. Investment into supportive housing is needed to address the lack of housing affordability, develop new housing stock, repair and upkeep existing stock, and provide supports to those who require it.

This analysis of the literature on supportive housing and qualitative research with key informants in the sector, has led to the development of several high level key findings to inform and guide the work of the supportive housing sector in Toronto. These findings include:

1. Future development should focus on permanent supportive housing options in self-contained units in scattered or dedicated sites and apply a Housing First approach.
2. Greater flexibility is needed within the system to increase or lower support intensity, and especially to enable the subsequent increase of supports if required.
3. The sector should consider prioritizing access into supportive housing.
4. Support is needed for the expansion of multidisciplinary teams using evidence-based interventions to meet complex needs.
5. The sector should develop a shared typology and definitions to describe housing and supports.
6. A harm reduction philosophy across the sector is necessary to address the needs of people with substance use challenges and to facilitate choice.
7. Develop rapid-access to interim supportive housing to facilitate bail release and community reintegration for individuals in jails[xi].
8. Promote anti-racist/anti-oppressive practice across the sector.
9. Promote community development and social inclusion through supportive housing programs.

While many of these findings are programmatic in nature and geared towards the supportive housing system, it is also important to note that most of the challenges detailed in this report transcend sector work and boundaries. The insufficient supply of housing in the city and the significant precarity experienced by those in need of supportive housing, is the result of broader social and economic processes and policy-making that over time have led to increasing inequality in Toronto and elsewhere.

For example, the financialization of the housing sector has emerged from a range of policies and practices that have supported the role of housing as a commodity rather than a basic human right, or something that everybody has access to by virtue of living in this society.[182] Similarly, the deleterious effects of poverty that impact the everyday lives of supportive housing tenants, and which supportive housing providers address through their work in service provision, is the result of ongoing decisions about the distribution of resources in society.

[xi] This key finding also reflects findings from a recent Needs Assessment by Wellesley Institute and CMHA-Toronto on Justice-focused Mental Health Supportive Housing in Toronto (2020), which details considerable unmet need for those who have experienced incarceration.

With this in mind, the strategies discussed here must also be accompanied by broader housing, social and economic policies that are designed to reduce inequities and promote well-being. To address the underlying structural causes of problems such as homelessness, broader policy responses and corresponding investment are required that address inequities in housing, income, work and access to health and social services. Finally, and in line with calls from other organizations in Toronto, there is a need to further consider this policy context through the lens of intersectionality. This approach would address the ways that groups are differentially affected by the housing crisis, along multiple, intersecting lines of marginalization and exclusion.[183]

9. Appendices

APPENDIX A - HOUSING STOCK TYPOLOGIES

Table 1: Supportive housing stock options

Housing Stock Typologies	Description
Dediciated building, shared unit	Housing is located at one-site, where all of the housing is supportive housing, with multiple individual or shared rooms and common living facilities (e.g., bathrooms or kitchens). Supports are usually attached to the housing site (less likely to be mobile with tenant) and building rules/eviction decisions are under the control of the supportive housing provider.
Dediciated building, self-contained unit	Housing is located at one-site, where all of the housing is supportive housing, with multiple self-contained units with individual living facilities; may include some common areas as well. Supports are usually attached to the housing site (less likely to be mobile with tenant) and building rules/eviction decisions are under the control of the supportive housing provider.
Scattered, self-contained unit	Housing without shared living space is typically located in the private housing market or non-profit housing providers, is dispersed throughout the community and acquired through rent supplements. This typology includes mixed housing (some affordable supportive and some regular market rentals without supports) and usually supports are more mobile within these arrangements and can follow tenants.
Scattered, shared unit	Housing with shared living spaces (e.g., bedrooms, kitchens, bathrooms) are typically located in the private housing market or non-profit housing providers, are dispersed throughout the community and acquired through rent supplements. Usually supports are more mobile within these arrangements and can follow tenants.
Residential continuum model (staged/transitional housing)	Individuals are placed into a residential setting prior to moving into permanent, independent housing. Intended to provide higher levels of on-site supports to individuals to achieve stability to take steps to access and maintain supportive housing. Differs from the other typologies in that it is not considered permanent.
Interim housing options	A short-term solution to house people in urgent need of supportive housing, but for which it is not immediately available and there are no other housing options. This housing is designed as an interim measure which provides necessary supports before supportive housing is available.

APPENDIX B - SUPPORT CATEGORIES & GUIDING SUB-THEMES FOR SUPPORT PROVISION

Table 1: Support categories for supportive housing

Category (Intersecting)	Examples of support/services
Tenancy support & eviction prevention	- identification of housing options - rent payment - lease management - housing-specific goal planning - landlord liaison
Social support	- interpersonal relations - communication
Health, wellness & clinical support	- psychiatry - primary care, nursing - chiropody - harm reduction - healing programs - Traditional Chinese medicine, acupuncture - behavioural therapy - medication education & monitoring - case management - symptom management - other evidence-based practices
Life skills & personal support	- self-care - bill payment - meal prep - housekeeping - medication management
Community linkages & social inclusion	- social programs - community kitchens - support groups - language supports - employment - education - volunteering - community support mapping - income supports - child care
System navigation	- income security - health system - legal/justice system - immigration - food security
Crisis prevention & support	- crisis de-escalation - conflict management
Peer support (embedded within all categories)	- expertise and perspectives of people with lived experience

• Support categories and sub-themes draw from both the literature review and the key informant interviews.

Table 2: Sub-themes related to support provision in supportive housing

Theme	Description
Flexibility	Flexibility to provide supports needed by individual; increase and reduce intensity of supports, or change types, includes processes for reassessment of support needs and support need intensity.
Individualized	Various supports can be combined or arranged in such a way as to meet particular needs of individual.
Choice & self-determination	Central tenet of supportive housing. Permanent housing is independent of engagement with support services as much as possible. Services accessed are determined by the individual with the assistance of support providers.
Recovery oriented and trauma-informed	System supports individual journey to wellness, includes key concepts of hope, strengths, empowerment and understands that recovery is personal and means different things to different people. Recognition that experiences of severe trauma are greater for people experiencing homelessness, resulting in engagement in trauma-informed approaches to prevent retraumatizing.
Coordination	Maximize coordination across service providers in communities (e.g., multiple support provider within close geographic proximity) and funders (e.g., better coordination of the mental health supportive housing system with the municipal systems of housing and homeless-related services and social housing).
Evidence-informed	Support provision is evidence-informed, meaning that it is based on the best available evidence, including diverse types of knowledge and expertise (research, lived expertise, provider experience). Continual evaluation and quality improvement of support programs by diverse stakeholders enables the promotion of best practices.
Social inclusion & community integration	Central goal of achieving social inclusion and community integration through provision of supports. Recognition of the basic needs of community belonging and meaning, and of the need to address the social exclusion of groups facing histories of intersecting marginalization (e.g., based on class, racialization, gender identity) and socioeconomic disadvantage.

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