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Supportive Housing For Those Dealing With Mental Health And Addiction Issues In Toronto : An Interview Study To Consider System Level Characeristics and Service Planning Issues

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SUPPORTIVE HOUSING FOR THOSE DEALING WITH MENTAL HEALTH AND ADDICTION ISSUES IN TORONTO: AN INTERVIEW STUDY TO CONSIDER SYSTEM LEVEL CHARACTERISTICS AND SERVICE PLANNING ISSUES

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ABSTRACT

This paper reports on an interview study that was conducted by the author with executive directors representing 10 agencies in Toronto which provide supportive housing for those dealing with mental health and/or addiction issues. It provides a review of the literature and evidence with respect to such housing, and describes its origin, evolution and general characteristic in Toronto. It then focuses on discussing themes identified over the course of the interviews, in relation to overall system planning...and lack thereof. Alongside of expected but important themes, such as the desperate shortage of housing stock, a number of more subtle trends are uncovered. For example, the increasing imposition of concepts and practices from the hospital and private data management sectors, are proving troublesome for some supportive housing providers as they threaten their community and client centered values, beliefs, principles and practices.

An article which discusses service planning issues within Toronto's system of supportive housing for those dealing with mental health and/or addiction issues, used key words: supportive housing, mental illness, addictions.

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1. INTRODUCTION

This paper reports on the findings of a study on the supportive housing system for those dealing with mental health &/or addiction issues in Toronto (hereafter referred to simply as supportive housing). The study elicited the knowledge & insights of key decision makers in order to explore strengths, weaknesses, opportunities & challenges within the present system.

As no recent study has taken an overall look at how supportive housing is being planned & delivered in Toronto, and as documentation on its complex inner workings is generally lacking , the study made an important contribution in this regard. It served the valuable function of documenting valuable knowledge, insights and informed opinion with respect to many aspects of the system which had hitherto only existed in the minds of those actually involved in the system. As there are presently over 4000 Torontonians on the waiting list for such housing, and as governments continue to move toward greater austerity, clearly additional knowledge, insights and ideas are desperately needed to make the most of increasingly limited resources.

The report begins with an initial chapter which introduces the concept of supportive housing, a second which reviews related research, and a third which provides a brief review of the origin and evolution of supportive housing in Toronto.

The second and central part of the report discusses the study itself and more specifically, key themes that were identified in the context of interviews which were conducted with a sample of executive directors representing 10 supporting housing agencies. Information from these interviews was also used to inform the other parts of the paper, where appropriate, as indicated with citations which reference the relevant participants (i.e., P1, P2, P3.....P10).

PART ONE:

DEFINITIONS, EVIDENCE, AND HISTORICAL CONTEXT

1. Defining supportive housing: what it is & what it isn't

Supportive housing in the case of this paper describes independent rental accommodations in the community provided in combination with some form of community based mental health and support services (Wong & Solomen, 2002; Rog 2004). While supportive housing also exists for different groups, such as those dealing with developmental issues or most prominently with issues in relation to aging, it also has a very different history and characteristics that accord with the distinct issues and needs that are being addressed. Unless otherwise noted, however, "supportive housing" will hereafter serve as short hand within this paper to refer to that which is provided to those with mental health or addiction issues.

1.1. Supportive versus Supported housing

Some writers also make a distinction between supportive housing, in which a tenant's housing and social support services are integrated and often delivered by the same agency, and supported housing in which the social services delivered to tenants are separate and portable in that they travel with the tenant as they move from one residence to another (CAMH, 2011). In the case of supportive housing, access to the social services of the agency is contingent upon successful tenancy and successful tenancy, in turn, requires successful engagement with its social services.

Arguments in favour of supportive housing focus upon the ability to engage, monitor and support tenants in a continuous and ongoing fashion, which may be particularly relevant in the case of those facing severe mental illness (Rog 2004) . Those in favour of supported housing focus on the independence and autonomy that it may foster and the manner in which individuals continue to be supported and engaged through continued access to social services even in the

event that specific housing situations do not 'work out'. As supported housing units are typically rented within the private sector, this also offers the advantage of avoiding the large upfront capital costs that would otherwise be associated with the construction or acquisition of new residential facilities (Rog 2004).

Based upon the early input of participants within the present study, a distinction will not be made between supportive versus supported housing in the case of the present study. Instead, all situations in which housing is delivered in combination with the relevant supports will be referred to as supportive housing[1]. As one early participant suggested, the distinction between supported and supportive housing is often blurred in practice making a distinction somewhat arbitrary at times (P10). Moreover, the present author did not wish to prematurely narrow the scope of the present study by virtue of drawing such a distinction. This is also in keeping with the practice employed by other researchers who have focussed on the Canadian experience (e.g., McKenzie 2004; George et al., 2005).

1.2. Transitional, custodial and social housing

Supportive housing will be distinguished from stand alone rent geared to income housing and social housing programs, although these may be paired with health and social services to create a form of informal supportive housing (George et al., 2005). In fact, one participant in the present study contended that, if adequate supports were provided to all of those who presently required it within the existing stock of Toronto Community Housing Corporation (TCHC) housing, it would handily become the single largest supportive housing provider in the city.

Supportive housing will also be distinguished from transitional housing. The latter refers to housing with supports which may be provided to those dealing with various issues (e.g.,

[1] [1] Similarly, literature referenced in relation to supportive housing will actually consist of literature in relation to both supported and supportive housing, unless the distinction would make inclusion inconsistent or misleading.

criminal justice involvement), including mental illness, but on a much more structured and time limited basis (Sylvestre et al., 2009). As the name suggests, transitional housing is viewed as a strict and more detailed program to equip tenants to ultimately integrate into broader community within a specified time frame, which is typically a year in duration (P5). By extension, tenants within transitional homes in Toronto may be evicted from such housing at the end of an agreed upon term of tenancy, as they are not protected by the Ontario Landlord and Tenant Act. In contrast, all tenants within supportive housing accommodations are protected by the Act, which has important implications for supportive housing providers

Supportive housing will also be distinguished from custodial housing. Such housing began in the 1930s and has been referred to as the early iteration of what was to become the province's supportive housing strategy (CAMH, 2011). While it is argued that the model upon which it is based now inappropriate and out of date, it still constitutes as much as 44% of what is considered to be dedicated housing for the mentally ill within communities (ibid). Custodial housing provides a common standardized basket of basic services to tenants, such as meals, laundry and supervision, but does not provide case management and the broader types of rehabilitation focussed programming and amenities that are found within supportive housing (Sylvestre et al., 2009). As a result of its strict and inflexible policies and standards it has been leading to "transinstitutionalization", which is the inappropriate application of institutional ideas to the community sphere. In contrast to the non profit supportive housing providers, custodial homes are owned and operated by private for profit entities (George et al., 2005).

1.3. Housing first approaches

Supportive housing may also be distinguished from the highly publicized "housing first" approaches, that have been employed in a number of cities in Canada[2] and abroad. Such approaches are aimed at 'hard to house' individuals who are homeless, and often suffer from mental health issues, or may be targeted specifically toward those with concurrent homelessness and mental illness. What sets such approaches apart from supportive housing is the manner in which they stress the fundamental goal of rapidly housing the individual, first and foremost, without any concomitant requirements in terms of engagement with social services (Falvo, 2009). The "housing first" approach arose in response to "treatment first" approaches which assumed that it was most appropriate and efficacious to engage clients in mental health treatment prior to any consideration housing needs, preferences and options (Klodawsky, 2010). This approach proved particularly ineffective in the case of the homeless and hard to house individuals as it created additional barriers to engagement, particularly in the typical case that they were simply not interested in treatment. As the number of homeless individuals suffering from mental illness grew, policy makers and practitioners ultimately had to accept this reality and pursue other options (ibid).

Nonetheless, "housing first" approaches typically do provide for minimal levels of case management for tenants and afford them with the opportunity to engage within a broader array of health and social services if they are interested . In the case that tenants accept this opportunity, it effectively creates de-facto supportive housing. As Rog (2004) has suggested, "housing first" has spurred programming that is similar to supportive housing but with the over-riding goal of decreasing homelessness, as opposed to any therapeutic outcomes per se. If one

[2] For example, Toronto's Streets To Homes program will be discussed in the next section of this paper.

were to draw a line between supportive and supported housing, "housing first" would be most clearly aligned with the latter (Rog 2004).

1.4. The Many flavours of supportive housing in Toronto

The general definition of supportive housing is where the simplicity ends. As the participants involved in the present study described, and as previous research has suggested (George et al., 2005), there are many flavours of supportive housing in Toronto. It may consist of a single, or shared room in a boarding house or group home. It may consist of a single and independent apartment within an otherwise traditional market building, or within a building dedicated to those with mental health issues (P2). It may foster wholly independent living, outside of the visits by social service workers, or may include special communal facilities and group programs for those with mental health issues (P6). In terms of support, social services may be provided by a worker who lives on premises, or a worker who visits clients within a number of scattered buildings (P1). Such workers may provide intense 24 hour services, in the case of those with severe mental illness, or less frequent 'check up' visits (P8).

The nature of the social services provided to tenants not only depend on the nature of tenant needs but on administrative decisions. For example, while a tenant's housing related issues (e.g., rent payment, compliance to rules of tenancy) and social and health related service needs may be dealt by a single case worker in one living situation, these domains may be split up amongst two case workers in another (P10).

Diversity exists not only in form but in underlying ideology. For example while some settings may emphasize a "maintenance" approach, whereby continued tenancy might be encouraged as a long terms means of contributing to the well being of individuals and the management of their mental health issues, others may ascribe to a more rehabilitative transitional approach whereby supportive housing is viewed as just one temporary step along the longer term path to recovery and fuller

community integration (Leff et al., 2009). Similarly, agencies may promote communal residential activities and tenant involvement therein to differing degrees, depending upon their perspective with regards to the goals of community integration and autonomy (P6). In the case of substance misuse, in particular[3], some agencies may view sobriety as a necessary prerequisite to tenancy, and others may adopt a harm reduction approach and/or accept such use as one of the number of the mental health issues that the tenant is working on (P5). By extension, a relapse may be viewed as grounds for expulsion from one program, but as a natural and expected part of the recovery process in another.

Clearly one of the main problems in defining supportive housing relates to the diversity of models that exist. Such diversity is the product of the complex context and issues surrounding this multifaceted intervention (Chilvers, Macdonald, Hayes, 2010) and of the varying needs and preferences of the great range of populations served. As will be described shortly, such diversity is also the product of the unique history and evolution of supportive housing agencies in the city that may operate according to very different guiding values, beliefs principles and beliefs as to best practice. Owing to the difficulties in defining supportive housing in conclusive terms, let alone evaluating it as such, it has been suggested that researchers should turn their attention away from this elusive task by focussing upon identifying specific features that contribute to specific outcomes within specific settings and populations (Fakhoury, Murray, Shepherd, Priebe, 2002).

[3] As substance misuse is the most common and clinically significant co morbidity amongst those with severe mental illness (Drake, Mueser, Brunette, McHugo, 2004), the manner in which it is addressed in supportive housing is all the more relevant.

2. A Review of the literature & evidence

2.1. The nexus of mental illness and (inadequate) housing

Evidence has gradually led governments to recognize that a significant portion of the homeless population has mental health problems. As such the intersection of housing and mental health is not only an important consideration for those seeking to promote success and stability amongst mentally ill populations, but for practitioners, decision makers and governments seeking to address the increasingly prominent issue of homelessness within communities (Kirsh et al., 2009).

The most comprehensive study of homelessness in Canada to date found that 30-35% of the homeless in Toronto suffered from some form of mental illness (City of Toronto, 1999). The rate was 95% for homeless women, which was in keeping with other studies that found such a similar gender bias . It has been suggested that the appearance and behaviour of mentally ill individuals, and particularly those being discharged from hospitals or jails, may make it difficult to impossible for them to secure housing in the private market.. Such individuals may also lack a sufficient or consistent income stream to pay for housing, as a result of interrupted work histories, or may simply struggle to fill in forms and to attend multiple meetings with potential landlords and housing related agencies (Sylvestre et al., 2009).

Of course, in considering the root causes of homelessness it is necessary to consider both micro (e.g., mental illness) and macro (e.g., housing policies, broader economic forces) factors (Gaetz, 2004). Moreover, the high rates of mental illness amongst the homeless should certainly not be misinterpreted as suggesting an obvious and simple causal relationship. Just as mental illness might contribute to homelessness, homelessness might contribute to mental illness; or there might be other more important lurking variables (ibid). Putting such academic

considerations aside, the simple fact that there are such high rates of mental illness amongst the homeless is clearly an important finding in and of itself with important policy implications.

2.2. The effectiveness of supportive housing

Several studies have pointed to positive outcomes accruing from supportive housing in comparison to other housing alternatives. Such outcomes have included: longer housing tenure; greater housing satisfaction; better quality of life; more meaningful activities and work; lower rates of psychiatric hospitalization; and lower overall social costs (Lipton et al., 2000). In one quasi experimental U.S. study, that is often cited, Leff and Trieman (2000) followed 900 formerly hospitalized patients within supportive housing and compared them to counterparts who remained in hospital. At five years those in supportive housing experienced considerable reductions in negative psychiatric symptoms and considerable improvements in social behaviour and domestic and life skills.

2.3. Cost effectiveness of supportive housing

Despite some conflicting evidence (Rosenheck et al., 2003), there is research to suggest that supportive housing may be effective in reducing overall social costs. In a large landmark study involving 4699 homeless and severely mentally ill individuals placed within supportive housing in New York City, overall hospital, criminal justice, and social service costs per individual were reduced $16, 281 per year in comparison to a matched control group. Moreover, the cost of the supportive housing was only $19, 299 per unit per year resulting in a net housing cost of $995 per individual (Culhane, Metraux, Hadley, 2002).

In the Canadian context, one study has estimated that the cost of supportive housing was a fraction of the cost of other facilities in which the homeless and mentally ill might find themselves. While a self contained apartment with support services on site was estimated to cost

$69-$88 per day alternate daily costs were: $380 in a psychiatric hospital, $140-$191 in mental health residential facilities, $80-$185 in a detox center and $155-$250 in a provincial correctional facility. Only an emergency homeless shelter had a comparable costs of $60-$85 per day, although the quality of such accommodations might clearly be drawn into question. Similarly, a study conducted in British Columbia concluded that it cost its government 33% more to provide health care, criminal justice and social services to homeless persons versus a socially housed unemployed individual (i.e., $24000 per year versus $18,000 per year).

2.4. Research reviews and the elusiveness of conclusive evidence

Despite the promising findings, just described, a number of researchers caution against embracing the supportive housing concept in light of a paucity of rigorous studies undertaken. Based upon a review and methodological evaluation of 15 studies, Rog (2004) concluded that there was only strong evidence to suggest that supportive housing improved access to quality housing stability, and reduced hospital usage. With respect to all other purported outcomes, evidence was weak and conflicting. The shortage of randomized control trials, differing outcome measures, and inconsistencies in defining and operational zing supportive housing itself were identified major shortcomings within existing studies. As all of the programs varied in terms of the services provided and the populations served, this was described as an added layer of complexity which made any consensus and comparisons difficult.

A recent Cochrane Review drew even more critical conclusions. In fact no randomized or quasi randomized studies were identified which met the quality criteria that had to be met for inclusion into the review. While suggesting that more research was in order, the authors acknowledged how the complexity of supportive housing interventions, and the diversity of models employed and populations served in practice, made such conclusive forms of research

prohibitive.. In the absence of such evidence they suggested that policy makers needed to be cautious about supportive housing policies and needed to ensure that they included an evaluative component. Practitioners were also advised to make recommendation with respect to supportive housing on the basis of both their professional judgment and the preferences of clients; by extension, clients need to be apprised of the subjective nature of that decision.

In contrast to the favourable economic arguments, described above, some writers have suggested that supportive housing is actually quite costly in light of the paucity of evidence with regard to its effectiveness (Fakhoury, Murray, Shepherd & Priebe, 2002). Others have suggested that policy decisions with regard to supportive housing need to be made on the basis of our underlying values, in as much as they should be made on the basis of the evidence (Sylvester, Nelson, Sabloff, Peddle, 2009). Of course, a value base approach provides one way forward in the absence of conclusive evidence upon which specific decisions might be based.

2.5. Supportive housing and community integration

Community integration has become an underlying goal within mental health systems in North America and Europe, and supportive housing has been touted as being a vehicle for achieving it. It is assumed that those with psychiatric disabilities can assume roles and lifestyles as participating members of a community when they are provided with appropriate services and supports within the most normalized living environment possible (Wong & Solomen, 2002) . Despite the intuitive appeal of this argument, and its central role as an attractive rationale for supportive housing, there is a surprisingly lack of empirical research to confirm the purported relationship. This has led to a call for greater research into this area (Wong and Solomen, 2002).

One qualitative study was identified involving 80 homeless subjects. The 46 who were ultimately placed within supportive housing self reported a greater sense of community

integration as a result but the same was also true for the others who were placed in housing without supports (Yanos, Barrow, Tsembelis, 2004). Wong and Solomen have also reviewed 19 studies involving community based housing for the mentally ill which included variables that might be considered to reflect dimensions of community integration. As they concluded most of these variables focussed upon the degree to which community activities and resources were accessed, and upon physical integration (e.g., venturing into the community). As the authors suggest, greater attention needed to be paid to the degree to which tenants actually interact with community members (i.e., "social integration") and the degree to which they feel like they are part of the community and have access to it (i.e., "psychological integration"). In their view future research needed to acknowledge the multidimensionality of community integration and consider the array of housing and social service characteristics that were relevant in promoting it; supportive housing was not some singular and clearly defined concept that could serve as a simple independent variable.

2.6. Key components/characteristics of supportive housing

Presently there is also little definitive research with respect to what specific components of supportive housing contribute to more positive outcomes (Rog, 2004). A number of studies have suggested that independent living arrangement and less restrictive housing policies are not only preferred by tenants within supportive housing, but may result in greater satisfaction with housing and neighbourhood. However, feelings of isolation and loneliness have also been reported more regularly by participants residing within more independent living arrangements within some studies. Similarly, living in setting that have fewer occupants has been shown to result in positive outcomes in some studies, but negative outcomes in others, pointing to a possible trade off between social support and independence. In the case of a study by Goldfinger

and colleagues (1999), participants living in independent apartments ultimately reported being homeless twice as many days as those in group homes (98 versus 43 days, respectively). Another Canadian study Kirpatrich & Younger, 1995) suggested that gender might be a complicating factor, for while men preferred independent living women preferred group setting primarily for safety reasons. Given such conflicting evidence, relationships between program characteristics and ultimate outcomes may clearly be complex and highly client specific.

One means by which the complexity of these relationships might be captured is through the type of qualitative research employed by Kirsh and colleagues (2009). These researchers identified the lack of research in relation to the key features of supportive housing in general, and research which incorporated the more detailed insights and perspectives of the actual providers and users of supportive housing in particular. In their study they conducted extensive qualitative interviews with the latter groups in Toronto which were then considered alongside of a review of existing research . While their final analysis is far too long and detailed to discuss at any length here, they identified the following as being key characteristics of successful supportive housing: choice and flexibility; neighbourhood fit; awareness and attention to stigma; quality relationships between residents and service providers; a range of supports; support with independent living; support in preventing and managing a crisis; support with pursing work and school; support and assistance with creating and maintaining social connections; and support and assistance with health issues.

2.9. Research on the characteristics of supportive housing tenants

While comprehensive data with regard to the characteristics of supportive housing tenants in Toronto is not yet available[4], a review of U.S. research has provided some interesting insights. Those with mental illness who are living within supportive housing tend to be older and less educated, compared to those with mental illness who are able to live more independently (Phillips & Hawes, 2005). They also tend to have greater cognitive deficits, a longer history of hospital care and higher unemployment rates. A diagnosis of schizophrenia has also been found to be common amongst those in supportive housing, leading to speculation that it may be attracting tenants with this condition owing to its features matching the needs of this population; it is argued that it may provide for the type of structure and support that is needed to prevent the decomposition that accompanies this condition.

2.8. Negative externalities & opposition to supportive housing

Supportive housing often faces fierce community opposition, or NYMBY[5]ism, and Toronto is certainly no exception in this regard. The local media has reported on a number of cases in recent years where citizens have come out in angry opposition to supportive housing developments in their neighbourhoods and in one particularly high profile case a long time city councillor is said to have lost the recent election in her ward largely due to her failure to voice her opposition (Kennedy, 2010). Arguments in opposition to supportive housing are typically based on the belief that the neighbourhood character will somehow change. Most typically the fear is that crime will increase, the general enjoyment of the neighbourhood will decrease, and property values will ultimately drop (Walker & Seasons, 2002). As the evidence does not ultimately support

[4] This will likely be made available in the near as a result of data that is now being collected through Toronto's Centralized Assessment to Supportive Housing (CASH) services.
[5] NIMBY is an acronym for Not in My Back Yard.

such beliefs, they are likely based upon false public perceptions with regard to the nature of mental illness and the characteristics and behaviour of mentally ill individuals (Walker & Seasons, 2002); perceptions that have been distorted by sensationalized depictions within popular media (Dream Team, 2010).

Of the few studies identified that considered the relationship between the location of supportive housing facilities and subsequent crime rates (Galster et al. 2004; de Wolff, 2008) and property values (Galster et al., 2003), not one found a significant relationship. In fact, a study by Galster and colleagues (2003) suggested that supportive housing facilities might have led to an increase in property values owing to its encouragement of further development in the vicinity. In addition, a study based on supportive housing facilities in Toronto found that their residents contributed a modest but significant amount to their local economies and contributed to creating neighbourhoods that were more vibrant, friendlier, and more civically engaged (de Wolff, 2008).

Despite the evidence NIMBYism continues. As some suggest, this continues to push supportive housing out of more affluent neighbourhoods and into less desirable areas of the city, leading to the same type of 'ghettoization' that occurred in the early days of deinstitutionalization, albeit to a less obvious degree (Walker & Seasons 2002) . Even when NIMBYism not successful, it has been described as delaying supportive housing development and as increasing its resultant cost. At a time when both supportive housing units and money are in very short supply, clearly such delays are of great concern. Even more fundamentally, NIMBYism has been described as constituting a human rights violation (The Dream Team, 2010).

In order to address NIMBYism groups led by mental health consumer survivors have arisen in a number of cities to lobby for and raise awareness about supportive housing. In Toronto, The Dream Team and Homecoming Community Choice Coalition (HCCC) both carry out extensive research and proactively educate policy makers. Of particular note, the Dream Team carried out

an extensive study on the community impacts of supportive housing in Toronto. It also led a recent court action to overturn what it described as discriminatory municipal bylaws that restricted housing types (e.g., rooming houses) that were typically associated with supportive housing for the mentally ill. The HCCC has created a step by step 'how to' manual to address issues (e.g., NIMBYism) that might be anticipated in developing supportive housing in the city.

3. The Origin & evolution & general characteristic of Toronto's system

3.1. The historical backdrop of deinstitutionalization

Supportive housing for the mentally ill in Toronto arose in response to the much broader deinstitionalization movement that took place within mental health systems in Canada, and abroad in the 1990s and 1980s (McKenzie, 2004; Fakhoury, Murray, Shepherd & Priebe, 2002). Underlying this movement was a belief in the possibility of community integration and of its benefits in terms of ultimately contributing to the recovery of those with serious mental illness. Community based care was considered to be more aligned with the values and goals of recovery than highly medicalized care within institutions. Such recovery was believed to be possible, in the absence of formal hospital based care, provided that appropriate community based treatment and supports were in place. By extension, there was a push toward community based housing for the mentally ill in the last 40 years, to replace hospital based residential care (Fakhoury, Murray, Shepherd & Priebe, 2002).

Beyond contributing to recovery this strategy was also supported upon purely humanitarian grounds and the notion of a common citizenship. The strategy reflected the belief that those with mental and/or physical disabilities had an inherent right, and should be afforded the opportunity, to study, work, and recreate alongside of their disability free peers (Wong & Solomen, 2002)

Critics of deinstitutionalization, however, suggest that this was merely a strategy aimed reducing government costs associated traditional forms of care. In support of this claim they point to the lack of resources that were ultimately invested within communities in order to compensate for the ultimate closures of hospitals and massive reductions in the number of hospital beds for those with serious mental illness (CAMH, 2011) . While the logic was that displaced patients would be cared for by the community and their families, in reality patients had to rely heavily

upon their families or were left in the lurch in the absence of any formal system of adequate community based supports. In this sense, one might suggest that deinstitutionalization was not the problem per se, as is commonly suggested, but rather that it was lack of compensatory measures taken in the wake of it. Whether the government was complicit in this or simply caught off guard is an open question, and ultimately academic relative to the actual outcomes.

Much has been written about how such dependence upon families created undue hardships upon them, bred continued dependence within patients, and failed to address the critical question of what would happen if family member ultimately passed on or were simply unable to continue providing such high levels of support (McKenzie, 2004). Patients who were discharged from hospital and who could not rely upon family or community support were typically left to fend for themselves and this often resulted in homelessness or housing arrangements that were far less than ideal. Commonly they found themselves within crowded and poorly maintained rooming houses with limited access to the services they required, let alone the broader community integration that they were supposed to enjoy. Such housing was typically clustered within rundown neighbourhoods of the city which were poorly served by community services and ultimately became known for such accommodations, rather than reflecting some broader community into which residents could integrate. While Toronto's Parkdale neighbourhood was a classic case in point, similar clusters of rooming houses frequented by the mentally ill, and generally marginalized, could also be found elsewhere in the city (ibid).

In addition to the crowded and poor conditions that residents faced within rooming houses, and other sub par accommodations, they were often taken advantage of as a result of their compromised mental state (McKenzie, 2004). They were often charged rents that were excessive and subject to rules, fees, and general treatment that would not be tolerated by a typical tenant in the city (P2). As some landlords received social assistance cheques on behalf of

their tenants, or simply became familiar with the amounts they were typically provided, this clearly raised ethical issues and opened the door to corrupt behaviour (P3).

While deinstitutionalization may have been supported on the basis of achieving cost reductions, the government's failure to provide for adequate supports has also been criticized as resulting in an inefficient system fraught with un necessary hospital expenditures. Some point to 'revolving door' phenomena (McKenzie, 2004), whereby patients discharged from hospitals too hastily and/or without appropriate supports within the community simply cycle back and forth between the community and hospital in a manner that is costly to society and undermines the long term health and/or recovery.

3.2. The pragmatic and heroic grassroots of the system

It is against this historical backdrop of deinstitutionalization that supportive housing first took root in Toronto. Individuals and groups concerned about one of a number of interrelated issues such homelessness, rooming house conditions and the fate of discharged hospital patients ultimately stepped up to the plate (P10). In order to create an early brand of supportive housing, creative arrangements were struck which secured good quality affordable housing units for tenants, while also providing for a guaranteed stream of rental income for private market landlords (P2). To fund such housing a variety of government, charitable and private funds were cobbled together. And as many of those involved in establishing such housing had a unique knowledge of and access to services, as a result of being employed within the mental health and general social services system, this became a channel for securing the necessary housing supports (P3).

In this sense supportive housing first evolved as a grass roots initiative, or rather initiatives, that initially sprang from a number of diverse quarters and social movements (P1, P5,P10). As

some suggest, it was also the direct result of the involvement of "truly dedicated heroic" types of people (P5).

3.3. 'After the fact' government involvement

While supportive housing eventually won government recognition and support, and was taken under its wing as an official policy and program with its own capital and operating dollars, this was certainly not true from the outset. That is, supportive housing was not the outcome of some overall and integrated plan or policy (P5). This is more than an interesting historical fact, as it ultimately helps to account for the diverse and complex nature of the seemingly fragmented system that exists today.

3.4. The two decisive waves of government funding

The availability of supportive housing in Toronto, and the very nature of the existing supportive housing stock, has also been determined largely by a legacy of changing government policies and priorities at the federal and provincial levels. However, there have been two distinctive periods of investment which clearly stand out. As one participant within the present study metaphorically described, they are clearly recorded within the existing supportive housing stock that we now see in the city, like the distinct geological layers in a rock face (P6).

3.5. The early years of inspired investment

In the early years the provincial government provided funding to provide for the creation of supportive housing units within existing rental housing stock, and the federal capital dollars to acquire and construct buildings. This was an era in which the supportive housing concept seemed to capture the attention and imagination of the provincial government, inspiring them to eventually invest therein. Between 1985 and 1996 the federal and provincial governments both

contributed significant capital funds to an affordable housing program which saw 59 buildings acquired and constructed by supportive housing agencies. To this day this period represents the largest capital investment in the supportive housing system.

3.6. The "common sense" years of rent supplements & homelessness initiatives

The election of a conservative provincial government in Ontario in 1995, and the introduction of its so called "common sense revolution", effectively brought all investment into affordable and supportive housing to an end (P8). When the provincial government did reinsert itself within supportive and affordable housing it did so through rental supplement programs, as opposed to capital investment, an approach that has been relied upon heavily since that time.

However significant funding, including capital dollars, did become available for the development of supportive housing under two phases of a Mental Health Homelessness Initiative (P9). This initiative led to a 135% increase in supportive housing in the province, with 66% of its funding going to the Toronto region (George et al., 2005)

3.9. The transfer and consolidation of supportive housing files

While 238 units of supportive housing units were originally developed and held by the Canada Mortgage and Housing Corporation, and 2421 units were held by the provincial Ministry of Municipal Affairs and Housing, these were transferred to and consolidated within the provincial Ministry of Health and Long Term Care (George et al., 2005) in 1998 and 2002, respectively. While this was clearly be viewed as logical from a planning and administrative perspective, it also meant that the MOHLTC found itself in the position of having to deal directly with housing related matters for the first time. This new and foreign reality might help to explain why health planning bodies that were eventually established on the local level, in the form of the Local Health

Integration Networks (LHINs), initially appeared to tread quite softly with respect to supportive housing; a possibility will be taken up in greater detail in Part B of this paper.

4.0. The present 'system'

4.1. The leading provincial role

The supportive housing portfolio presently sits with the Ministry of Health and Long Term Care (MOHLTC). The Ministry's central Supportive Housing Unit provides agencies with the operating and rent subsidies to cover the "bricks and mortar" housing costs, while Local Health Integration Networks (which will be described shortly) provide agencies with the funding to deliver services and supports to consumers.

Ontario's entire system consists of roughly 6300 units of supportive housing, about half of which was developed as a result of the two phases of the province's Mental Health and Homelessness Initiative (Sylvestre et al., 2009). The provincial government currently allocates about $30 million dollars per year to the housing component of the system, and $100 million to accompanying services and support (ibid).

However, it is important to point out that the provincial contribution to supportive housing is not necessarily restricted to those specific items described above. For example, while residing within a supportive housing unit an individual may clearly access a wide array of health and social services, in addition to those which might be tied to the unit on an accounting basis. While these other services may be essential in terms of successful tenancy within supportive housing, they may clearly not make it into the final accounting of the government's overall investment therein. Similarly, while the housing component of ODSP or OW may contribute to the rents paid within supportive housing units, these are not considered government expenditures on supportive housing per se.

4.2. The LHINs

Local Health Integration Networks (LHINs) are local non profit corporations that were established by the provincial government in 2006 for the purpose of planning, integrating and funding local health services, in collaboration with local service providers and community members (MOHLTC, 2011). While the Ministry previously had regional offices which dealt with supportive housing agencies within their jurisdictions, these were essentially replaced when the LHINs were introduced. There are currently 14 LHINs in Ontario, four of which operate within Toronto. Apart from providing supportive housing agencies with the funds required to deliver the services to tenants and cover their own office operating costs, LHINs are also intended to encourage collaboration amongst them. A single supportive housing agency in Toronto may actually be accountable to multiple LHINs, as their jurisdiction boundaries of the latter are much smaller than the previous regional office and do not align with the catchment area of agencies; participants within the present study actually identified this as a significant ongoing challenge owing to divergent and sometime conflicting priorities and requirements of the LHINs and the time and energy wasted as a result of duplication (P1, P8).

4.3. The Mental Health and Addictions Supportive Housing Network and CASH

The Mental Health and Addictions Supportive Housing Network was established by supportive housing agencies in Toronto in 2000 to provide a forum for the exchange of information and ideas and to facilitate potential partnerships (LOFT, 2012). Under the umbrella of the network, and with funding from the LHINs, the Coordinated Access to Supportive Housing (CASH) program was established in 2010 in order to provide those requiring supportive housing with a universal one stop application and referral process to access the full range of programs in

the city (ibid). The LHINs, the network, and CASH, will all be discussed in greater detail in Part B of this paper.

4.4. A system that is not really a system

The supportive housing system in Toronto is diverse as separate agencies have arisen to respond to particular populations and/or need. It is the product of its unique history and of the complex relationships that exist between its constituent agencies as well as with the various levels of government (P3, P9). Most important, perhaps, it is a product of the diverse needs and populations that it serves (P10). The nature and necessity of such diversity was best captured in the words of one of the participants who were interviewed for this study. As no agency was doing exactly what they needed to do they had to "invent the wheel"; they simply looked for "for rent" signs, talked to many reluctant landlords, and eventually developed a program and approach that would "work" for them (P9).

For all intents and purposes the supportive housing system in Toronto is not a system at all; at least not in the strictest sense of the word. There is no single overall plan, planner or organizational structure to guide supportive housing in the city (P5). Instead it consists of a number of very different and relatively autonomous agencies that may collaborate with one another, but are not compelled to do so in any overall way (P6). While the LHINs, the Network and CASH all encourage integration and collaboration, at the end of the day that is all they can do (P3).

4.5. An overview of Toronto's supportive housing landscape

At present there are 31 supportive housing agencies in Toronto which provide 4400 units of supportive housing (See Table A). These range from very small agencies that may provide a handful of such units within one or two buildings, to those with many hundreds of units within

buildings scattered across the city. They include agencies whose focus is solely on supportive housing, to multiservice agencies that provide a whole host of social services within their communities. They consist of providers which accommodate a diverse range of populations and needs, to those which cater specifically to the needs of men, women, or specific ethno cultural groups. They consist of agencies that are independent or connected to hospitals or other community organizations.

Despite its diversity, the supportive housing system in Toronto is clearly one which is dominated by a great number of relatively small agencies, coupled with a handful of very large ones. As table 1 describes, 23 of the 31 agencies in the city have under 100 units while three, which we profile in the next section, have well over 800 units each.

Table A: Supportive Housing Agencies in Toronto

Organization	Number of Units
1. Accommodation Information & Support	95
2. Bayview Community Services Inc.	16
3. Canadian Mental Health Association	249
4. Centre for Addiction & Mental Health	48
5. Chai Tikvah Foundation	11
6. Community Outreach Services	18
9. COTA	201
8. Eden Community Homes	20
9. George Herman House	10
10. Good Shepherd Non-Profit Homes	185
11. Habitat Services	860
12. Hong Fook Mental Health Association	52
13. House of Compassion	21
14. Houselink Community Homes	390
15. LOFT Community Services	856
16. Madison Ave. Housing & Support Services	44
19. Mainstay Housing	869
18. Margaret Frazer House	31
19. Parkdale Activity-Recreation Centre (PARC)	10
20. Pilot Place Society	20
21. Progress Place	45
22. Regeneration House	108
23. Rouge Valley Health System	36
24. Scarborough Hospital, Manse Road Residential	10
25. St. Jude Community Homes	89
26. St. Stephen's Community House	13
29. Street Haven at the Crossroads	33
28. Supportive Housing in Peel/SHEY	84
29. The Salvation Army - Liberty Housing & Support Services	29
30. Wood Green Community Services	9
31. YWCA Toronto	100

5. The Contrasting Profiles Toronto's Three Largest Supportive Housing Agencies

In order to provide a for a richer and more tangible understanding of the diverse nature and historical basis of the system, a more detailed examination was undertaken of the origin and evolution of three largest and most prominent supportive housing agencies in Toronto: Mainstay Housing, Habitat Services and Loft Community Services As these three agencies boast a total of 2583 units, that is well over half of the total units in the system, clearly this also provided a glimpse into a good portion of the system as a whole. While a brief profile of each agency follows, those readers more familiar with the supportive housing system in Toronto may wish to proceed directly to Section B of this report.

5.1. Mainstay Housing[6]

Mainstay housing, originally known as the Supportive Housing Network of Metropolitan Toronto, was created in 1982. As the original name implies, it was initially contemplated to play a much broader policy level role. The Network originally brought together a number of individual and groups who then lobbied the provincial government to provide dedicated supportive housing for the mentally ill and educated the public as to this important issue. To that end, it initially developed a "Blueprint for Supportive Housing" and made the first submissions regarding supportive housing to the Ministry of Health.

Eventually it was successful in winning the support of a Minister of Health, by the name of Larry Grossman, who provided core funding to the Network and funds for the purpose of creating the first government funded supportive housing in the city. From this point forward the Network effectively became the "middle man" in conveying provincial funds to agencies interested in

[6] This entire section was informed by the information derived from the participants involved in the interview study, including a participant representing Mainstay Housing. However, participant codes have not been included in this case in order to protect confidentiality, and to avoid the specific possibility that linkages might be made to interview comments presented in the second part of this paper.

providing supportive housing. New non profit supportive housing agencies were created in order to access such funds, or pre-existing social service agencies morphed into organizations took on an additional role as supportive housing providers.

While the Network initially conveyed funds for the purpose of covering the cost of rent and services provided within existing buildings in the city, provincial and federal government dollars were eventually provided by which agencies could acquire and construct dedicated buildings. As the Network had served as an advocate for the mentally ill and was well apprised of the issues 'on the ground', it provided the senior levels of government with the assurance that funds were being directed responsibly and appropriately.

It was only by default that Network ultimately became an actual provider of supportive housing. In cases in which agencies ultimately could not fulfill their supportive housing obligations, their properties were ultimately taken back by the Network. This new role contributed to the Network's rebranding as Mainstay in 2004. The unexpected manner in which it was thrust into this role and acquired properties as a result, ultimately contributed to its rather unique model of supportive housing delivery.

In contrast to other supportive housing providers in the city who either provide their own on site services, or have formal arrangements with other agencies to do so, Mainstay applies a 'bring your own' philosophy. That is tenants may apply to Mainstay, or more typically other agencies may refer their clients there, but they must ultimately come with supportive services in place. As a result of its unusual model, some have referred to Mainstay as a provider of housing for supportive housing, rather than as a supportive housing provider per se. In actual fact, Mainstay does have support workers to assist tenants with basic housing related matters, and to engage them within recreational and communal activities, but it very intentionally does not engage in intense individual case management. This philosophy is reflected clearly in its staffing

numbers. While other supportive housing agencies in the city typically have tenant to support worker ratios in the area of 1:20, the ratio at Mainstay stands at 1:80.

In summary, while Mainstay was originally envisioned as the type of upper tier planning body that might have ultimately provided for comprehensive system wide planning, this was clearly overshadowed by its early and more pragmatic role in simply getting supportive funding 'out the door'.

5.2. Habitat Community Housing Services[7]

In the 1980s, mental health workers, consumer advocates and housing providers began to voice their concerns about the living conditions of mentally ill tenants who were housed in boarding homes in the city . They formed Habitat Services in 1989 in order to consider how they might address this issue and ultimately arrived at an innovative strategy that ultimately became known as the "Habitat model".

Habitat enters into a contract with building owners, on behalf of individual tenants, and this contract lays out minimum standards in terms of physical housing quality and related services. The owners, in turn, are motivated by the steady stream of guaranteed income that Habitat provides. It pays a per diem subsidy to such owners, which is funded on a cost shared basis between the provincial Ministry of Health and Long Term Care and the City of Toronto.

Each Habitat building has a housing co-ordinator who monitors standard and services, meets regularly with tenant and the building operators, and deals with disputes between them through a formal process. A housing inspector also makes regular visits to buildings to ensure that building standards are met and applicable services (e.g., meals, supplies) are provided by the

[7] This entire section was informed by the information derived from the participants involved in the interview study, including a participant representing Habitat Housing Services. However, participant codes have not been included in this case in order to protect confidentiality, and to avoid the specific possibility that linkages might be made to interview comments presented in the second part of this paper.

building owner. Habitat also employs on site support workers to engage tenants in communal activities and provides for ongoing individual assistance with personal issues and goals. It partners with Community Occupational Therapy (COTA) Health, another supportive housing agency, which provides support to those tenants with severe mental illness.

While Habitat does not own its own buildings, the contracts effectively provide it with a large portfolio of supportive housing units which it can call its own. Moreover, it has been able to influence significant improvements in the quality of the overall boarding home stock the city as a result of the increasing number of building owners who now vie for its contracts. It has been credited with eliminating the existence of triple occupancy rooms and is now pushing the standard further by rewarding more contracts to owners who provide a greater portion of single room occupancy units.

5.3. Loft Community Services[8]

Loft Community Services was formed in 1953 when two programs run by the Anglican Church were merged to form Anglican Houses, an independent non denominational Charity. It was ultimately renamed Loft Community Services to reflect the broad array of needs and populations that it serves.

Loft may be distinguished from other supportive housing providers not only in terms of its size but in terms of its flexibility and general willingness to take risks and to embrace changes in the name of addressing emerging and unmet needs. In response to such needs it has developed innovate supportive housing programs for a number of very specific populations such as seniors dealing with mental illness and homelessness, men and women dealing mental illness, addictions,

[8] This entire section was informed by the information derived from the participants involved in the interview study, including a participant representing Loft Community Services. However, participant codes have not been included in this case in order to protect confidentiality, and to avoid the specific possibility that linkages might be made to interview comments presented in the second part of this paper.

homelessness and HIV/AIDS, the underserviced sub population of young women dealing with addiction issues. In cases where needs have been deemed to have been met, as by the entry of other agencies, Loft has also taken the difficult step of ending programs in order to transfer resources toward more urgent emerging areas.

Loft is also unique in terms of being not simply a supportive housing provider, but a full fledged multi service agency. In addition to having 800 units of supportive housing within 90 sites, it serves 1800 clients per year through community support teams and street outreach programs in both in Toronto and York Region.

In keeping with an important role it plays at the system wide level, LOFT was recently selected to serve as the host agency site for the new CASH system.

PART B:

THE INTERVIEW STUDY

4. The Rationale

6.1. Why interviews with executive directors?

A simple lack of existing data required that primary research be conducted. There is no recent literature that describes, let alone critiques, the overall planning and delivery of supportive housing for those dealing with mental health and addiction issues in Toronto. Literature focussed on supportive housing in Ontario as a whole is also dated and limited in terms of both quantity and depth of analysis. Coming to a true understanding of the very complex system that exists in Toronto required a much finer, more timely and nuanced understanding of the history and evolution of the system, organizational relationships, funding arrangements etc. For example, supportive housing in the city is continually subject to the shifting tides of policies established at both the municipal and provincial level as its housing and support components are funded through a confusing patchwork of public sources.

Such detailed knowledge as exists presently resides within the undocumented[9] professional experiences and insights of those who are actually involved in the system. In order to access this collective memory and knowledge, interviews with key informants, in the form of the executive directors from supportive housing agencies, was determined to represent the most suitable approach. Key informant interviews involve those possessing particularly rich body of knowledge and experience with regard to the study phenomena. They provide an efficient means of gathering information (Jackson, 2003), as was necessary in light of the limited time that was available for the present study.

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[9] As became apparent over the course of the research, those working within the system, such as executive directors, simply did not have the time to document such system wide information as they were focussed upon the more urgent day to day issues facing their respective agencies.

The involvement of human subjects was also necessitated by the nature of the data which would not simply constitute knowledge and fact, but perceptions, insights, attitudes and opinions. For example, a consideration of the potential strengths, weaknesses, opportunities and challenges inherent in the present system is clearly a subjective process that is informed by individual and organizational experiences, opinions, attitudes, values and beliefs. These are not question that can be answered conclusively by resorting to some clear and objective data for the latter does not actually exist. Some level of speculation and subjectivity is ultimately involved. Moreover, in the case of dealing with such a vulnerable and marginalized group, as those who are dealing with mental health and addictions, the subjective issues of justice and humanity inevitably come to the fore. However, as little was known about the specific strengths, weaknesses opportunities and challenges inherent in the present system an exploratory qualitative approach, employing semi structured questions, was necessary. As previous literature has suggested (Nelson, 2005) the system ultimately needs to be guided and evaluated on the basis of values, as well hard evidence of best practice.

7. The Method

7.1. The interviews

Face to face interviews were conducted with the Executive Directors representing agencies which currently provide supportive housing for those dealing with mental health and/or addiction issues in Toronto. The interviews were guided by the semi structured questionnaire provided in Appendix A. Participants were asked questions with regard to their agency's experiences in delivering supportive housing and as to issues that stood out in that regard. They were asked about the present and potential future state of system, and asked about potential improvements. In particular, they were questioned as to the extent of system wide integration & collaboration at present and as to the potential feasibility and outcomes of a more comprehensive and system wide approach to planning.

7.2. The analysis

The interviews were 45-60 minutes in length and were recorded & transcribed verbatim. Both the interviews and their analysis were guided by the exploratory, inductive and iterative principles typically associated with a grounded theory approach[10]. Participants were provided with broad latitude to identify & expand upon issues & ideas of importance to them, and subsequent probes were then based upon these. The transcripts were open coded to identify ideas that arose within the data itself, and these codes were then tested, adjusted, and refined in an iterative process consisting of multiple re-readings of the transcripts. Ultimately such

[10] This approach does not presuppose that there is a substantive theory to guide the data collection and analysis process but rather that substantive theory is built from the 'ground up' based upon an open minded data collection and analysis process.

codes provided the basis for the higher level themes that were developed. The QSR In Vivo 9 software package was used to code the transcripts and to store, organize, and rearrange excerpts from them in accordance with the emerging relationships between the codes and changes therein that occurred as the higher level themes emerged.

8. The Sample

8.1. Number of participants

The sample consisted of executive directors from 10 of the 29 agencies which currently provided supportive housing to those dealing with mental health and addictions issues in Toronto. While this might be considered to constitute a small sample, it clearly represented a sizable (i.e., 35%) portion of the overall target population. While qualitative exploratory qualitative approaches, such as those employed in this research, do not make claims with respect to broad generalizeability, clearly capturing such a large portion of the target population bodes well in terms of making an argument on behalf of the veracity of the ultimate findings.

8.2. Characteristics of participants

Moreover, as the executive directors recruited appeared to represent agencies with very diverse characteristics, this supported the possibility that a reasonable cross section had been achieved. Three represented some of the largest agencies in the system (i.e., 800+ housing units), three represented some of the smallest (i.e., less than 50 units), and the remainder lay somewhere between. Six represented multiservice agencies, meaning they delivered a wide array of health and/or social services, while the remainder represented those focussed mainly upon supportive housing. One agency provided only the housing component of supportive housing via a large portfolio of dedicated buildings that it held, while another only delivered services, had no building to speak of, and relied solely upon rent supplements to secure housing within the private market. One of the participants represented one of only four agencies in Toronto that provided housing formally designated and funded to provide so called

"high needs" support[11], while another represented the single agency in they system which had an exclusively ethno cultural focus. Four of the participants represented agencies that had originated as result of funding provided under the provincial homelessness programs 1990s, consisting primarily of rent supplements, while the remainder came about as a result of the capital funds that the provincial health ministry had first invested into supportive housing in the mid 1980s. Only one of the participants had an office located outside of the boundaries of the old City of Toronto; with that said, office location did not necessarily reflect the distribution of their actual housing units. In terms of personal characteristics, exactly half of the participants were men and half were women.

[11] Such housing providers receive special funding to accommodate clients who typically need around the clock assistance with their mental health and addiction issues, medication dispensing, and often very basic daily tasks such as meal preparation

9. The Thematic Findings

The 30 themes which were ultimately identified are presented in the sections that follow, and 2 which were deemed to be supplementary are included in a Appendix B. However, a number of points should be made with respect to the manner in which the data has been presented. Firstly, in the interest of protecting the identity of participants they have only been identified by a participant code (i.e., P1, P2,...,P9, P10), where appropriate, and gender has also been reversed in some cases; that is, if a participant code corresponds to a male participant, they might actually be discussed as "her" or "she". Specific details of participants' accounts may also have been omitted or altered slightly, but only in cases where these might indirectly identify participants and were deemed to be immaterial to the ideas being advanced.

Throughout these sections the term "most" will be used to describe 6-9 participants, "many" will describe 4-5 participants, and "some" will describe 2-3 participants. However, more description (e.g., "a couple", "all but one") may also be provided where appropriate and if one or all of the participants respond in a certain way it will be described literally (i.e., "one participant", "all participants").

Finally, it is important to emphasize that the themes that follow reflect the values, beliefs, perspectives and ideas of the participants-- at least in so far as the analysis was able to capture them--so they should not be taken as definite and objective 'facts' or considered to reflect the personal views of this writer.

9.1. A drastic shortage of supportive and affordable housing

Most respondents identified a drastic shortage of supportive housing in the city as one of the major issues at present, and many pointed to the long waiting list that existed. As one described, "there are almost 5000 people on the waiting list for supportive housing and only

4400 units " (P6); similar figures were cited by the other participants. As participants reiterated, this demonstrated not only that there was a considerable number of people out there who were in need of decent and affordable housing, but that many of those same people also desperately need help to manage their mental illness and even to carry out some basic daily tasks. This situation was described as "double troubling" by one participant, and by another as quite simply a "crime". One participant suggested that those who were unable to secure supportive housing were likely costing society much more in hospital and criminal justice expenses thereby contributing to both an "economic and humanitarian issue" (P5). As another described, those who were unable to secure a supportive housing unit were ultimately left to "fend for themselves" in unsuitable and often dilapidated housing, in homeless shelters, or even on the streets (P9).

Even in the case of those fortunate enough to find a spot within supportive housing, it appears that limited supply contributes to housing situations that are often less than ideal. As one participant described, over 40% of units in the system were shared, meaning a "highly functioning 50 year old adult" might still have to share a kitchen and bathroom with others and would have very limited opportunities to engage in the types of intimate relationships that are a normal part of life and which “most of us simply take for granted" (P6).

Some participants felt that demand would continue to outstrip supply and, as a result, the list would continue to grow. In support of this view, one participant described how the creation of a few supportive housing units was often heralded as a major accomplishment, and even trumpeted by providers themselves. Meanwhile, this ultimately amounted to a mere drop in the bucket as far as actually addressing demand (P8). Another participant described how such things as waiting lists had a tendency to become "normalized" once the "initial shock wears off"; she also described a general complacency within contemporary society and mused as to where the social activism that had led to creation of supportive housing in the 1990s and 1980s had gone (P3).

Some participants pointed to how the shortage of supportive housing might be viewed

as part of a larger shortage in investment within other community mental health services, particularly relative to much larger scale investments within hospital based programs. For example, a couple of participants pointed to long and equally troubling waiting lists for mental health case management services in the city. Most participants also described the shortage of supportive housing as being part and parcel of an overall shortage of social and affordable housing. As one contended, it was "impossible to separate supportive housing from affordable housing", and the situation in the case of the former was "absurd" (P6). Some pointed to how the rent supplement approach, in particular, had failed on the basis of there simply not being sufficient and appropriate affordable rental housing stock available for those with mental health and addiction issues (P2). As one participant described:

"one of the greatest challenges is finding a building where rents are affordable, so if you do not have a rent supplement or enough of a rent supplement, you are at the mercy of whatever you can afford. So for $600 month you are still looking at shared accommodations within old buildings that are typically in bad neighbourhoods, and this can lead to 'ghettoization' as people with mental health issues can only afford to live in certain areas....and those with addictions issues may end up living in parts of the city with drug dealing which may actually end up being a detriment, rather than benefit, to their health" (P9).

Similarly, another participant described how they were often not able to locate clients close to important amenities or their existing social networks of friends and family, owing to the high costs of housing in the city (P9).

9.2. The greatest shortage for those in greatest need

Most of the participants identified high support housing as being in particularly short supply. As they described, this is housing for individuals with particularly complex and/or severe mental health issues and which typically involves 24 hour on site staff, meal preparation, medication storage, and generally more intense levels of case management; it is also necessary in the case of an individual is "on the edge" in terms of their mental health, and for whom isolation is particularly dangerous (P5). Living in the community was described as not typically being an option for such individuals, particularly as community based treatment homes did not exist. If supportive housing was not available to them they simply had to remain in hospital (P1,

P8) , or as one participant described, simply fell through the cracks into homelessness or ill equipped hostel systems. In the midst of increasing hospital bed closures, more and more of such individuals were ending up in hostels and on the streets, and this was described as taking a very negative toll on their health and well being (P3, P8).

Participants identified only four agencies in the city which currently provided a very limited amount of high needs supportive housing. As one described, those requiring high needs housing tend to "sit on the waiting list for a very long time" as there are "just not enough high support units" and thus "people are just not moving off the list" (P6). Most telling with regard to the shortage of such housing, however, was how a number of participants (P3, P5, P8) continually identified the same recent development project, consisting of about 40 units of high needs supportive housing, as the most significant development in this area in recent years. While even such small progress is clearly a step in the right direction, it might clearly be considered to pale in comparison to the scale and urgency of the issue at hand.

As a number of participants described, they would often have liked to have been able to provide the type of higher level care that was required but simply could not do so within the limits of their funding and staffing. To do so was not only described as unrealistic but as a major source of potential liability (P4, P6). One participant recounted a case in which a chronically ailing client might have been trapped in her apartment for days had it not been for a chance visit by maintenance staff; this caused them to seriously reconsider the level of care that they could reasonably offer (P4).

Some participants also suggested that the increasingly popular rent supplement programs did not address the need for high needs supportive housing as they were not accompanied by the funding required to deliver intensive care. As one described, even the rare capital investments that were still being made within the system did nothing to address this important support issue as the necessary support dollars did not follow. As he suggested, "the government wants to give less money to programs with onsite staff with the idea that people will gradually require less support, but this will not always be the case with the types of severe

and persistent mental illnesses that exist" (P3).

9.3. A convergence with issues of population aging

Participants reported a large number of long term clients, who had been engaged in services with them for a number of years, and others had come to them after many years of living in sub-standard housing, and in some cases homelessness. As a result, their agencies were now contending not only with providing support for mental health issues but support for the typical issues related to aging as well; this was described as a "formidable" challenge that required a significant shift in focus and priorities, and a reassignment of already limited resources. As some pointed out this actually went beyond simply having to deal with dual issues, as years of mental illness and/or living in precarious housing had led to health conditions that were much more prominent and severe than those experienced by the general population, as a natural part of the ageing process. This included a very high prevalence of obesity and type 2 diabetes brought about by low levels of physical activity, poor eating habits and extremely high levels of psychiatric medication use; the was described as contributing to lethargy and low metabolism. As one recounted, it was not uncommon for a client to gain 60 or 90 pounds within 6 months of pharmacological treatment for schizophrenia, one of the most common conditions encountered. One participant described an "epidemic of diabetes within supportive housing" and described a program he had recently developed to address it, which included special meals prepared for tenants, a dietician, and nutritional counselling (P6).

In a cruel irony, one participant described how just as some of his clients were just beginning to get a handle on managing they mental health issues, the issues of aging reared their head. (P5). Many of the participants pointed to a recent report which documented the significant manner in which mental illness, homelessness and years of precarious housing took its toll on supportive housing tenants in the city. Echoing the title of the report, one participant stated that , "40 is too young to die", and added that those who did manage to survive have typically aged 20 more years compared to a similarly aged counterpart in the general population.

One respondent went so far as to suggest that this would become an increasingly urgent "human rights issue" as more and more people would be going into their senior years "in really bad shape", having taken psychiatric medications and suffered a variety of physical health problems, on top of typical age related ailments like dementia. As she suggested, someone will ultimately need to "take responsibility" as the old "blame the victim" approach, typified by diabetes education programs, would ultimately fall by the way side in the wake of the scale of the problem and the image of grandfather and grandmothers in such poor health.

Some participants spoke to the particular importance of aging in place for those with mental health and addiction issues, and to the challenges they faced in trying to facilitate this. As one described, aging in place has served to maintain the types of vital supportive social networks that they had finally developed and needed in order to continue to manage their condition (P0). As another described, their agency was working through the very complicated process of identifying potential funding and navigating zoning related issues associated with the establishment of garden suites upon one of their building sites, as accessibility in their main building was becoming an issue for some of the tenants (P4). As she described, a number of agencies were beginning to face similar issues with respect to much of the older multi unit buildings that made up the supportive housing stock and which were not necessary equipped to deal with accessibility issues; this was identified as constituting major capital cost in the future.

A couple of respondents also pointed to how the increasing challenge of having to deal with aging in the general population might actually serve to bring the to bring supportive housing for the mentally illness into the light of public awareness (P3, P8). As one described, the health care system is going to need to develop new an innovative community base approaches for dealing with the tremendous growth in the number of seniors who will otherwise be ending up within the hospital system. As this was not unlike the challenge the government faced when it first introduced supportive housing as a means of diverting mentally ill patients away from hospitals and so logically, he concluded there would logically be a cross fertilization in terms of awareness and ideas (P8). On the other hand, one participant pointed

to how inadequacies were already being identified in the levels of support provided to seniors in the community (P1, P6), begging the question: if we can't make it work for a group that can garner as much public and government support as seniors, "who can we make it work for?" (P1).

9.4. Complex and misaligned funding arrangements

Another prominent theme related to the incredible complexity of existing funding and operational arrangements. As one participant described, there were "myriad different provincial funding formulae" that applied across, and even within different supportive housing agencies (P8). There were arrangements not only with the LHINs[12], but between different agencies. Memoranda of understanding (MOU) were cited as being commonly used tools to connect multiple agencies which each provide some aspect of the housing or support services within a single supportive housing program. In one case a participant described how an agency was funded directly by the LHINs to provide high needs case management services, but then transferred part of that funding to a second agency which supplied the actual housing and less intense daily housing related[13] support to clients (P8). In another case, a participant described how her agency provided the housing, but that a number of other agencies actually collaborated to provide the supports; this was all strung together through MOUs (P0).

One participant described the existing situation as a case of "too many cooks in the kitchen" that served to create "confusion and chaos". As he described, "...the Ministry of Health and Long Term Care had its rent supplements and previous capital investments in play, and the City of Toronto administered rent supplements provided by the Ministry of Housing and Municipal Affairs as well as capital contributions through various federal municipal affordable housing programs that provided funds for supportive housing projects" (P1).

Another participant who received operating funds for its units from both the City of

[12] Local health integration Networks (LHINs) are provincially mandated local bodies who are responsible for the funding and general organization of health related services within their respective jurisdictions.
[13] Housing related support includes assistance with the payment of rent, tenant disputes, and the general upkeep of units. It may also include the organization of various social and recreational activities within a building or housing complex.

Toronto and the MOHLTC, on a cost shared basis, admitted to not even being sure about the details of their unusual[14] agreement; what she did notice was their lack of coordination and an underlying antagonism (P2). As she recounted, the province had once increased its contribution to keep pace with levels of inflation, but the city then dragged its feet for another two years until it finally followed suit; the city had "different decision making cycles" and simply "did not wish to be dictated to by the province". Meanwhile it was clearly the "clients who suffered".

Most participants pointed to the distinction between the Ministry of Health and Long Term Care (MOHLTC) and the Local Health Integration Networks (LHINs) as another major source of complexity. While the former was described as being responsible for capital investments and rent supplements, the latter was described as being responsible for operational costs associated with accompanying support services. A number of participants still seemed confused by this division or questioned its logic. A common complaint was that these two bodies operated within separate silos and failed to co-ordinate their decision-making. In one case a participant described how she had been offered rent supplements by the MOHLTC but was then advised to speak to the local LHIN when she inquired about funding for accompanying supports services. The LHIN, in turn, failed to respond to her inquiry in a timely fashion putting the rent supplements in jeopardy. As she suggested, "...if they could just talk to each other for a change and then come to us with the money it would be so much easier" (P9).

The general misalignment between funding provided for capital versus operating costs was a general theme amongst many participants. As one described, their agency might have applied for previous affordable housing programs that provided capital funding on a number of previous occasions, only there were not rent supplements being provided at the time. Had they forged forward with the capital project they would have assumed tremendous risk in the case that rent supplements were not forthcoming. Such a move might have spelled financial disaster for the agency, and or resulted in rents that were far higher than their tenants could have

[14] As the agreement had a long history, she was not even sure how much of it was documented and suggested that some aspects might have simply been carried out on the basis of a phone call and a handshake.

reasonably afforded.

The fact that supportive housing constituted only one, and a very small one, of the programs that the MOHLTC and LHINs actually dealt with was also identified as a challenge by some participants. In alluding to the problems and delays in having to deal with such large and bureaucratic organizations, one cited the example of how her agency once sought funding approval simply to add a few units to one of their building sites. This led to such a long and complicated five stage approval process that they ultimately opted to fundraise (P4).

9.5. Creativity and the ability to 'stretch a dollar'

In response to the complexity inherent within the system, and increasingly limited government funding, it would appear that agencies have also become incredibly inventive in terms of cobbling together funds from a variety of divergent programs and in ultimately stretching every dollar received to the greatest possible extent. Rather than there being some common blueprint or approach, many participants described how they more commonly arrive at pragmatic, situation specific solutions according to the circumstances and resources at hand.

As a specific example, one participant described how they were able to stretch the rent supplements allotted to provide supportive housing for a specific number of homeless individuals in order to ultimately serve many more. To accommodate this, congregate accommodations were proactively sought for those clients with families which maximized their buying power and thereby served to reduce the rent subsidies that the agency ultimately had to provide. As the participant described, a person might be granted a $400 housing allowance under ODSP and the typical rent for a bachelor apartment was close to $1000; this meant that the agency would need to provide a further $600. In contrast, a couple with two children were entitled to a shelter allowance of $900, and the typical market rent for a two bedroom apartment was $1200; this meant that the agency only needed to provide an additional $300, if it was able to facilitate a group living arrangement. As it happens, the agency was also able to take advantage of the fact that it dealt extensively with ethno-cultural groups within which the

concept of family is highly revered, and multigenerational homes were more common. This provided it with the flexibility to consider an even wider variety of family arrangement that might be beneficial from an economic and financial perspective (P9). As a result of the success of this approach, the participant described how the agency actually began to develop a focus on and niche in family centered approaches to housing and care.

Some participants also reported simply organizing and scheduling their staff so as to serve a greater number of clients than was the intention of the original rent supplements provided. As two described, funding that was originally provided to serve 16 and 48 clients respectively, was ultimately stretched to serve 20 and 60. As one admitted, however, this had begun to raise concerns with regard to quality of care and long term staff burnout (P10). As one suggested, there was also the danger that it would raise the expectation of funders to an unrealistic degree, in terms of what could be reasonably achieved with a given amount of resources (P2).

Creativity in the face of complexity and scarcity also led to a situation in which rules were not always followed and funds were not always directed toward their intended purpose. For example, one participant described how it was sometimes possible to use funds designated for certain number of high needs clients in order to serve a much greater number of lower needs clients owing to higher staff to client ratios that the latter afforded (P9). Another described how the MOHLTC had been willing to "turn a blind" eye in some cases in which supportive housing agencies had also played the role of developer within head lease schemes by establishing arms length bodies that had legal possession of the properties being developed and subsequently rented by the provider (P6). As will be described shortly, the rent supplements upon which such schemes were based were intended for use in the private sector and were not intended to create a situation in which supportive housing providers were ultimately paying rent to themselves.

9.6. The entrepreneurial imperative

Owing to reduced government funding, and the increased bureaucracy and delays associated with it, many participants reported on how their agencies had become more independent and entrepreneurial. They described how their agencies were much more actively involved in fundraising initiatives (P5, P8) and had begun to seriously consider issues in relation to branding (P0 P9) and marketing themselves to the public and potential donors (P4).

Some participants also discussed how their agencies had begun to explore the opportunities for leveraging the equity that had built up within their properties. However, they also described how their ability to do so was often constrained by the government's legal involvement within the original ownership and financing arrangements in relation to properties. As one described, they were the legal owners of a number of buildings that might be used as equity for the purpose of securing loans for further construction, but as the government was also involved, these properties were "not considered to be worth a penny on their actual balance sheet" (P6). As another suggested, the government was expecting them to be more creative and resourceful, and yet was maintaining restrictions that did not afford them the flexibility to do so (P3).

While some participants pointed to the accumulation of funds in the form of various agency reserves, they also conceded that it would not likely be sufficient to support the development of more supportive housing. However, a couple of participants did point to the possibility of pooling resources amongst a number of agencies in order to fund such future development. One participant described how his agency had actually developed an independent stream of revenue from the commercial tenants within one of its buildings; this was in addition to revenues that were also being collected from cellular towers that were perched on top (P4). While the agency had lacked any commercial property management experience, it had benefited from the business and legal expertise that existed within the membership of its Board of Directors.

9.9. A necessary 'love/hate' relationship with private developers

The most typical form of entrepreneurial behaviour came in the form of an increasing number of partnerships that were being forged with private property developers. As many of the participants described, the most typical scenario in the present funding context involved developers who agreed to provide, refurbish or build rental buildings in return for the period of guaranteed rental income that supportive housing agencies could provide to them via rent supplements. Typically, the supportive housing agencies would enter into a head lease agreements with such developers in which they agreed to pay a fixed rent to the developers and thereafter assume all responsibility for individual rent collection, tenant issues, and general maintenance. At the end the agreement period, which typically lasted about 25 years (P8), the developer would retain ownership of the property.

Many participants expressed a great deal of frustration with such agreements. As they described, it was the developers who ultimately reaped the benefits of a considerable level of capital appreciation (P9,P8), having already benefitted from a guaranteed stream of rental income, which would serve to cover mortgage payments, and from any capital subsidies that might have been provided by the government in exchange for the construction of such affordable housing stock. One participant, pointed to the fact that they were essentially providing the developer with free property management services and yet were not being compensated for it (P5, P6). As one participant described quite simply, "it was one subsidy on another" (P9).

While some suggested that there were some "good developers" out there (P4), the consensus was that they were driven by the profit motive, and the "lure of easy money" (P6), rather than by any real sense of benevolence (P5, P9). As one participant pointed out, most supportive housing providers were actually aware of inequities inherent within such head lease agreements but as they needed units and had no capital funds, they simply had no choice (P6).

As some participants suggested, rules in relation to rent supplements were the problem.

Rent supplements needed to be spent within the private sector, meaning that supportive housing providers were prevented from constructing their own rental housing on the basis of rent supplements which they might ultimately pay out to themselves. This obstacle was described as a "perverse obstacle" by one such participant who suggested that there was a "desperate need for some form of social innovation" in this area (P5). Another described how his agency had actually considered the possibility of creating a separate and arms length development company, but this was a complicated undertaking that was beyond their resources and expertise (P6).

9.8. NIMBYism, NIMBism and exclusionary zoning

While participants described NIMBYism as a persistent issue, the fact they did not discuss it with great passion or in great detail might have reflected the simple fact that few dedicated buildings had been constructed in the city in recent years. In keeping with the growing reliance upon rent supplements, however, some participants did provide detailed accounts of discrimination on the part of landlords when they attempted to secure rental accommodation for their clients (P6, P9). In a typical case of such Not In My Building (NIMB) ism, one participant described how she commonly inspected new units for clients only to be told that they were suddenly not available once the landlord learned about potential clients with mental health issues (P9).

Participants also pointed to an even more systemic case of discrimination in the form of exclusionary zoning. Many described how the supportive units provided by their respective agencies were typically scattered throughout the city, and somewhat more concentrated within the boundaries of the former City of Toronto, but were conspicuously absent from many areas within the boundaries of the former cities of Scarborough, North York and Etobicoke. As one described, zoning bylaws within all of these areas strongly restricted congregate style accommodations, such as rooming houses and group homes, that might facilitate a critical mass of supportive housing (P5, P10) . As one participant described, there had been an attempt to

address these bylaws when the new city of Toronto was amalgamated but they have somehow "managed to stay on the books" (P1). Another participant described how zoning bylaws within some of the inner boroughs of the city also set arbitrary minimum distances between buildings which housed uses such as supportive housing (P9). As one participant concluded with regard to the existing regulations, it seemed that "supportive housing represented one of the few cases where outright discrimination was still allowed" (P1)

In order to debunk fears about the negative impacts of supportive housing, some participants pointed to the positive relations that their clients had developed with their community (P1). As one described, neighbours had greatly appreciated a community garden that their tenants had created in front one of their building and commonly interacted with them at the local dog park. Another recounted how neighbours had contacted the agency to express their concern with regard to the well being of a well known tenant who was conspicuously absent from the neighbourhood (P4). In keeping with the research evidence (de Wolff, 2008; The Dream Team, 2010) , no problems or conflicts with the community were identified over the course of any of the interviews that were conducted.

9. 9. The perception of an oversold housing first approach

While some participants conceded that that so called "housing first" approaches might succeed in the case of clients who were otherwise difficult to engage, most also seemed to feel that this approach was being over sold in terms of its overall and long term potential to assist those with significant mental health issues. In fact, some participants appeared to take strong issue with housing first programs over the course of the interviews.

As one participant described, "you can not simply drop someone with a mental heath and addiction problem into a market unit, that may be surrounded by drug dealers, and think everything is going to be great" (P0). As another suggested, if homeless people with mental health issues were simply "placed in a nice apartment", they would be back out on the street within a year. As he explained, many would struggle with everyday tasks, such as cooking, and

as a result of loneliness would ultimately seek out the companionship of their friends on the street (P10);.

As one participant suggested, those promoting housing first approaches often alluded to the romantic notion of a broader supportive community that was simply "out there" and ready to embrace individuals who "had no money and carried the stigma of a mental illness", whereas in reality that simply did not exist. What was needed, he argued, was the type of real and tangible community of peers that dedicated supportive housing could provide (P6).

Some participants suggested housing first approaches did not engage with their fundamental belief that "housing was more than just housing".(P0). As they described, the housing component of supportive housing actually serves as a medium through which agencies were able to monitor and stay connected to their tenants in order to monitor and address their mental health and broader needs. Eviction processes, for example, were viewed as an opportunity to gain deeper insights into the personal issues being faced by clients and to provide them with enhanced skills and valuable life lessons (P0). Even in the case that clients withdrew from case management and social activities, agencies were able to monitor their condition through contacts with their neighbours and through something as simple as building maintenance visits (P9). As one participant described, it was essential to stay abreast of whether an individual's mental health was "sliding" as it provided them with a critical opportunity to intervene quickly; for example, in the case that clients were not taking their medication and/or it needed to be adjusted, the agencies needed to reach them while they were still lucid (P10).

As another participant described, "the goal of supportive housing was never to simply get clients housing, but to provide clients the opportunity to establish networks of support for broader problems solving that would flow out in terms of achieving other important things" (P0). Similarly another described how they were about "creating stigma free recovery communities in which tenants were free to express themselves and to take part in a host of self improvement activities" (P6).

A recent report[15] funded by the Mental Health Commission of Canada, served as a lightning rod for the participant's critiques of housing first. As one described, this study "failed to even acknowledge" the existence of the type of dedicated supportive housing that they provided, and ultimately appeared more like a piece of marketing on behalf of housing fist approaches. As he suggested, it would have been enlightening to have compared the outcomes of these two approaches, but no such comparison was conducted; comparisons were conducted merely between people in their housing first model, versus those who were on the street, in jail, or in hospital. Another participant admitted that their model would likely work for some people, but that they would only be representative of a "very small segment" of the population that they dealt with: as he concluded, "...it is a one size solution, but the problem is that one size did not fit all" (P5).

While one might logically assume that those working in supportive housing would have a close relationship with those working with housing first approaches, given their common interests and issues, this did not appear to be the case. In fact, the very characterization of the housing first programs, presented above, does not seem to reflect their reality. For example, housing first is more than just the provision of housing to clients experiencing homelessness and mental health issues. While housing first programs do not impose additional support services upon its tenants they are commonly made available; providing them with choice in all of such matters is the guiding principle . Thus there is either a lack of knowledge with regard to this program and/or perhaps some type of animosity that exists on an ideological level. The latter will be explored further in the final discussion.

9. 10. The rent supplement debate

Participants pointed to both the benefits and drawbacks of rent supplements. In terms of benefits, one participant described how it was an effective means of getting more supportive

[15] This report was entitled, Turning the Key: Assessing the Housing and Related Supports for Persons Living with Mental Health Problems and Illnesses. It was conducted by the Centre for Addiction and Mental Health, in collaboration with the Canadian Council on Social Development.

housing units into the system quickly and avoiding the NIMBYism and related delays that often accompanied the introduction of new dedicated buildings (P5). Some pointed to the opportunities they offered in terms of allowing tenants to access a whole new range of market units, which would not otherwise have been available to them (P5); it was also suggested that such scattered units might allow tenants to integrate more effectively into the general population (P9).

In contrast, some participants criticized rent supplement approaches on the basis that they did not take into account prevailing market conditions and the discriminatory practices of landlords (P5). As one asked, "what good are the rent supplements when there is a 1.4% vacancy rate in the city and landlords continue to discriminate against those with mental illness...at best tenants with mental health issues will be concentrated in run down buildings and neighbourhoods" (P6).

Another participant suggested that rent supplements did not make sense in the case of the increasingly important[16] subset of high needs clients. Whereas rent supplements were effective in securing scattered individual rental units, the efficient delivery of services to high needs clients required congregate or clustered housing arrangements.[17] As he explained, travelling across the city to get from one client to another would detract from crucial case management time and/or significantly limit the number of clients that could be served (P8).

As some participants described, their agencies actually lost ground in the context of rent supplement programs as increases in the supplements typically did not keep pace with the increases in market rent (P0). Others pointed to how the lack of capital investment that accompanied rent supplement programs meant that they were unable to build equity that they could leverage for the purpose of future development. By not getting on to the property ladder, they also described how they were unable to benefit from the substantial year to year gains that were being realized within the city's hot real estate market (P6). Instead, the private

[16] See "The greatest shortage for those in greatest need"

[17] As participants described, one would be extremely lucky to find available rental units clustered together at precisely the time when rent supplements became available

developers and landlords were the ones to profit. As one participant suggested, "twenty years from now we are going to realize that rent supplements are costing us too much as a result of high and ever increasing rents, and yet we will have nothing to fall back on in terms of housing stock that we actually own as we did not make the earlier capital investments" (P9).

Some participants expressed the view that both housing first and rent supplement approaches, were indicative of an increasing government trend toward trying to do things "on the cheap" (P3, P6). Another extended this economic argument to hospitals by suggesting that they were "likely to embrace" such approaches, if it simply meant getting more patients "off of their books" (P0). Another warned that the agencies promoting rent supplements, were often the very same ones that relied upon them for their own revenue and thus "had the most to lose or gain" (P6).

Ultimately most participants agreed that rent supplements had certain benefits and advantages and that, for better or worse, they were presently an essential component of the system. However, most of them also agreed that there was presently a tremendous and very troubling overemphasis upon rent supplements; in fact, even participants who were form agencies which utilized rent supplements were in agreement on this point. Many participants argued that a wider variety of funding models were required in order to address the diversity of needs. As one participant summed up the general sentiment, "it is not a matter of this or that approach, but of having a set of different tools that create options for clients. The problem is that today's toolbox is driven entirely by rent supplements" (P10).

9.11. The drastic need for capital investment

Throughout the interviews, and as already suggested in the discussion above, most participants reiterated an urgent need to acquire and build more supportive housing stock. A number alluded to the two major periods of capital investment in the system which took place in the mid 1980s and early 1990s, and which still account for most of the current dedicated housing stock. Others referred to this early housing stock as still constituting the essential,

albeit "increasingly tenuous, backbone of the system" (P6). Some criticized the dismal lack of capital investment over the past 20 years, and suggested that greater investment was necessary in order to simply ensure its viability and sustainability.

One participant helped to make this idea of sustainability via capital investments even more tangible. He described that his agency started with one main dedicated supportive housing building and then fanned out to provide supportive housing services in the broader community, using tools such as rent supplements. While they now reached a much larger and more diverse population, he emphasized how they still relied upon that one original building. It continued to serve a central hub from which all services and supplies then made their way out to the broader community. He emphasized that all of this would not have been possible without that original capital investment; as he argued such strategic capital investments were now desperately needed in order to provide a framework for the necessary system growth (P9).

In arguing on behalf of greater capital investment within the system, one participant pointed to hospitals as a prime example of society's commitment to investing in order to have important health-related resources concentrated and secured permanently (P6). In contrast, another suggested that it would prove increasingly difficult to convince government to actually make such investments owing to increasingly bleak economic forecasts and prevailing conservative ideologies (P8).

9.12. The ODSP and OW as even more fundamental concerns in their own right

The fact that the Ontario Works (OW) Ontario Disability Support Programs (ODSP) weaved into conversations with all of the participants was not surprising for as one participant put it, most supportive clients were on one or the other of these programs (P9). Most typically participants alluded to how the financial support provided was insufficient, and to how the shelter components were particularly meagre in a city as expensive as Toronto. One participant pondered whether the "crime" was actually the lack of supportive housing, or more fundamentally, the fact that programs such as ODSP and OW did not provide people with the

basic level of income to access housing and all of the other things they needed to survive (P8).

As one described, the housing allowance under the ODSP was "ridiculous", for even if a person could find an affordable or rent geared to income apartment, which was difficult, housing costs would typically still require dipping into the rest of the remainder of his/her ODSP, which was intended for basic living costs; as he calculated[18], in some cases a person might be left with a mere $200 to cover food, transportation, clothing and all other living costs for the month (P8). As another participant suggested, the amount left over from ODSP after covering housing expenses provided little opportunity for clients to actually go out to develop supportive social networks or to seek employment, as they "might not even have money for a bus fare". As he described those formulating policy in relation to ODSP, rent supplements and affordable housing, "rarely spoke to one another, let alone co-ordinated their actions" to take into account such realities on the ground; it was "like two separate hands trying to clap" (P 9).

Some participants pointed to structural problems inherent within ODSP and OW which made it difficult for their clients to lead more productive lives and to eventually even move on from supportive housing. As they described, ODSP "penalizes people too strictly and severely for earning a bit of extra money" that they might need to simply get "on their feet", and they may even put their rent supplements in danger by doing so. As one explained, it does not recognize that the incomes of those dealing with mental health issues may "fluctuate significantly" owing to "repeated entries and exits from the work force" that might be necessitated by their condition; it simply "claws back" income in a "drastic manner" with little regard for the circumstances or impact upon people's lives. Many participants suggested that ODSP and OW needed to be fundamentally reformed in order to provide their tenants with the incentives and ongoing support necessary to move forward to improve their lives (P0, P5, P6, P9,

[18] As he expanded, if a person managed to find a bachelor apartment for $750 in Toronto, which was "optimistic", and got a typical housing allowance of about $450, then the extra $300 would need to come out of the rest of their ODSP. He/she might then be left with a mere $200 to cover food, transportation clothing and all of other living expenses for the month. (P8).

P8, P9).

9.13. The ill addressed issue of cultural diversity

Some participants argued that ethno-cultural and linguistic issues needed to be taken into greater account in service provision (P6, P9, P9). As one participant contended, it was one of the biggest and most obvious issues, for as the city became increasingly diverse, agencies still served a largely homogeneous population of white English speaking clients. As he suggested, long time tenants, who happened to be white, still made up a large portion of the overall population in supportive housing as a result of a low turnover of units and a shortage of new supply (P6). As another suggested, those areas of the city in which many new immigrant groups tend to settle, were also those in which culturally specific supportive housing is absent and where new projects are presently restricted by exclusionary zoning; the Scarborough district was described as a specific case in point (P6).

As another participant suggested, it is a case of "we don't know, what we don't know, so if there is an underserved Vietnamese population at Jane and Finch, I certainly would not know as I am not connected to that culture" (P9). Putting this into a broader and more critical structural context, he added that if you looked across the room at health-related forums and meetings in Ontario you would see a " pretty much homogenous group of predominantly white and mainly male participants" as higher level boards tend to "self select in their own community" (P9) ; the exception, which supported the rule, came in the case of organizations focused specifically on ethno-cultural issues. As he suggested, you can then "pan out from there in terms of considering who does and does not get served adequately" (P9). Coincidentally, such sentiments were supported by the nature of the present study sample itself, as all of the executive directors interviewed were white and predominantly male.

Some participants emphasized the importance of becoming more culturally sensitive. One described how mental illness was far more stigmatized in certain cultures and how those from different cultures often had very different perspectives and norms with regard to

communal living (P9). Another stated, " supportive housing might look very different to the hundreds of thousands of people coming here from Somalia, or Vietnam or Iran?" (P5).

While participants did point to some programs that aimed to make supportive housing more ethno-culturally relevant [19], the consensus was that this was simply not enough in light of the scale and importance of the issue. And while a number of participants pointed to a supportive housing agency which had cultural issues at the heart of its mandate, a participant from that agency pointed to the challenges they faced and to the limitations of their work. As she described, they were only funded to provide services to Chinese, Cambodian, Korean and Vietnamese clients. While other important groups had been identified, such as Tamils and newcomers from India, they were not included within their organization's mandate as they simply did not have the staff and resources to assist them; at the basic level, they did not have staff fluent in the necessary languages.

9.14. An ongoing hospital focus and imposition of institutional concepts & ideas

While most participants argued that community based supportive housing constituted the most appropriate and effective use of mental health resources, they also pointed to the continued dominance of hospitals in terms of garnering the greatest government funding and policy attention. As one stated, "over 85% of provincial health care spending goes to institutions, leaving little resources to address even more basic determinants of health that exist in the community" (P5). As another argued, if only 1% of the budget of hospitals were directed to the community sector, this would have a "much more significant impact upon population health" (P1). In a rather telling example, one participant described how hospitals had dedicated and ongoing capital programs, whereas supportive housing had to wait for special funding programs or go to the MOHLTC "cup in hand" in order to get things built or even

[19] For example, Fred Victor Center was identified as delivering a program to raise awareness about supportive housing amongst newcomers to Canada and Madison homes was identified as being involved in a recent program for newcomers with mental health issues which incorporated information on supportive housing. One participant also reported having collaborating with Across Boundaries in the past, but did not elaborate.

repaired[20] (P5).

Hospitals were not simply maintaining center stage in the health care system, according to the participants, but were actually beginning to become increasingly involved in supportive housing. As many described, the CAMH had not only become involved as a partner in recent supportive housing projects in the city, including one involving the agency of one of the participants, but had collaborated with the MHCC on recent research to explore specific models for its delivery (CAMH, n.d.). Such increased involvement raised suspicion amongst some of the participants for as one described, supportive housing had originally been developed as an alternative to hospital-based care. Some worried that this might lead to the greater imposition of hospital based ideas and concepts, which will be described shortly, while others simply felt that those in the hospital sector might logically protect their own interests. For example, one participant suggested that it was not surprising that their research with the MHCC ultimately promoted rent supplements as less capital expenditure on dedicated supportive housing in the community would mean more capital funds for hospitals. As another suggested, CAMH would welcome rent supplements amidst reductions in government funding to hospital beds, as it could then quickly move long term patients into existing market apartments; irrespective of whether they necessarily provide them with appropriate and/or adequate care. As one participant suggested, involving the hospitals within supportive housing was like "letting the fox into the henhouse" (P9).

Many participants also described how concepts and ideas derived from the hospital sector were frequently and inappropriately imposed upon the supportive housing system. They depicted this as a clash between two very different cultures which was manifested most clearly in the contexts of the LHINs[21]. As one participant lamented, "we have been building and refining our organizational approach for years and now everything is changing with words like

[20] As he described, hospitals could tap into an ongoing capital program in case a new wing was needed to accommodate more patients, but there were no such dedicated capital program for community based agencies

[21] Local Health Integration Networks.

flow through, standardization, discharge, all of these terms that they use in hospitals". As she adds, "but nobody is critically thinking about what this will mean or about if it even makes any sense" (P3).

Nowhere was this clash more evident than in the case of "flow ", a concept cited repeatedly by most of the participants. As they explained, the LHINs were beginning to scrutinize the work of supportive housing agencies in terms of how efficiently they "moved people through the system". As one explained, such 'flow through' approaches were successfully applied in the context of hospitals, in order to address their skyrocketing costs, so the assumption was that they could be applied equally well to the supportive housing sector (P3).

As one participant argued, the concept of flow through disrespected the considerable amount of time and effort that agencies had to invest with clients and it implied that their job was simply to "fix people and then send them on their way" (P8). As another described people do not "simply recover from mental illness in stepwise and linear fashion", as might be expected in the case of physical injuries and illnesses treated in a hospital. Instead they commonly cycled back and forth between stable stages, and stages in which they suffered setbacks and required higher levels of support; as she summed it up, "that is the nature of mental illness", she explained (P9).

As one participant suggested, "flow through for us, if you even call it that" is about providing for a more "seamless transition between different options with differing levels of support than it is about progressively moving a person toward an end goal of an exit from the system" (P8). As he recounted, there were often individuals who struggled when they moved on to more independent forms of supportive living but thrived once they were provided with an opportunity to live within more communal congregate arrangements; while this was a "positive flow" in his view, he remarked that the LHIN would likely see it very differently (P8).

Some participants questioned the concept of flow on the basis of economic and material realties. As they all generally asked: why would those in supportive housing want to

move out, or be expected to move out, if they had decent and affordable housing for the first time in their lives and were finally in an environment where they got the tools and resources they needed to manage their mental health issues (P0, P2, P4, P9). As one suggested, "flow" through was all the more unrealistic given lack of affordable housing and case management services available in the broader community; that is, there was nowhere to flow to. From this perspective he added "there is nothing surprising or wrong about having no flow through" (P0).

Some participants argued that the concept of "flow " conflicted with both the fundamental beliefs and the legal obligations of supportive housing agencies. As they pointed out, supportive housing was premised upon a belief that people with mental health and addiction issues had a right to security of tenure, and that such security actually contributed to their health, well being and recovery (P3); flow clearly suggested that no such security existed. As a couple of participants pointed out, supportive housing providers were also mandated to provide permanent housing and their tenure rights were fully protected under the Ontario Landlord and Tenant Act (P4). As one remarked, this was a fact that was often overlooked by those at the MOHLTC and in the LHINs (P2). As she continued, it was "bewildering and disappointing" to hear LHIN representatives suggesting that we should reconsider whether our clients really need all the support we are providing and that we should work harder to "counsel people to move on".

In the context of this discussion of "flow ", it is telling to point out how many of the participants expressed pride in the longevity of many of their tenants. As one described: "we have clients that have been here for 15 years or more, and a great number who have been for at least five years"; as another noted "our very first client is still with us" (P9).

A couple of participants also spoke to how new data collection and management tools seemed to reflect this clash of cultures. As one pointed out, the language of the OCAN was based on a "faith in hard data" and "framed in the language of needs and deficits "; in contrast, he suggested that supportive housing was focused on an individual's strengths and assets and on striving to enhance positive health and wellbeing (P6) . Similarly many participants alluded

to how the LHINs were beginning to impose the types of organizational models, intensely data focussed management approaches, and "business school type language" (P8) that was more typical of large hospitals; some questioned its appropriateness and value in the context of community based supportive housing (P3).

9.15. Dancing to the ever-changing tune of government priorities

Participants described how supportive housing agencies often shifted their organizational focus and direction according to increasingly fickle provincial priorities, and the resultant funding streams. As one described, "if the funding shifts then so too do the agencies...if the LHIN says we are funding programs for children, then suddenly agencies pull a rabbit out and suggest that their contact with families makes them experts in the area" (P9). As another described, many agencies with dedicated housing stock have suddenly had to become "engaged with the concept of rent supplements, and knowledgeable about how they work", even if they do not necessarily believe in them" (P2).

One participant was very pragmatic about this phenomena in stating "we are flexible and we are certainly not proud, so if they give us an opportunity but they want us to call it x we will call it x, if they want us to call it y we will call it y. If they want us to jump up and down we will jump up and down. But at the end of the day we try to stick to our value system, and for us the central concept of recovery is paramount" (P5). Another, however, was much more critical in describing what he referred to as planning on a "quote on quote, priority population basis" (P8). As an example, he pointed to how the MOHLTC had recently offered funding toward supportive housing for those with addiction issues, for which a number of agencies then clamoured to apply. As he explained, the decision to provide this funding was not based upon overall planning or any system level consideration, but was made to address one high profile issue and to appease one high profile politician. As it happened, there was an urgent need to reduce emergency room costs, which were often frequented regularly by addicted and

homeless patients, and the acting Minister of Health happened to have dealt with his own addiction related issues.

One participant also suggested that agencies ran the long term risk of "organizational drift" (P3) as a result of continually chasing government priorities and money. As she described, suddenly all the reports and correspondence coming out of agencies have to be reshaped in order to somehow fit into LHINs' newest strategic directions; while it was sometimes mere "semantics", she described how it could gradually pull an organization further and further away from its own vision, core values goals and objectives.

9.16. The encroachment of LHINs

While participants acknowledged the important role that LHINs played in the health care system, many suggested that they had thus far been quite hands off in the case of supportive housing. As one suggested, this was most evident when one considered their much more active, aggressive, and visible role with regards to institutional care[22]. As another remarked, "you don't really see a whole lot about supportive housing when the LHINs put out reports and when you hear about them in the news...we are usually a side note" (P9). Such relative (in) attention was explained on basis of scale. As the supportive housing system as a whole accounted for a mere fraction of the money spent on hospitals, some participants suggested that finding efficiencies in the latter was a much higher priority for LHINs.

However, most participants also agreed that LHINs would become much more involved in the years to come. Some pointed to the increasingly focused role that the LHINs had already begun to assume by virtue of encouraging and supporting initiatives such as the Coordinated Access to Supportive Housing (CASH), the Ontario Common Assessment of Need (OCAN) and the Integrated Assessment and Referral (IAR) system; these were considered to be harbingers of things to come.

[22] For example, the LHINs were involved in the amalgamation of a number of hospitals in Ontario in the 1990s, which was alluded to by some of the participants.

Others anticipated that LHINs would become increasingly involved with supportive housing as policy makers became increasingly aware of its potential value in terms of getting people out of expensive hospital beds and into the community; once initial steps had been taken to reduce hospital cost directly, their attention would inevitably turn to reducing them even further by making supportive housing more effective and efficient.

Some participants did, however, suggest that the LHINs were not quite as well equipped to deal with the issues associated with the housing aspect of supportive housing. As one remarked, they are "health people not housing people" and those are "two different worlds with two different skill sets" (P6). Another described how their local LHIN had not even set out any specific goals or objectives with respect to housing, as it had with some other health system components, beyond a vague suggestion that they would visit this issue at some point in future (P9).

9.17. Recent steps toward a more "formal" system wide integration of services

All participants discussed recent and formal steps that had been taken to achieve greater system wide integration. The advent of the Toronto Mental Health and Addictions Supportive Housing Network, and its offspring in the form of the CASH[23] program, featured prominently. Some participants suggested that the monthly meetings of the network provided an important means of networking with other agencies to share ideas and resources (P3, P9). Most also praised the manner in which CASH provided those with mental health and addiction issues more equitable and convenient one stop access to all of the available supportive housing options in Toronto, and criticized the fragmented and ad-hoc system that had previously existed (P5). As one participant described, "previously those looking for supportive housing, or their loved ones, had to send different applications to over twenty agencies, and had to knock on a lot of doors...now they can get information on them through a single website and can apply to

[23] Coordinated Access for Supportive Housing (CASH), is a centralized application and referral service for supportive housing in Toronto which was recently introduced, largely as a result of the efforts of the Toronto Mental Health and Addictions Supportive Housing Network

them all through one application process" (P1). As another described, "CASH finally provides an opportunity for people to access all of the diverse supportive housing options that are actually out there" (P9). Other participants described how CASH finally made the process "fair" (P10), "equitable" (P2), "universal and transparent" (P0).

Participants also pointed to the broader strategic advantages of CASH. As it ultimately demonstrated that there were thousands of people who were in need of supportive housing, many participants suggested that it was a valuable tool in advocating for greater government investment in this area (P4, P9). As one suggested, "to be able to state that there over 4000 people out there who not only need decent housing, but also basic supports to manage their mental illness, is a powerful thing" (P9).

Some participants also pointed to how the CASH waiting list finally provided a basis to more appropriately distribute the supportive housing stock [24](P3, P5). As one argued, finally having one overall list of applicants, and knowing exactly what resources were available at a given time, would allow them to match needs to services and to rationalize more appropriately if certain resources were in short supply. However, participants also conceded to the obvious challenges with, and lack of specific metrics, for making a determination as to the greatest priorities and needs[25] (P5).

There were also critiques of CASH. As most participants were quick to point out, CASH provided better access to supportive housing but it did nothing to address the severe housing shortage (P3, P4, P10). As some suggested, it might actually have created false hopes (P6). Others pointed to how the universal CASH system actually served to disrupt a number of long standing partnerships that supportive housing providers had developed with specific institutions

[24] As one participant suggested, there were undoubtedly those in the system who were presently receiving more support services than required and alternatively, those who might not be receiving enough.

[25] As one participant suggested, they did not presently have a "precise measure of severity and need for adults dealing with mental health issues"; even in the case of seniors in the general population who required supportive housing, applicable measures were described as being of questionable value.

and programs[26]; the preferential access to supportive units enjoyed by the latter was lost as a result of the new and universal referral service (P0, P2).

Some participants described how the universal application had resulted in them receiving many inappropriate referrals and led to pressure to accept applicants who were not necessarily a good fit[27] with their program (P0). Some also criticized the application as being quite long and onerous to fill in and process, owing to the fact that it had included input from so many agencies; and they warned, this might actually discourage some from even applying (P3)

One participant described how CASH had also been envisioned as a means of compiling important data on supportive housing applicants; for example, he described how information with regard to the fate of those on the waiting list may prove to be particularly valuable in terms of making the case for supportive housing (P8). However, he also conceded that this had not materialized as a result of a lack of resources. At present, staff were struggling to enter all of the data from the applications, while also identifying suitable housing units for fortunate applicants. As he lamented, they were also unable to maintain contact with those on the waiting list, let alone provide them with potentially critical interim support. It would appear that CASH had created a catch 22 situation.

9.18. Privacy in the age of the OCAN and the IAR

Most participants also identified the Ontario Common Assessment of Need (OCAN)[28] process and the Integrated Assessment and Referral (IAR) [29] service as important recent

[26] While such relationships had typically been established with hospitals (P6), one participant described how a very longstanding and value driven relationship[26] with a homeless shelter also had to be dissolved as a result of CASH (P0).

[27] While they accepted that it was important to provide applicants with equitable access to all options, they also felt that a certain level of agency discretion was necessary in order to assure that it was a good fit for both the applicant and the agency.

[28] The Ontario Common Assessment of Need (OCAN) is a standardized and recorded process by which agencies are now required to continually revaluate each client's status and needs at regular 6 month intervals

[29] The Integrated Assessment & Referral (IAR) is a virtual portal through which the OCAN and a wide array of other health and social service related reports can be accessed in relation to a client; it is available to a wide range of professionals from whom the client might seek services or care.

developments in terms of promoting better overall integration and co-ordination of services. They applauded it for forcing all agencies to take a more systematic accounting of the progress made by clients so that they might make any necessary adjustments.[30] As they suggested, the less formal dialogue that case workers typically had with clients with regard to "how they were doing" might be "less apt to get at everything" (P9). The IAR was described as reducing unnecessary delays, enhancing the continuity of care, and relieving clients of the burden of having to "tell their story over and over again" (P5).

However, a number of participants also expressed concerns. As one suggested the OCAN was often times "redundant and patronizing", particularly in the case of their long term and essentially permanent residents; potentially sending the message that "you are not doing enough to get better". More importantly, participants expressed increasing concern over privacy in light of the amount of personal information collected. As one suggested, the OCAN might be considered to be a "personality profile" as it collected "such an incredible amount of personal information" on clients (P0).

Others questioned whether such large amounts of personal information should be shared so freely amongst so many professionals via the IAR. As one asked rhetorically" Do they all really need to know every single detail of someone's mental health history in order to do a good job; as a case in point she added, "do recreation therapist really need to know about all of that stuff in order to teach them to swim or to work with others on team?" [31]. As another argued, each professional might need access to certain types of information, but beyond that there might be little to no benefit. As she posited, a client care might actually suffer in those cases as providers began to view them through the lens that has been distorted by the knowledge of all of the clients previous setbacks and missteps. This was all the more likely, she added, as "those who worked in the mental health and addictions field tended to be curious and

[30] As they described, it sometimes revealed client needs and interests of which they were not previously aware and provided agencies with an important opportunity to adjust goals or to break them into smaller and "more realistic" pieces in the case that they were not seeing progress

[31] The participant identified this profession as being one that was slated to receive access to the IAR.

nosy by nature".[32]

One participant pointed out how many of the community based professional s who would ultimately have access to client information under the IAR would not necessarily be subject to the same strict accountability structures as were already in place for doctors and nurses[33]; as a result, he questioned the level of confidentiality that could ultimately be assured (P8). Another pointed to how such community based professionals, including those working in supportive housing, would have access to hospital records for the very first time via the IAR; the implications were far more significant and "fraught with danger" than most appreciated, he argued, and he was not even sure if he wanted or needed such access (P6).

As a simple password would provide access to all of a client's information under the proposed IAR, one participant questioned whether it was an appropriate system; at the very least, should there not be firewalls in place to protect certain information from general consumption?, she asked.[34]

Most participants also pointed to the unique aspects of client information that made privacy issues a central concern. As one described, those with mental health issues tend to have histories of hospitalization and criminal justice involvement which they might wish to keep private as a result of its potential implications this might have on their relationships, employment prospects, and experiences within health and social services systems[35] . In fact, a formal and recorded diagnosis of severe mental illness, in-and-of itself, was described as resulting in Canadians potentially being denied access into the United States. As one participant

[32] She did not make this remark in a disparaging way, as she also had a background in front line work, and suggested that workers therein were inevitably drawn in to the lives of their clients.
[33] For example, strict and formal ethical policies and processes in place under the Ontario College of Physicians and Surgeons
[34] As she described, it was difficult to accept an explanation that was offered up by the software company suggesting that such measures could not be implemented, given that educational institutions had successfully implemented them in the case of student records.
[35] As one participant suggested, those with mental health issues may often experience differential treatment within hospital emergency rooms owing to their general appearance and behaviour; having said that, he also suggested that a documented mental illness might actually lead to better treatment as emergency room staff might be better prepared and held to a higher standard by virtue of being apprised of the nature of the situation

highlighted, what was at risk was not simply exposing highly confidential and potentially damaging information, but of exposing such information with respect to a segment of the population which was already extremely vulnerable and marginalized.

Not surprisingly, this led to some participants taking exception with the overall move toward "harvesting" more and more personal information on clients (P10). As one reflected on all of the new processes, versus the old:

"...when people applied to us in the past we would sit down and talk to them briefly in order to see if they would be a good fit for our program. As we were most concerned with their present situation and functional status, there was no need to go into great depth about their past.

Now, if an applicant innocently applies to our program they are immediately met with this long and imposing application form and then if they manage to secure housing they still have to submit to a series of long and personal evaluations." (P3)

In a similar vein, another simply asked, "why should they have to give up so much information simply to access decent housing and support....who else is expected to do that?" (P4

9.19. The insertion of profit driven data management companies

As all agencies had to purchase expensive proprietary data management software from the same companies, who also hosted mandatory training sessions, some participants expressed concern regarding the increasing private sector influence that this invited. As one suggested, "it is a whole different world when you involve private companies who are selling you these products and are driven by profit margins" P3). One participant described her horror when her questions with regard to securing a client's informed consent were met with the suggestion that they "did not need to know all of the details about IAR" and should simply emphasize that it is "for their own good"; this was all very "patronizing" and seemed to create a situation where the "tail was wagging the dog". As she added, it also came from people "with degrees in business and information technology who just did not understand the "nature of community health" and the "importance of concepts such as empowerment" (P0). Similarly, others described how there was a "whole lot of confusion" about the issue of informed consent (P4) and what exactly it meant in the context of marginalized individuals who "were not always of sound mind"(P8).

9. 20. The creation of a new bureaucracy to protect privacy...or deflect liability?

One participant did point to a process which was to be incorporated in the IAR which would flag cases in which client records were inappropriately accessed (P5). However, another criticized this process as "naive" given the difficulty in establishing that a file was inappropriately accessed, particularly as operational funds to carry out such tasks were being continually cut back[36]. Even if they did catch someone, she added, this would not address any negative impacts already suffered by the client.

Some participants also described how they were facing an increasing amount of provincial policy in relation to privacy, driven largely by the OCAN and IRA. As one described, the MOHLTC was even beginning to contemplate the establishment of a new organization for the sole purpose of dealing with s matters of privacy. However, a couple of participants also suggested that such policies tended to focus too narrowly upon liability, and were typically framed so as to protect the MOHLTC by placing greater responsibility upon agencies. As one described, "they must have a team of lawyers going over all of this stuff" as they are "constantly shooting out agreements to cover them"; ultimately, it was suggested that the agencies would be the ones to pay the price in terms of the considerable and inevitable liability issues that would arise[37] (P3). In any case, given the significant resources that were being directed toward protecting privacy seemed apparent that any savings achieved through gathering all of such information ultimately needed to be weighed against the significant and increasing resources that were now being directed to simply address privacy and liability concerns.

[36] As she suggested it would be quite easy to conjure up an official reason for having accessed a client file, and would be quite difficult to prove otherwise. Moreover, it was described as overly optimistic to suggest that a great deal of resources would be put toward pursuing such inherently complicated matters, owing to the fact that there was not likely to be increased operating funds available to do so during a forthcoming period of funding cuts and general austerity.

[37] As a specific example, she pointed to how clients were typically also employed by supportive housing agencies on a part time basis, in keeping with their focus on expanding their opportunities, and yet might now have their hospital records scrutinized in the case of extended absenteeism; this in turn might trigger lawsuits on the basis of workplace discrimination

9.21. Questioning hard data as the holy grail

While more and more data were being collected from agencies through the CASH, the OCAN and the increasing LHIN reporting requirements, some participants admitted to how they often did not know how it was all ultimately being used (P4). Others suggested that there were significant drawbacks in terms of the very nature of the data which limited how it could be applied and the conclusions that might be drawn. As one described, the LHIN driven practice of recording the number of "contacts" made with clients was of limited value and potentially misleading. As she described, a staff member might spend an entire day, or even several, simply encouraging a suicidal tenant to go to hospital and then escorting them there to provide support and ensure that they ultimately followed through; as she suggested, this would only be considered to constitute a single client contact and yet clearly it was necessarily much more urgent and involved. Another pointed to how present measures failed to take into account important outcomes that were not necessarily valued equally by the LHINs: "how does one place a value upon one day clean and sober?", he asked. Another spoke about how existing measures were not capturing the extensive efforts that they had made to involve clients within the operations of the agency, by offering them opportunities to be involved in its governance and by creating part time and casual employment; the resultant capacity building and empowerment were equally important outcomes and measures of success which were not captured by the existing measures.

One participant pointed to a specific example in order to highlight the weakness of existing approaches. Over the course of his involvement with a new supportive housing program for addicted clients, he recalled how "the great brains" at the Ministry came up the idea of recording how many addicted patients returned to hospitals within 30 days of being discharged. They did not consider whether patients had returned to hospital for injuries or

illnesses that were actually related to their addiction[38], and they did not consider whether patients might originally have been discharged from hospitals prematurely[39]. Most surprising, perhaps, individuals were identified as having made contact with the CASH service, but then no further information was collected as to if and when they were ultimately able to secure housing. As the participant concluded, it was clearly impossible to evaluate supportive housing based on such data for even a chance fall by a tenant that led to a hospital visit, or a hospital visit by someone who had not accessed supportive housing at all, might lead to the false assumption that supportive housing had ultimately failed (P8). As he described, there was significant "push back" to this measure by agencies as it clearly added little in the way of value.

One participant simply warned of the dangers associated with considering "hard data" to represent some "panacea or holy grail" for the supportive housing system. As he described, there was "unavoidable flaws and limitations inherent within all hard data", and "values and practical experience had to come into play". To reflect this reality, he described how the term "evidence based practice" had subsequently been changed to "evidence informed practice" within the annual reports of his own agency; for as he explained, a "simple resort to the facts" was often not adequate in terms of setting priorities and determining what was a "right and just" course of action, particularly in relation to such a vulnerable and marginalized population (P8).

9.22. The myth of "fat" in the system

Many participants suggested that the system had been unfairly and inaccurately characterized as being plagued with fragmentation, duplication, and waste. One participant coined this as the "myth of fat in the system" (P4) while another suggested that it was an " illusion of inefficiency" created by all of the diversity that had arisen from a process of organic growth; as she added, it was ultimately needed in order to deal with the great diversity of needs

[38] as opposed to any number of common injuries and illness, unrelated to addictions issues, that might be encountered by those in the general population

[39] The participant noted how patients were commonly discharged prematurely in order to free up beds for new patients.

and situations that existed in the city (P2). Finally, one remarked that "the government is hot on the idea of duplication in our system, but if you drill down deeper it doesn't exist" (P6).

As some argued, these characterizations were also refuted by the lean and frugal management that actually existed within their agencies. As one described:

"if we had our finance person come in one less day per week, this would still not save us anything as she already has too much to do... [and]... eventually someone would still have to file all those LHIN reports. It is not like she has oodles of time that she might be spending on something else" (P3).

As another argued, there is a problem if an agency has "2 managers for only 2 staff but we have 3 managers for over 30 staff and the ratios are pretty consistent from agency to agency. As he also added, the staff to client ratios were often dictated by broader policies and funding arrangement, so the huge efficiencies that policy makers claimed they could find really were "just not there" (P9).

A number of participants pointed to how the CASH waiting list ultimately seemed to vindicate the system in terms of efficiency, at least as far as initial administrative duplication and waste was concerned. While policy makers felt that a number of applicants were on multiple waiting lists prior to CASH, and that suggested demand was inflated as a result, this was not borne out by the facts. As one participant pointed out , only 20 of 900 original applicants to CASH indicated previously being on multiple lists, and 4 of those had been on more than two; as he concluded, duplication did not factor into the demand, which soon resulted in a list of over 4000 applicants (P6).

9.23. The hidden pockets of collaboration

A number of participants also refuted the notion of "fat" in the system directly, or indirectly, by pointing to the great number of collaborative relationships between agencies, and to their resultant efficiencies; of course, this also served to refute the common belief that integration was wholly absent (P3). These relationships reached well beyond the formal partnerships, discussed earlier, that had been established to deliver actual supportive housing programs. As one participant described, the multitude of relationships were not fully

appreciated and in many cases not documented (P2).

Participants described how their agencies participated on the steering committee of CASH, which held regularly monthly meetings. However, agencies were also described as taking part in the regular meetings of various special working groups that had been established apart from and prior to the advent of CASH: for example, one working group was made up of agencies who dealt with addictions issues and another involved agencies who delivered high needs supportive housing (P8). In addition, the LHIN was described as hosting regular meetings of all mental health providers within their jurisdictions, and this was described as providing an obvious opportunity for networking between participants' agencies and other system players (P9).

Some participants described how their agencies were also members of organizations that fostered collaboration and achieved added efficiencies. For example, the Federation of Community Mental Health and Addiction Programs and the Ontario Non Profit Housing Association, were described as providing valuable education and training programs, networking opportunities, and discounted group premiums on insurance and employee benefit programs (P2, P3).

On a less obvious but even more direct basis, some participants described how they served on the boards of a number of organizations of system wide relevance[40], alongside of their colleagues in other supportive housing agencies; this served as a valuable form of networking through which ideas and information was often exchanged. Others pointed to how supportive housing agencies often collaborated in order to achieve "backroom integration and efficiencies". For example, one described how they provided quasi-training sessions to other agencies in order to convey the information that they had gathered from formal training sessions and conferences (P4). Another discussed how their dietician travelled to other agencies in order to share information and ideas, and how they were in the process of

[40] Homecoming Community Choice Coalition was cited as one such organization, as it educates on and advocates for the housing rights of those dealing with mental health and addiction issues in Toronto

establishing a process for sharing a common information technology system and support service for a handful of small agencies (P3). Agencies were also described as collaborating in research and as producing joint reports on important issues; these were then utilized by other agencies to address similar internal matters and/or used to lobby for broader system wide changes (P0, P2, P3, P4, P6). [41]

It became apparent that the supportive housing system was actually a tight knit family in which individual players shared resources, interacted regularly and typically knew one another quite well; in fact multiple participants reported being previously employed by other supportive housing agencies and remaining involved with them on an informal basis (P3, P6,P8). By extension, numerous examples were cited whereby the clients from different supportive housing agencies came together to enjoy shared experiences and resources. In one case, a participant described how clients from other programs came to take part in art programs that they offered to their clients. In another, agencies were described as bringing together both clients and resources to provide for social outings in the broader community.[42]

9.24. No more agencies, but not necessarily any fewer

Interestingly, when participants were asked directly whether they felt that the present number of supportive housing agencies was appropriate or needed to be either increased or decreased, all of them agreed that no further agencies should be introduced. However, only one suggested that the number should actually be reduced; as he argued, the existing number reduced efficiency, tied resources up within management, and meant that there were "simply too many interests to overcome"[43] (P1). The remainder took a more tentative position, and while acknowledging the potential challenges faced by smaller organizations (P5), pointed to the value that a number of agencies might provide.

[41] For example participants pointed to two recent reports on the issue of bed bugs within supportive housing buildings and on possible means of addressing alarmingly high rates of early mortality amongst supportive housing tenants.
[42] In one case a participant referred to shared trips that were taken to the Toronto Islands.
[43] He also suggested that his was not likely a common or popular opinion amongst other participants.

One argued that a greater number of agencies provided for levels of consumer choice that were essential given the great diversity of client populations, housing needs, funding streams and planning contexts. As we had well over 29 different types of coffee shops in the city to satisfy our "wants" was that really too many agencies to address such vital "needs?", he asked. As he then calculated, about 30 different agencies for a city region consisting of about 4 million people, effectively meant 1 supportive agency for every 133,000 residents in Toronto; or one agency for a city the size of Oshawa (P1). As he continued, the overall ratio was likely even larger, as 5 or 6 of the existing agencies had arisen to meet the needs of specific groups within particular areas of the city .

Some participants pointed to how an elimination of agencies, would also mean a loss of the free and invaluable skills, knowledge and experience that was presently derived from their boards of directors and from the many community relationships that they had formed over the years (P3). One pointed to how this would also lead to the irretrievable loss of valuable organizational knowledge which would ultimately be essential to inform system level planning and decision making (P9). As I discovered for myself over the course of the interviews, such knowledge was often not documented, existing only in the minds of those involved in the system.

Finally, some participants simply questioned the economies of scale that would be achieved by reducing the number or agencies owing to their relatively lean and frugal management. In questioning arbitrary assumptions that were sometimes made, in light of the complex nature of the system, one asked, "how can we really say that having 10 organizations is really going to be more efficient than having 29"(P2). This was all the more questionable, of course, if one considered the previous suggestion that manager-to-staff ratios were generally consistent across agencies and that staff-to-client ratios were often dictated by broader policies and funding arrangements (P9).

9.25. Administrative demands and the precarious fate of the small agency

Discussion with regard to the number of agencies ultimately merged with a discussion regarding the value and fate of small agencies. For example, one described how a reduction in the number of agencies might threaten the "client centered and community like" culture of small agencies such as theirs, by causing them to amalgamate and become "large, impersonal and bureaucratic" or by forcing them out of the system altogether (P8).[44]

Others suggested that such changes might already be at hand. All but one of the participants described how there were much greater administrative demands being placed upon their agency as a result of the advent of CASH, the OCAN, IAR, and the increasing--and increasingly complicated--LHIN reporting requirements. While those from larger agencies seem to take it in stride, and accept it as a necessary part of doing business (P1, P5)[45] , those from smaller agencies were much more critical and worried about potential impacts upon their operations and viability. A participant from one small agency expressed frustration in having to hire an accountant to come in once a week just to do the agency's financial reports, and in having to resubmit them regularly as a result of the LHIN constantly changing its reporting requirements (P3). Another described how having to send her staff off to day long training sessions as a result of initiatives such as the OCAN and IAR, was beginning to put a serious strain on her small and overworked staff and was beginning to detract from their ability to focus on their more critical front line work (P4).

Even participants from the larger agencies seemed to be sympathetic to these issues faced by their smaller counterparts. One suggested that it would be "very difficult for small agencies to compete and survive as a result of such cumbersome and technical demands" (P6),

[44] As an example, this participant described how they had an open door policy, in terms of allowing clients to drop into the office freely and at any time. In fact, he pointed to a community lounge that had been set up to encourage this and described how clients played a number of paid and involuntary roles within the organization that were afforded by the informal manner in which they tried to conduct their business. He suggested that this might be threatened if the organization were to become larger and more bureaucratic.

[45] As a couple of participant from larger agencies commented, these requirements were somewhat burdensome (P7) but would get easier once they got into the habit of doing them (P8).

while another expected that they would likely face "staff burnout" as a result (P5).

9.26. The need for a system wide planning of services

As CASH dealt mainly with the "mechanics" of "agency reporting" and of "people "applying to and moving through the system", some felt that it simply did not go far enough in terms of dealing with the real issues of overall planning and coordination (P1, P9, P8). While many participants expressed a general view that greater system wide planning was in order, one participant provided a particularly passionate, detailed and reasoned argument. As he suggested, system wide planning would firstly serve as a an important advocacy tool by virtue of educating the public and policy makers about the nature and importance of supportive housing, and by encouraging the provincial government to finally make a "solid commitment" to the tangible and long term course of action that it laid out (P8). As he described, there was presently a "back and forth cycle" within the system whereby different proponents would argue on behalf of different supportive housing approaches and as it was often impossible to establish that one proposal was any better than another, from an objective point of view, politics and happenstance would often determine the outcome. If there was one overall strategic plan, he argued, there would be a commitment to a long term vision and course of action from which all other decisions would more logically flow. For example, funding directed toward rent supplements in the short term could be justified on the basis that the necessary capital investments into new and dedicated housing stock were also scheduled for some future point in time.

In expressing his confusion as to why there was no single plan for supportive housing in the city one participant mused, "every large and successful company has a plan" (P6). As another suggested it was just "common sense" as " it is difficult to ask the provincial government for the type of money that we need if we do not first have some type of plan to suggest how it should be spent"; on that basis he actually argued that a focus on comprehensive planning should "precede any discussion of increased funding" (P10).

Some participants also suggested that there are limits to what could ultimately occur in terms of system wide planning, by virtue of the organic manner in which the system had originally evolved. As one described, "the system did not follow from some strict and rational premise or blueprint so it is not clearly organized, logical or even equitable" and as a result decisions will "inevitably always be based on politics to a great extent" (P5). As he added, "what they had was what they had", and while it "was not perfect", it was still "pretty good" and "getting better and better" with the advent of initiatives like CASH (p5).

9.27. From CASH to comprehensive planning?

An obvious question which was posed over the course of the interviews was whether the Mental Health and Supportive Housing Network might build upon CASH to ultimately become the base for a more comprehensive and system wide process of planning.
While some suggested that this was a possibility (P5), most seemed surprisingly resistant and pointed to a variety of logistical challenges. As some suggested, this was never the intention of the network as it was to be a site for greater coordination and the sharing of ideas, "not a master planner" (P1, P6).

While such resistance to the idea of CASH becoming a site for planning was somewhat bewildering, the comments of one participant served to put it into a political perspective. As she suggested, "it would be next to impossible to get all of the agencies to cooperate in order to establish some overall plan for the network as each of their underlying values and philosophies are so different"[46] (P9). As she suggested, the only way in which the network might become a site of comprehensive planning was if some "outside body stepped in to take the lead", and this would definitely not be welcomed.

[46] In making her point, she described how her agency once parted ways with another that it had originally partnered with as it ultimately had very different ideas as to what constituted legitimate grounds for expelling clients. According to the other agency, a hospital readmission constituted a "relapse" for which a tenant was punished with an eviction.

9.28. On the cusp of big, but as of yet unappreciated, changes

Many participants felt that the supportive housing system was on the cusp of tremendous changes. As one described, the LHINs had "more than hinted" at their intention to encourage greater integration and consolidation within the system" and it was not inconceivable that they would ultimately push to have only a handful of major agencies involved. He also added that the supportive housing agencies involved with CASH were already discussing how they might take greater proactive steps to offset any unilateral and draconian steps that might be in the wings; as he described they had recently decided it was important to "take control of their own collective destiny", rather than having it dictated to them; the LHINs had encouraged them to integrate voluntarily but was now quite ready to involuntarily impose it (P6).

Another participant described how they might well be at a "crisis stage". For while the LHINs were encouraging greater and greater standardization, uniformity and integration, the supportive housing system was still made up of a great number of agencies that all varied tremendously in terms of their size, characteristics, and "general way of doing things"; in his words, "something had to give" (P8). One participant predicted that the number of agencies would inevitably be merged or eliminated within the next five years, leading to a system that looks "very different than it is today" (P6).

Two participants pointed to significant legal challenges that stood in the way of the province simply stepping in to take charge of the system, and these might also have accounted for them not taking a strong hand earlier. As one described, supportive housing agencies had whole or partial ownership of their properties, and were bound to agreements in relation to them with charities and a variety of other community bodies. Even if it was the government's intention, it was suggested that it could not simply sweep in and pull all of these properties under its wings unilaterally; at least, not without considerable negotiation and potential litigation(P8). Having said that, he conceded that they still wielded the balance of power by

virtue of holding the purse strings for all ongoing support dollars.

Some participants focused upon an apparent lack of awareness about forthcoming changes. As one suggested, the average person "does not even know what a LHIN is or what it does" and yet they are about to make these big changes that are going to have a serious affect on people's lives. As she suggested, they would not only have a very direct and dramatic impact upon her clients, but potential impact upon everyone as a result of the basic human rights and privacy issues involved (P3). Reflecting on how social activism had led to the very establishment of supportive housing, another participant mused about the present lack of concern; "was it a generational thing"? As she added, it was even more astounding that people involved in the system were not trumpeting these as "huge changes" that people needed to pay attention to (P4).

Others expressed concern that the changes that were already underway were being implemented too hastily and had unpredictable consequences. As one participant suggested, with the new CASH application, OCAN and the IAR, they were simply "trying to do too much all at once" (P8). As another described, we are "being encouraged to go out and tell our clients that it is okay to participate in the IAR, but the truth of the matter is we really do not know what it going to happen once all their data is put in one big repository" (P4). One participant remarked, "one would think that there was some common understanding" of these changes "across the board" but they were not nearly as co-ordinated as one would assume"; for example emerging relationships new players such as data management companies really were not clear (p3)

Participants' views of the future were undoubtedly coloured by a recently released report on public service reform in the province[47], which some referenced directly. As it painted a "grim picture" (P1) in terms of recommending cuts and general austerity in all areas, possible

[47]This was the 2012 report by The Commission on the Reform of Ontario's Public Service that was headed by Dwight Drummond.

efficiencies would need to be a top priority for everyone (P6, P8).[48]

8. Summary of findings and concluding discussion

The thematic analysis presented above has a number of important implications. The supportive housing system for those with mental health and addiction issues must clearly evolve to meet the demands of an increasingly diverse ethno-cultural population in Toronto, and to meet the immense and increasingly complex demands that will continue to be placed upon it by an aging population. Clearly, urban planning must also evolve with these demands by recognizing that there is a desperate and essential need for supportive housing, and thus enabling zoning bylaws, within all areas of the city. As part of their role in creating a civil city, planners must work to create opportunities for more supportive housing, rather than putting forth obstacles to it. Exclusionary zoning, NIMBYism and NIMBism must all be recognized as an affront to human rights, and proactive policies must be put in place in order to address any related conflicts in a much stronger and more systematic fashion.

As those dealing with mental health and addictions typically constitute a vulnerable and extremely marginalized group, the significant, immediate and demonstrated need to create more supportive housing represents a clear humanitarian issue, that lies even above and beyond any economic arguments that might be put forth. The fact that those most in need of such housing are also those with the most significant support related needs, simply amplifies an already intolerable situation. It is clearly unacceptable that those with such significant challenges should have to continue struggling to survive and to fend for themselves on the street, in shelters, or in sub-standard housing.

There is a strong argument in support of greater capital investments into the system in order to address the tremendous demand at hand and to ensure the long term sustainability of

[48] While it was suggested that the Drummond Report might offer an opportunity in the case that money was shifted more appropriately the community sector as a means of achieving greater overall health system effectiveness and efficiency--particularly as no new spending was anticipated in any area--it was considered to be highly doubtful that this would not likely be embraced by the hospital sector.

the system. In that vein, policy makers must clearly ask themselves whether the existing approach makes sense on purely economic grounds; one in which private developers profit on the guaranteed income and capital gains that are ultimately secured by initial government subsidies. As one participant suggested, is there going to come a day when the government realizes that the amount being paid toward rent is simply too high and if so, what then?

As supportive housing agencies are becoming increasingly entrepreneurial, the study findings suggest that there is also a reasonable argument for providing them with the opportunity to take greater control of their financial destinies by making it easier for them to leverage their properties and to take more direct advantage of tools such as rent supplements. In effect, it might make more sense to get rid of the middle man by allowing supportive housing agencies to also become property developers, alone or in financial partnership with fellow agencies.

With that said, the analysis has also suggested that the increasingly narrow emphasis upon rent supplements might be worth reconsidering. The diversity of populations, needs and situations that exist, means that there is also a need for a wide variety of housing options supported by a wide variety of funding arrangements, which include direct capital investment. As the analysis has suggested, there are a number of compelling arguments in favour of rent supplements, and related 'housing first' approaches, but there is also a danger that they may become over popularized as a result of exaggerated claims and expectations. For example, it may be overly optimistic to assume that all of those dealing with mental health and/or addictions can achieve the levels of independence assumed by such approaches and that private landlords will embrace the mentally ill with open arms, particularly if vacancy rates in the city remain low. Most importantly, governments must avoid the temptation to try to 'do supportive housing on the cheap' through an exclusive and economically driven reliance upon such measures for, as the adage goes, you ultimately get what you pay for.

On a broader level, clearly there is a strong argument to be made for greater investments into the affordable housing stock more generally in order to provide all of Toronto's

residents with a decent standard of living, and not simply those dealing with mental health and addiction issues. However, as the analysis has revealed, more affordable housing might also have the added benefit of providing those presently residing in supportive housing units with a viable option to transition to the broader community, thereby not only contributing to their ability to move forward with their lives but freeing up their units for those in the greatest need.

Significant problems in the ODSP and OW also constitute broader issues that clearly affect a much larger population, and yet have an inevitable and magnified impact in the case of those who also struggle with the added burden of mental illness and housing issues. Reforms are clearly needed in order to provide people with a basic level of income and with the opportunities to improve their own lot in life; these may clearly represent even more fundamental and upstream determinants of health than the provision of supportive housing itself.

Clearly the funding and operational arrangements in relation to existing supportive housing programs are extremely complex. While this has contributed to a high degree of innovation and creativity amongst agencies which should be applauded, one must clearly ask whether this is in keeping with system-wide planning and coordination and whether it actually results the most efficient use of limited resources. For example, considerable resources must clearly be devoted to the very process of navigating, negotiating, and aligning the various programs. Moreover one must ask if it is morally or rationally defensible that government funding originally intended for one population and/or purpose is ultimately put toward another, even if this might be justified on local pragmatic grounds. After all, should decisions involving taxpayer dollars not be transparent and should government policies and programs not be implemented so that they can ultimately be evaluated as to whether they have met their intended goals? Clearly neither is possible in the case that situation specific decisions are being made covertly by agencies and sometimes on the basis of a nod or a wink. Moreover, what struck this researcher was how murky the system still appeared despite spending a considerable amount of time researching supportive housing and having the benefit of a graduate level

education. It begged the question of whether this situation might prove problematic in the case that the ultimate goal was to generate support for the system and perhaps even bring a broader community voice to the planning and decision making table; how might that be accomplished if the system could not even be described in a clear and more concise fashion? It also begged the question of whether aspects of the system might somehow be re-organized so as to function in a manner in which could ultimately be evaluated more simply in terms of value for the money; although this writer acknowledges that the complexity of the needs addressed by the system might limit such opportunities.

Hidden pockets of integration and the generally lean and frugal management within supportive housing agencies seemed to refute the image that participants' felt existed in certain circles: that is of a supportive housing system which is riddled with inefficiencies, duplication and waste. Moreover, it seems reasonable to assume that much of what might appear to be redundant to the casual observer, might actually reflect aspects of the system that have evolved organically and are ultimately necessary for addressing the diversity of populations, needs and situations at hand. While some efficiencies may be found through enhanced integration, any suggestion that huge savings might be achieved through the removal of large “chunks of fat" from the system would be exaggerated and overblown. To the contrary, it seems that many agencies have gone to such great lengths to stretch each government dollar that concerns are actually beginning to arise as to whether this is creating unrealistic expectations amongst funders and burnout amongst agency staff.

By extension, it would also appear that any proposal to simply reduce the number of agencies in the name of achieving big and easy savings is optimistic and overlooks the important benefits that such agencies bring to the table in terms of diversity, experience and innovation. In fact, in light of such benefits there is definite cause to be concerned about the precarious fate of smaller agencies. In the wake of increasing administrative demands resulting from a growing number and complexity of LHIN reporting requirements, a number of agencies may simply and unceremoniously vanish, with no consideration as to the value that they bring to the table and

to the important opportunities, knowledge, and experience that might be lost. It would certainly seem more sensible to have a reasoned discussion with regard to their future based upon a more thoughtful consideration of their overall benefits and costs to the system.

Examples provided within the analysis seem to support the contention that some of the supportive housing outcomes being considered by decision makers such as the LHINs are not always appropriate and/or adequate enough to provide for informed decision making. Such findings raise questions as to whether the quest for data has actually become an end in itself. As one participant suggested, perhaps evidence-informed practice should take the place of evidence-based practice, owing to the inherent flaws and limitations of hard data and the equal importance of values and practical experience. Such a critical and insightful position resonates with the early work of Nelson (2005), who characterized Ontario's system of supportive housing as a whole as one that ultimately needs to be driven by both values and evidence.

The increasing focus on data within the supportive housing system would clearly seem to reflect the influence of popular business models, and the increasing involvement of profit driven private sector players from the data management industry. As the analysis suggests, it also seems to reflects the resurfacing of a historical institutional hegemony within the health care system which prioritizes concepts such as "levels of care" and "flow thru"; concepts that were originally applied to, and arguably most suited for, the treatment of physical illness, injury and disease within hospital settings.

As the study findings suggest, this institutional hegemony is also reflected in and supported by a disproportionate amount of health care spending that continues to go toward hospitals, as opposed to supportive housing and other forms of community-based care. There is certainly a strong argument that can be made for having more funds directed to the latter, particularly if one subscribes to a popularly held view that preventive community-based care is ultimately more appropriate and cost effective

While it would seem that most participants agreed that recent initiatives aimed at bringing about greater and more formal system wide integration, such as the CASH, OCAN and

IAR, are steps in the right direction in principle, there are clearly significant concerns with regards to how things have materialized in practice. Most importantly perhaps, are major and seemingly justified concerns regarding how the increasing focus on data collection and management is putting the privacy of client populations in jeopardy. As one participant asked, why should people who are struggling with an illness have to forgo their privacy and risk so much simply in order to secure support and a decent and affordable place to live? This certainly does not seem to be keeping with increasing public concerns with regard to individual privacy, and it is certainly doubtful as to whether the average citizen would accept this as a reasonable trade off for attaining something so fundamental. One might logically ask why marginalized groups are not entitled to the same level of consideration, particularly as they may already struggle with stigma and discrimination and may arguably have even more fundamental rights and entitlements at stake.

There are clearly significant benefits to be had through even more comprehensive and ongoing system wide approaches to planning, that reach beyond service integration initiatives such as CASH. As one participant argued, the existing process of chasing after funding streams deriving from ever changing and somewhat fickle government priorities, could be replaced with a process of system-wide planning in Toronto in which specific long term goals were established and then continually and consistently strived toward within each and every funding-related decision. Having said that, it would also appear to be quite challenging to achieve such a system, owing to the very different values, beliefs and principles of agencies; even as CASH has finally set the table for master planning, it appears that agencies still have very different ideas about supportive housing that will need to be overcome.

In closing, a final theme identified over the course of the analysis was how many of the changes described above were suddenly taking place within the system and how even more drastic changes were expected. At the broadest level such changes clearly include a potential shift away from the core values, beliefs and principles associated with community based mental health promotion and service delivery and toward those aligned with business models and

hospital based institutional care. Moreover, the analysis suggests that the general population, and even some of those within the system itself, may not be aware of these changes and/or grasp their full impact upon people's lives. It is hoped that this paper has helped to address this gap in knowledge and awareness by providing a first exploratory description and discussion of these changes, alongside of providing more general insights into the inner workings of the supportive housing system. If so, it has served one of its primary goals in terms of documenting the invaluable collective knowledge and memory that presently exists within the supportive housing community.

Appendix A: Questionnaire and Interview Guide

Questionnaire and Interview Guide

[Begin the interview with the following explicit instructions:]

Before I begin posing questions, I should stress that you should take as much time as you wish in responding to each. While I may not say much please do not misinterpret this as disinterest. I will be making a concerted effort not to interrupt you as I as I wish to afford you as much latitude as possible to talk about issues and ideas which you feel are most interest, relevant and important.

As I come to this research with relatively little in depth knowledge or practical experience with regard to supportive housing, please do not assume that any detail is too simple or obvious to discuss. There is presently very little written about the complex inner working of the supportive housing system for those dealing with mental health and addiction issues in Toronto, and so I greatly value your role as an expert in this regard.

Furthermore, as a relative novice I certainly do not come to this interview with preconceived ideas as to the present or potential future state of the system. While I may pose questions with regard to more centralized planning for example, I am most certainly appreciate that there may be significant challenges and shortcoming associated with such an system and not an advocate for one approach or another.

Having said that, let us begin.

[Proceed with the following questions]

BASIC ORGANIZATIONAL INFORMATION (~10-15 minutes)

1. *What specific housing and/or social services do you provide?*

2. *What specific populations do you serve?*

3. *Is there a particular vision, values, principles or ideas that guide the work of your organization?*

4. *In general terms--that is, without providing specific locations-- how are your supportive housing units distributed throughout the City of Toronto? How did your organization first come to own and manage supportive housing units, and how did your portfolio evolve in terms of subsequent building acquisitions and construction?*

5. *What sources of funding has your organization utilized for the acquisition and construction of housing units and the subsequent provision of services to your clients?*

[In proceeding with the remaining questions, provide participant with the time to answer as each as fully as possible. Engage the participant with physical (e.g., nods, eye contact) and verbal cues (e.g., "yeah") so as to encourage them to expand upon their thoughts and ideas. If there are lulls comfort them (e.g., *"take your time*") and encourage additional discussion ("is there anything further you would like to add on that subject").
As the participant is responding interrupt as little as possible with questions. Instead, jot down key words to represent those questions, and other important information and ideas raised by the respondent. Once the respondent has indicated that they are finished responding, probe them with additional questions based on the key word list]

EXPERIENCES & ISSUES (45-50 minutes)

Organizational experiences & issues

6. *How has your organization evolved in terms of the services provided and populations served?*

7. *What would you describe as your greatest strengths and accomplishments of your organization?*

8. *What would you describe as the greatest challenges to your organization?*

System wide experiences and issues

9. *What do you feel are the greatest strengths and accomplishments of the overall supportive housing system in Toronto? What are its greatest challenges? Are there specific changes you feel are necessary?*

10. *Are there examples of collaboration between the various players in the supportive housing system? Are there way in which your organization has collaborated with others within the system? If so, please elaborate.*

11. *Are there opportunities for greater co-ordination and integration within the supportive housing system? Are there specific challenges to achieving greater system wide co-ordination and integration? Are there any risks or drawbacks to moving toward a more integrated, comprehensive and system process of planning for supportive housing in Toronto?*

12. *How would you describe the role of the Local Health Integration Networks in relation to supportive housing? In your view have they been successful in terms of achieving greater integration and collaboration amongst supportive housing providers? Is there something that you feel they should be doing differently?*

13. *Do you anticipate any changes within the supportive housing system in Toronto in the foreseeable future? If so, please explain.*

Appendix B: Additional Themes

B1. In defense of the integrated supportive housing agency

Participants did not generally engage with the somewhat dated "supportive" versus "supported" housing debate identified in the literature. As on participant put it: "that distinction was relevant in the 1980s and maybe 1990's, when supportive housing was synonymous with a far more custodial and institutional approach in which the housing and supports happen to be combined....it no longer applies in practice" (P0). However, some participants did feel compelled to defend programs which still tended to somewhat more structured than others and in which their agency delivered both the housing and support service components as a means of providing for a continuity of care and a greater sense of community. As one explained, ""when one agency delivers the building and support there is no doubt that clients are getting what they need... if you only have the building and need to contact a support agency it is less effective as a result of delays" (P8). As case workers often reduced visits to clients once they were stable, and took on additional such existing ones were stabilized, they were often less able to respond in the case that the original clients suddenly experienced setbacks and needed immediate assistance (P0, P8). With support tied to housing, the same pressures did not exist to simply move people through the system. In discussing the benefits of their integrated model one participant reflected upon how he wished that the special addiction support that had to be called in for specific tenants would simply spend more time with them.[49]

Another participant referred to an unfairly critical stance that had been taken toward integrated models of housing and support within a recent and highly touted MHCC report. As

[49] Having said that, he admitted that it was sometimes difficult to continue case managing clients who exited their housing as a result of their own case loads and focus upon resident clients, which speak to one of the primary arguments in favour of separating the housing and support components. By having a separate support component it is argued that the supports are portable and may more easily travel with the individual.

he described, the Commission promoted a rent supplements approach and still characterized their integrated model a highly institutionalized, patriarchal and custodial in nature. They ignored how it had actually evolved into a much more recovery based model centered upon more effectively addressing clients needs and creating the sense of community that was still so desperately needed and/or desired by a great number of those dealing with mental illness, and particularly those with the most severe of needs (P6).

B2. The questionable applicability of the Vancouver model

When participants were presented with the example of the City of Vancouver as a contrasting example of more comprehensive planning toward which Toronto's supportive housing system might strive[50], participants pointed to how that city benefitted from much stronger provincial and municipal leadership from the outset on all matters of affordable housing (P0, p6), and to how their supportive housing sector had necessarily chosen to focus largely upon specific populations (e.g., illicit drug users) and certain housing types (e.g., hotel style housing) within the city's notoriously impoverished east end neighbourhoods[51] (P5). In contrast, the supportive housing system in Toronto was described as grappling with a diversity of populations, housing stock, and subsequent housing solutions within the multitude of neighbourhoods across the city upon which they have chosen to focus their equal attention.[52] Some suggested that while the system in Vancouver appeared comprehensive and rational on paper, in reality it was likely much more complex and akin to what was observed in Toronto (P5).

[50] as a report discussed earlier in this paper appeared to suggest that a more centralized and comprehensive system of planning for supportive planning existed in that city, participants were asked to comment upon it

[51] The "East End" or "Hastings Avenue" is commonly used to refer to a specific section of Vancouver's inner city which is characterized by drug use, mental illness, poverty, and 'third world' living conditions.

[52] Interestingly, the difference between these two cities in terms of supportive housing might have mirrored differences in terms of illicit drug use and/or illicit drug use control, with the latter also being much more concentrated in certain areas of Vancouver, and much more diffuse in the case of Toronto. While this possibility arose in the context of the interview, it would clearly need to be verified through more data and research.

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