



## Supportive Housing

### What is supportive housing?

Definitions of “supportive housing” vary within Canada. Basically, supportive housing combines permanent housing with access to supportive services as one of the benefits of living there. The Ontario Ministry of Health and Long-Term Care defines it by the 24-hour availability of personal care and homemaking services (2000). Rather than emphasizing discrete services, alternate definitions see supportive housing as integrating housing with access to a comprehensive and coordinated package of services and programs necessary to support individuals to maintain their optimal level of health and well-being. Supportive housing is said to promote mental and physical health by encouraging independence, providing opportunities for socialization and friendship, ensuring a secure living environment, and providing regular contact with staff and other residents who would be aware of changes in a resident’s well-being (British Columbia Ministry of Health 1999; Canadian Medical Association, 1987; Toronto District Health Council, 2003).

According to Canada Mortgage and Housing Corporation (2000) and The National Advisory Council on Aging (2002), supportive housing allows people to “maximize their independence, privacy, decision making and involvement, dignity and choices and preferences.”

The key characteristics of supportive housing include:

- affordability;
- security and safety;
- enabling and home-like atmosphere;
- privacy;
- access to a flexible menu of support services (e.g., help with daily living, personal care and

- home making) that are coordinated and case managed around individual needs;
- common areas and organized opportunities for social and recreational activities.

Thus, supportive housing is neither fully independent living, nor institutional long-term care. Some supportive housing advocates offer a very pithy definition: “doing whatever it takes to keep people healthy, happy, at home, and connected to their communities.”

Internationally, other terms for supportive housing may include:

- retirement villages and hostels in Australia;
- sheltered housing in the UK;
- assisted living in the USA.

### Why focus on supportive housing?

#### Demographic pressures

People over 65 make up approximately 13.0% of the population in Canada but are projected to make up about 25% by 2031. The proportion of people over 80 years will also increase sharply from an estimated 1 in 30 in 2005 to 1 in 10 Canadians by 2056 (Statistics Canada, 2005). Presently, over half of seniors aged 74-84 have difficulty with one or more of the activities of daily living, as do three-quarters of the over 85 age group (Canada Mortgage and Housing Corporation, 2000). As the population ages, more people will need help with daily living activities.

#### Technological advances

Medical procedures that previously required hospitalization can now be accessed on an outpatient basis, allowing clients to remain at home. Furthermore, advances in medical interventions mean that greater numbers of elderly people will live longer and more at risk

fragile infants will survive, some of whom will require life long care and supports.

### Preference and choice

Supportive housing is in tune with changing social values. Today's growing numbers of seniors are relatively healthy, active and independent, and want choices regarding where to age in place. Other emerging needs groups (persons with disabilities and children with complex care needs and their families) also want choices in their living and caring arrangements. There is no question that some require institutional care. Others however prefer to live in a home-like setting where they can access on-site assistance with activities of daily living, health counselling and support.

## What do we know about this topic?

### Types of living arrangements

People in supportive housing can have different types of living arrangements including:

- accessory apartments (apartments built into existing housing, 'in-law suites');
- garden suites or granny flats (small manufactured homes that are built on the same property of a 'host house' and share the same electricity and water source);
- congregate housing (private, self-contained suites within supervised buildings);
- Abbeyfield houses (In the UK, these are large houses where residents have a private room, and perhaps their own bathroom, but other living spaces are shared with 10 to 12 other residents. House managers provide meals, cleaning and other supports) <http://www.abbeyfield.com/>;
- multi-level facilities designed for aging in place (a combination of independent apartments, congregate-style supportive housing and nursing home care).

### De-linked and linked models

Supportive housing consists of two key components: housing as well as programs and services to support residents (Ontario Association of Community Care Access Centres, 2003).

In a "de-linked" model, one organization provides housing while another organization provides programs and support services. In a "linked model" the same organization provides housing and support services. There are successful examples of both de-linked and linked models in Canada.

In a de-linked model, service providers can focus on providing services to clients without the distractions of housing management issues. Clients are said to benefit because:

- the roles of the housing and support service providers are clarified
- non-service activities of supportive service agencies are minimized;
- service delivery is simplified when tenancy and service issues are separated.

In a linked model, service providers say that clients benefit because there is better coordination of housing and service delivery issues. Clients are said to benefit because there is:

- better capacity of service providers to make physical changes in living spaces to accommodate the changing needs of residents;
- timeliness regarding housing issues (e.g., faster repairs);
- greater continuity of service and timeliness in responding to client needs.

### How supportive housing is funded

- In Canada, funds to build housing can come from a variety of sources including government, private for-profit enterprises, nonprofit organizations, charities and foundations and the community.
- Operating costs are mostly covered by rents which may be at market value or geared-to-income and hence subsidized by government. Individuals may also own life leases in which case they contribute to the operating costs through monthly fees.
- Funds to cover the costs of programs and services come mainly from government supplemented by fund-raising, private donations and in small part, user fees.

### International and Canadian research

Little systematic evidence exists that assesses the relative costs, benefits or outcomes of the various supportive housing models in Canada. Nonetheless, there is an increasing body of research documenting the benefits of supportive housing for individuals, and for the health system as a whole.

- Jarbrink et al. (2001) assessed the costs and outcomes of supportive housing for a small sample population in the UK. The study found lower overall costs for supportive housing than residential care. The authors caution that cost comparisons between supportive housing models and across communities is very difficult, given variations in the levels of support provided, individual characteristics and access to informal care.
- The Kent studies conducted by the Personal Social Services Research Unit (PSSRU) in the UK also suggest that community care coordinated by intensive case management (a defining characteristic of supportive housing) resulted in improved quality of life along with a reduction in the use of more expensive institutional care facilities. (Challis & Davies, 1986)
- A study of homeless people in San Francisco area between 1996 and 2000 looked at more than 250 people (1/3 came directly from streets, 2/3 from shelters or transitional housing; 95% had mental illnesses, chemical addictions, or both showed). It showed that supportive housing resulted in: 57% ↓ emergency room visits; 85% ↓ emergency detox services; 57% ↓ in hospital in-patient days, with another 20% decline the second year (Proscio, 2000).
- A University of Pennsylvania's Center for Mental Health Policy study of almost 5,000 homeless people with mental illness in New York between 1989 and 1996 showed that the costs of providing stable supportive housing was almost the same as leaving people homeless, and that the use of such public services as hospital stays, emergency shelters and prisons was reduced by \$16,000 per housing unit, per year (Culhane et al., 2002).
- In Skaevinge, Denmark, a nursing home was converted into sheltered residences for elderly persons in 1986. A cost analysis of selected health care services provided to older residents before and after the conversion showed that more people benefited from the same resources of staff time and expenditures through better utilization of resources. By redistributing human and economic resources, greater numbers of elderly people could live independently without increasing overall costs for the health system (Cates, 1994; Coleman, 1995; Wagner, 1992).
- A study by Lum, Ruff and Williams (2005) found that supportive housing helped seniors maintain their independence, autonomy, and physical and mental health, despite being older and sicker (more clinical ailments) than the average senior in Toronto. It also suggested that case managed services enable seniors to live independently in supportive housing for one-third the cost of institutional care by:
  - providing an appropriate level of care to support the individual to maintain an optimum level of health and well-being;
  - substituting lower cost services for more expensive institutional supports;
  - intervening before issues become crises, thereby moderating demand for more costly acute and institutional care;
  - and, decreasing caregiver burden and such attendant consequences as work absenteeism.
- Contending studies in the United States however argue that home and community-based care is more expensive than institutional care, particularly when a person requires 8-12 hours or more home care per week (Cates, 1994; Wissert, 1988).

## So what? Implications for health policy planning and program development

In general, available research suggests that:

- Supportive housing contributes to quality of life and can be more cost effective than institutional care, making it a viable housing option for governments seeking to decrease health expenditures.
- Successful supportive housing programs ensure that resources are allocated to case management.

Watch for our next supportive housing In Focus which will look at best practices around building and operating supportive housing.

## How can I learn more?

Abbeyfield model of supportive housing is at <http://www.abbeyfield.com>

Canada Mortgage and Housing Corporation website has a number of useful reports: The PDF links are: [Research highlights: Supportive housing for seniors (2000); A legal framework for supportive housing for seniors: Options for Canadian policy makers: Final report; Searchable database of supportive housing for seniors in Canada (2005)]. All reports are available at: <http://www.cmhc-schl.gc.ca/en/inpr/rehi/index.cfm>

The Corporation for Supportive Housing (CHS) supports non-profit initiatives to develop supported housing for people coping with homelessness and extreme poverty, as well as chronic health conditions such as mental illness, addiction or HIV/AIDS. [www.csh.org](http://www.csh.org)

Leap of Faith Together (LOFT) offers permanent housing, community outreach and supportive

housing services to vulnerable and homeless people in the Greater Toronto area and York Region. <http://www.loftcs.org>

Lum, JM, Ruff & Williams, AP. 2005. "When home is community." The PDF link is: <http://www.senior-link.com/PDF/United%20Way%20Final%20Report.pdf>

Mainstay Housing is an example of a non-profit provider of supportive housing for mental health consumer-survivors in Ontario. <http://www.supportivehousing.ca/about/overview.htm>

The National Advisory Council on Aging presents its position on supportive housing. The NACA position on supportive housing for seniors. PDF link is [http://www.naca.ca/position/22\\_supportive\\_housing/pdf/SupportiveHousing\\_e.pdf](http://www.naca.ca/position/22_supportive_housing/pdf/SupportiveHousing_e.pdf)

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## Last Edited

October 1, 2006

## References

Canada Mortgage and Housing Corporation. (2000). Supportive housing for seniors. *Research Highlights: Socioeconomic Series*, 56

Canadian Medical Association. (1987). Health care for the elderly: Today's challenges, tomorrow's options. Ottawa: Canadian Medical Association.

Cates, N. (1994). Denmark: Changes in health and social services for the elderly and comparative observations. *Home Health Care Services Quarterly*, 15(1), 57-71.

Challis, D., & Davies, B. (1986). Case management in community care. Aldershot: Gower, UK.

Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, 13(1), 107-163.

Jarbrink, K., Hallam, A., & Knapp, M. (2001). Costs and outcome management in supported housing. *Journal of Mental Health*, 10(1), 99-108.

Lum, J. M., Ruff, S., & Williams, A. P. (2005). When home is community: Community support services and the well-being of seniors in supportive and social housing. Toronto: United Way of Greater Toronto.

Ministry of Health and Long-term Care, Health Care Programs Division. (2000). 2001/2002 planning, funding and accountability policies and procedures manual for long term care services. (8th ed.). Toronto: Ministry of Health and Long-term Care.

National Advisory Council on Aging. (2002). The NACA position on supportive housing for seniors. Ottawa: Minister of Public Works and Government Services Canada.

Ontario Association of Community Care Access Centres. (2003). Supportive housing in Ontario: Discussion paper. Toronto: Ontario Association of Community Care Access Centres.

Proscio, T. (2000). Supportive housing and its impact on the public health crisis of homelessness. New York: Corporation for Supportive Housing.

Statistics Canada. (2005). The daily: Population projections. Retrieved March 7, 2006, 2006 from <http://www.statcan.ca/Daily/English/051215/d051215b.htm>

Wagner, L. (1992). Non-institutional care for the elderly. *Danish Medical Bulletin*, 39(3), 236-238.

Wissert, W. (1988). The past and future of home and community based long term care. *The Milbank Quarterly*, 66(2), 309-388.