

# **Seeking Supportive Housing: Characteristics, Needs and Outcomes of Applicants to The Access Point**

**Toronto Mental Health and Addictions Access Point  
Waiting List Analysis**

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Frank Sirotich, Anna Durbin, Greg Suttor, Seong-gee Um and Lin Fang

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**The Access Point**  
The Toronto Mental Health and  
Addictions Access Point



**Canadian Mental  
Health Association**  
**Toronto**

**Wellesley  
Institute**   
advancing urban health

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## ***Toronto Mental Health and Addictions Access Point Waiting List Analysis***

### **Executive Summary**

This study used data from the administrative database of The Access Point, the coordinated access system for supportive housing in Toronto, to examine the characteristics of applicants, their support needs and housing preferences, and the patterns of wait times and outcomes of applying.

#### **Summary of findings**

##### **Social and economic characteristics**

- A majority of applicants were male (59%) and this pattern applies to most age groups. Applicants were fairly evenly spread by age group: most fell in the range of 25 to 64, with a peak between the years of 45 to 54 and small numbers who are youth or seniors.
- Most applicants had income sources that signal very low incomes. Most received social assistance: half of applicants received Ontario Disability Support Program (ODSP); one fifth received Ontario Works; 12 percent had no source of income while various smaller categories comprise the rest.
- Most applicants reported speaking English but one fifth stated a preference for non-English services.

##### **Living situation**

- More than half of applicants self-identified as homeless when they applied. This included 11 percent (of all applicants) being in a shelter, 16 percent having no fixed address, 7 percent homeless and in hospital, 3 percent homeless and in jail or prison, and 16 percent homeless and residing in self-contained or congregate housing. Homeless applicants include those in housing they considered temporary.
- In terms of residence type when they applied, just over one third of Access Point applicants had no fixed address or were residing in a shelter or institution; one third lived in a self-contained dwelling; and almost one third lived in diverse congregate or other accommodation.
- Among people in self-contained dwellings when they applied, 9 percent (of total applicants) were in social or subsidized rentals, while 23 percent were in private rentals or homeownership. Compared to other applicants, people in self-contained dwellings far more often lived with family and notably more were female.

- The diverse “other” housing included rooming houses, boarding homes, long term care facilities, retirement homes, congregate supportive housing and other categories. Some of these typically provide support, but not necessarily for mental health.
- Half of applicants lived with non-relatives when they applied, mostly in shelters or institutions rather than in a dwelling; one quarter lived on their own in a room or a dwelling; the rest mostly lived with family, including family of origin, spouses or partners and a few with children.

#### **Diagnosis and co-occurring conditions**

- Mood disorders and psychotic disorders were the most common primary mental health diagnoses reported by applicants (each 34 percent of all applicants). The next most common were anxiety disorders (14 percent), with various other diagnoses among the rest.
- One quarter of applicants stated that they had a secondary (co-occurring) mental health diagnosis. This was relatively less common among those with psychotic disorders. This does not include co-occurring addiction issues, which are discussed separately below.
- One quarter of applicants reported a co-occurring, diagnosed substance abuse/dependence disorder. This was most common among people with personality or anxiety disorders and lower among those with psychotic disorders, with mood disorders falling in the middle.
- A dual diagnosis (developmental disability and mental illness) was reported by 6 percent of applicants, while 3 percent reported neurological disorders along with mental illness.

#### **Referral sources and partnerships applicants**

- Nearly two thirds of applicants were referred for supportive housing by a community mental health and addictions organization (38%) or a hospital (25%).
- One fifth of people who were placed in a supportive housing unit (in a subsample analysed) were selected by the housing provider rather than drawn from the wait list. These partnership applicants were less likely to report being homeless, prior hospitalization for mental health reasons or criminal justice involvement, and they had fewer support needs on average.

#### **Support needs identified by applicants at the time of application**

- The specific support needs that people identified on application to The Access Point were analysed separately and also clustered into six domains: social needs, health, social determinants of health, in-home activities of daily living, out-of-home activities of daily living, and legal. The requested intensity of support (24-hour, daily or occasional) was also analysed.
- The most common support needs that applicants identified pertained to developing relationships, employment and education (each requested by about half of applicants).
- Applicants most frequently identified support needs in the health and social determinants clusters (75% of applicants), followed by out-of-home activities of daily living (66%), social (63%), and in-home activities of daily living (46%). Applicants had high rates of needs in multiple domains (e.g. health plus functional needs plus social determinants). Very few applicants had need in single domains.

- The most common safety issues reported by applicants related to risk of harm to self, such as past suicidal thoughts (40%), suicide attempts (20%), alcohol and drug use (24% and 25% respectively) and to anger management (25%).
- The support intensity into which applicants were placed does not always match what they request when they apply for housing: 72 percent requested occasional support, but 55 percent were placed in this category; 18 percent requested daily support, but 37 percent were placed in this category. The Access Point attributes this discrepancy to more detailed assessments done by its staff when applicants are being matched to available housing. Another factor was the more numerous openings available in boarding homes that provide daily support.
- People placed in units with 24-hour support tended to be in the oldest or youngest age groups, have more inpatient hospital use, and to be homeless while in hospital. They were more likely to require provision of meals, support with shopping and managing specific symptoms.
- People requesting occasional support were more likely than other applicants to be homeless while in jail, or to be staying in shelters or have no fixed address. This may reflect their need and/or preference for low-barrier services and supports. In this group the most common primary diagnoses were mood or anxiety disorders. Applicants who requested and who were placed in occasional support were more likely to have safety risks including suicidal thoughts or attempts and alcohol/drug use resulting in harm. More of them than of other applicants requested self-contained units.
- Applicants with a primary diagnosis of a personality disorder identified more support needs overall. They were the most likely to identify support needs to help avoid unsafe situations, avoid crises and deal with alcohol and/or drug use. These individuals were also the most likely to identify safety risks of suicidal thoughts, suicide attempts and self-harm.
- Applicants with a primary diagnosis of a psychotic disorder were more likely to identify in-home functional support needs such as self-care, looking after the home and meal preparation.
- Based on the support needs associated with actual placement into units with 24 hour, daily or occasional support, it is projected that applicants waiting for housing required approximately 4,600 units with occasional support (59%), 2,900 with daily support (37%) and 300 with 24-hour support (4%). This projection is subject to adjustment to offset any existing imbalances (e.g. many actual placements are in boarding homes with daily support).

### **Housing needs and preferences**

- A large majority of applicants stated a preference for self-contained supportive housing unit: 48 percent requested a self-contained dwelling; 43 percent requested “either” self-contained or shared accommodation; and only 6 percent specifically requested only shared accommodation. The large proportion requesting “either” may partly reflect advice given to applicants that restricting their options will lengthen their wait time, and that shared accommodation offers more openings and faster placement.
- The few who request only shared units were disproportionately male and older, and reported psychotic disorders, high hospital use and more functional support needs.

- 8 percent of applicants requested a family unit. They were mostly women (69%), often living with a partner and/or children, and living in self-contained housing at the time they applied.

### **Populations with complex needs**

- Many applicants reported substance use challenges, with more than one third identifying it as a problem and more than 40 percent reporting the presence of a concurrent disorder or problematic current substance use.
- Applicants' reporting of substance use challenges was associated with criminal justice involvement, high hospital emergency department (ED) use, being homeless while residing in jail or shelter, or being of no fixed address. It also associated with support needs and safety issues related to managing crises.
- Having criminal justice involvement at the time of application was associated with being male, younger in age and homeless. It was also associated with having support needs related to managing crises and substance use problems. What most distinguished those with justice involvement was reporting past violence towards others and past problems controlling anger.
- There was considerable overlap between applicants reporting substance use challenges and those reporting criminal justice involvement, with respect to diagnosis, homelessness status, support needs and housing preferences.
- Among applicants reporting high hospital use, homeless applicants residing in hospital, alternate level of care (ALC) applicants<sup>1</sup> and Health Links applicants, common features included: the presence of a psychotic disorder, greater functional needs and preference for higher intensity (24 hour or daily) support.
- High ED utilization was associated with the presence of a personality disorder, substance abuse, past suicide attempts and self-harm behaviours, suicidal ideation, and with support needs related to avoiding unsafe situations.

### **Wait times and outcomes**

- Demand for supportive housing far outstrips available supply. Between October 2013 and September 2015, over 4,000 new applicants were placed on the wait list, while less than 600 were placed in supportive housing.
- Nearly half of applicants placed in housing were placed in less than one year. Among applicants still on the supportive housing waitlist at the end of the study period, however, nearly 60 percent (4,431) had been waiting for housing for two or more years and those waiting longest (top 10% on the waitlist) had been waiting 4.5 years or longer.
- Applicants' wait time from application to placement in housing did not substantially vary on the basis of mental health diagnosis, homelessness status at application or inpatient hospital use.

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<sup>1</sup> The term alternate level of care is used in health care settings to describe persons who occupy a bed in a facility (e.g. hospital) but no longer require the intensity of resources provided in that setting.

- Applicants who reported substance use challenges, criminal justice involvement, or greater support needs waited disproportionately longer for housing.
- Wait times differed notably by the intensity of housing support in which applicants were placed. Those placed in housing with daily support had much shorter times. This finding reflects the availability of units in boarding homes with high turnover and therefore more rapid placement.
- There is wide variation in how long people wait for supportive housing. This suggests that the waitlist is akin to a waiting pool from which applicants are selected, rather than a chronological waitlist with those at the top being placed first.
- The 10 percent of applicants who waited longest reported lower support needs and less urgent housing needs. They also identified fewer support needs and safety risks, and were less likely to report substance use challenges or criminal justice involvement. Finally, they were less likely to be homeless when they applied, and more likely to request self-contained housing only.
- Among applicants who were declined by housing providers, nearly 40 percent were identified as having support needs too high for the provider to meet. These applicants were considerably more likely to be homeless, to have substance abuse challenges and criminal justice involvement, and to have safety risks involving harm to themselves or others.
- More than half of applicants who were offered supportive housing refused the first offer made. The reason varied: 23 percent had changed their housing preference; 27 percent could not be located, were institutionalized, or were otherwise unable to accept; 30 percent were no longer interested; 20 percent provided other reasons. Regardless of the reason for refusal, these applicants were more likely to have requested “either” a shared unit or a self-contained unit in their application.

## **Implications**

- 1) Applicants have high levels of homelessness and housing need, and this is an under-served population in terms of affordable housing. Half of them self-identify as being homeless or residing in temporary accommodation at application.
- 2) Most applicants identify large needs for more than just housing, including health- and housing-related supports, which suggests that applicants require the assistance of support workers and not just affordable housing.
- 3) The number of people applying far exceeds the available housing and support. Consequently, people typically wait multiple years for supportive housing. This points to a need for policy responses at different levels – from broad investment to operational practices.
- 4) Long wait times confirm an urgent need to expand the system. Expanding the supportive housing system will require additional Ontario government funding for housing support services, rent subsidies and capital or loan funds for housing development/acquisition.
- 5) The shortfall of supportive housing supply compared to needs is a strong reason to take steps to

foster more turnover and availability in existing supportive housing, by funding more rent-subsidized alternatives that supportive housing tenants can move on to.

- 6) Applicants' diverse characteristics and needs confirm the necessity for a system with a range of support intensity (24-hour, daily, occasional) and a variety of types of support.
- 7) Among the diverse applicants, there is a notable distinction between two large groups with high or complex support needs: people with psychosis diagnoses and support needs related to activities of daily living and medication management; and, people with problematic substance use, criminal justice involvement and needs related to managing crises and substance misuse.
- 8) The group of applicants with problematic substance and/or criminal justice involvement are not as well served by the supportive housing system as other applicants are, in terms of access outcomes. They have longer wait times and are more likely to be declined by housing providers.
- 9) Many homeless applicants in shelters or with no fixed address have urgent housing needs but often report only moderate support needs and request only occasional support. This may reflect their need and preference for low-barrier, less intrusive supports and services.
- 10) Homeless applicants also include people with significant use of hospitals and correctional facilities, for whom more rapid access to housing could reduce use and costs of such institutions.
- 11) The distinct needs of applicants with psychosis, and those with personality disorders, reinforce the value of implementing evidence-based support models for each of these groups (e.g. cognitive behavioural therapy for psychosis, dialectical behaviour therapy for borderline personality disorder). Incorporating evidence-based services within supportive housing models, or providing them separately as adjunctive interventions, can help ensure a stable housing situation for these groups of applicants.
- 12) The many applicants with problematic substance use and the "provider declined" patterns point to a need for enhanced provider capacity targeting substance misuse. This could include incorporating evidence-based interventions as part of providers' core support services, enhancing system capacity for crisis response, and flexible step-up/step-down support services.
- 13) Among applicants, the prevalence of substance use, criminal justice involvement and related safety risks point to a need for more specialized addiction-targeted and mental health and justice targeted supportive housing. This would include more housing with low-barrier access, few preconditions and a Housing First approach to placement and supports.
- 14) The prevalence of criminal justice involvement among applicants points to a need for assessments and services that are targeted to attenuating risk of recidivism.



- 15) The high percentage of applicants who are residing in shelters or homeless in other ways points to the importance of coordinating the mental health supportive housing system with the municipal systems of housing and homeless-related services.
- 16) Applicants' diversity in support needs, safety risks, housing or homeless situations and their degree of urgency, all point to a need to prioritize applicants on more than one dimension, with some triaging in terms of greater or lesser urgency or alternative service responses.
- 17) The complexity of applicants' needs, the complexity of prioritization, and the need for more early assessment, all point to the need to integrate the use of evidence-based assessment and screening tools into the practices of The Access Point.
- 18) The mental health and addictions supportive housing system requires clear, shared definitions of support intensity (24-hour, daily, occasional) to facilitate matching applicants to housing with best use of resources.
- 19) Partnership placements (i.e. where a provider houses an applicant directly under an arrangement with a support provider, rather than from the waitlist) should be reviewed to ensure they give suitable priority to people with higher or more urgent needs.
- 20) The preference for self-contained units suggests a need to reconsider the role of congregate/shared housing. This could include conversion to short-term housing, to different support intensity or to independent dwelling units.
- 21) There is great potential to expand use of Access Point administrative data for needs analysis and system planning, including linking it to other databases. For The Access Point and LHIN funders, this confirms the importance of continuing to invest in IT infrastructure and research capability.
- 22) More systematic research is needed on applicants' evolving housing and support situations while they are on the waiting list.
- 23) Given the large number of applicants who refuse their first housing offer, more research is needed on the role of housing preferences, social compatibility, neighbourhood/location and physical health factors in applicants' refusals of housing offered. This would involve systematic tracking of the type, characteristics and location of housing that is offered in each case, as well as data on physical health and mobility limitations, current supports, and analyses of these.
- 24) There is a need to better understand the housing and support needs of applicants already in self-contained housing, including those living with family and those in regular social housing. For applicants living with family, such analysis could help show to what extent the need is for appropriate supports, for independence from the family of origin, or for family-friendly supportive housing. For those in social/subsidized housing, there may be possibilities of providing supports in that context.



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# 1. Introduction

This report is an analysis of the applicants to mental health and addictions supportive housing in Toronto and the related access system processes and outcomes. A [summary report](#) of key findings and recommendations is also available. The study examines the characteristics of applicants, their support needs and housing preferences, and the patterns of referral, wait times and service request outcome for those who apply. The data analysed here are extracted from the administrative database of The Access Point, the coordinated access system for this supportive housing sector in Toronto. Section 1.2 sets out the specific scope and objectives.

## 1.1 Overview: trends and challenges

### Priority for community mental health housing

This analysis of supportive housing applicants to The Access Point has been undertaken in a context of pressures and change. The escalating waiting list is at the forefront. There is renewed focus on supportive housing as an element of community mental health – on the part of the Ontario government, local health integration networks (LHINs), and community-based providers. There are related concerns about homelessness associated with mental illness and addictions. The current Ontario context also includes restructuring and new forms of collaboration in the LHIN sphere.

Toronto Central LHIN and Central LHIN have taken a strong interest in supportive housing for mental illness and addictions. The 2013-2016 and 2016-2019 TC LHIN Integrated Health Service Plans included priorities in the areas of mental health and addictions, and services to people with complex needs. In 2015 the TC LHIN Strategic Advisory Committee issued a report articulating the importance of housing for people with complex needs.<sup>2</sup> Ensuring that people are effectively matched to suitable housing with support is a priority. The Ministry and the LHINs are interested in moving further toward coordinated access systems across Ontario, and the experience of The Access Point is relevant to that.

This research is intended to inform Access Point operational policies and processes, the priorities and practices of participating providers, options for service design or enhancements and other steps that will help meet applicants' needs effectively. It can inform decisions as Ontario moves toward access and prioritization on a sub-LHIN basis. It is hoped that the research can also inform broader funding and policy decisions by the LHINs, the Ontario Ministry of Health and Long-Term Care.

The Access Point has engaged in ongoing strategic planning and change processes to deal with its evolving role and the related service demands. It has carried out various internal analyses of the

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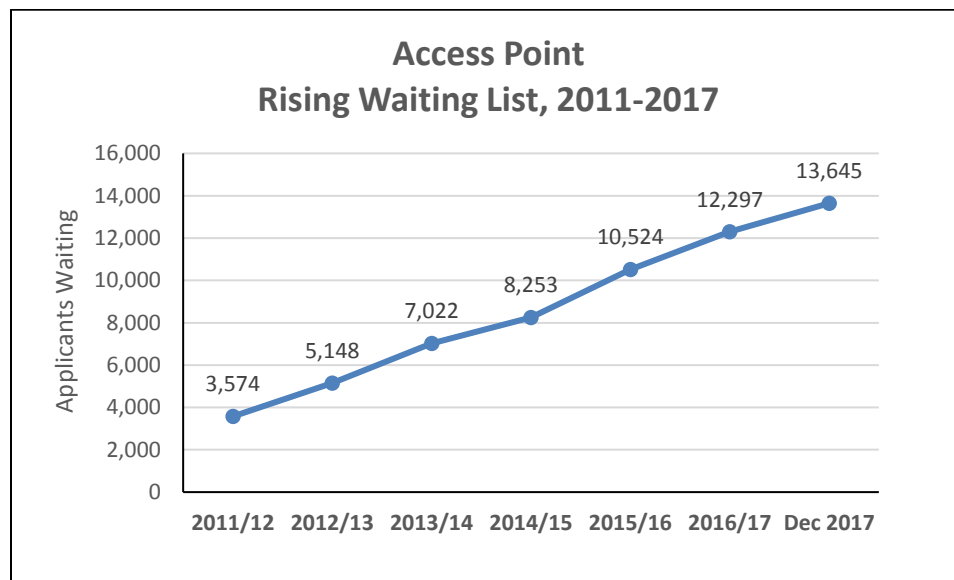
<sup>2</sup> Toronto Central LHIN Strategic Advisory Council (2015), *Housing and Its Impact on Health Outcomes for Populations with (and at risk of) Complex Care Needs* (Toronto Central Local Health Integration Network). <http://www.homelesshub.ca/sites/default/files/SAC%2520Housing%2520and%2520Health%2520FINAL.pdf>

applicant population and the patterns of referral and outcomes. This report is a more comprehensive analysis of characteristics, needs and outcomes than The Access Point has previously undertaken.

### Challenging waiting list trends

The escalating waiting list spotlights the challenges facing The Access Point (see Figure 1.1). It creates a more urgent need to understand the needs and situation of applicants. This includes examining different groups of applicants; probing the nature of applicants' needs in more detail; and focusing on both housing and support. It includes analysing the factors associated with the large number of declines and refusals. (The latter refers to cases where an applicant is referred to a supportive housing provider, but then is declined by the provider or refuses its offer of housing.)

**Figure 1.1**



## Role of The Access Point

The Toronto Mental Health and Addictions Access Point (The Access Point) is a community agency that operates the access system for supportive housing targeted to people with a mental illness or addiction in the City of Toronto (population 2.7 million, the inner half of Greater Toronto Area), as well as for Intensive Case Management (ICM) and Assertive Community Treatment (ACT). The Access Point is funded by the Toronto Central Local Health Integration Network and the Central Local Health Integration Network. TC LHIN serves 1.1 million people in the inner part of the City, while Central LHIN serves 1.8 million people in the northern part of the City, northern GTA and southern Simcoe County.

The housing to which people apply to through The Access Point is funded by the Ontario Ministry of Health and Long Term Care and its regional health authorities, the LHINs. There are 29 participating non-profit supportive housing providers. The Access Point is jointly trusted by Toronto North Support Services and LOFT Community Services. Providers and other organizations are members of an Integrated Access Steering Committee that plays a key advisory role. The Access Point is separate from the general system of coordinated access to social housing in Toronto, funded and operated by the City of Toronto through Access Housing Connections.

The participating supportive housing providers operate diverse housing: about 5,000 units that include self-contained apartments, rooms in shared dwellings and beds in boarding homes. Each provider has its own origins, mandate and organizational culture. There are various specialized programs, such as for people coming out of long-term hospital stays, people with addictions, people experiencing chronic homelessness and people with criminal justice involvement. Distinct subsets of the housing include 931 beds in boarding homes, 515 units funded under the Mental Health and Justice (MHJ) supportive housing initiative and 304 funded under Supportive Housing for Persons with Problematic Substance Use (SHPPSU).

Given this range of providers and programs, and applicants with diverse and complex needs, the task of taking applications, assessing need, matching applicants to openings, and referring to providers is complicated. The Access Point employs Service Navigator staff who assess applicants' needs, stay in touch with them, and assist them, family members or support providers to access other services as well as supportive housing. The application process is described in subsection 5.1 and Appendix 2.

Key dates in the evolution of The Access Point:

- In 2002, the Access 1 system was established to provide centralized access to Intensive Case Management and Assertive Community Treatment in North York. This centralized access system for community mental health support services was expanded across the City of Toronto in 2013.
- In 2009, Coordinated Access to Supportive Housing (CASH) was initiated by participating supportive housing providers in collaboration with TC LHIN.
- In 2012, the MHJ supportive housing program (operating since 2005) and the Supportive Housing for People with Problematic Substance Use program (operating since 2008) were integrated into CASH.
- In October 2013, Access 1, providing access to Intensive Case Management (ICM) and Assertive Community Treatment (ACT), was co-located with Coordinated Access to Supportive Housing.
- In 2014, the co-located programs were integrated and renamed The Access Point.

## 1.2 Scope and purpose of the research

The objectives of the research are as follows. A more detailed set of objectives is set out in Appendix 1.

- 1) To analyse the characteristics, situation, and needs and preferences of applicants to The Access Point who are waiting for supportive housing and/or placed in supportive housing
- 2) To gauge the extent to which different groups of applicants exist, with emphasis on applicants with higher or complex needs and to examine their characteristics and needs
- 3) To analyse referral patterns, wait times and service request outcomes for supportive housing
- 4) To examine the relationships between applicant characteristics, needs and service request outcomes<sup>3</sup>
- 5) To identify operational and policy implications of the findings

This analysis has been undertaken collaboratively by The Access Point, Canadian Mental Health Association, Toronto Branch (CMHA Toronto) and the Wellesley Institute. CMHA Toronto is one of the larger providers participating in The Access Point network of service providers and has in-house research capacity. The Wellesley Institute is an independent institute that carries out policy-relevant research pertaining to the social determinants of health, including housing and supportive housing.

The work was carried out with the active involvement of The Access Point's Executive Director, Karen Mann, and her predecessors in senior management roles. It has benefited from presentations to and feedback from service users and consumer/survivors, participating housing providers, related organizations, and senior management of the participating organizations: Wellesley Institute and CMHA Toronto, as well as LOFT Community Services and Toronto North Support Services as the two lead agencies for The Access Point.

Research ethics approval for this study was given by the Community Research Ethics Office of the Centre for Community Based Research (Canada).

This report deals with three categories of supportive housing:

- "Mental health supportive housing" is the term used to refer to the diverse overall sector and stock of supportive housing, excluding the specialized MHJ and SHPPSU programs. This consists of the providers and projects that were part of CASH in 2009-2014 (with some units added in 2009 onwards).
- The Mental Health and Justice (MHJ) initiative comprises 515 units, targeted to persons with serious mental illness who have criminal justice involvement.

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<sup>3</sup> Service request outcome refers to an applicant being placed in housing, refusing the offer of housing, or being declined by the provider when referred to it.



- Supportive Housing for Persons with Problematic Substance Use (SHPPSU) comprises 304 units targeted to that population.

This study does not cover applicants to ICM and ACT, except to the extent that some of them are also applicants to housing.

### 1.3 Research methods

#### Data sources

The data source for this project was The Access Point's administrative database of supportive housing applicants. The extracted database for this study consists of information on persons (age 16 or older) who applied for supportive housing from January 2009 through October 2015, with some exclusions noted here.

When a person applies for supportive housing, the applicant (or a staff person at a referring agency or a family member on the person's behalf) inputs requested information into the application (See hyperlink to the application form in Appendix 1). This information is stored in The Access Point database. Subsequently, Access Point staff contact the applicant to clarify or expand on information in the application. After housing is offered, the service request outcome (decline, refuse, accept) and the date of this outcome are entered into the database by Access Point staff. This information was used to calculate wait times.

To anonymize the dataset for this research, Access Point staff removed any information that could potentially be used to identify applicants. Data in this report are aggregate and frequencies fewer than 5 are suppressed to protect applicant privacy. The anonymized dataset was stored in a secure server at CMHA Toronto and accessed by the researchers through a virtual private network (VPN).

In Access Point operations the term 'referral' is used in the application and placement process. This report uses the terms *applications* for supportive housing, *referrals* to housing providers when a unit becomes available, and *placement* in the housing if the applicant accepts an offer of housing.

#### The sample

Applicants may apply to The Access Point for more than one type of supportive housing. For example, an applicant may apply for general supportive housing and for addiction-targeted housing, and this would appear as two service requests for the same applicant in The Access Point database. To ensure that the sample only included unique applicants, the analysis uses one service request per applicant. For applicants who have not been placed, the applicant's first service request was included. For applicants who have already been placed, the service request linked to their placement was used.

The final sample consists of 12,733 persons who applied to supportive housing between January 2009 and October 2015. This sample has approximately 20 percent fewer individuals than the total database,

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because it excludes applicants who were ineligible and those who had not consented to their information being used for research.

Analyses of past wait times and placement outcomes was based on applicants placed between August 2013 and October 2015. Wait time and outcome data prior to August 2013 (when The Access Point implemented a new client management database) were less reliable. The analysis of past wait times is based on 642 applicants who were placed in supportive housing during this period and had wait data available. The analysis of intensity of support when applicants were placed is based on 674 applicants (details in Appendix 1).

### **Indigenous applicants**

Indigenous persons compose five percent of the unique individuals in the database used in this analysis. In accordance with Tri-Council Policy,<sup>4</sup> analyses focusing specifically on Indigenous applicants has not been undertaken, as the research team has not yet consulted with appropriate representatives of Indigenous communities.

### **Variables**

Variables were mostly derived from responses to the application (see details in Appendix 1).

Variables derived from individuals' applications were:

- Demographic variables (e.g. age, gender, language)
- Socio-economic variables (e.g. primary income source, type of residence, homelessness)
- Mental health clinical variables (e.g. mental health diagnosis, co-occurring conditions, use of acute care services for mental health reasons)
- Support needs (e.g. requires support with managing medication, preparing meals, etc.)
- Safety issues (e.g. history of suicide attempts/self-harm, violence, substance abuse, etc.)
- Housing preferences (e.g. shared versus self-contained units)
- Intensity of support requested
- Referral source
- Program stream requested (e.g. MSHS, SHPPSU, MHJ)

Variables added by The Access Point staff after supportive housing units are offered included:

- Service request outcomes (e.g. placed in supportive housing, applicant refused an offer, or provider declined the applicant when referred)
- Past wait times for service request outcomes

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<sup>4</sup> Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans 2 - Chapter 9 Research Involving the First Nations, Inuit and Métis Peoples of Canada: <http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9>.

Values on numerous variables (e.g. applicant age, wait times) were grouped into categories for analysis.

The research team also constructed certain variables from those in the database, and recoded some answers. For example, there is a composite variable for substance use, and consistent treatment of inconsistent answers on whether a person in an institution is living alone or with others.

### **Limitations of data**

The data on applicant characteristics, housing preferences, support needs and safety risks, as well as related matters, captures what the applicant stated at the time of application (or what the service provider or family member stated on their behalf). They do not necessarily incorporate adjustments based on an applicant's evolving situation or needs. Nor do they incorporate more detailed information on individual needs that Access Point staff determines at a later stage.

The data on past wait times measures the period from the date an applicant is determined to be eligible and is put on the housing wait list, up to the date they are housed. For those still waiting as of October 31, 2015 (the cut-off for this study's data), the latter date is used.

Data on the characteristics and location of supportive housing offered to applicants were not available. In addition, data on the characteristics of the supportive housing stock in Toronto were also not available (e.g. number of self-contained versus shared units and number of units with 24 hour, daily and occasional support).

Data on physical health and applicants' use of health services was limited and incomplete and therefore mostly excluded from the analysis, with specific exceptions.

In the context of Toronto's diversity, the research team and The Access Point had a strong interest in ethno-cultural and immigration characteristics of applicants. Although these are part of the application and the dataset used in the study, the high frequency of non-response on these variables, and related data quality issues, made it necessary to exclude these from the analysis.

Some variables had a high non-response rate and/or high frequency of "don't know" responses or equivalent. For some variables there are uncertainties about data quality. Applicants may understand some questions in different ways, for example, what is a "safety risk" related to drug use or homelessness, or what constitutes daily versus occasional support.

### **Data Analysis**

To describe and compare groups of applicants, descriptive statistics were compared using chi-square tests, and effect sizes were measured using Phi or Cramer's V. Effect size refers to the strength or magnitude of the difference between groups (without reference to statistical measures affected by sample size).<sup>5</sup>

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<sup>5</sup> For a description of effect size for chi-square tests, please see: <http://www.real-statistics.com/chi-square-and-f-distributions/effect-size-chi-square/>.

Data analysis commenced in early 2016 and was completed in early 2017, using SPSS version 23 and Stata.

### **Consultations on implications and conclusions**

Interim findings were presented to key stakeholders, including groupings of providers and funders, the Integrated Access Steering Committee, Access Point staff, executive leads at the three organizations carrying out this research, and people with lived experience. The feedback and interpretive information provided in those meetings have contributed to the final report.

The implications and conclusions were developed with input from this process of presentation and feedback, and in consultation with The Access Point's senior management and executive leads.

Nevertheless, the implications and conclusions expressed in this report are those of the research team and not of The Access Point, its funders, or participating providers.

## 2. Characteristics of applicants

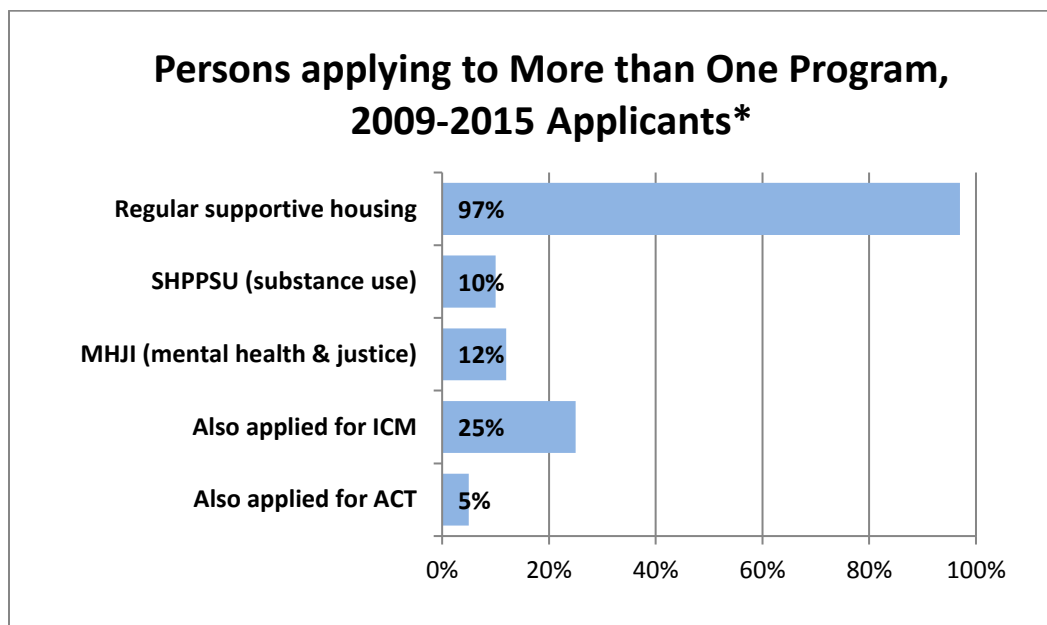
### 2.1 Introduction: Characteristics

Among the 12,733 unique adults who applied to The Access Point for supportive housing between January 2009 and October 2015, and were eligible and included for analysis:

- 97 percent applied to general mental health supportive housing
- 12 percent applied to Mental Health and Justice Initiative (MHJI)
- 10 percent applied to Supportive Housing for Persons with Problematic Substance Use (SHPPSU)

These categories overlap and total more than 100 percent, because a person can apply to more than one of these programs if eligible (see Figure 2.1). Many applicants also applied to Intensive Case Management (ICM) and Assertive Community Treatment (ACT).

**Figure 2.1**



*\*N=12,733 applicants 2009-2015; data on SHPPSU and MHJI supportive housing applicants and ICM/ACT applicants available for 2012 to 2015.*

This section reviews the characteristics of the 12,733 unique supportive housing applicants (2009-2015) under the following categories:

- Social and demographic characteristics – including preferred language and income
- Living situation – including residence type and household living arrangement
- Diagnosis and co-occurring conditions

Later sections examine the support needs and housing preferences of applicants and of specific groups of applicants (e.g. people with substance use challenges and people who are homeless).

### ***Comparison to related populations***

The 2009-2015 applicants analysed in this report have very similar characteristics and needs when compared to the population of applicants on the current waitlist – as of October 2015, the cut-off date for this study. This is as expected, because the escalating waiting list and modest ongoing number of placements into housing means that the October 2015 waitlist is dominated by 2009-2015 applicants.

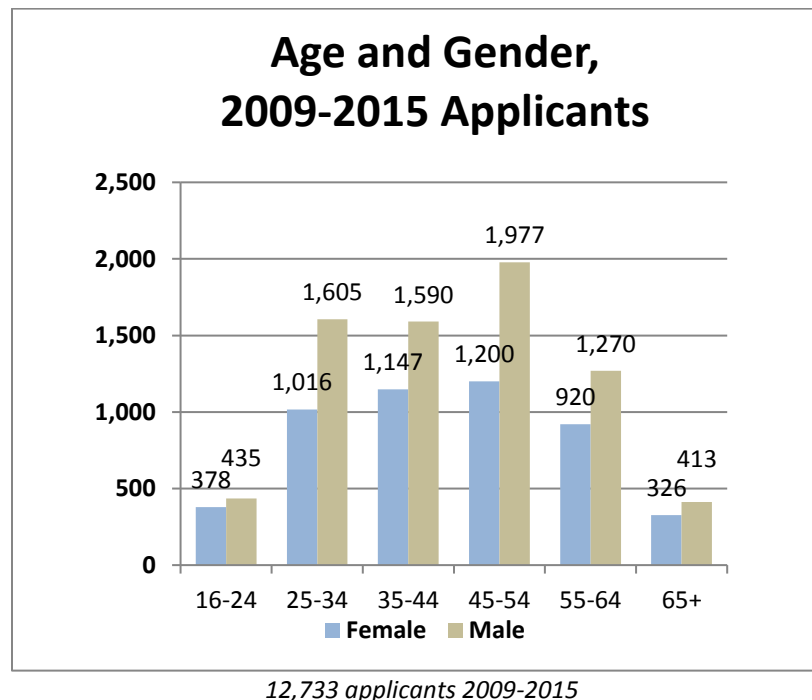
## **2.2 Social and demographic characteristics**

[Table 1](#) provides a detailed description of applicant characteristics.

### ***Age and gender***

A majority of applicants were male, at 59 percent compared to 41 percent female.

**Figure 2.2**



Transsexual people were also present among Access Point applicants, accounting for less than 1 percent of the total. Because the number of people in this group is very small, they are not reported on as a separate group in the analyses that follow.

### ***Waiting List Analysis – The Access Point – March 2018***

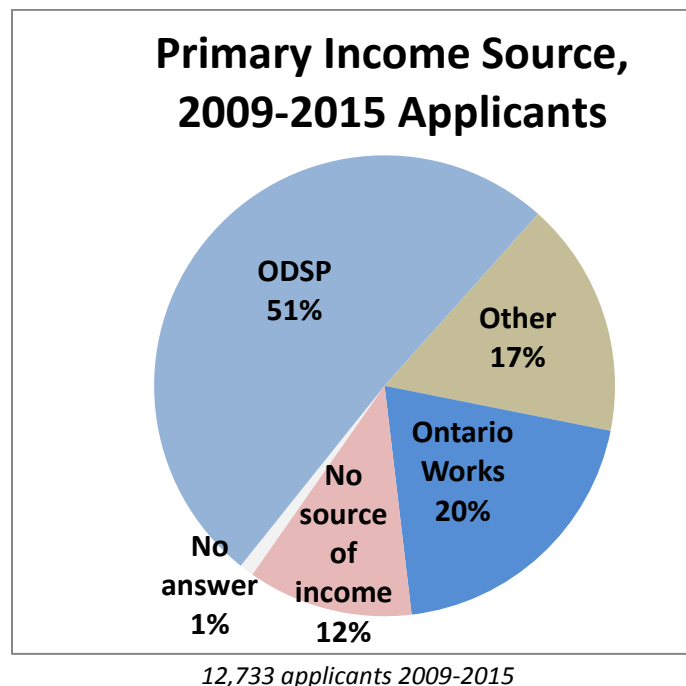
Applicants were fairly equally spread across the various 25 to 54 age brackets – each comprising 21 to 26 percent of total applicants but peaking somewhat at age 45-54 (see Figure 2.2). A slightly smaller group was 55-64 and smaller numbers of applicants are youth (under 25) or seniors (65+), respectively 7 and 6 percent of the total. The average age was 44. Most age brackets from 25 to 44 show a gender mix similar to that found in the whole applicant population, but the under-25 age group had almost as many women as men.

### ***Income***

Applicants are asked about their primary (main) income source at the time they apply. A large majority of applicants have primarily social assistance income (see Figure 2.3).

- Half (51%) received Ontario Disability Support Program (ODSP), i.e. long-term social assistance for individuals with a disability, while 20 percent received Ontario Works (temporary income assistance) as their primary income.
- 12 percent had no source of income.
- Among the 17 percent with “other” types of income, about half received various types of pension income, relating either to age or disability. Also included here were very small percentages of people who depended on family or lived on their employment income.

***Figure 2.3***



High reliance on social assistance income among people with a serious mental health condition normally reflects the fact that many are unable to obtain and sustain employment that would support them. The

large share with no income source is characteristic of people who are homeless or in institutions for relatively long periods. For correctional facilities and long-term hospital stays, the “no source of income” status also reflects applicants’ ineligibility for social assistance in that circumstance.

### ***Language and immigration***

Most applicants reported speaking English, but 6 percent did not. Only 1 percent stated a need for an interpreter. However, one in every five applicants (21%) stated a preference for non-English services. The much higher figure for non-English preference compared to non-English speakers may reflect less than full English fluency and also a desire for culturally appropriate services.

As noted in section 1.3, high non-response and data quality issues made it necessary to exclude most ethno-cultural and immigration variables from the analysis. Most applicants were Canadian citizens (80%) or landed immigrants (9%), although the length of time since arrival in Canada is not known.

## **2.3 Living situation**

The living situation of applicants is directly related to their applying for supportive housing. Provision of housing is expensive and supply falls well short of need. Understanding applicants’ housing situation can help us better understand applicants’ housing needs, and what options and assistance would best help with this.

Applicants’ living situation at the time of application is derived from two variables: residence type (the type of housing a person lives in) and living arrangement (who they live with). These two variables are interrelated in terms of housing consumption, options in the housing market and housing need. For example, in general, living in a couple or in a family raises the likelihood of higher income and of being in self-contained housing, and lowers the likelihood of being in Core Housing Need – having affordability, housing quality, or crowding problems. A household with more than one income can more easily afford the costs of renting an apartment than a low-income single person individual can.<sup>6</sup>

In examining applicants’ living situation, two caveats must be considered. Applicants’ living situations are not static and often change during the period they are on the waiting list. As well – in the experience of Access Point staff and as reported to the research team – in some cases the applicant stated residence type reflects the address of a family member or friend, provided for convenience.

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<sup>6</sup> See for example, Canada Mortgage and Housing Corporation (2014), “Characteristics of Households in Core Housing Need, Ontario, 2011” <https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/upload/Characteristics-of-Households-in-Core-Housing-Need-Ontario-2001-2006-2011.xls>.



## Residence type

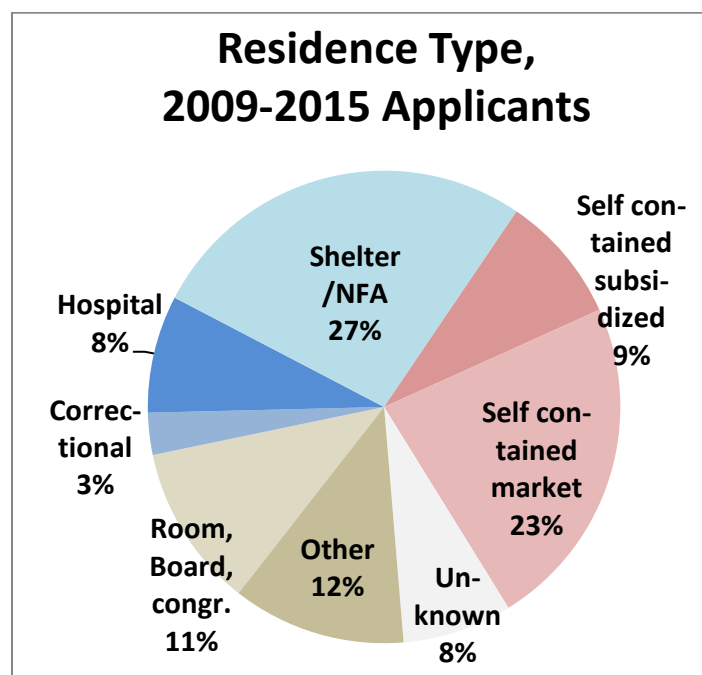
People had a diverse range of housing situations when they applied to The Access Point – from self-contained housing, to collective or institutional accommodation, to homelessness (see Figure 2.4).

- More than one third of applicants (38%) were living in shelters or institutions when they applied, or had no fixed address.
- About one third of applicants (32%) lived in self-contained dwellings (a separate house or apartment).
- The rest, slightly less than one third, lived in diverse other accommodation or did not specify their residence type at application.

### *People who were homeless or in institutions when they applied:*

- Just over one quarter of applicants were in shelters or had no fixed address (NFA): 11 and 16 percent respectively. Based on information provided by Access Point staff to the research team, the NFA group may be partly the same population as homeless shelter users, but can also include people with a wider range of homeless situations, including those who are homeless on the street or public spaces but avoid shelters, and those who are couch-surfing and staying temporarily with friends.
- A further 8 percent of applicants resided in a hospital and 3 percent in a correctional facility, such as a jail or prison. Some but not all of the applicants residing in hospital or correctional facilities were homeless (see analysis of homeless applicants in section 4.4).

**Figure 2.4**



*12,733 applicants 2009-2015*

***People living in self-contained dwellings when they applied:***

(see [Table 2](#))

- 9 percent of total applicants lived in self-contained subsidized rental housing; 23 percent in self-contained market housing (private rental or in a few cases homeownership).
- A relatively large share of those in self-contained accommodation were living with family (43% of this group versus 6% of others). Being in self-contained housing meant far less occurrence of living with non-relatives (11% versus 66% if not self-contained).
- At the time of application for supportive housing, female applicants were more likely to be in self-contained housing than males (39% of females versus 27% of males).
- As expected, being in self-contained housing meant far less often self-identifying as homeless (18% of people in self-contained versus 67% of others).
- Applicants living in self-contained housing were more likely than applicants living in other types of housing to be receiving ODSP (56% versus 49%) and less likely to be receiving Ontario Works (16% versus 22%). Other income differences were small.

The extent to which people in self-contained dwellings have support needs different from other applicants is among the matters considered in section 3.1.

***People living in other housing when they applied:***

- 11 percent of applicants lived in rooming houses or boarding homes (7%), or supportive congregate housing (4%) when they applied for supportive housing. The latter can include non-mental-health supportive housing, and either of these subsets could include Homes for Special Care or domiciliary hostels.
- 12 percent of applicants lived in diverse “other” accommodation, most of it providing some supports but not necessarily for mental health. This includes Long Term Care facilities, retirement homes, and other types not specified at application.

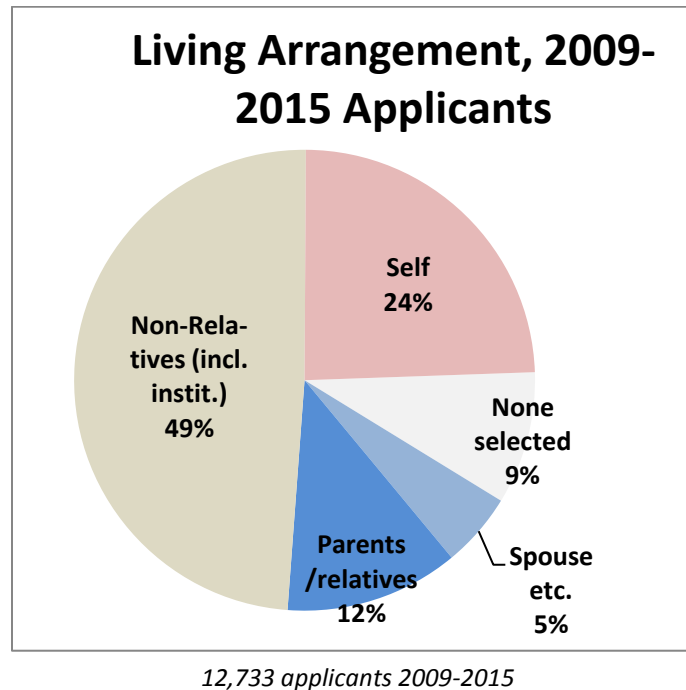
In aggregate, 43 percent of applicants were in self-contained accommodation or were in rooming houses, boarding homes or other congregate housing at the time they applied. However, this apparently “housed” group includes many people who self-identify as being homeless or in temporary housing (see above) and many with relatively high needs (see later sections). These applicants are not necessarily in stable or adequate or affordable housing.

**Living arrangement**

Half of applicants (49%) lived with non-relatives at time of application (see Figure 2.5). For this analysis, all persons in institutional or collective accommodation such as shelters, hospitals, correctional facilities and other institutions were recoded as living with non-relatives. The number of applicants living in

institutional or collective accommodation was much larger than the number living with non-relatives in a dwelling unit.

*Figure 2.5*



One quarter of applicants (24%) lived on their own at the time of application. This included some people in self-contained dwellings and others in rented rooms.

The remaining one quarter were in diverse living arrangements:

- 12 percent lived with parents or relatives
- 5 percent lived with a spouse or partner
- Both the foregoing categories include a small number who live with their children
- 9 percent did not report their living arrangement

### **Homeless applicants**

Half of applicants were homeless in some degree and over one third were absolutely homeless (see Figure 2.6). On the application form, applicants were asked, “Are you currently in temporary housing or homeless?” The categories of homelessness used here are a hybrid constructed from applicants’ answers to that question and their residence type (details in Appendix 1, Methodology).

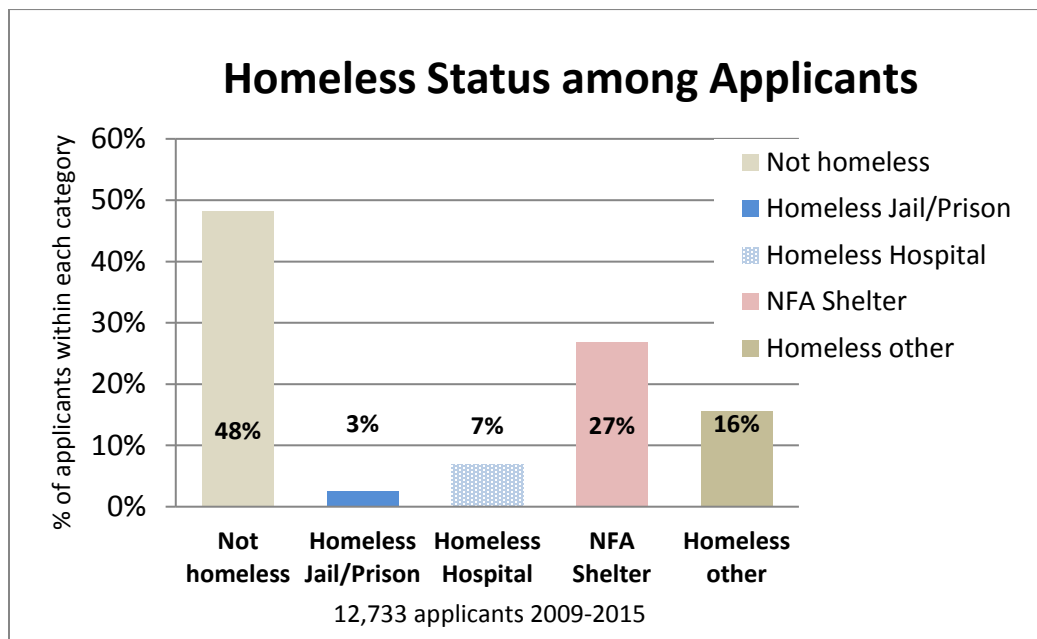
- One quarter (27%) of applicants were in the shelter/NFA homeless group when they applied. This group also constituted half of all people who self-identified as homeless in their application.

- 7 percent of applicants were in the homeless hospital group.
- 3 percent of applicants were in the homeless jail group.
- One sixth (16%) of applicants self-identified as homeless or in temporary accommodation while residing in some form of self-contained or congregate housing. This reflects various degrees of precariousness – including but not limited to “temporary” arrangements as specified in the application question – and is reflected in several needs characteristics below.
- This group included 18 percent of all who resided in a self-contained dwelling at the time they applied and 43 percent of all who resided in congregate housing.

Half (48%) of applicants were not homeless when they applied. In other words, they had a residence type other than shelter or no fixed address, and also did not self-identify as homelessness.

Subsection 4.4 provides a more detailed examination of the characteristics and needs of homeless applicants.

**Figure 2.6**



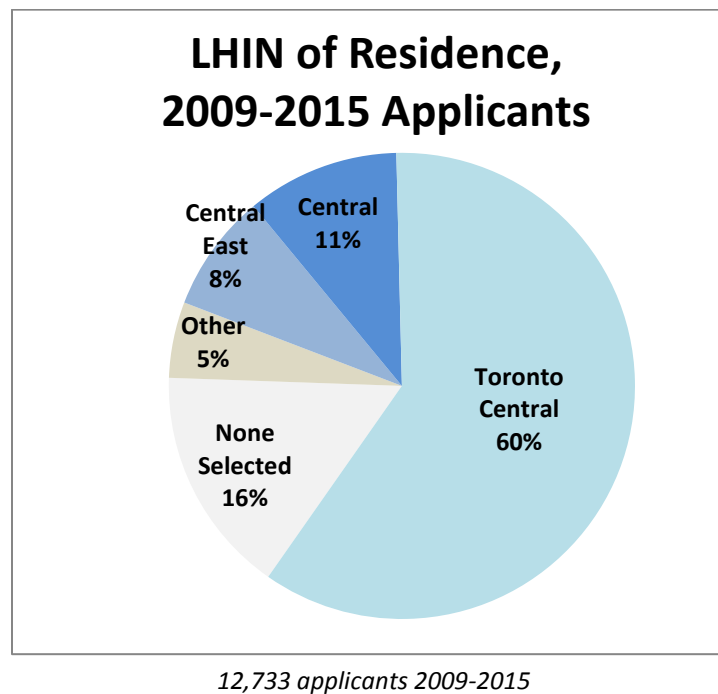
### Geographic Area of Residence

- Toronto Central LHIN accounts for 60 percent of applicants. Central LHIN accounts for 11 percent and Central East LHIN for 8 percent (Figure 2.7).

- The remaining 5 percent are widely dispersed across various LHINs. (A relatively large share, 16 percent, did not answer this question.)

These proportions by LHIN are much as expected. Over 90 percent of the City of Toronto population lives in one of these three LHINs. The share of applicants in TC LHIN exceeds its 44 percent share of City of Toronto population;<sup>7</sup> this too is expected, given the concentration in central Toronto of shelters and mental health agencies through which many people are referred to The Access Point.

**Figure 2.7**



## 2.4 Diagnosis and co-occurring conditions

[Table 1](#) provides a detailed description of applicants' diagnostic characteristics and co-occurring conditions.

When applying to The Access Point, people self-reported their primary mental health (psychiatric) diagnosis and their secondary diagnosis if applicable. These were classified into six main categories: mood disorders, psychotic disorders, anxiety disorders, personality disorders, other diagnoses and unknown diagnosis.

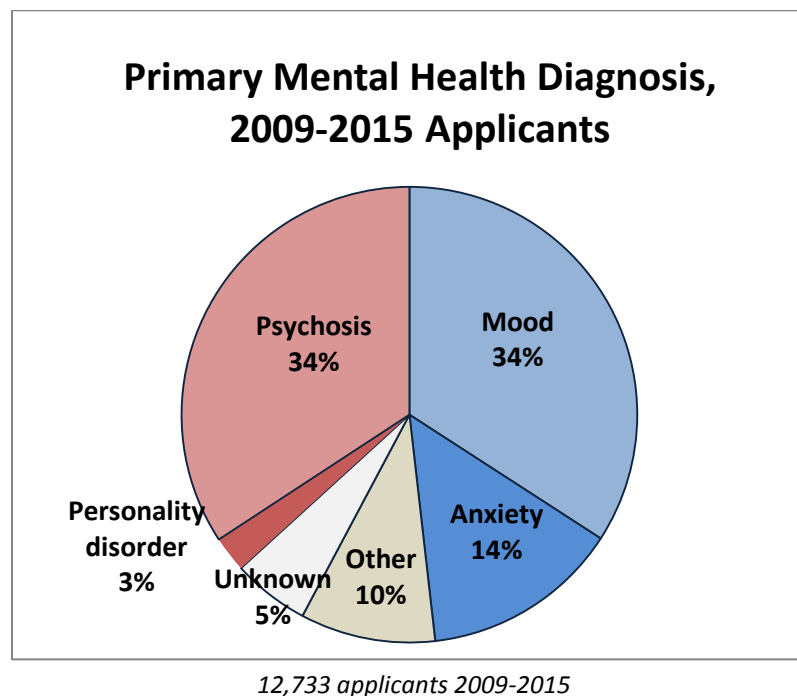
<sup>7</sup> TC LHIN 1.15 million of 2.62 million City of Toronto population = 44 percent (Statistics Canada, 2011 census profile, cat. no. 98-316-XWE).

The “other diagnoses” category comprises a diverse range of conditions, which are aggregated due to small frequencies. This includes adjustment disorder, neurocognitive disorders (including acquired brain injury), dissociative identity disorders, eating disorders, impulse control disorders, intellectual disabilities, mental disorders due to general medical conditions, somatoform disorders, specific disorders of adolescence, substance use related disorders and other (not specified).

### **Primary mental health diagnosis**

Mood disorders and psychotic disorders were the most commonly reported primary MH diagnoses, each accounting for one third of applicants (see Figure 2.8). The next most prevalent conditions were (in order of frequency) anxiety disorders, other diagnoses, unknown diagnosis and personality disorders.

**Figure 2.8**



### **Co-occurring conditions**

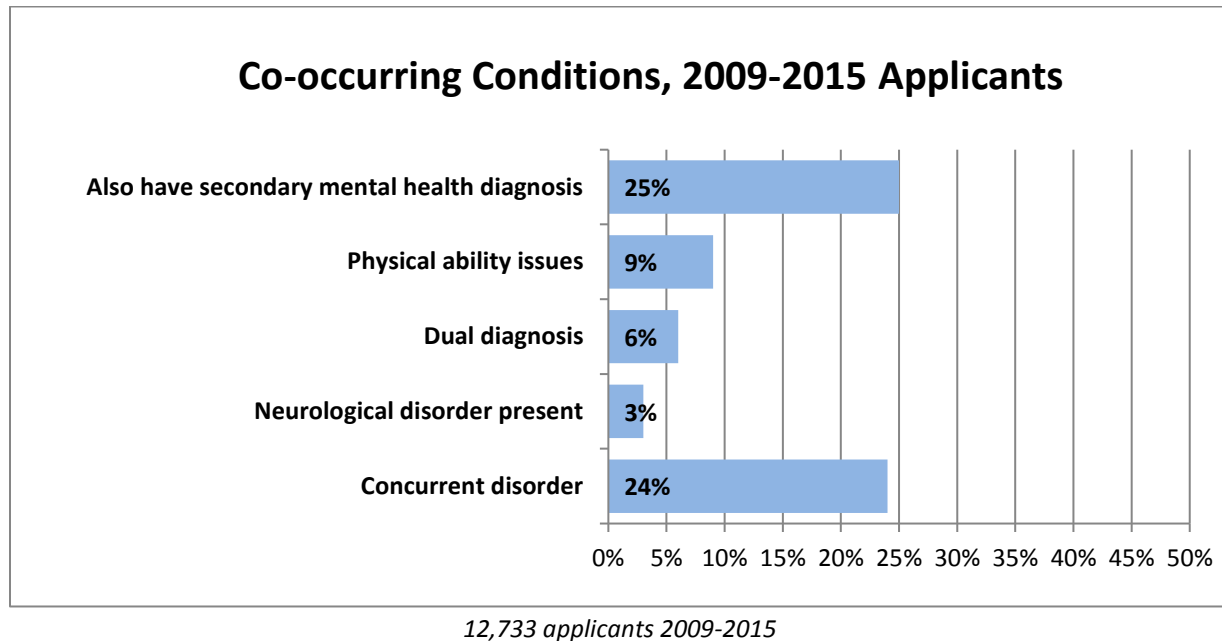
#### ***Secondary mental health diagnosis:***

One quarter of applicants reported having a secondary (co-occurring) mental health diagnosis (see Figure 2.9). This excludes those with a co-occurring addiction problem, discussed specifically below.

- Co-occurring mental illness was most common among people with a primary diagnosis of personality disorder (50%), followed by those with anxiety disorders (39%), mood disorders (33%), psychotic disorders (17%) and other diagnoses (16%).

- The most common secondary mental health diagnoses were mood disorders and anxiety disorders, reported by 38 percent and 37 percent respectively of applicants with a co-occurring mental illness.

**Figure 2.9**



***Concurrent disorders:***

Concurrent disorder refers to the presence of both a mental illness and a diagnosed substance use disorder. One quarter of applicants (24%) reported having a substance use disorder and a mental illness. This was most common among applicants with a primary diagnosis of a personality disorder (37%), followed by those with anxiety disorders (31%), mood disorders (27%), “other” diagnoses (22%) and psychotic disorders (18%).

Substance misuse is not limited to those with a diagnosed concurrent disorder, and is analysed in more detail in subsection 4.2.

***Dual diagnosis:***

Dual diagnosis refers to the presence of both a mental illness and a developmental disability.<sup>8</sup> Common forms of the latter are intellectual disabilities, fetal alcohol spectrum disorders, Down Syndrome, autism

<sup>8</sup> Lumsky, Y. & Weiss, J., (2012) Dual Diagnosis: An information Guide. Toronto: Centre for Addiction and Mental Health. Retrieved from: [http://www.community-networks.ca/wp-content/uploads/2015/11/dual\\_diagnosis\\_infoguide.pdf](http://www.community-networks.ca/wp-content/uploads/2015/11/dual_diagnosis_infoguide.pdf).

spectrum disorders and pervasive developmental disorders. A dual diagnosis was reported by 6 percent of applicants. Among this group, mood disorders (35%) and psychotic disorders (28%) were the most common primary mental health diagnoses.

***Neurological disorders:***

Neurological disorders are conditions that affect the central and peripheral nervous system and may include diseases such as Alzheimer’s and other dementias, Parkinson’s disease, brain tumours and conditions such as traumatic head injuries. A neurological disorder was reported by 3 percent of applicants. Among this subgroup, there was little difference in the prevalence of specific primary mental health diagnoses, compared to applicants in general.

## **2.5 Characteristics: Selected other applicant groups**

### **Applicants by referral source**

People are referred to The Access Point in various ways. This subsection considers the extent to which applicants coming via different referral sources have different characteristics. Subsection 3.4 considers the corresponding support needs and safety risks of these referral source categories.

The research team grouped the over 400 unique referral sources in The Access Point database into six referral source groups: community mental health and addictions (CMH&A) organizations, hospitals, community agencies, hostel/shelter services,<sup>9</sup> self/family/friend, and other. [Table 3](#) shows the distribution of these referral source groups and the characteristics of applicants by referral source.

Only patterns that are distinctive are noted here.

***Living situation:***

The distinctive patterns occurred among applicants referred by hostel/shelter services on one hand and those referred by self, family or friends on the other:

- People referred by hostel/shelter services (unsurprisingly) had characteristics associated with being homeless. They were far more likely than other applicants to identify as homeless, with 80 percent in this situation and the majority having no fixed address or living in a shelter. (Other applicants ranged from 39 percent homeless for those referred by self/family/friend, to 56 percent for those referred by community agencies).
- Applicants referred by self/family/friend more often lived in a self-contained unit (45%) than other applicants.

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<sup>9</sup> These include violence against women shelters and multi-service organizations that have homeless shelters as part of the services they offer.

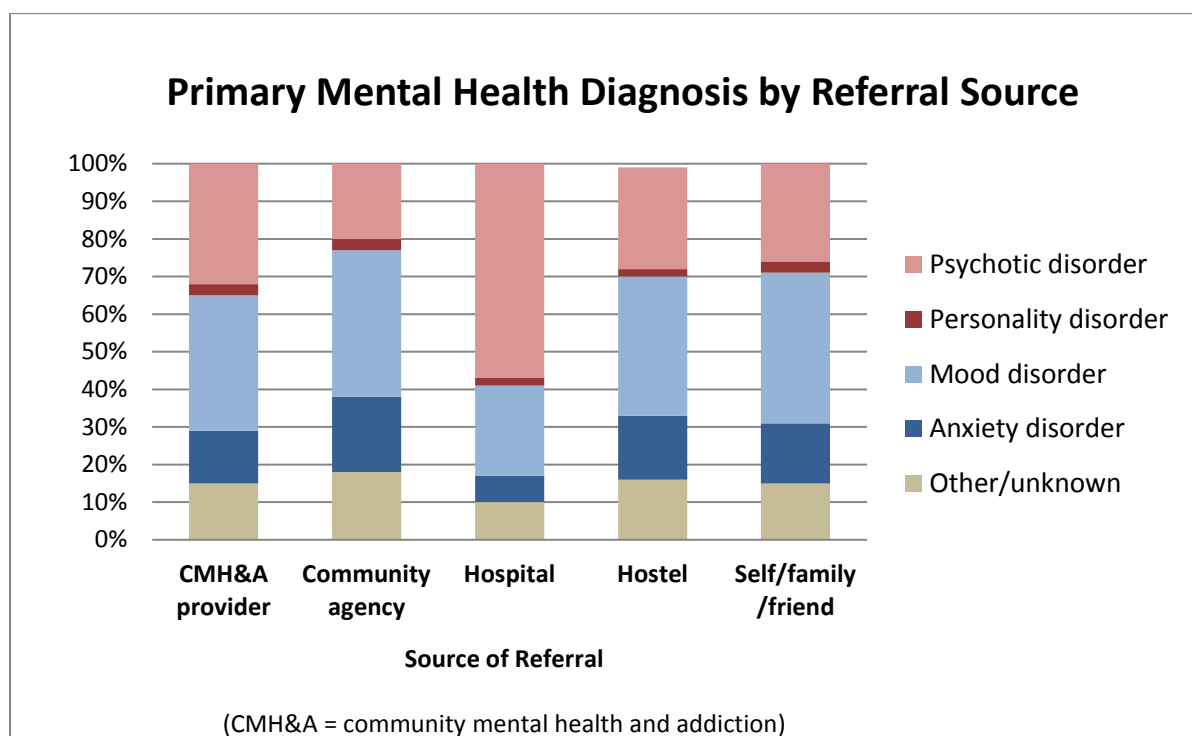


### ***Clinical characteristics:***

The distinctive patterns occurred among applicants referred by hospitals:

- 57 percent had a psychotic disorder as their primary mental health diagnosis – a much higher percentage than for any other group. The corollary is that 24 percent had a mood disorder and 7 percent anxiety disorder – lower than for the other groups (see Figure 2.10).
- One in four had spent 50 or more days in hospital due to mental health issues in the two years before applying. This was twice the incidence found among applicants in general.

**Figure 2.10**



*12,733 applicants 2009-2015. Counts in the five categories shown were respectively 4791, 850, 3131, 799, 1425, 1063 (674 missing data).*

### **Partnership applicants**

Partnership applicants are usually identified by the housing provider and given priority access to a supportive housing unit, rather than being identified from the waitlist and matched to the opening by The Access Point. The housing provider admits an applicant directly based on an existing partnership arrangement with other service providers. The Access Point is informed of the placement after it has occurred. These partnerships have been established for various reasons, but usually as a way to create priority access for certain clients or to ensure an appropriate level of support is available for individuals

### ***Waiting List Analysis – The Access Point – March 2018***

with high needs. The Access Point began collecting reliable data on partnership applicants in August 2013.

Between August 2013 and October 2015, 772 applicants were placed in supportive housing, and 169 (22%) of these were partnership applicants.

[Table 4](#) compares the characteristics of partnership applicants and non-partnership applicants placed in supportive housing.

Partnership applicants:

- were less likely to report being homeless when they applied (56% versus 68%). However, they had a higher proportion of missing data related to demographic and socio-economic characteristics (preferred language, income source, living arrangement and residence type).
- were more likely to report having an anxiety disorder (20% versus 10%) and less likely to report having a psychotic disorder (31% versus 52%) as their primary mental health diagnosis.
- were less likely to report having a hospitalization for mental health reasons in the two-year period proceeding their housing application (38% versus 50%) and were less likely to report having current or recent criminal justice involvement (26% versus 37%).

The related support needs and safety risks of this group of applicants are presented in subsection 3.4.

## **2.7 Summary and implications: Applicant characteristics**

### **2.7.1 Summary**

#### **Social and economic characteristics**

- A majority of applicants are male (59%), and this pattern applies to most age groups. Applicants are fairly evenly spread across the 25-64 age groups, with a peak at age 45-54 and small numbers who are youth or seniors.
- Most applicants have income sources that signal very low incomes. Most received social assistance, including half with Ontario Disability Support Program (ODSP) and one fifth Ontario Works; 12 percent had no source of income while various smaller categories comprised the rest.
- Most applicants reported speaking English, but one fifth stated a preference for non-English services.

#### **Living situation**

- More than half of applicants self-identified as homeless when they applied. This included 11 percent (of all applicants) being in a shelter, 16 percent having no fixed address, 7 percent homeless and in hospital, 3 percent homeless and in jail or prison, and 16 percent homeless and

residing in self-contained or congregate housing. Homeless applicants include those in housing they considered temporary.

- In terms of residence type when they applied, just over one third of Access Point applicants had no fixed address or were residing in a shelter or institution, one third lived in a self-contained dwelling and almost one third lived in diverse congregate or other accommodation.
- Among people in self-contained dwellings when they applied, 9 percent (of total applicants) were in social or subsidized rental, while 23 percent were in private rental or homeownership. Compared to other applicants, people in self-contained dwellings far more often lived with family, and notably more were female.
- The diverse “other” housing included rooming houses, boarding homes, long term care facilities, retirement homes, congregate supportive housing and other categories. Some of these typically provide support, but not necessarily for mental health.
- Half of applicants lived with non-relatives when they applied, mostly in shelters or institutions rather than in a dwelling; one quarter lived on their own in a room or a dwelling; the rest mostly lived with family, including family of origin, spouses or partners, and a few with children.

#### **Diagnosis and co-occurring conditions**

- Mood disorders and psychotic disorders were the most common primary mental health diagnoses reported by applicants (each 34 percent of all applicants). Next most common were anxiety disorders (14 percent), with various other diagnoses among the rest.
- One quarter of applicants stated that they had a secondary (co-occurring) mental health diagnosis. This was relatively less common among those with psychotic disorders. This does not include co-occurring addiction issues, discussed separately below.
- One quarter of applicants reported a co-occurring, diagnosed substance use disorder. This was most common among people with personality or anxiety disorders and lower among those with psychotic disorders, with mood disorders falling in the middle.
- A dual diagnosis (developmental disability and mental illness) was reported by 6 percent of applicants, while 3 percent reported neurological disorders along with mental illness.

#### **Referral sources and partnership applicants**

- Nearly two thirds of applicants were referred for supportive housing by a community mental health and addictions organization (38%) or a hospital (25%).
- One fifth of people who were placed in a supportive housing unit (in a subsample analysed) were selected by the housing provider rather than drawn from the wait list. These partnership applicants were less likely to report being homeless, prior hospitalization for mental health reasons, or criminal justice involvement, and they had fewer support needs on average.

## 2.7.2 Implications: Applicant characteristics

### a) **Applicants have high levels of homelessness and housing need, and this is an under-served population in terms of affordable housing.**

Most people applying to The Access Point for supportive housing have a high level of housing need. Many are homeless or live in various forms of congregate or temporary accommodation. Many applicants were literally homeless, with one quarter staying in shelters or having no fixed address, and others residing in institutions including hospitals and jails/prisons.

The population applying to The Access Point is very under-served in terms of housing, compared to other Toronto residents. Just 9 percent of applicants are in subsidized rental housing. By comparison, an estimated 8 percent of the total City of Toronto population – not just the low-income population – lives in social housing.<sup>10</sup> Among low-income renter households in the City of Toronto, approximately one quarter are in rent-geared-to-income (RGI) social housing.

### b) **More systematic research is needed on applicants' evolving housing and support situations while they are on the waiting list.**

The large numbers of applicants, the prevalence of urgent needs and homelessness, and the high incidence of applicant refusals when housing is offered (see Section 5.3.1 for details), point to potential benefits from more analysis. An important aspect of this involves tracking and understanding applicants' evolving housing situations and evolving support needs while they are on the waiting list. Feedback from Access Point staff indicates that this information is updated in various ways through the periodic contact that applicants (or their workers) have with them while they are on the waitlist. Integrating this information into the client database would enable more systematic understanding and analysis of these evolving situations and needs. This would, in turn, support efforts to ensure that The Access Point functions as a system that helps applicants in various ways while they are on the waiting list, including linking them to alternative types of support and a range of housing options.

### c) **There is a need to better understand the housing and support needs of applicants already in self-contained housing, including those living with family and those in regular social housing.**

For the one quarter of applicants who appear to be adequately housed, more needs to be understood about their housing situation and needs and how this relates to support needs. While Access Point staff would know this information in particular cases, it should be analysed more comprehensively. These applicants are a diverse mix of people living on their own (with or without subsidy), with family or with others. Although they are "housed" when they applied, it is not necessarily in stable or affordable housing, and this report has shown that many applicants have fairly high needs.

For applicants living with family, such analysis could help show to what extent the need is for appropriate supports, for independence from the family of origin, or for family-friendly supportive housing. For those in social/subsidized housing, there may be possibilities of

<sup>10</sup> City of Toronto (2017), *2017 Budget: Shelter, Support and Housing Administration*, p. 22, reported 83,998 social housing units with ongoing subsidy, plus 2,621 private-landlord rent supplement and 3,668 units in post-1999 new affordable rental projects. The federal co-op system has 2,679 units in Toronto while the health-funded system (net of boarding homes) totals 4,011 units (Wellesley, *Taking Stock*). This is the basis for the generalization of 97,000 social housing units in the City of Toronto. At 2.0 to 2.4 persons per unit, this stock houses between 7.5 percent and 8.5 percent of the City's 2.7 million population (2016 census).

providing supports in that context. Some applicants in independent dwellings may need supports, whereas others may need housing subsidies. Better understanding these matters could enable The Access Point to link people to services while they are on the waiting list, or to ensure their existing situation is stable.

Many applicant characteristics are relevant to support needs and other matters analysed in subsequent sections of this report. The related implications are articulated in those sections.

### 3. The housing and support people request

Section 3 analyses the housing and support that people request when they apply. The first four subsections cover several aspects of support needs and safety risks. Subsection 3.5 then looks at housing preferences. The final two subsections consider the implications of these findings.

More detailed information on applicants' support needs and safety risks is provided in [Table 1](#).

#### 3.1 Support needs and safety risks: Overview

When people apply to The Access Point they are asked whether they need support in each of 27 domains. These range from immediate daily needs, to problematic drug use and avoiding crises, to longer-term issues of personal development and participation in society. Of the 27 types of support need, 22 were included as housing-related ones for purposes of this analysis (others apply to ICM/ACT).

People applying are also asked whether they have struggled with or had difficulty with 17 specified "challenging issues" that would help indicate the types of support they may need. These include matters such as suicide attempts, violence, problematic alcohol/drug use and mishandling fire. In this report, these are referred to as safety risks or safety issues.

The support needs and safety issues reported when people apply to The Access Point are a rich set of indicators about what people need, but are not a needs assessment. These needs and issues are identified by the applicant, or by workers or family members who may be involved in helping fill out the application. These stated needs and risks are helpful to The Access Point as it carries out the process of matching applicants to available openings in supportive housing, and to providers when applicants are referred. The Access Point also does further assessment of applicants' needs at later points in time. Supportive housing providers also conduct needs assessments for people referred to them or those newly housed. Applicants' needs may change during the period they are on the waiting list. In sum, the support needs and safety risk data are very useful indicators of the types of support that applicants require, but they also have limitations, in that they represent a point in time and are not derived from a validated screening tool.

#### Support needs

The following were the most common types of support needs, in order of frequency (see Table 3.1 and Figure 3.1 below):

- The support needs most often cited pertain to broad social needs and personal development: developing relationships and employability (both 54%), meeting people (53%) and education (50%). While vital for long-term health, these may not address immediate needs of being in stable housing, out of hospital, and avoiding mental health or substance use crises.
- Next most frequently identified were needs pertaining to day-to-day stability in the context of a person's mental illness or addictions: adding structure to the day (49%) and avoiding crises (40%).

- Similarly prevalent were needs related to financial responsibilities (46%), wellness planning (43%) and getting to appointments (38%). Although falling in different realms of health, social and functional supports, these all relate to ensuring the conditions for personal well-being.
- About one third of applicants identified a need for support in avoiding unsafe situations (35%) and drug and alcohol use (32%).
- Almost one third of applicants stated a need for help in managing medications.
- One quarter to one third of applicants stated a need for functional support with practical daily tasks, such as looking after the home, shopping and using transportation.

<b>Table 3.1</b>		
<b>Support Needs:</b>		
<b>Number of Applicants Identifying Each Need</b>		
Low (0-4) needs	4327	34%
Medium (5-9) needs	4574	36%
High needs (10+) group	3832	30%
Developing relationships	6834	54%
Employability	6816	54%
Meeting people	6728	53%
Education	6317	50%
Adding structure to day	6208	49%
Financial responsibilities	5852	46%
Wellness planning	5460	43%
Avoiding crises	5077	40%
Getting to appointments	4781	38%
Avoiding unsafe situations	4421	35%
Drug and alcohol use	4023	32%
Looking after home	3998	31%
Self-managing medication(s)	3932	31%
Shopping	3435	27%
Self-care	3236	25%
Meal preparation	2972	23%
Using transportation	2935	23%
English skills	2168	17%
Managing specific symptoms	1910	15%
Meals provided	1609	13%
Daily living skills	1302	10%
Legal issues	708	6%
12,733 supportive housing applicants, 2009-2015		

**Figure 3.1****Support Needs Identified at Referral - All Applicants**

12,733 applicants, 2009 to 2015

**How to read radar graphs**

Radar graphs in this report show group differences in the prevalence of support needs or safety risks.

Here, the 22 types of support needs are shown on 22 individual axes radiating from the centre. A coloured line that is further from the centre indicates a higher frequency of that particular support need. (In this graph, for example, developing relationships has a higher frequency than daily meals provided.)

Support needs are clustered into broader groups or domains: social, social determinants, functional, legal and health needs. Functional needs are grouped into two sections. In-home functional needs are needs that likely require frequent (e.g. daily) contact to manage. Out-of-home functional needs can be managed with less frequent contact (e.g. standard case management services, referrals to other services).



- Almost 1 in 4 applicants need help with meal preparation, while about 1 in 8 stated a need for meals to be provided.
- 1 in 10 applicants stated a need for help with daily living skills. Based on Access Point staff feedback, this may be understood in diverse ways by applicants and their service providers. Some may use it to mean basic activities of daily living (ADL) such as bathing, dressing, toileting, hygiene and mobility; while others may also include cooking, household tasks, shopping, etc.

### ***Low, medium and high needs:***

Among the 12,733 applicants, 34 percent identified 0 to 4 needs, 36 percent identified 5 to 9 needs and 30 percent identified 10 or more. These three groups were operationally defined as low needs, medium needs and high needs.

### ***Need in multiple domains:***

Needs are clustered in this study into six domains: social, social determinants, out-of-home activities of daily living, in-home activities of daily living, health and legal (see Figure 3.2). The most common need clusters were health and social determinants – each present in 75 percent of applicants. The next most common were out-of-home activities or daily living (66%) and social (62%), followed by in-home activities of daily living (46%). The least common needs were legal (6%). Applicants had high rates of needs in multiple domains; for example, of applicants who had needs in health domain, 58 percent also had need in the out-of-home activities domain.

**Figure 3.2**

	Social <sup>1</sup>	Social determinants <sup>2</sup>	Out of home activities of daily living <sup>3</sup>	In-home activities of daily living <sup>4</sup>	Health <sup>5</sup>	Legal <sup>6</sup>
% of 12,733 applicants w/ need in this domain	62.4%	75.0%	65.5%	46.2%	75.0%	5.6%
% of 12,733 applicants w/ need in this domain <b>only</b>	0.8%	4.0%	0.7%	0.8%	2.0%	0.1%
<b>Social</b>		53.9%	35.4%	38.1%	55.4%	4.9%
<b>Social determinants</b>			50.5%	35.4%	55.4%	4.4%
<b>Out of home activities of daily living</b>				40.2%	58.2%	4.6%
<b>In-home activities of daily living</b>					41.3%	4.0%
<b>Health</b>						5.2%
<b>Legal</b>						

<sup>1</sup> Social: Need for support in relationships & meeting people

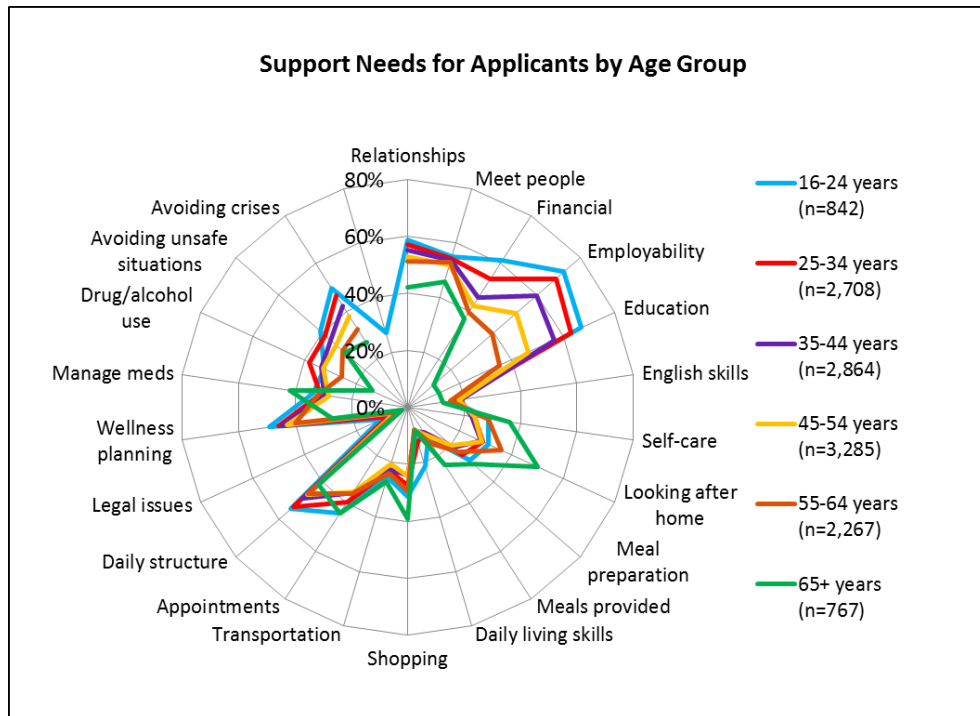
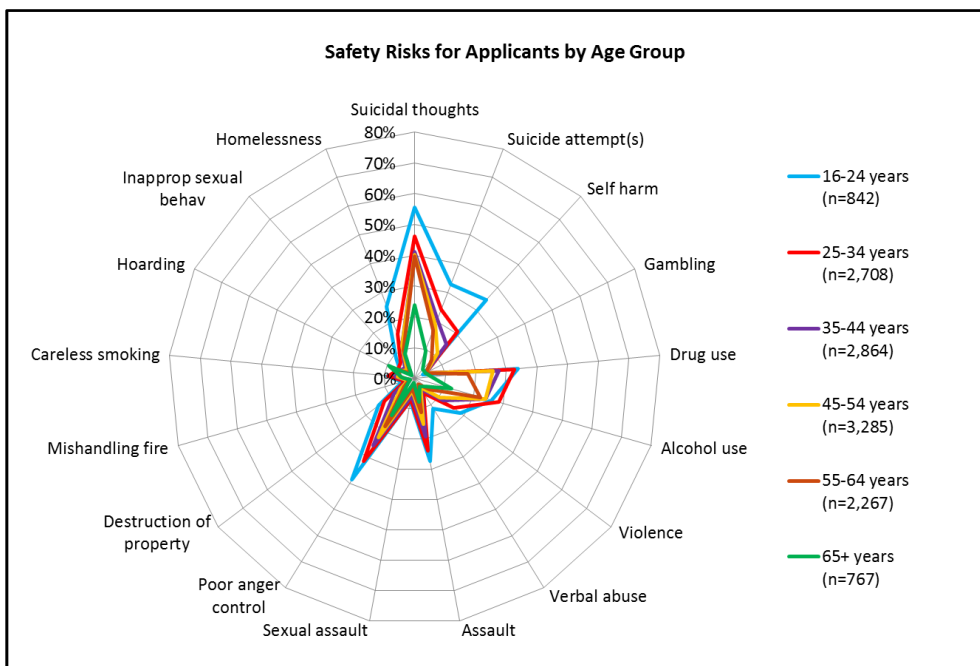
<sup>2</sup> Social determinants : Need for support in financial, education, employability, & English skills

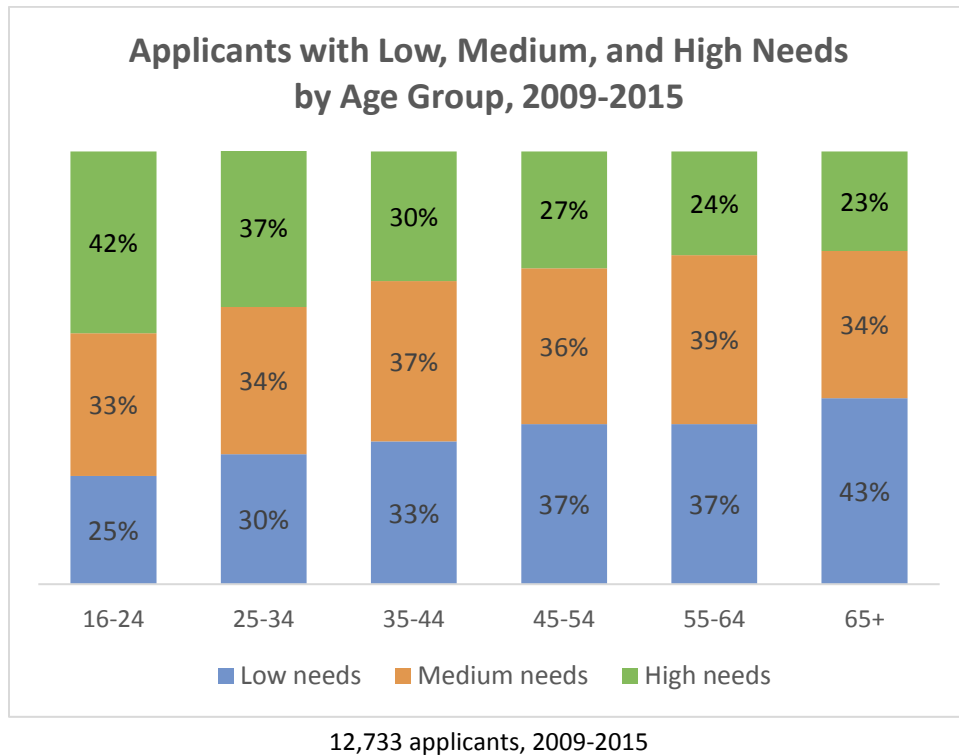
<sup>3</sup> Out of the home activities of daily living: Need for support in shopping, transportation, appointments, & daily structure

<sup>4</sup> In home activities of daily living: Need for support in self-care, looking after home, meal preparation, meals provided & daily living skills

<sup>5</sup> Health: Need for support in managing specific symptoms, avoiding crises, unsafe situations, drug/alcohol use, managing medications, & wellness planning

<sup>6</sup> Legal: Need for support with legal issues

**Figure 3.3a****Figure 3.3b**

**Figure 3.4****Support needs by age:**

[Table 5](#) and Figures 3.3a and 3.3b provide a detailed description of the support needs and safety risks (see page 32) among applicants by age group. Using the 22 types of support needs that are considered housing-related, support needs tend to decline fairly steadily with age (see Figure 3.4). This should not be taken as saying that all support needs decline with age. Access Point staff and providers have noted that other support needs tend to rise with age. The latter may include, for example, supports pertaining to mobility, cognitive disabilities, multiple physical health problems and activities of daily living.

**Applicants in self-contained dwellings when they applied:**

Applicants in self-contained dwellings (with their own bath and kitchen, rather than in rooms in shared accommodation) generally had lower support needs and safety issues than other applicants when they applied (see [Table 2](#)). Although many support needs and safety issues were similar between these applicants and others, the following differences were notable:

- Those in self-contained dwellings less often reported a history of homelessness or being at risk of homelessness (9% versus 14%).
- There was less need for support around alcohol/drug use (23% versus 36%) and avoiding unsafe situations (30% versus 37%). This fits the finding that applicants in self-contained units had

considerably less current substance use (25% versus 42%), somewhat less history of alcohol use (18% versus 27%) and drug use (19% versus 28%).

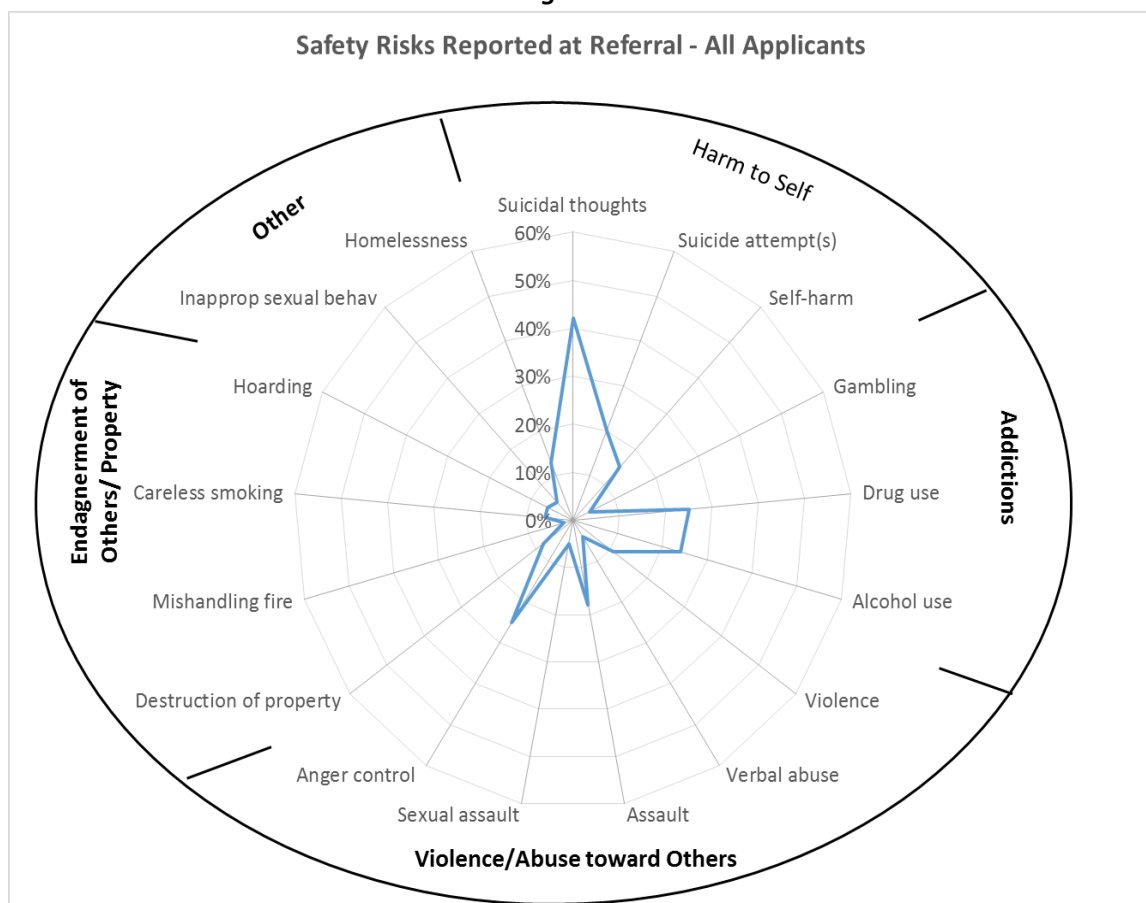
- A few support needs were slightly *higher* among applicants in self-contained dwellings. These differences were found in support for meal preparation (25% versus 22%), daily living skills (12% versus 9%) and meeting people (56% versus 51%).

In sum, it appears that people in self-contained housing more often mention support needs relating to household stability/skills and personal development, and less often mention needs relating to substance use or homelessness.

### Safety risks/issues

- As noted above, applicants identify safety issues they have struggled with, which help indicate the types of support they may need. Thus, safety issues are expressed in terms of personal history. For the 17 safety issues measured on the application, 27 percent of applicants identified no issues, 36 percent stated 1 or 2 issues and 37 stated 3 or more such issues (see Table 3.2 below).

**Figure 3.5**



12,733 applicants, 2009 to 2015

- The most common safety risk was suicidal thoughts (42%), with suicide attempts also common (20%) (see Figure 3.5).
- Next most common were three issues, each affecting about a quarter of the applicants – problems controlling anger, alcohol use causing harm and drug use causing harm.
- The other safety risks, which were each cited by more than 1 in 10 applicants – besides risk of homelessness – were history of assaulting others (18%) and of violence against others (11%).
- Three safety risks pertaining to property were each cited by 6 to 8 percent of applicants: history of destruction of property, lack of attention while smoking and compulsive hoarding.
- Smaller numbers – each 2 to 5 percent of applicants – cited risks pertaining to sexually assaulting others, inappropriate sexual behaviour, verbally abusing others, gambling or mishandling fire.

<b>Table 3.2</b> <b>Safety Risks:</b> <b>Number of Applicants Identifying Each Risk</b>		
Low (0) safety issues	3428	27%
Medium (1-2) safety issues	4585	36%
High (3+) safety issues	4720	37%
History of suicidal thoughts	5290	42%
History of drug use causing harm	3226	25%
History of problems controlling anger	3180	25%
History of alcohol use resulting in harm	3063	24%
History of suicide attempt(s)	2580	20%
History of assaulting others	2238	18%
History of / risk of homelessness	1629	13%
History of violence against others	1431	11%
History of destruction of property	996	8%
History of lack of attention while smoking	807	6%
History of compulsive hoarding	753	6%
History of sexually assaulting others	647	5%
History of inappropriate sexual behaviour	575	5%
History of verbally abusing others	549	4%
History of problem gambling	244	4%
History of mishandling fire	316	2%
12,733 supportive housing applicants, 2009-2015		

## 3.2 Support intensity

People applying for supportive housing are asked whether they seek housing with occasional, daily or 24-hour support. This is referred to in this report as support intensity.

This section first analyses the characteristics and needs associated with applicants who apply for different support intensities. It then examines the characteristics and needs associated with the support intensity level of the housing where applicants are actually placed. Although the latter is more strictly a matter of outcomes (section 4), it is most usefully reviewed in tandem with what is requested. This analysis can contribute to understanding which applicants are more likely to need higher or lower support.

### 3.2.1 Support intensity requested: Characteristics and needs

This section focuses on differences between applicant groups in their need profiles.

Among the 12,733 applicants, over three quarters requested occasional support (78%), while 14 percent requested daily support and 7 percent 24-hour support.

[Table 6](#) provides details on the demographic and clinical characteristics, support needs and safety issues, and housing preferences, for applicants who requested units with varying support intensity.

#### ***Applicants who requested 24-hour support:***

Those requesting 24-hour support were more likely than other applicants to:

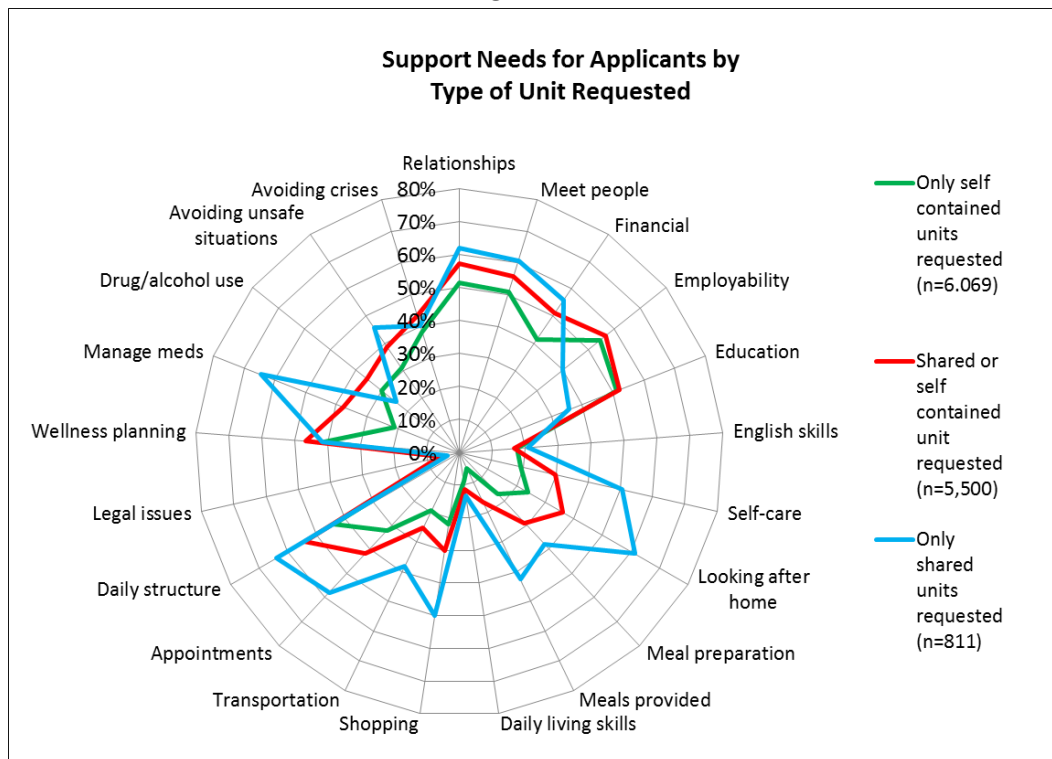
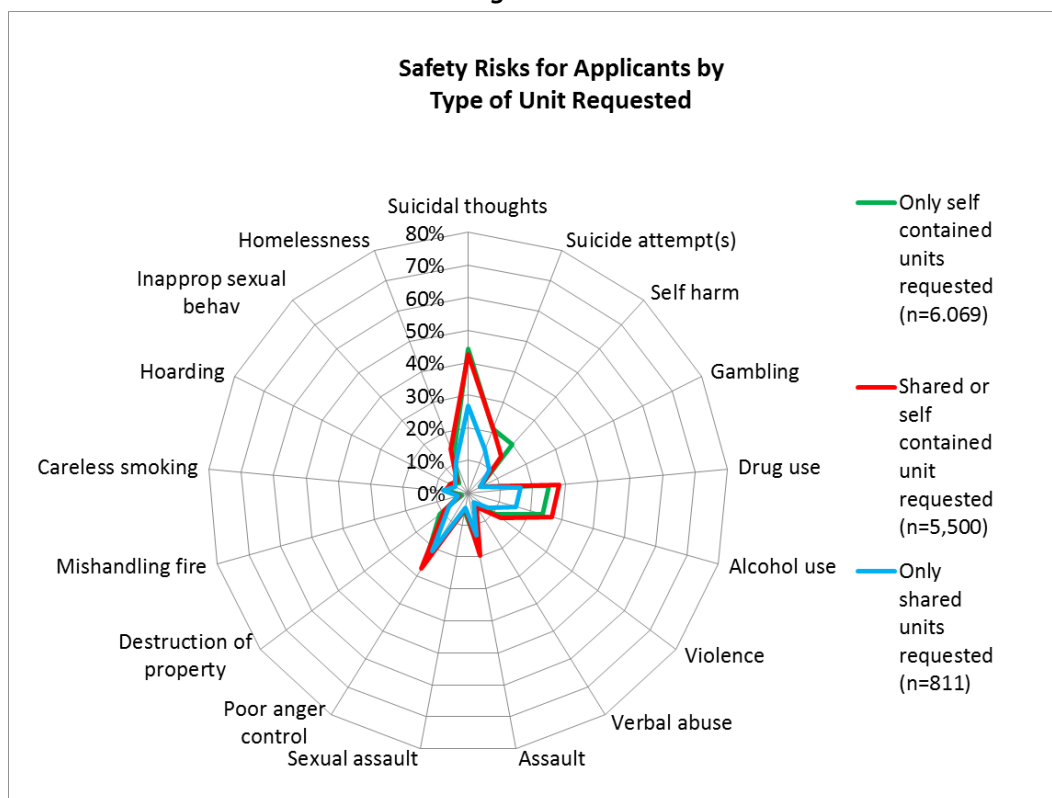
- be older (40% age 55 or older versus 32% or less for other support intensity groups)
- be receiving ODSP (58% versus 49% for occasional)
- be living in a hospital when they applied (21%), or be living in rooming or boarding housing or other congregate housing (17%)
- have psychosis as a primary mental health diagnosis (57%)

This group was accordingly less likely than others to be in self-contained market housing. This group was also less likely to be in a shelter or have no fixed address, and they less often self-identified as homeless.

In support needs, people in this group were more likely than other applicants to identify (Figure 3.6a):

- 10 or more support needs (54%)
- support needs for self-managing medications, self-care, providing meals, help with shopping and help looking after the home

Applicants requesting 24-hour support were more likely to request shared units. Feedback from Access Point staff and providers indicates that this request may relate to applicants' awareness that most higher-support housing options are congregate housing.

**Figure 3.6a****Figure 3.6b**

*N=12,733 applicants, 2009-2015*

***Applicants who requested daily support:***

Those requesting daily support were:

- just as likely as those who requested 24-hour support to receive ODSP or have no income source
- most likely to be in the “homeless – other” category (i.e. self-identified homeless but in self-contained or congregate accommodation rather than a shelter, hospital or correctional facility)

In support needs, people in this group were more likely than others to request support for:

- getting to appointments, meal preparation, developing relationship, meeting people, wellness planning
- drug and alcohol use

***Applicants who requested occasional support:***

Those requesting occasional support were more likely than other applicants to:

- receive Ontario Works
- be homeless and in jail, or to be homeless and living in shelters or with no fixed address
- have mood or anxiety disorders as their primary mental health diagnosis

In support needs, these applicants were more likely to have a lower number of support needs (0-4 needs) and were less likely to identify social, functional and health needs (except for alcohol/drug use), compared to other applicants.

For safety issues, people in this group were more likely than other applicants to have:

- 3 or more of the total 17 potential safety issues (substantially more likely)
- histories of suicide attempts, suicidal thoughts and alcohol/drug use (slightly more likely)

The occasional support group was most likely to request self-contained rather than shared units.

**3.2.2 Support intensity at placement: Characteristics and needs**

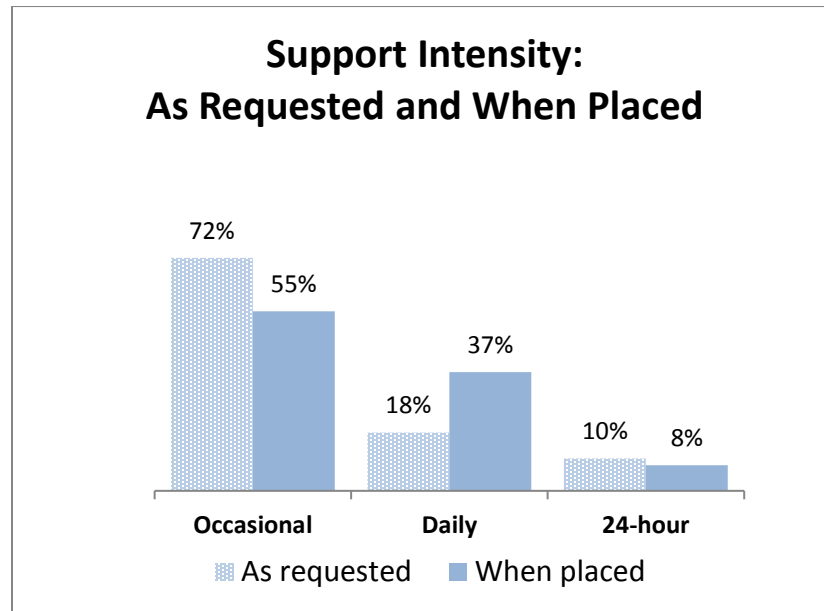
There are large discrepancies between the support intensity requested and the support intensities of units in which applicants were placed (see Figure 3.7).

[Table 7](#) provides more detailed data on applicants placed in housing by the level of support within which they were placed. These analyses were based on applicants placed between August 2013 and October 2015. This reference period was used for analyses because The Access Point introduced a new database



in August 2013 and could more reliably track applicant outcomes, including the level of support applicants were placed within.

**Figure 3.7**



Among people placed from August 2013 to October 2015,<sup>11</sup> just over half were placed in housing with occasional supports; slightly over one third were placed in daily supports. The share of this sub-sample placed in housing with occasional support is much lower than the share that requested it; the reverse is true for daily support (see section 3.2.1). The proportion seeking housing with 24-hour support was similar to the percentage placed in it (see Figure 3.7).

Feedback from Access Point staff suggests that this discrepancy in support intensity (requested versus placed) can be attributed to three main factors. Applicants' statements about support intensity when they apply are not based on a standardized assessment, and follow-up contact by Access Point staff normally produces a better understanding of the needs. There may not be consistent understanding among applicants of what the three levels mean. As well, the system-wide availability of housing with different support intensity may not match the stated or actual need.

The following summarizes the different characteristics of people placed in housing with occasional, daily and 24-hour support.<sup>12</sup> There are also differences between these groups in their specific reported support needs (see section 3.2.3).

<sup>11</sup> This analysis is based on the 664 individuals placed in supportive housing by The Access Point between August 1, 2013 and October 31, 2015, for whom support level requested and at placement were both available.

<sup>12</sup> This analysis is based on the 674 individuals placed in supportive housing by The Access Point between August 1, 2013 and October 31, 2015, for whom support level at placement was both available.

***People placed in housing with 24-hour support:***

People placed in units with 24-hour support tended to be (see Figures 3.8a, 3.8b, 3.9a and 3.9b):

- at the older and younger ends of the age spectrum (under 25 and over 55)
- far more likely to have high inpatient hospital use (over 50 mental health days in the prior two years)
- more likely to report being homeless and residing in hospital, but less likely to report being homeless and residing in a shelter or other types of accommodation

This group had relatively more:

- physical ability issues
- people with 10 or more support needs
- functional support needs related to in-home and out-of-home activities of daily living
- needs related to managing medications

***People placed in housing with daily support:***

The middle part of the support intensity range generally has characteristics falling between those placed in 24-hour and those placed in occasional support. A few exceptions may be noted. This middle group was most likely to:

- be male
- have a primary diagnosis of psychosis
- have a history of homelessness or a risk of homelessness (not shown on chart)

***People placed in housing with occasional support:***

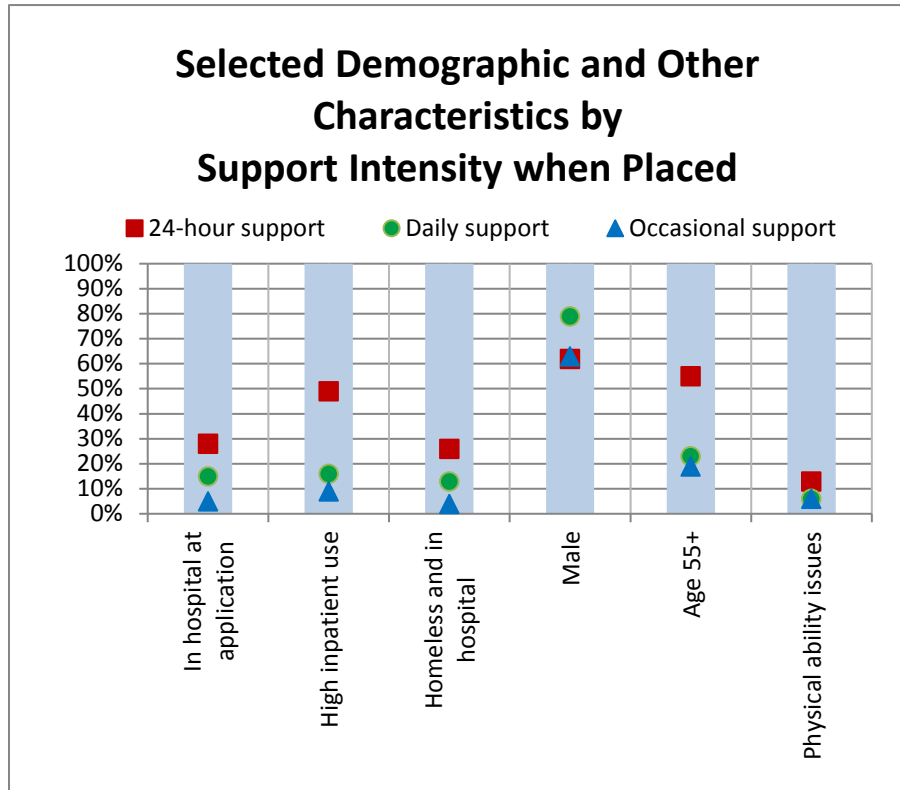
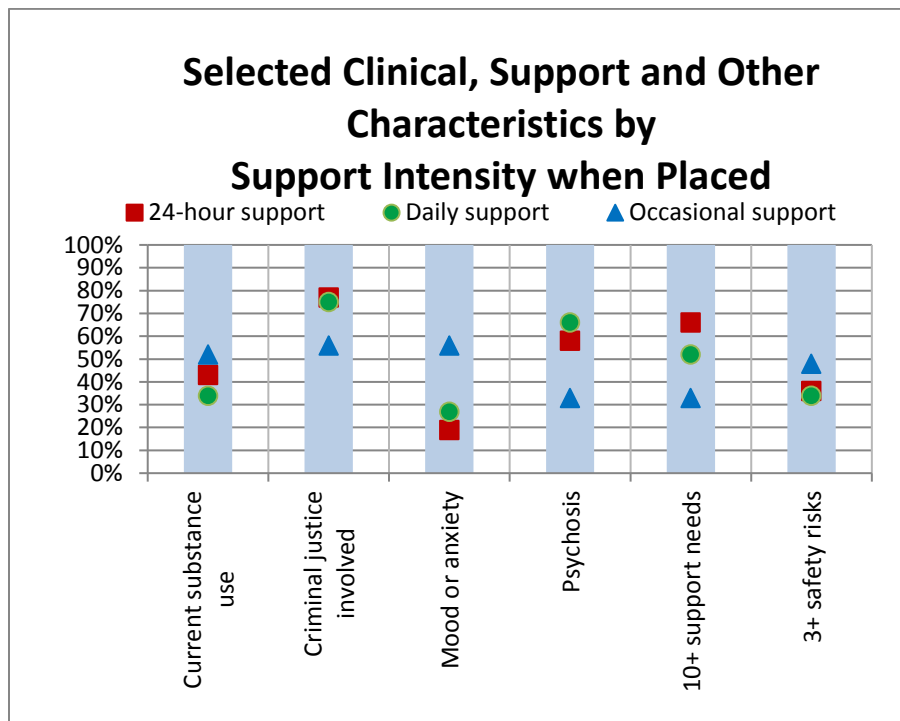
Applicants placed in units with occasional support were more likely to:

- be homeless at application
- have a mood or anxiety disorder
- have a current substance use problem
- have criminal justice involvement

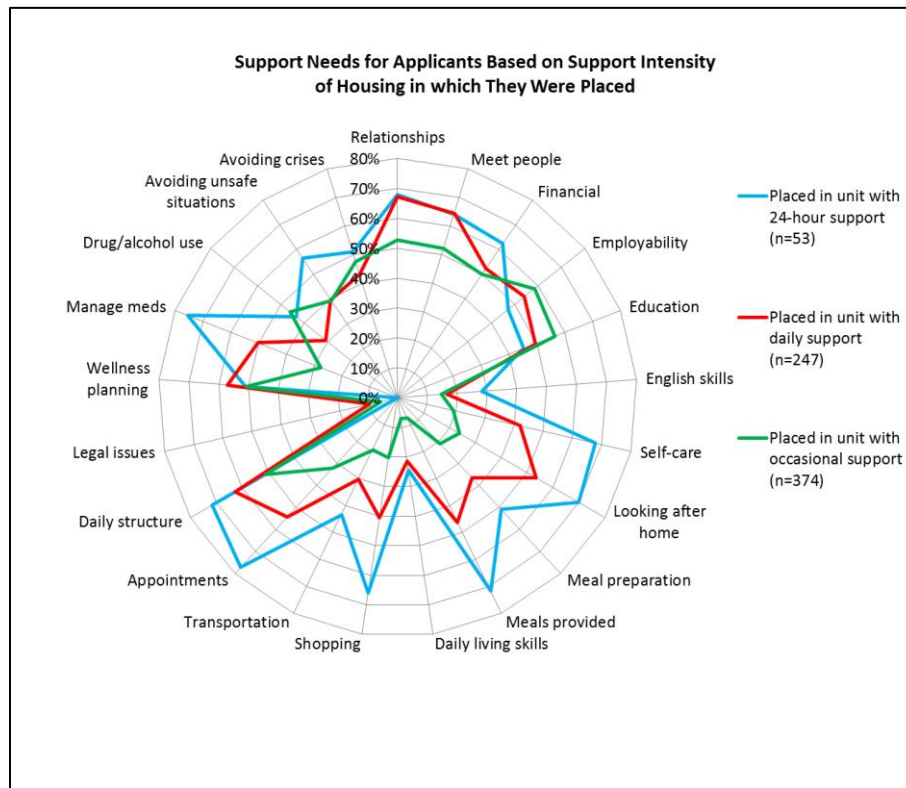
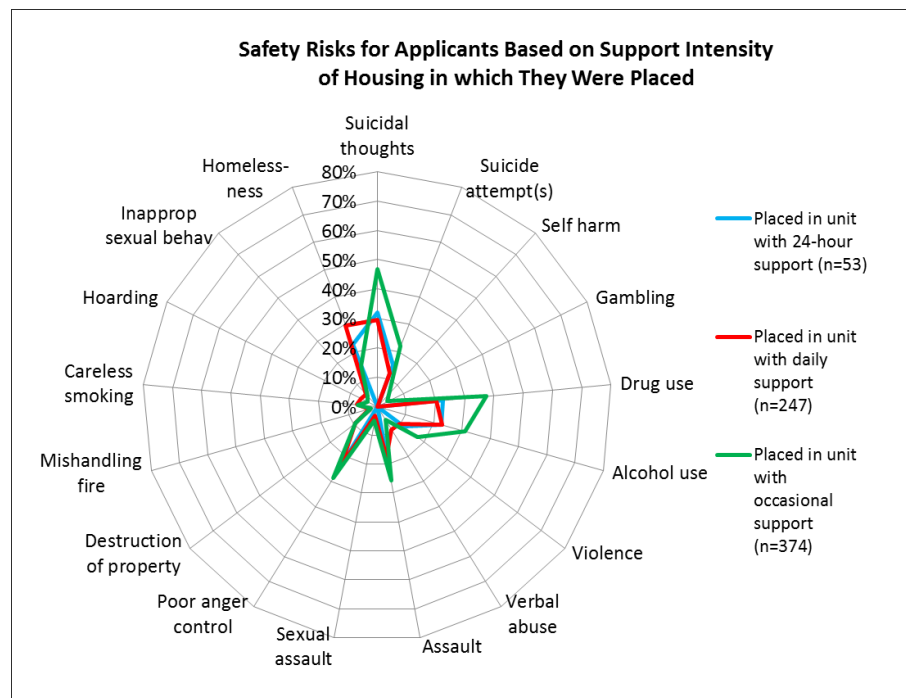
The number of support needs was lowest for this group (as expected), with some exceptions. However, this group more often:

- reported 3 or more safety issues
- identified support needs related to drug and alcohol use
- identified support needs related to education or employment

The safety issues that were particularly common in this group were suicidal thoughts, suicide attempts and a history of drug use causing harm.

**Figure 3.8a****Figure 3.8b**

674 applicants placed in supportive housing August 2013 to October 2015

**Figure 3.9a****Figure 3.9b**

*N=674 applicants placed between August 2013 and October 2015*

### 3.2.3 Modelling support intensity by type of support need

This section analyses the relation between support intensity (24-hour, daily and occasional support) and the particular combination of support needs that each applicant requests. This analysis is based on 674 applicants who were placed in supportive housing between August 2013 and October 2015, and for whom information was available in the intensity of support where they were placed. This analysis uses the 22 support needs discussed above.

- First a regression analysis is used to model the statistical relationship between an applicant identifying particular support needs (or combinations of these) and the applicant's probability of being placed into one of three levels of support intensity: 24-hour, daily or occasional.
- This analysis is then used to predict two things. First, to what extent do applicants requesting a given level of support intensity require that level or a different support intensity? Second, what system-wide mix of support intensity – how much housing with occasional, daily, and 24-hour support – would be needed to accommodate applicants on the waiting list (as of October 2015), based on their stated types of support needs?

Detailed data on this analysis is provided in [Table 8](#).

#### **Stated needs in relation to support intensity when placed**

##### ***Predicting actual support intensity based on requested intensity:***

Compared to applicants who requested occasional support, applicants who requested 24-hour or daily support (each of these groups) were much more likely to be placed in housing with 24-hour support, or with daily support, rather than in housing with occasional support. The corollary is that those who requested occasional support were most likely to be placed in units with occasional support.

##### ***Stated support needs associated with placement in 24-hour rather than occasional support:***

Being placed in housing with 24-hour rather than occasional support was associated with these types of support identified at the time of application:

- Meals being provided
- Help with shopping

Some other stated support needs were individually associated with placement in housing with 24-hour rather than occasional support, but were not statistically significant in the final regression model. These were managing medications, self-care, meal preparation, looking after the home, and getting to appointments.

***Stated support needs associated with placement in daily rather than occasional support:***

Being placed in housing with daily rather than occasional support was associated with a stated need, at time of application, for:

- Meals being provided
- Managing specific symptoms.

Some other stated support needs were individually associated with placement in housing with daily rather than occasional support, but were not statistically significant in the final regression model. These were managing medications, self-care, meal preparation, using transportation, developing relationships, meeting people, shopping, looking after the home, adding structure to day and getting to appointments.

Support for avoiding unsafe situations and drug and alcohol were associated with a lower probability of being placed in housing with daily rather than occasional support.

**Implications for the mix of support intensity required**

Figure 3.10 shows the probability of being placed in housing with occasional, daily or 24-hour support for applicants that requested each of these categories.

- Requesting either occasional or daily support is a moderately good predictor of being placed in the corresponding support intensity. For about two thirds of applicants in these categories, the requested support intensity fits the types of support needs that are stated by people placed in such housing.
- For the other one third of those requesting occasional support, the suitable intensity (fitting the stated support needs) is daily. Likewise, for about one third of people requesting daily support, the suitable intensity is occasional. These applicants rarely had stated support needs similar to people who were placed in housing with 24-hour support.
- Requesting 24-hour support was a less reliable predictor. Over 70 percent of this group had stated support needs similar to people who were placed in daily support. For the remainder, approximately equal shares (13 to 15 percent) were suited to occasional support and 24-hour support, in terms of stated support needs.

This analysis can also be used to estimate the overall mix of support intensity required to serve the current waiting list (as of October 2015). Based on the known association between applicants' stated needs and support intensity at placement, there would be a need for 4,600 housing units (59%) with occasional support, 2,900 (37%) with daily support and 300 (4%) with 24-hour support.<sup>13</sup>

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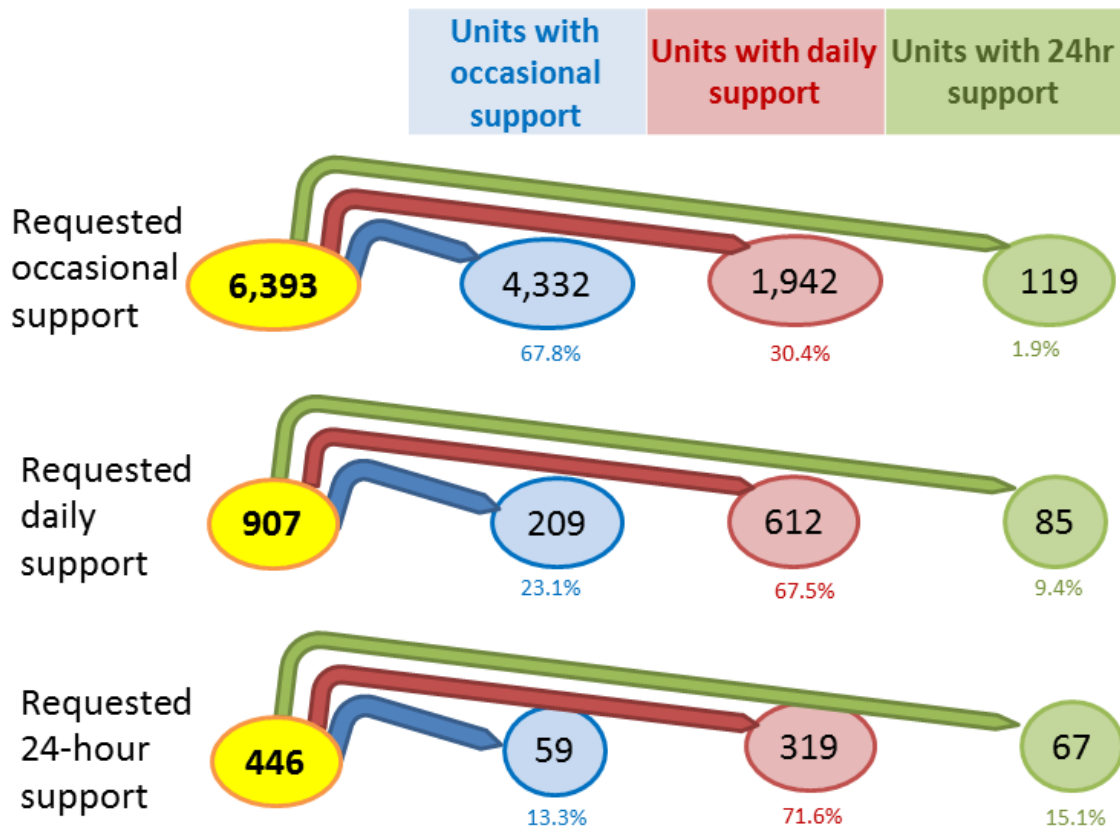
<sup>13</sup> These are rounded results. The precise modelling results, for 7,744 applicants, were 4,600 persons (59.4% of applicants) in housing with occasional support, 2,873 (37.1%) in daily support and 271 (3.5%) in 24-hour support. (The total number of applicants shifts from 7,746 to 7,744 due to rounding within the model.)

However, this finding is subject to the fact that housing supply constraints may affect the existing patterns of placement on which this projection is based. For example, more people are placed in housing with daily support than request it, and Access Point staff feedback indicates that this is a function of turnover and availability of boarding home beds. Therefore, this projection requires validation based on further analysis of applicants' support needs.<sup>14</sup>

**Figure 3.10**

**Projected units required for applicants on the October 2015 waitlist  
Based on actual placement patterns by support intensity**

**7,746 applicants waiting would be placed in:**



<sup>14</sup> The above projection should be replicated with applicants placed in boarding homes excluded from the analysis to confirm whether the profile of supports needs we found, associated with placement in housing with daily support, is still applicable. Data on the specific type of housing that applicants were placed in (e.g. boarding home versus self-contained unit) was not available for the above analyses.

### 3.3 Support needs and safety risks by diagnosis

A person's support needs can be related to their mental illness, so diagnosis can be a predictor of what supports applicants require.

[Table 9](#) displays more detailed data on the demographic, clinical, support needs, safety issues and other characteristics of applicants by diagnostic category.

Primary diagnosis is self-reported on the Access Point application form (see section 2.4 and Appendix 1), as are support needs (see Figure 3.11a) and safety risks (see Figure 3.11b). Diagnosis is analysed here in six categories: psychotic disorders, mood disorders, anxiety disorders, personality disorders, other diagnoses and not specified. The majority of applicants are in the first two groups.

#### ***Applicants with psychotic disorders:***

Applicants diagnosed with a psychotic disorder were more likely than other applicants to request 24 hour or daily support, and to identify ten or more support needs. They were more likely to identify support needs related to:

- Managing medications (46% versus 22% to 31% for other diagnostic groups)
- Self-care (32% versus 25% or less)
- Looking after the home (41% versus 31% or less)
- Preparing meals (31% versus 24% or less)

They were also twice as likely as others to need meals prepared for them (20% versus 9% to 11% for other groups).

Applicants with a psychotic disorder were less likely to require support dealing with alcohol or drug use.

Though identifying more support needs than most applicants, people with psychotic diagnoses were also less likely to report safety issues involving harm to self or others. Compared to other groups, they were less likely to have had suicidal thoughts, suicide attempts, self-harm behaviour, anger control problems, and alcohol/drug misuse resulting in harm.

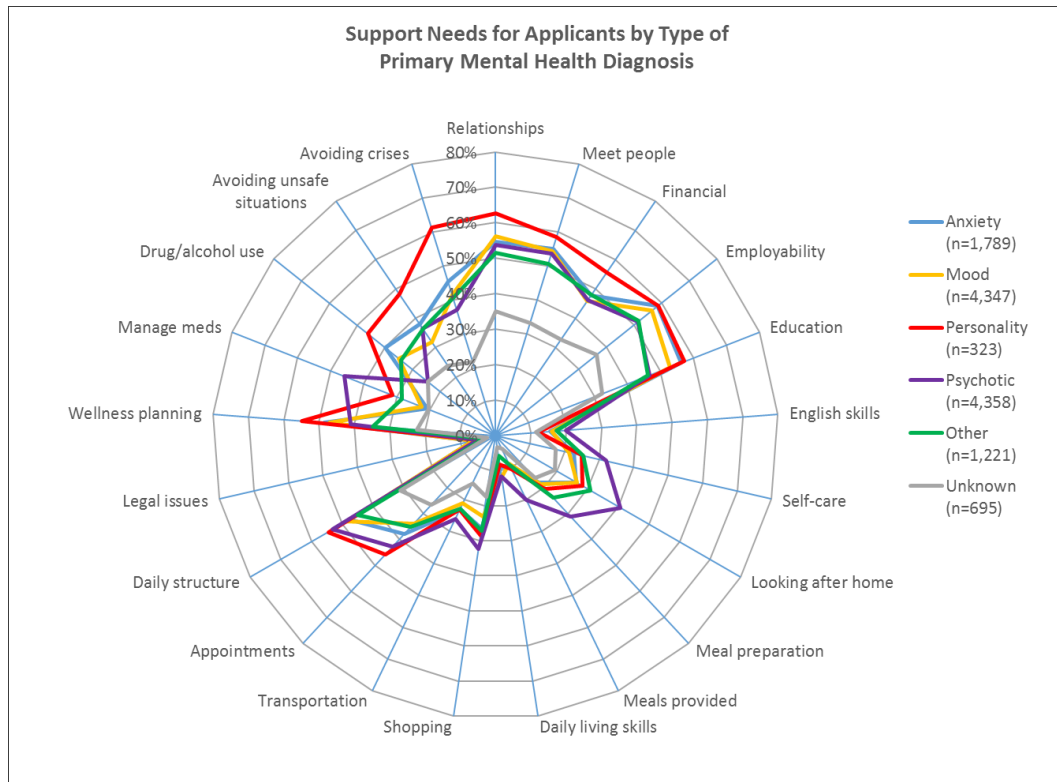
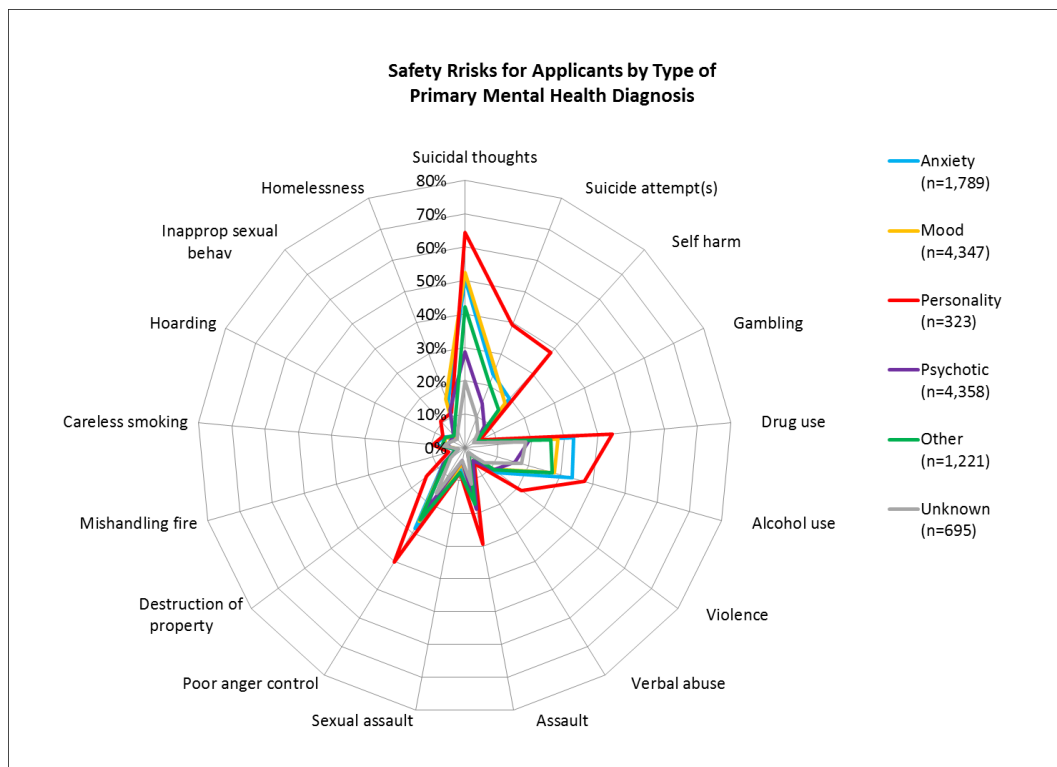
#### ***Applicants with mood or anxiety disorders:***

Applicants diagnosed with a mood or anxiety disorder generally had similar support needs as other applicants. However, people in this group were:

- more likely to require support dealing with alcohol and/or drug use compared to other applicants (except those with personality disorders).
- more likely to request occasional support (86% versus lower for psychotic and "other" diagnoses).
- less likely to require assistance with managing medications or with functional needs such self-care, looking after the home or preparing meals.

This group had fewer support needs than applicants with a psychotic disorder or personality disorder.



**Figure 3.11a****Figure 3.11b**

*N=12,733 applicants, 2009-2015*

Applicants with a mood or anxiety disorder were more likely than most diagnostic groups to report safety issues:

- More than 40 percent identified three or more safety risks – compared to just over a quarter of applicants with a psychotic disorder and just over one third in the “other” diagnostic category.
- They were more likely than all other groups, except those with a personality disorder, to report risks pertaining to suicidal thoughts, suicide attempts, self-harm, and alcohol/drug misuse resulting in harm.

***Applicants with personality disorders:***

Applicants with a primary diagnosis of a personality disorder identified the highest number of support needs.

- Just over 40 percent of these applicants identified ten or more support needs – while applicants across all other diagnostic groupings ranged from 17 to 35 percent.
- This group was more likely than other applicants to identify requiring support with avoiding unsafe situations (48%), avoiding crises (61%), dealing with alcohol and/or drug use (46%), getting to appointments (46%), developing relationships (63%) and wellness planning (55%).
- This group had the greatest prevalence of reported safety issues, with nearly two thirds having three or more risks associated with potential harm to self or others. They were more likely than other applicants to identify suicidal thoughts (64%), suicide attempts (39%) and self-harm (38%). More than 50 percent reported either attempting suicide or engaging in self harm in the past five years. They were also more likely to report anger control problems (40%), physical assault (29%) and alcohol use (37%) or drug use (44%) resulting in harm (see Figure 3.11b).

This group requested daily or 24-hour support less often than applicants with a psychotic disorder, other diagnoses or unspecified diagnosis.

***Applicants with other diagnoses:***

Applicants with a diagnosis other than mood, anxiety, personality or psychotic disorder are a diverse group (see section 2.4). In this group:

- People are more likely to request 24-hour or daily support than other applicants except for those with a psychotic disorder
- Applicants are mid-range in several key areas of support and risks. They more often identified need for support with daily functional needs than applicants with an anxiety or mood disorder, but less than those with a psychotic disorder.

There was a similar middling pattern in the prevalence of risk behaviours. These applicants with “other” diagnoses identified behaviours associated with addictions and potential harm to self more frequently than applicants with a psychotic disorder but less than applicants with mood, anxiety or personality disorders.

### ***Applicants with unknown diagnoses***

This group had the lowest support needs and safety risks, across almost all categories of these. In this group, 58 percent identified only 0 to 4 needs and 52 percent identified no risk behaviours. These applicants were also more likely than any other group to not specify the desired frequency of support. It is possible that this group less often completes the support needs and safety risk components of the application. It is unknown whether the lower identified needs and risks are due to missing data.

## **3.4 Support needs and safety risks: Selected other applicant groups**

### **Applicants by referral source**

As noted earlier (section 2.5), applicants were categorized into six types of referral sources: community mental health and addictions organizations, hospitals, community agencies, hostel/shelter services, self/family/friend, and other.

The support needs of applicants referred by hospitals were distinctive (see [Table 3](#)). These points correspond with this group's diagnostic profile and hospital use patterns (see also subsection 2.5):

- More intensive support was requested by this group than by other applicants: 11 percent requested 24-hour, 20 percent daily and 67 percent occasional support.
- More of this group requested support with managing medications: 44 percent versus 24 to 28 percent for other groups.

Among those referred by self/family/friends:

- more requested support with daily living skills (15% versus 7 to 10%).
- fewer request intensive support (3% 24-hour support, 10% daily and 78% occasional).

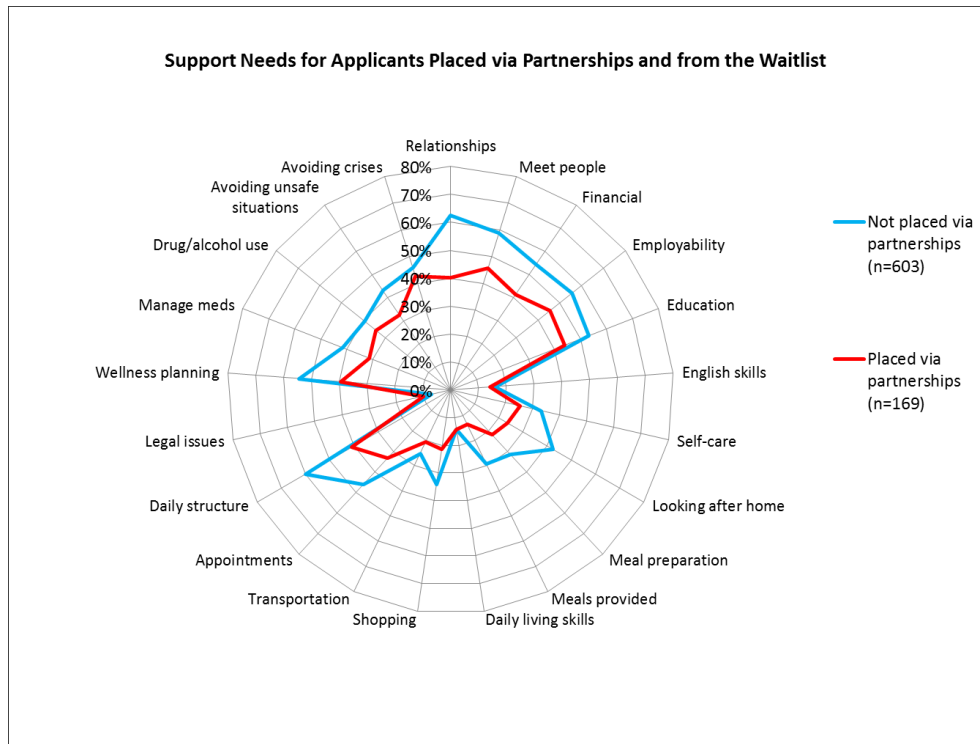
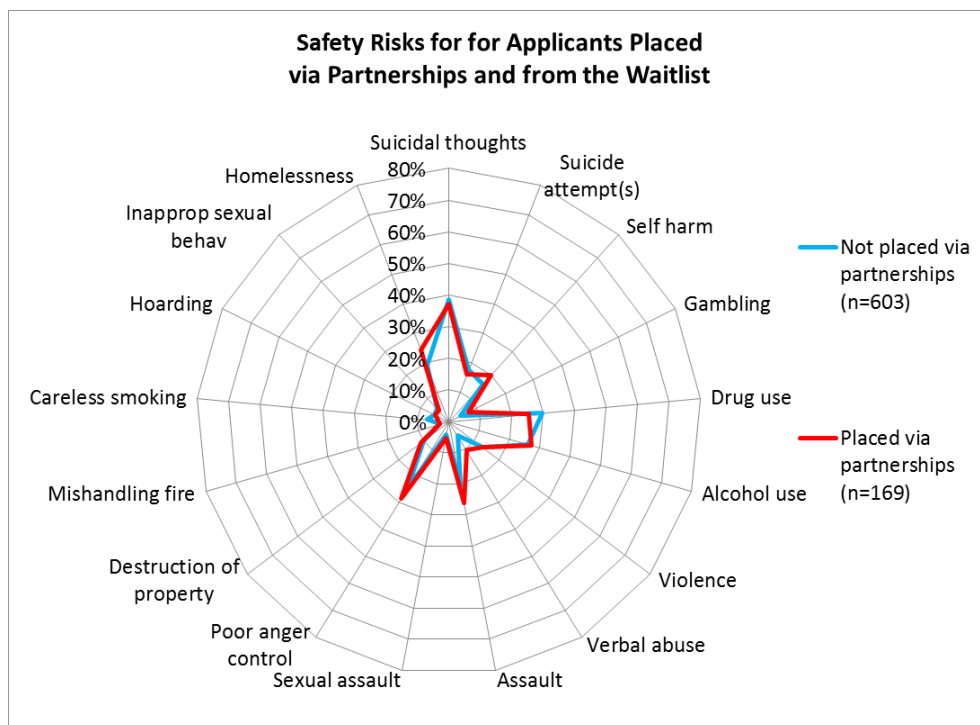
In support needs and safety issues, there were few other differences between the six referral source groupings, other than those just noted.

### **Partnership applicants**

As noted earlier (section 2.5), partnership applicants are given priority access to a supportive housing unit by a housing provider, rather than being matched to the opening by The Access Point.

Partnership applicants:

- were less likely to have an application for MHJ housing (11% versus 27%) and to request daily support (9% versus 21%).

**Figure 3.12a****Figure 3.12b**

*N=722 applicants placed October 2013-2015*

- were more likely to report four or fewer support needs (43% versus 24%) when they applied and less likely to report having ten or more support needs (27% versus 45%);
- reported fewer support needs than non-partnership applicants (see Figure 3.12a above). However, there was no difference between groups with respect to reported safety risks (see Figure 3.12b).
- were more likely to request self-contained units (43% versus 26%) and less likely to request shared units only (4% versus 12%) or either shared or self-contained (43% versus 61%).

[Table 4](#) provides a detailed description of partnership applicants' reported support needs.

### 3.5 Housing needs and preferences

Housing that is suited to one's needs and preferences is important for anyone, even in an urgent situation. A suitable dwelling in a suitable neighbourhood will help people maintain stability in their housing. The large number of declines and refusals (see section 5.3) underscores the importance of matching people to housing that is suitable. This section summarizes some of the main housing needs and preferences that applicants express.

[Table 10](#) compares the characteristics and needs of applicants based on the type of housing they requested.

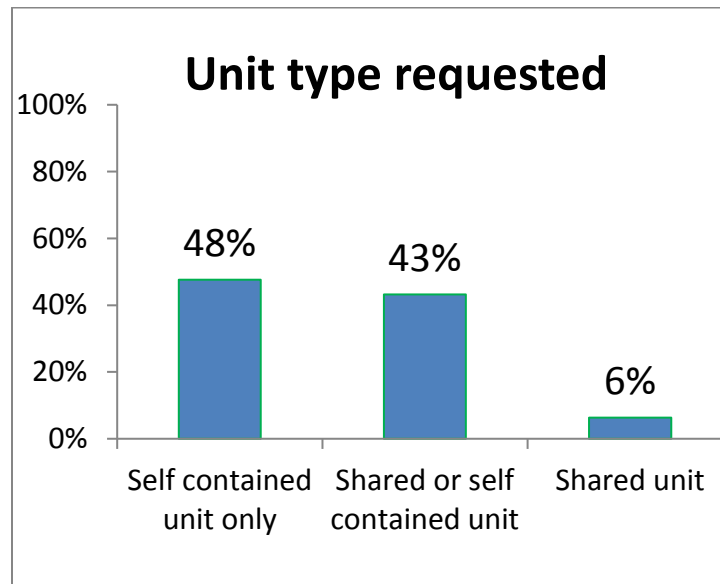
#### ***Shared and self-contained:***

The term self-contained dwelling unit refers to a living space with its own kitchen and bathroom, not shared with others who are not part of one's family or household of choice. While The Access Point's application form distinguishes between requests for self-contained units in dedicated projects (small buildings that are entirely supportive housing) and those which are private-rental units with rent supplement, differences between these two types were not analysed.

Figure 3.13 illustrates the prevalence of unit type requested by applicants. A large majority of applicants wanted to live in a self-contained unit if possible.

- 48 percent requested a self-contained dwelling.
- 43 percent requested a self-contained or shared unit (either/or).
- Only 6 percent requested a shared unit specifically.

Applicants residing in self-contained dwelling units when they applied were more likely to request self-contained units only (64% versus 40%).

**Figure 3.13**

*Notes: 12,733 applicants, 2009-2015. No preference stated for 3 percent of applicants.*

Information provided by Access Point staff and providers to the research team is that applicants' preference for shared units is shaped by the higher turnover and availability of these units. This includes close to 900 of the units in the system, which are shared bedrooms in Habitat boarding homes, and also the shared houses operated by several providers. Many applicants who need housing urgently apply for shared housing as a route to get housing quickly, rather than as a true preference.

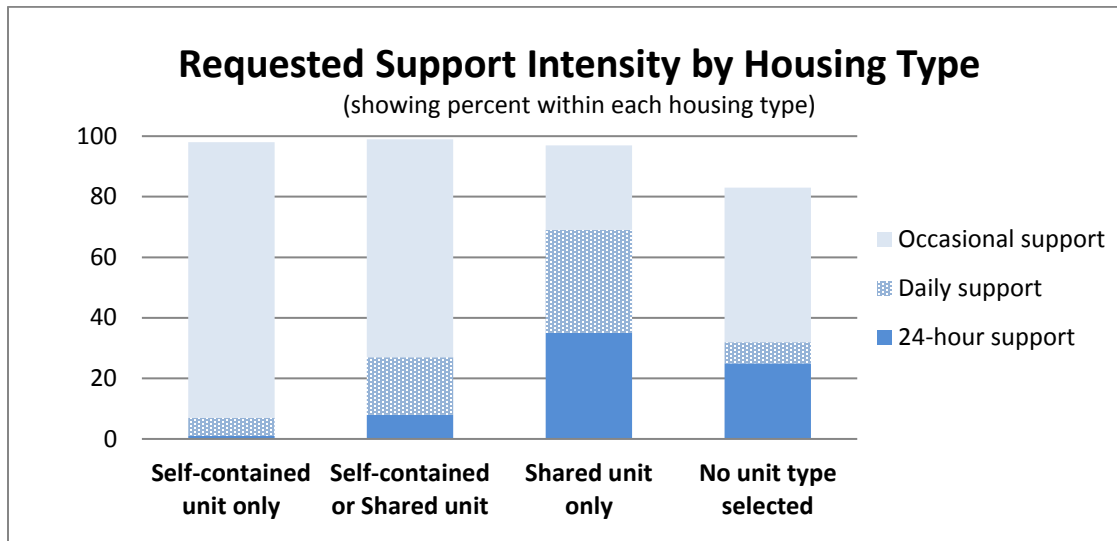
Those who requested only shared units tended to be:

- in older age groups (over one third of this group were age 55+, versus one quarter of others)
- male (two thirds of this group were men)
- receiving Ontario Works as their primary income (21% versus 7% of those requesting only self-contained)
- less likely to have ODSP as their primary income (52% versus 60%)
- residing in hospital/jail or in a rooming/boarding house when they applied (12% to 13% in each of these categories requested only shared)

The higher prevalence of Ontario Works among applicants with a preference for shared units may also relate to their lesser ability to pay, compared to people receiving ODSP.

People who requested only self-contained units were less likely to be homeless and far more likely to live with family members or other relatives and to reside in self-contained housing.

By comparison, those requesting "either" shared or self-contained units were most likely to be homeless at application (63% versus 44% requesting self-contained only and 53% requesting shared). This may be seen as a reflection of urgent need and willingness to accept various options when in this situation.

**Figure 3.14**

There were differences in clinical characteristics by type of housing unit requested. This shows most strongly in comparing the groups that requested only self-contained or only shared; the group requesting “either” shared or self-contained is usually intermediate in characteristics and needs.

People requesting only shared units (by comparison to those requesting only self-contained):

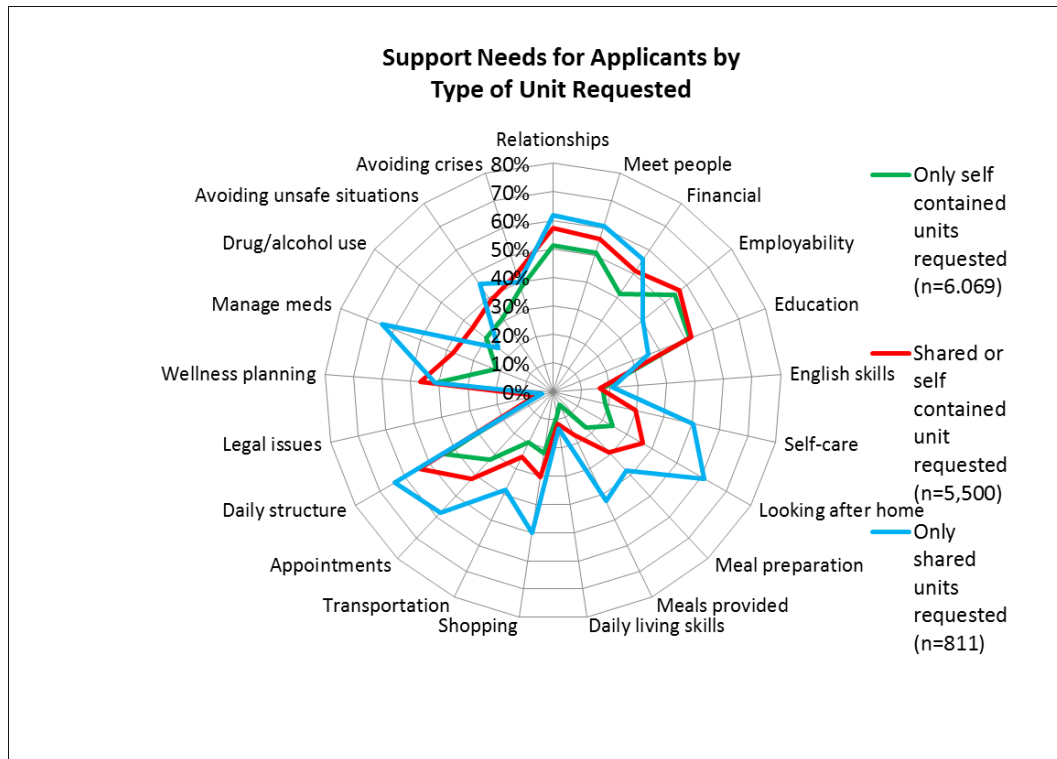
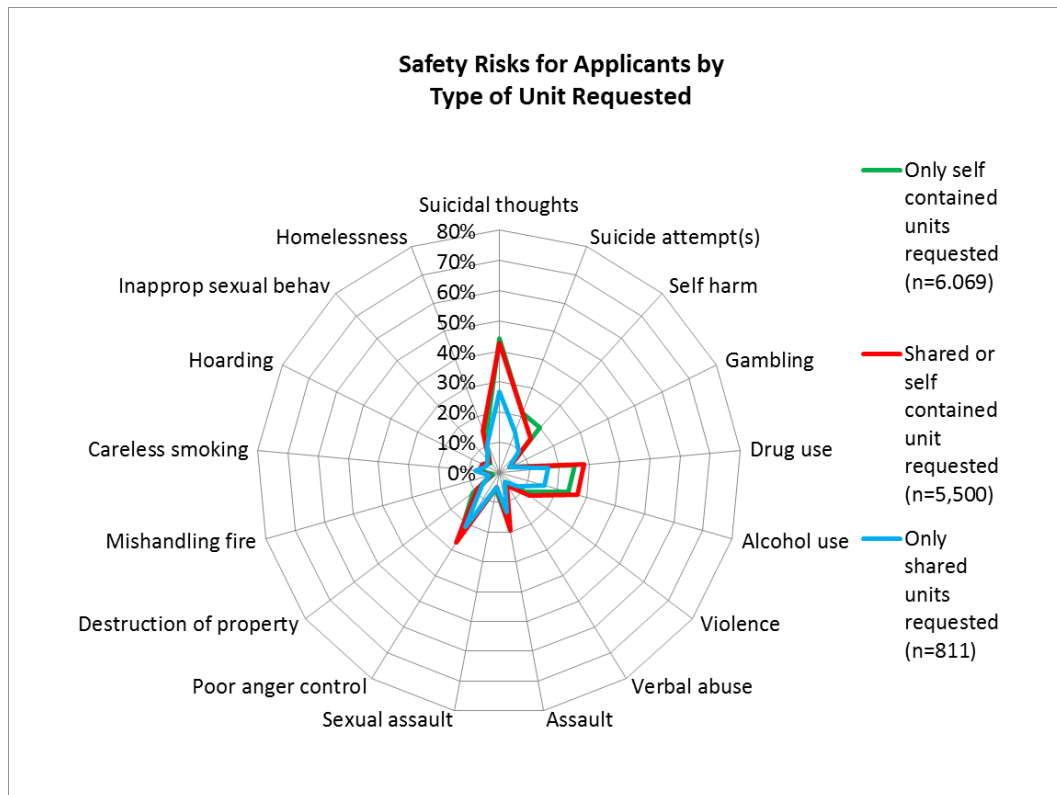
- reported more days in hospital due to mental health issues.
- were much more likely to have a primary diagnosis of a psychotic disorder (64% versus 27%).
- were less likely to have anxiety or mood disorder (22% versus 57%).

Applicants requesting only shared units tended to have higher support needs on more than one dimension (see Figure 3.15a). Among this group (with comparative figures for only self-contained applicants):

- 35 percent requested 24-hour support (compared to 1 percent).
- nearly half identified 10 or more support needs (compared to one quarter).
- there were higher support needs for medication management, self-care, meal preparation, looking after the home, shopping, using transportation, getting to appointments and daily structure.

On the other hand, shared-unit applicants tended to have lower safety issues (see Figure 3.15b). Just 27 percent of the applicants who requested shared only were in the high safety issues group (with 3 to 17 safety issues), compared to 38 percent of those requesting self-contained.

This profile confirms that those applying only for shared units are a group with high hospital use, high prevalence of psychosis, and many functional and other support needs. This group includes relatively few people experiencing substance use, mood or anxiety disorders, or large safety issues.

**Figure 3.15a****Figure 3.15b**

*N=12,733 applicants, 2009-2015*



***Disabilities and unit characteristics:***

Section 2.4 noted that 9 percent of applicants have physical disabilities. While this is a notable share of applicants, the data do not clarify to what extent this is a constraint on housing choices. Providers have indicated that the ability to climb stairs is a significant mobility constraint for some applicants, but this was not available in the application data.

One percent of applicants stated a requirement for wheelchair access.

***Applicants requesting family units:***

The Access Point application includes a question asking whether or not the applicant would prefer a family unit. A family unit is understood by the research team to refer to a larger unit suitable for a couple or parent(s) and children, rather than a single person. [Table 11](#) provides a detailed description of the characteristics of applicants requesting family units.

Among the 12,733 supportive housing applicants, 8 percent requested a family unit. A large majority of these applicants were women (69%), making them more than three times as likely as men to request a family unit. Family unit applicants were far more likely than others to live with their spouse, partner and/or children (40% versus 2%). They were twice as likely to live in a self-contained house or apartment (57% versus 29%), whether subsidized or market, and less likely to be residing in shelter or have no fixed address (19% versus 28%).

Family unit applicants were twice as likely to have a mood rather than psychotic disorder (44% versus 21%) as their primary diagnosis, whereas these two conditions were equally common among other applicants (33% and 35% for the respective diagnoses).

Other than the differences noted here, applicants requesting family units did not show much difference in clinical profiles, support needs and safety issues from other applicants.

Applicants *not* residing in self-contained dwelling units were less likely to request family units (5% versus 15%).

These findings suggest a profile of family unit applicants as predominantly women, often with mood disorders, predominantly housed rather than homeless, quite often living with a partner and/or children and expecting to move with their families to the new housing once it is available.

### 3.6 Summary and implications: Support needs and housing requests

#### 3.6.1 Summary

##### Support Needs

- The specific support needs that people identified when they applied to The Access Point were analysed separately and also clustered into six domains: social needs, health, social determinants of health, in-home activities of daily living, out-of-home activities of daily living and legal. The requested intensity of support (24-hour, daily, or occasional) was also analysed.
- The most common support needs that people identified when they applied pertained to developing relationships, employment and education (each of these was requested by about half of applicants).
- Applicants most frequently identified support needs in the health and social determinants clusters (75% of applicants), followed by out-of-home activities of daily living (66%), social (63%) and in-home activities of daily living (46%). Applicants had high rates of needs in multiple domains (e.g. health plus functional needs plus social determinants). Very few applicants had need in single domains.
- The most common safety issues reported by applicants related to risk of harm to self, such as past suicidal thoughts (40%), suicide attempts (20%), anger management (25%) and alcohol and drug use (24% and 25% respectively).
- The support intensity into which applicants were placed does not always match what they request when they apply for housing: 72 percent requested occasional support but 55 percent were placed in this category; 18 percent requested daily support but 37 percent were placed in this category. The Access Point attributes this discrepancy to more detailed assessments done by its staff when people are being matched to available housing, as well as to the more numerous openings available in boarding homes that provide daily support.
- People placed in units with 24-hour support tended to be in the oldest or youngest age groups, have more inpatient hospital use and to be homeless while in hospital. They were more likely to require provision of meals, and support with shopping and managing specific symptoms.
- People requesting occasional support were more likely than other applicants to be homeless while in jail, or to be staying in shelters or have no fixed address. This fact may reflect their need and/or preference for low-barrier services and supports. Among this group the most common primary diagnoses were mood or anxiety disorders. Applicants who requested and who were placed in occasional support were more likely to have safety risks, including suicidal thoughts or attempts and alcohol/drug use resulting in harm. More from this group than of other applicants requested self-contained units.
- Applicants with a primary diagnosis of a personality disorder identified more support needs overall. They were the most likely to identify support needs to help avoid unsafe situations, avoid crises and deal with alcohol and/or drug use. They were also the most likely to identify safety risks of suicidal thoughts, suicide attempts and self-harm.

- Applicants with a primary diagnosis of a psychotic disorder were more likely to identify in-home functional support needs such as self-care, looking after the home, and meal preparation.
- Based on support needs associated with actual placement by support intensity, it is projected that applicants waiting for housing required approximately 4,600 units with occasional support (59%), 2,900 with daily support (37%) and 300 with 24-hour support (4%). This projection is subject to adjustment to offset any existing imbalances (e.g. many actual placements are in boarding homes with daily support).

### **Housing needs and preferences**

- A large majority of applicants stated a preference for self-contained supportive housing unit: 48 percent requested a self-contained dwelling, 43 percent requested “either” self-contained or shared accommodation and only 6 percent specifically requested only shared accommodation. The large proportion requesting “either” may partly reflect advice given to applicants that restricting their options will lengthen their wait time, and that shared accommodation offers more openings and faster placement.
- The few who request only shared units were disproportionately male and older, and reported psychotic disorders, high hospital use, and more support needs, especially related to managing medications and to activities of daily living.
- 8 percent of applicants requested a family unit. They were mostly women (69%), often living with a partner and/or children, and living in self-contained housing at the time they applied.

### **3.6.2 Implications: Support needs and housing requests**

#### **a) Most applicants identify large needs for more than just housing, including health- and housing-related supports.**

The vast majority of supportive applicants identify needs related to health, in-home and out-of-home daily activities. In many cases this identification of needs reflects the input of workers at various providers who are involved in the application. This is then corroborated at later stages when Access Point staff confirm the needs when matching people to available housing. These needs across multiple domains confirm that the overwhelming majority of applicants to The Access Point require support workers and not just social/affordable housing or rent subsidies.

#### **b) Applicants’ diverse characteristics and needs confirm the need for a system with a range of support intensity (24-hour, daily, occasional) and a variety of types of support.**

The diversity of applicants’ support needs, varying from one group to another, is strongly evident in the research findings. Some people identify and need only occasional support, while others need quite high levels, including 24-hour support. Applicants are also diverse in the types of support they need and in their safety risks. Different groups of applicants have different needs, for example, in avoiding crises, practical household support, meals and personal care. The mental health and addictions supportive housing system should continue recognizing and responding to this diversity. The findings point to the value of preserving a necessary diversity of

approaches in providing housing with support. In addition, they point to a need for expanding the mental health and addictions supportive housing system on that basis.

**c) The large identified needs for support with social determinants of health confirms their importance as part of the range of support that providers offer or help link residents to.**

A majority of applicants identified need for services such as supported employment, peer support and social-recreational activities – services that historically extend beyond the core functions offered within supportive housing programs. The prevalence of these needs underscores the importance of linking clients to these services or incorporating these services within the range of supports provided within supportive housing programs. For example, some supportive housing programs include employment specialists who utilize an individual placement and support (IPS) model of supportive employment to help housing clients achieve competitive employment.<sup>15</sup> These employment specialists participate regularly in clinical team meetings and provide ongoing, follow-along supports, thereby promoting the integration of mental health and rehabilitation services within a supportive housing context.

**d) The mental health and addictions supportive housing system requires clear, shared definitions of support intensity (i.e. 24-hour, daily, occasional) to facilitate matching applicants to housing with the best use of resources.**

The absence of common criteria or definitions for the support intensity available within the supportive housing stock may contribute to the discrepancy found between the support intensity requested by applicants and the support intensity eventually received. For example, there was feedback from Access Point staff that 24-hour support could be understood by some people to mean round-the-clock, on-site staffing, or to mean 24-hour on-call. Moreover, daily support may cover a continuum of support from onsite staff available nearly 24 hours to short daily visits by a case manager or multi-disciplinary team. Similarly, occasional support may include visits by support services multiple times during the week or once per month. Consistent definitions and common eligibility criteria are needed, shared and understood by participating providers, by workers in agencies that refer people to The Access Point, and by Access Point staff.

Participating providers have previously carried out a process to define “levels of support” but it did not result in clear shared definitions or criteria that could be applied in the access and matching process. There is a need for renewed analysis and consultation to arrive at a clear, shared typology and definitions of support level intensity. These definitions and criteria may be predicated on a validated level of service intensity assessment tool. Such definitions would also be helpful to providers as they adjust their support resources when a resident’s needs change over time.

**e) The greater proportion of applicants placed in housing with daily support, who request occasional support, may be influenced by available housing stock.**

Although a majority of applicants state a need for only occasional support, nearly 40 percent were placed in housing with daily support. Daily support is associated with specific needs such as help with medications, help with meals and personal care. However, based on Access Point

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<sup>15</sup> Tsemberis, S. (2010). *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction*. Center City, Minnesota: Hazelden.

feedback, the greater proportion of applicants placed in housing with daily support than requesting it related to the availability of boarding home beds. The latter have higher turnover rates and, therefore, more openings and faster access to housing. Because boarding homes have onsite staff, this raises the percentage housed with daily support. There is a need to understand more fully what share of applicants placed in boarding homes do not require daily support, and are placed in this housing due to urgent housing need for housing and beds being available.

**f) The preference for self-contained units suggests a need to reconsider the role of congregate/shared housing. This could include conversion to short-term housing, a different support intensity or independent dwelling units.**

Few applicants prefer shared (congregate) housing – a finding that is consistent with other research.<sup>16</sup> Feedback from Access Point staff confirms that many who request shared units do so to get faster access, given the higher turnover in that housing, especially in boarding homes.<sup>17</sup>

Shared/congregate housing can create hurdles for successful placement when applicants are referred to it. Some providers are less able to accept applicants who have safety risks involving drugs or violence, because the impacts on other residents are more direct and create more need to manage these issues.

Further expansion of the supportive housing system should be in the form of self-contained units – whether scattered in the private rental apartment stock or in dedicated buildings. Prior research suggests that people have better outcomes when their housing preferences are accommodated;<sup>18</sup> housing stability in self-contained units may promote good health outcomes. The weak preference for shared/congregate housing points to some questions about the appropriate role of this housing in the system, bearing in mind the role it plays in rapid access and higher support options. There may be opportunities to position some congregate housing more explicitly as transitional supportive housing. There may be benefits from reconfiguring some of the properties into self-contained housing, despite the capital costs involved.

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<sup>16</sup> Previous research conducted among clients enrolled in supportive housing in Toronto found that clients generally prefer to live alone or with a loved-one in self-contained units. See Crépaul, J.F. & Blackstone, M. (2012) *Road to Recovery: Client Experiences in Supportive Housing*. Toronto, ON: Centre for Addiction and Mental Health. Retrieved from:

[https://www.camh.ca/en/hospital/about\\_camh/influencing\\_public\\_policy/Documents/Road\\_to\\_Recovery-Client\\_Experiences\\_in\\_Supportive\\_Housing.pdf](https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/Road_to_Recovery-Client_Experiences_in_Supportive_Housing.pdf).

<sup>17</sup> The latter point is reflected in the correlation of requesting shared housing and requesting higher support intensity.

<sup>18</sup> Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal* 31(2): 139-152; Tsemberis, S., Gulcur, L. & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health* 94:651-656.

## 4. Applicants with complex needs

### 4.1 Introduction: Groups with complex needs

Section 4 focuses on several applicant groups with complex needs. The groups are: people with co-occurring substance abuse and mental health problems; those with criminal justice involvement; homeless people; and four groups that have high use of hospital services – people who have high inpatient use, have high emergency department (ED) use, are designated alternate level of care (ALC), or are Health Link clients.

This focus on complex needs responds to concepts in the research literature and frameworks adopted by Toronto Central LHIN (TC LHIN). It also responds to the complexities that The Access Point grapples with in its work and which are evident in its client database used in this research.

There are various definitions of health or patient complexity in the research literature. The term has been applied to people with multimorbidity (the presence of multiple chronic health conditions), to those who encounter economic and social barriers to healthcare, and to individuals that are frequent users of high cost health resources.<sup>19</sup> TC LHIN has adopted an expansive view of health complexity, which incorporates multimorbidity, health care utilization and psychosocial factors.<sup>20</sup> Its definition includes people with multiple physical and/or mental health challenges (e.g. concurrent disorders), social capital issues (e.g. homelessness) and high health care and social service usage (e.g. frequent use of emergency departments, inpatient services, or criminal justice involvement). Thus the populations with complex needs examined in this section are congruent with TC LHIN definitions. People with complex care needs have an array of needs that frequently extend beyond the capacity of any one healthcare provider or health sector. As a result, they often experience more fragmented care, which may lead to illness complications and more persistent symptoms, greater impairment, and high use of acute care services.<sup>21</sup>

The groups examined here overlap, as illustrated in Figure 4.1. That is, some applicants may meet multiple criteria for health complexity as they have co-occurring conditions and face homelessness and/or frequently use acute care services. Complexity may be conceptualized as a continuum, and when a person has a greater number of issues this indicates higher complexity. It is also recognized that applicants who are not included in the groups named here may have complex needs in other ways.

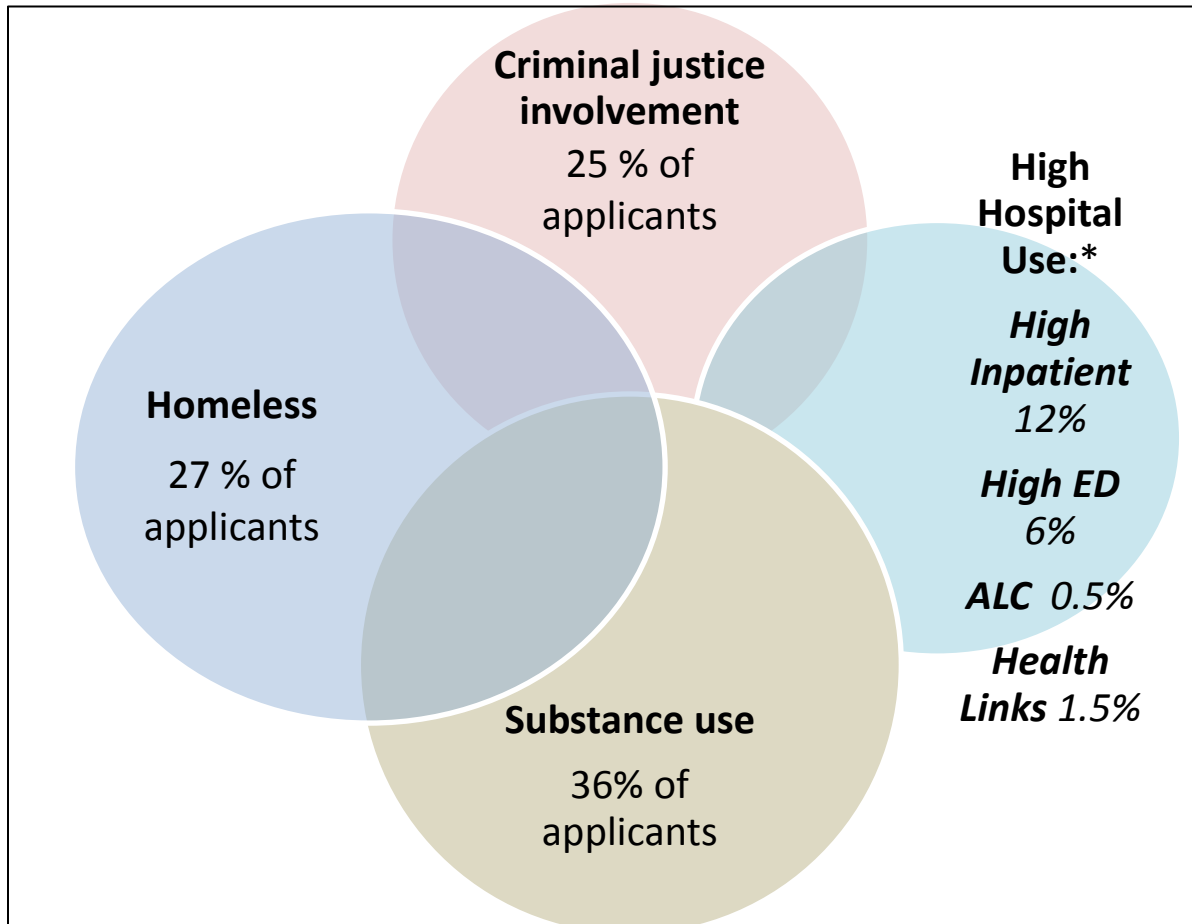
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<sup>19</sup> Schaink, A.K., Kuluski, K. Lyons, R.F. Fortin, M., Jada, A. R., Upshur, R., & Wodhis, W.P. (2012). A scoping review of thematic classification of patient complexity: Offering a unifying framework. *Journal of Comorbidity* 2: 1-9.

<sup>20</sup> Toronto Central Local Health Integration Network (2013). *Enhancing Capacity to Connect Complex and At-Risk Clients to Services to Increase Access, Improve Coordination and Enhance Care Management. Final Report.* Toronto: Toronto Central Local Health Integration Network.

<sup>21</sup> Kathol, R. G., Perez, R. & Cohen, J.S. (2010). *The Integrated Case Management Manual: Assisting Complex Patients Regain Physical and Mental Health.* New York: Springer Publishing Company.

**Figure 4.1**  
**Overlapping Applicant Groups with Complex Needs**



**Notes:**

*Definitions of groups are explained in text.*

*Graph portrays the presence of overlap but not the extent of overlap.*

*\*denotes data are for less than full 2009-2015 period.*

## **4.2 Substance use**

This subsection examines the characteristics and needs of people with substance use challenges (problematic drug or alcohol use). This analysis uses one of the several definitions of substance use and related support needs that are available in the client database, as illustrated here:

Variable	Description	Applicants 2009-2014	Percent of Applicants
<i>Concurrent Disorder diagnosis</i>	Applicant has a primary or secondary mental health diagnosis of substance use disorder	3,021	24%
<i>Substance use challenge</i>	Applicant has identified a need for support in dealing with drug and alcohol use	4,623	36%
<i>Concurrent disorder or substance use challenge</i>	Applicant has a concurrent disorder diagnosis and/or has identified a need for support in dealing with drug and alcohol use	5,168	41%

This section uses “substance use challenge,” the second of the three variables in the chart above. It is a composite variable for substance use support need, and includes all who fit one or more of the following when they applied to The Access Point:

- The applicant stated a need for support with drug and alcohol use.<sup>22</sup>
- The applicant stated that he or she was currently struggling with issues relating to substance use (drugs or alcohol).
- The applicant applied for Supportive Housing for People with Problematic Substance Use (SHPPSU).

The characteristics of applicants identifying a substance use problem are compared to other supportive housing applicants in [Table 12](#).

Compared to other applicants, those with substance use issues tended to be homeless (62% versus 46%) and have no fixed address (17% versus 8%). Related to this, they are less likely to live in a self-contained dwelling whether subsidized (6% versus 10%) or market housing (16% versus 27%).

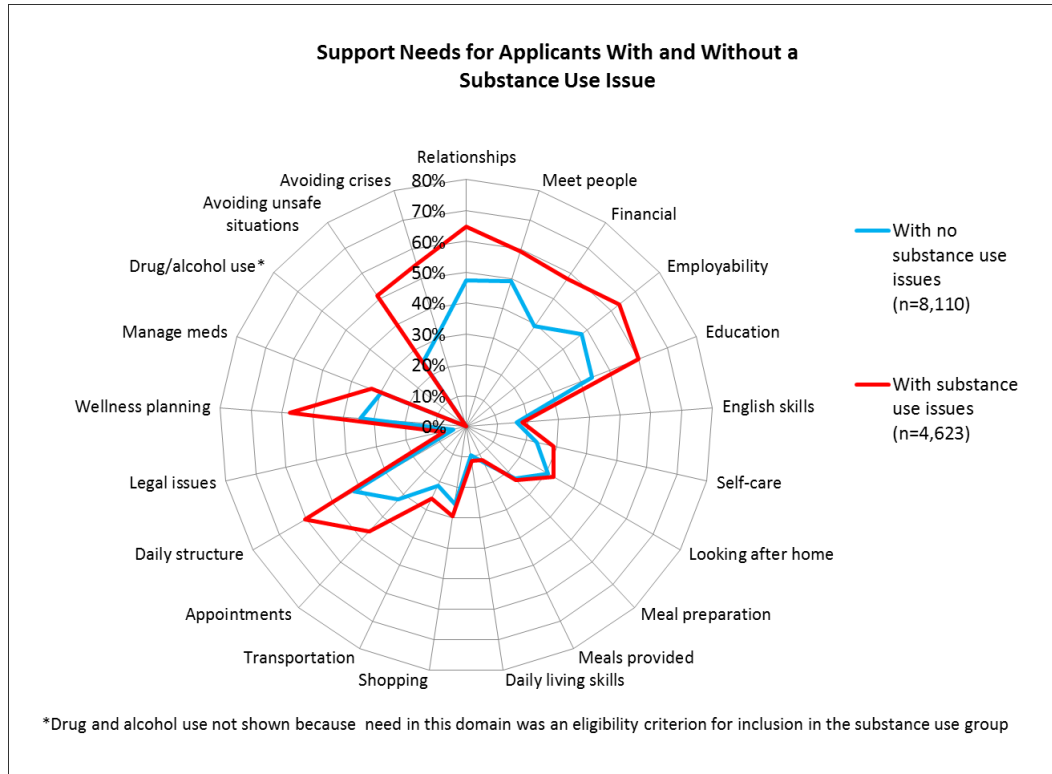
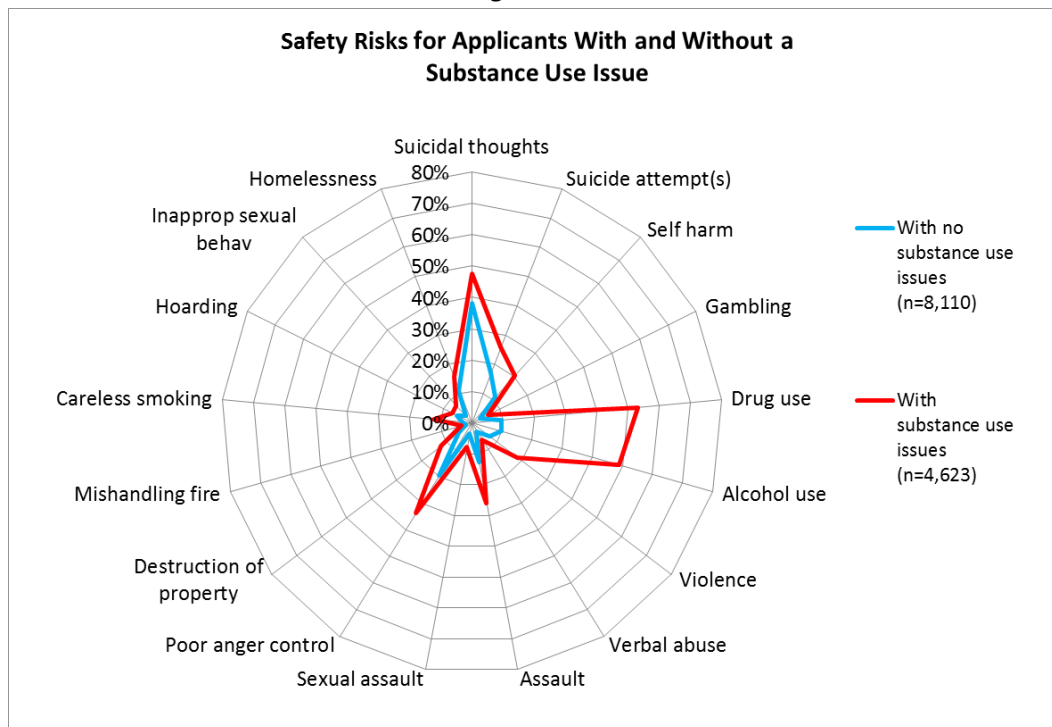
Comparing mental health diagnoses to those of other applicants, slightly more applicants with substance use issues were diagnosed with anxiety disorders (17% versus 12%), mood disorders (36% versus 33%) and personality disorders (4% versus 2%). Correspondingly fewer of those with substance use issues had a diagnosis of a psychotic disorders (26% versus 39%). As expected, those who report having substance use challenges are more likely to be diagnosed with concurrent disorders (54% versus 7% of others).

People with substance use issues at the time of application identified a greater number of support needs and safety issues than other applicants (see Figure 4.2a and 4.2b).

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<sup>22</sup> This criterion is the same variable presented in section 3.1. This section accordingly uses a broader definition of substance use support than in section 3.1.



**Figure 4.2a****Figure 4.2b**

N=12,733 applicants, 2009-2015

- Twice as many in this group identified 10 or more support needs, compared to other applicants (45% versus 22%).
- This group was more likely to require support dealing with crises (55% versus 31%), avoiding unsafe situations (51% versus 25%) and wellness planning (57% versus 35%) (see Figure 4.2a).
- Close to 60 percent of people with a substance use problem reported three or more safety behaviours, compared to 25 percent other applicants.
- Applicants with substance use issues had a higher prevalence of safety issues across all 17 safety categories. They were more likely to report problematic alcohol use causing harm (49% versus 10% of others), or problematic drug use causing harm (53% versus 9%). The differences between those with and without substance use issues were mostly modest on other safety risk categories.

Applicants with and without substance use issues were similar in the types of housing units they requested, and likewise the support intensity requested.

### 4.3 Criminal justice involvement

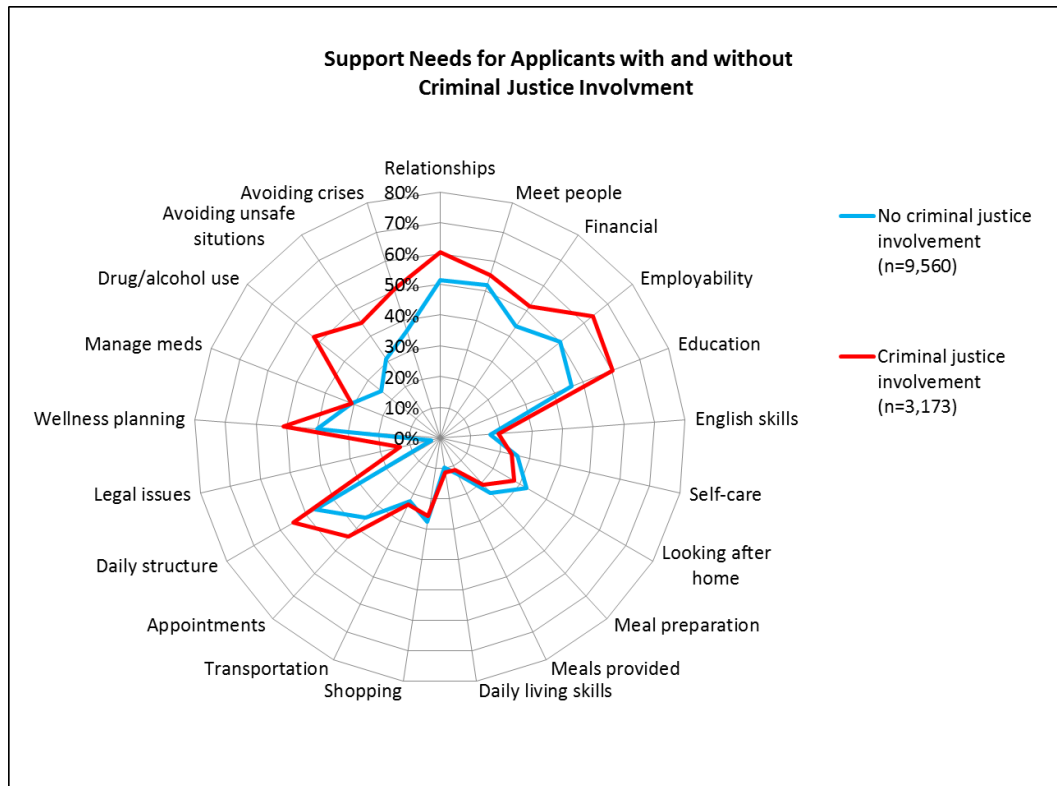
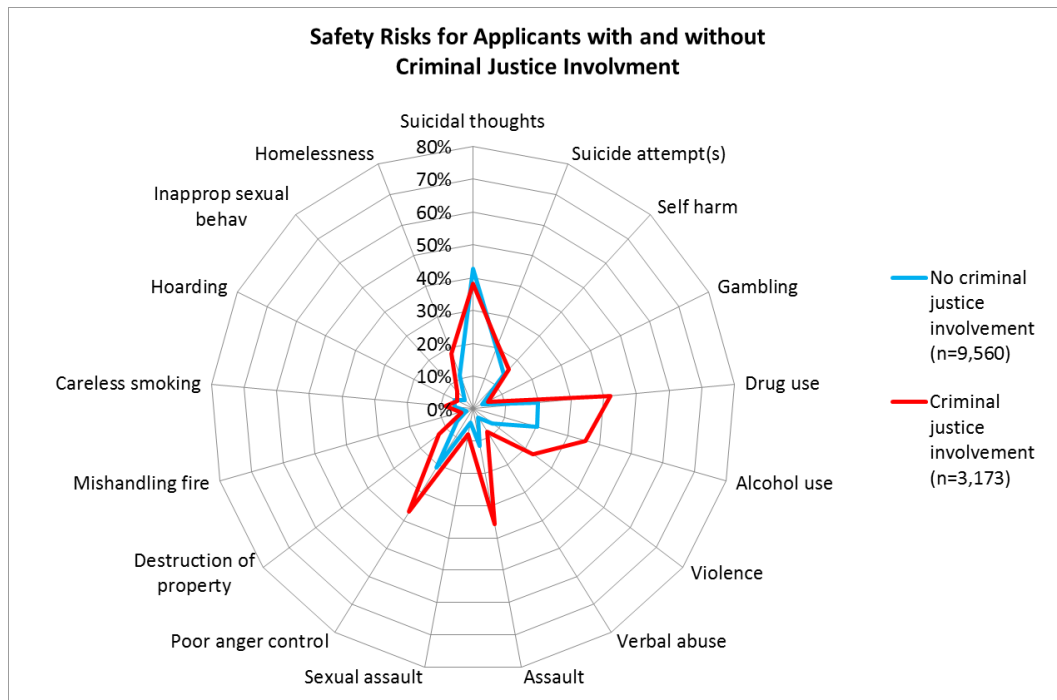
This subsection compares the characteristics of applicants with criminal justice involvement to other applicants. Criminal justice involvement is a composite variable defined by the research team as having any one or more of the following, as measured in the application data.

- Having current criminal charges
- Residing in a correctional or detention facility at time of application
- Being on probation or parole
- Being under the purview of the Ontario Review Board after being found not criminally responsible for a criminal offense or unfit to stand trial
- Being held in a forensic mental health hospital pending a disposition by the Ontario Review Board
- Being screened as eligible for MHJ housing by the Access Point

Fully 25 percent of applicants have some criminal justice involvement. This is far more than ever apply to the Mental Health and Justice Initiative (MHJ), one of the specific program options for Access Point applicants, as described in subsection 1.1.

#### ***Characteristics of applicants with criminal justice involvement:***

[Table 13](#) displays the characteristics of applicants with and without criminal justice involvement.

**Figure 4.3a****Figure 4.3b**

*N=12,733 applicants, 2009-2015*

Compared to other applicants, those with criminal justice involvement were much more likely to be:

- male (70% versus 53%)
- younger (62% versus 46% under age 45)
- homeless when they applied (72% versus 45%)
- residing in a correctional facility or hospital when they applied (21% versus 7%)
- residing in a shelter or with no fixed address (35% versus 24%)

The criminal justice group had comparable diagnostic profiles to other applicants, except for concurrent disorders (mental illness and substance use). The justice-involved group was more than twice as likely to have a co-occurring substance abuse/dependence diagnosis (41% versus 18%).

Applicants with justice involvement identified a greater number of support needs than other applicants (see Figure 4.3a).

- More than one third of this group identified ten or more support needs, compared to just over one quarter of other applicants.
- These applicants were more likely to require support managing alcohol and/or drug use, dealing with crises and avoiding unsafe situations.
- This group more often identified support needs across most other support need domains (compared to other applicants), but the difference was generally modest.

Justice-involved applicants also identified a greater number of risk behaviours. More than half of these applicants identified three or more risk behaviours, compared to less than one third of other applicants.

Those with justice involvement were more likely to report physical assault behaviour, violence towards others, anger management challenges and problematic alcohol/drug use resulting in harm (see Figure 4.3b).

There was relatively little difference in housing preferences between justice-involved and other applicants. The support intensity requested was also similar.

#### 4.4 Homelessness

Many applicants to The Access Point are or have been homeless, or are in housing situations that are temporary or precarious. This section describes the characteristics and need of homeless applicants. The main focus here is people who were in shelters or had no fixed address when they applied, as well as those who were in hospitals or correctional facilities and also self-identified as homeless.

Homelessness involves not only absolute lack of a home, but varying degrees and duration of this.<sup>23</sup> The data capture the applicants' situation at the time of application. Individual applicants' situations often

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<sup>23</sup> Canadian Observatory on Homelessness (2012), *Canadian Definition of Homelessness*.

change during the period they are on the waiting list, and this includes their living situation and homelessness. A snapshot is nevertheless a valuable window onto the needs of applicants in general.

As noted in section 2 and Appendix 1 (Methodology), four categories of homelessness were constructed from the combination of applicants' residence type and their answer to the question on the application form, "Are you currently in temporary housing or homeless?" Section 2 showed the homeless status of all applicants as follows:

- 27 percent were in the shelter/NFA homeless group when they applied
- 7 percent were in the homeless hospital group
- 3 percent were in the homeless jail group
- 16 percent self-identified as homeless or in temporary accommodation, while residing in some form of self-contained or congregate housing
- The remaining 48 percent were not homeless

#### **Characteristics of homeless applicants:**

[Table 14](#) displays the characteristics of each homeless applicant group, which were derived from their applications for supportive housing.

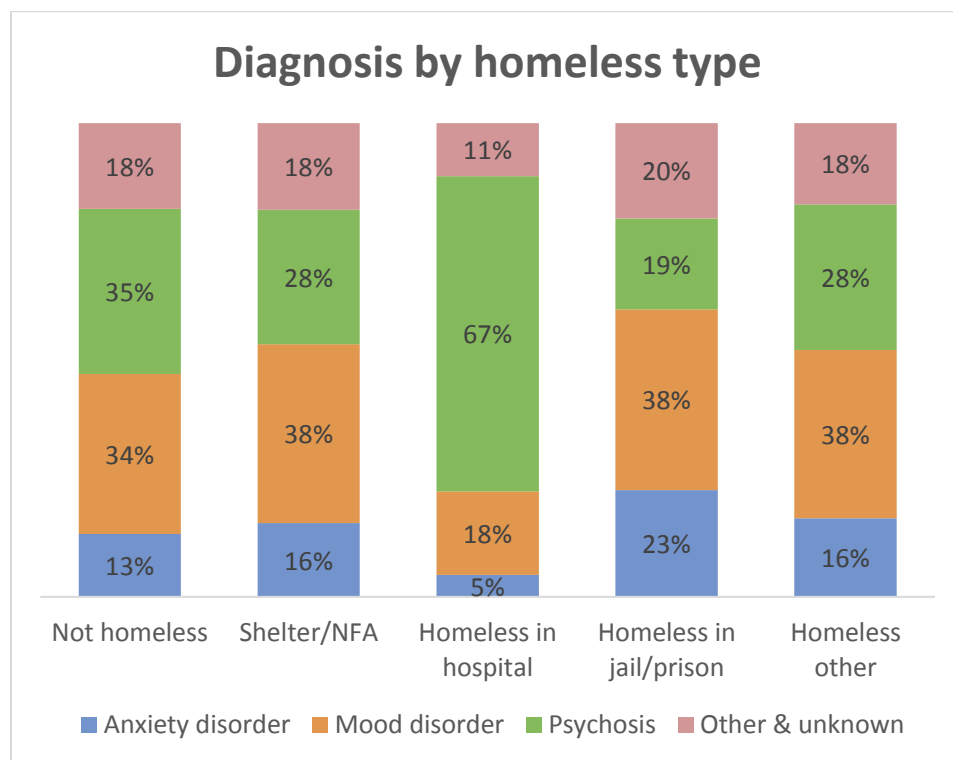
#### ***Social and economic characteristics:***

- Homeless applicants tended to be younger. People under age 35 accounted for 30 percent of homeless applicants in general and 45 percent of those in jail/prison, compared to 25 percent of non-homeless applicants. Relatively few homeless applicants in jail/prison were age 45 or older.
- More homeless applicants were men: 61 percent of all homeless (and of shelter/NFA) versus 53 percent of non-homeless. Males were 69 percent of homeless applicants in hospital.
- Shelter/NFA applicants and also homeless applicants in jail/prison were less likely to receive ODSP and more likely to receive Ontario Works (respectively 27% and 20% OW, versus 16% of non-homeless). Homeless applicants in hospital and especially in jail/prison were most likely to have no source of income (respectively 18% and 36%, versus 10% of non-homeless). Homeless applicants in hospital and non-homeless were most likely to have ODSP income (56% and 53%).
- Toronto Central LHIN accounted for a disproportionate share of homeless applicants: 65 percent (61 to 68 percent among various homeless categories), compared to 54 percent of non-homeless. This is expected, given the concentration of shelters and hospitals in central Toronto.

**Diagnosis and substance use of homeless applicants** (see Figure 4.4):<sup>24</sup>

- Homeless applicants in hospital had a distinct diagnostic profile, 67 percent having psychosis as their primary mental health diagnosis and correspondingly fewer with mood or anxiety disorders.
- Mood disorders were slightly more prevalent among homeless applicants in the NFA/shelter category and among homeless applicants in jail/prison (38% in each group) than among non-homeless applicants (34%). This also applied to anxiety disorders (respectively 16%, 23% and 13% for these three applicant groups).
- Problematic drug and drug/alcohol use is more prevalent among homeless than non-homeless applicants, whether measured by substance use diagnosis or identified problems. For homeless applicants in hospital the prevalence was only slightly different from non-homeless.
- Shelter/NFA applicants had high rates of identified substance use problems (45% versus 28% for non-homeless) and of substance use disorder diagnoses (31% versus 17 percent). “Homeless–other” applicants were similar. These issues were greatest among homeless applicants in jail/prison: 75 percent had identified drug/alcohol problems, 55 percent a substance abuse/dependence diagnosis.

**Figure 4.4**



N=12,733 applicants, 2009-2015

<sup>24</sup> Residence type and living arrangement were also very different for homeless applicants, as a function or correlate of the homelessness definitions used here.

***Service use and program requested:***

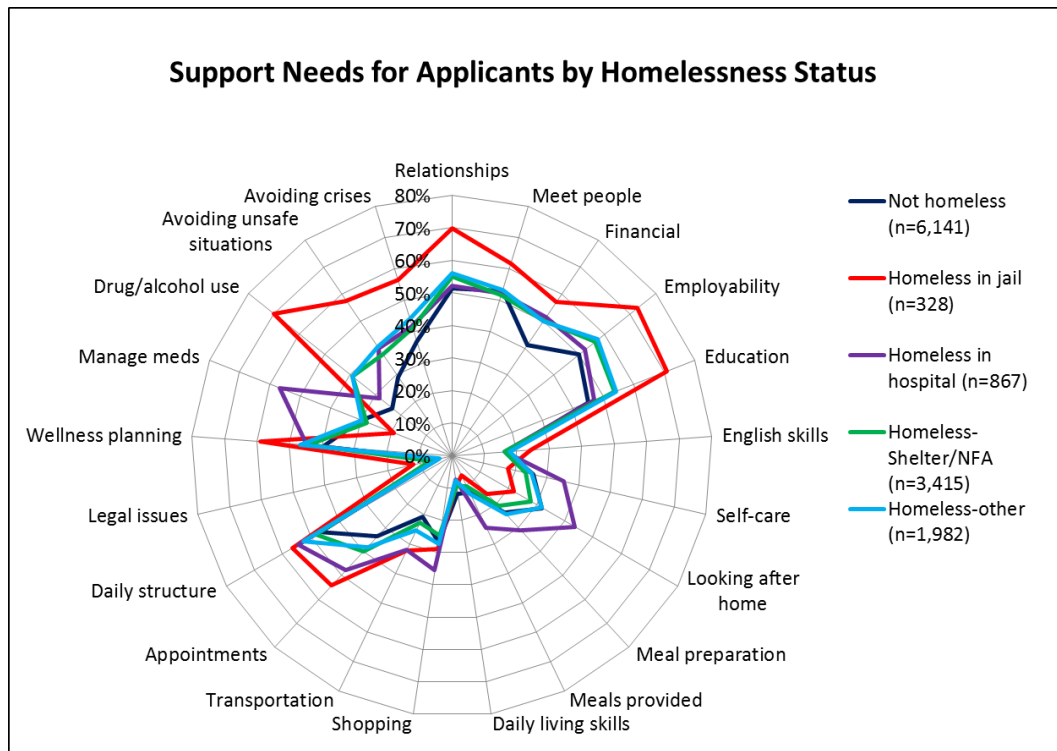
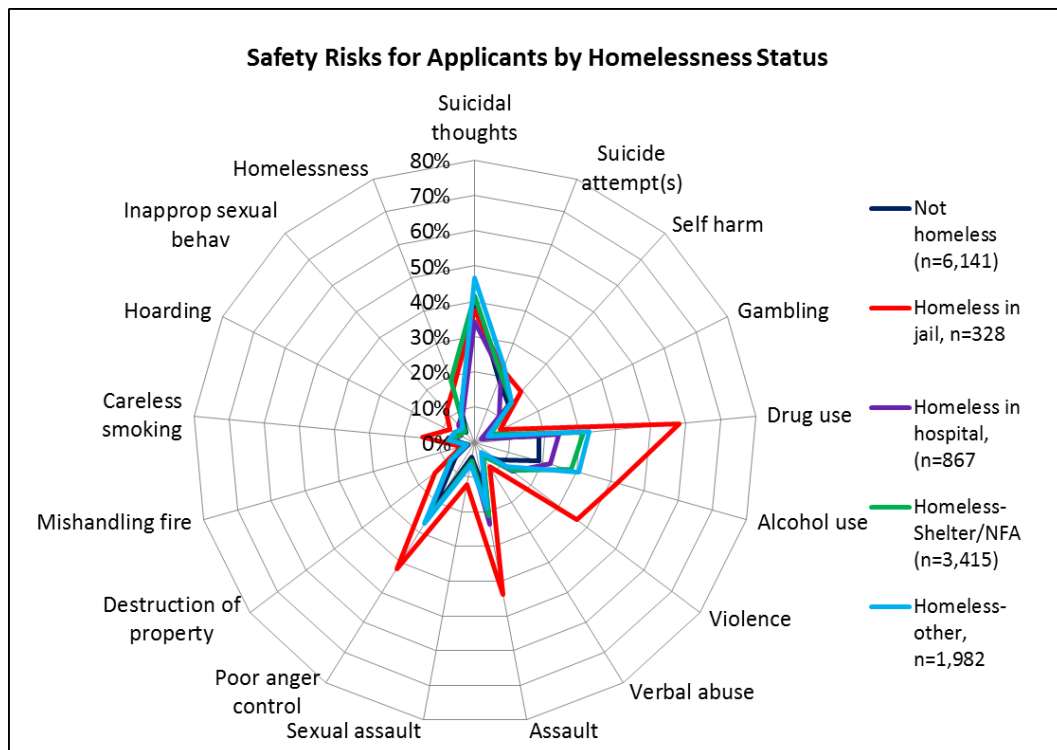
- Not only those in jail/prison but also 33 percent of shelter/NFA and hospital homeless and 28 percent of “homeless–other” had criminal justice involvement (versus 15% of non-homeless).<sup>25</sup>
- Very large shares of homeless applicants in correctional facilities applied to the Mental Health and Justice (MHJ) program (65% versus 6% of non-homeless), as did a relatively high share of other homeless applicants (13% to 17% of other homeless categories).
- A large share of homeless applicants in jail/prison applied to the addiction-targeted SHPPSU program (27% versus 7% of non-homeless), as did shelter/NFA and “homeless–other” (13% and 11% respectively).
- Homeless applicants in hospital were least likely to request self-contained units only (19% versus 39% to 59% for all other categories) and most likely to request shared only (16% versus 6% or less). Shelter/NFA and “homeless–other” applicants were less likely than non-homeless applicants to request only self-contained units (39% and 49% versus 55% respectively).

***Support needs and intensity requested:***

- Homeless applicants in hospital were more likely than others to request 24-hour support (nearly 20% versus 7% or less for all other categories) or daily support (27% versus 14% or less). Homeless applicants in jail/prison were most likely to request occasional support (92% of this group, versus 78% to 82% for shelter/NFA, “homeless–other” and non-homeless).
- Homeless applicants in jail were more often in the high needs group, citing 10 or more of the 22 housing-related needs (45% versus 27% of non-homeless), and so were the other homeless groups (between 31% and 36% in the three categories). The opposite was true for the low needs group (0 to 4 needs). There was little difference among the four homeless and one non-homeless group in the share that had medium needs.
- Homeless applicants in hospital had higher support needs than other groups on several health and functional domains, including medications, self-care, meals and transportation (see Figure 4.5a).
- Homeless applicants in hospital and in jail/prison had higher support needs than other groups for adding structure to the day, avoiding crises and getting to appointments. Those in jail/prison had the highest needs in regard to drug and alcohol use and avoiding crises and unsafe situations.
- Homeless applicants in jail/prison had a high overall frequency of safety issues. In particular, they had the most safety issues in regard to drugs and alcohol causing harm and violence against others.
- Shelter/NFA applicants had a relatively low number of support needs but a notable presence of safety risks associated with drugs/alcohol and to a lesser extent violence (see Figure 4.5b).

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<sup>25</sup> As expected, homeless applicants in hospital had the highest incidence of high inpatient mental health days.

**Figure 4.5a****Figure 4.5b**

12,733 applicants 2009-2015



## 4.5 High emergency department and inpatient use

This section examines the characteristics and the support need and risk profile of applicants with frequent emergency department (ED) visits for mental health reasons, and those with high psychiatric inpatient days. High use of ED and inpatient services may indicate gaps in community-based services or poor access to care that would prevent use of acute care services.<sup>26</sup> Understanding the characteristics and needs of applicants with high hospital use can therefore inform service design to address the underlying factors contributing to high utilization of acute care services.

### High emergency department visits for mental health

Data on emergency department use were collected when people applied for supportive housing, for application dates between January 2009 and March 2013. Applicants were asked how many ED visits for mental health reasons they had in the proceeding two years. Frequent ED use was defined for this analysis as eight or more visits in the two-year period prior to applying. Data were available for 4,323 applicants in 2009-2013, and 240 of them (6%) were in the frequent user group.

[Table 15](#) compares the characteristics of applicants with and without frequent ED use.

Frequent ED use was not associated with any particular demographic or basic socio-economic characteristics. There was no significant difference between applicants with frequent ED use and others, in gender, age, preferred language or primary income source.

Applicants with frequent ED use were more likely than others to report having no fixed address when they applied for housing (41% versus 28%).

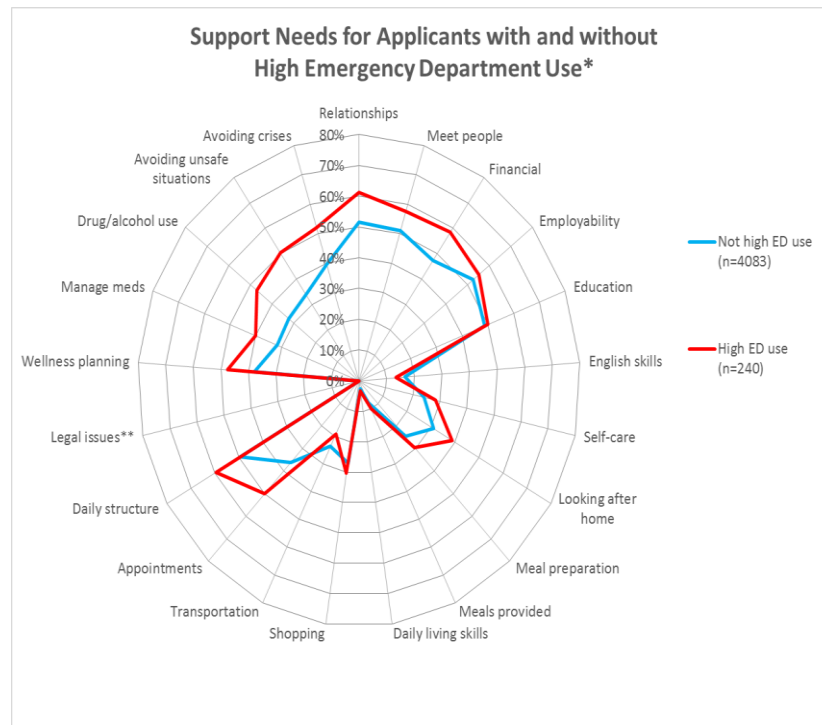
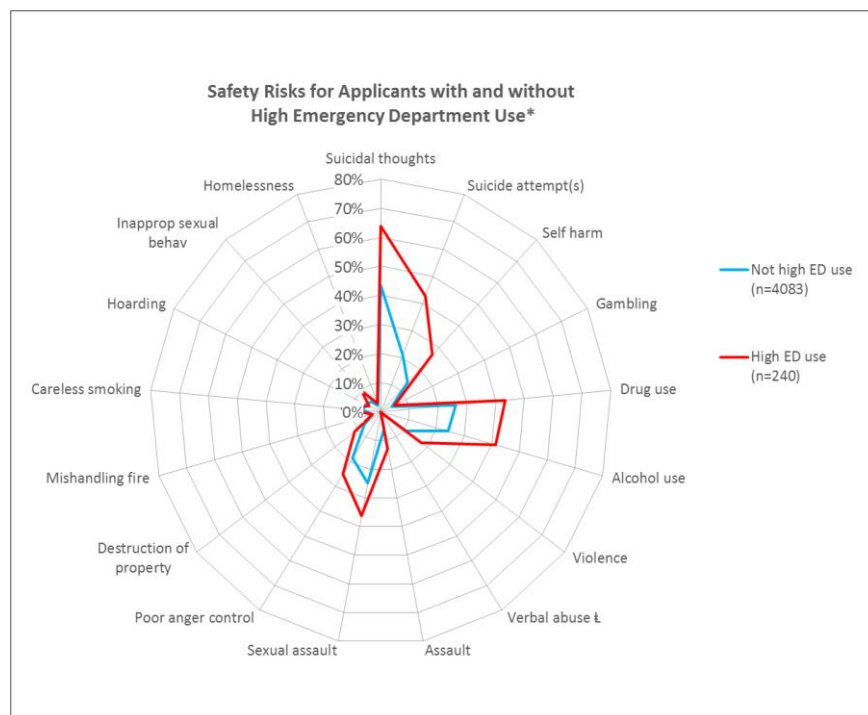
A number of clinical factors were associated with greater ED use. Compared to other applicants, those with frequent ED use:

- were three times as likely to have a personality disorder as a primary mental health diagnosis, although the prevalence in the frequent ED use group was still small (8%). There were no other significant differences between this group and other applicants.
- had a greater prevalence of substance use problems (50% versus 35%).
- were nearly twice as likely to have spent 50+ days in hospital for mental health reasons (24% versus 13%). In other words, high ED use was moderately associated with more inpatient days.

Frequent ED users had higher support needs and safety risks than other applicants (see Figure 4.6a & 4.6b). This group reported a greater prevalence of needs across most need domains (except assistance with using transportation and enhancing English skills). Larger shares of applicants in this group:

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<sup>26</sup> Besier, 2005; Bower & Gilbody, 2005.

**Figure 4.6a****Figure 4.6b**

\*Emergency department use was available for 4323 applicants between January 2009 and March 2013

\*\*Value suppressed because count was <5 for High ED use group

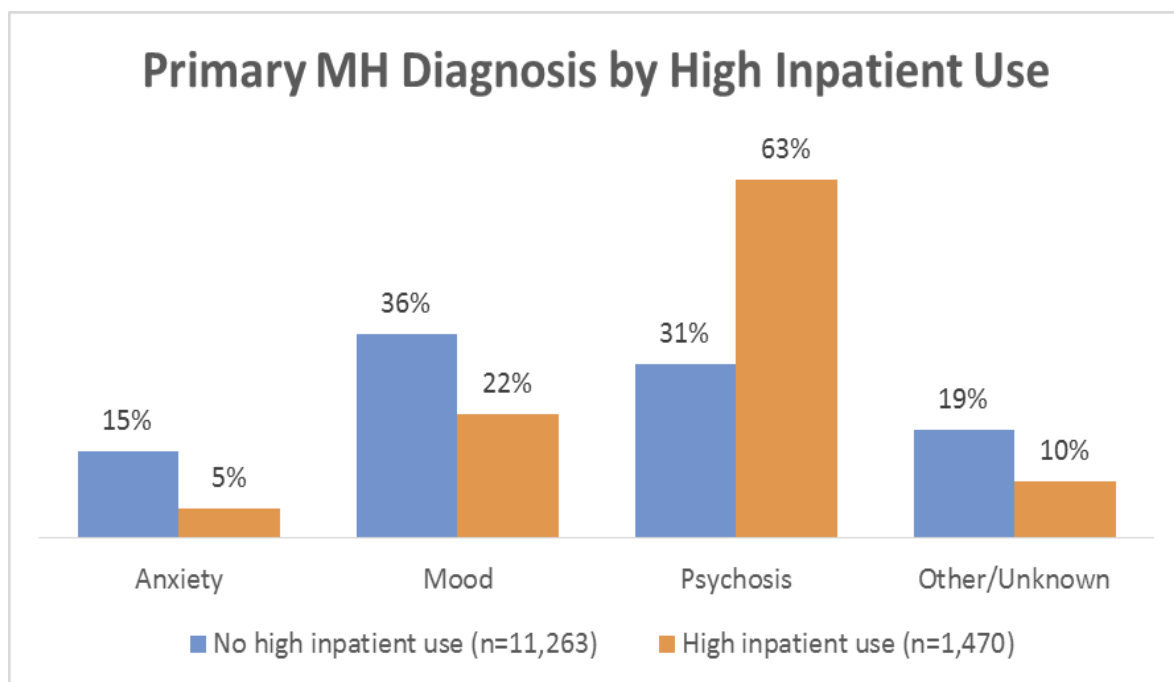
- identified 10 or more support needs (38% versus 26% for other applicants).
- requested 24-hour or daily support (34% versus 21%).
- identified support needs in avoiding unsafe situations, dealing with drug and alcohol use and getting to appointments.
- identified three or more safety risks.
- reported past suicidal thoughts, suicide attempts or self-harm behaviours.
- reported alcohol and drug use resulting in harm.

### **High inpatient use**

From 2009 onwards, data were collected on inpatient use. When they applied, people were asked how many days in the previous two years they had spent in hospital for mental health issues. High inpatient use is operationally defined as 50 or more inpatient days for mental health reasons in the two years before applying.

Two fifths (41%) of applicants reported one or more inpatient days for mental health reasons in the prior two years. The average inpatient days reported was 27, with wide variation (standard deviation=124). One in eight (12%) reported 50 or more inpatient days.

**Figure 4.7**



*N=12,733 applicants from 2009-2015; High inpatient use = 50+inpatient days in previous 2 years*

[Table 16](#) compares the characteristics of applicants with and without high inpatient use.

Compared to other applicants, those with high inpatient use were more likely to:

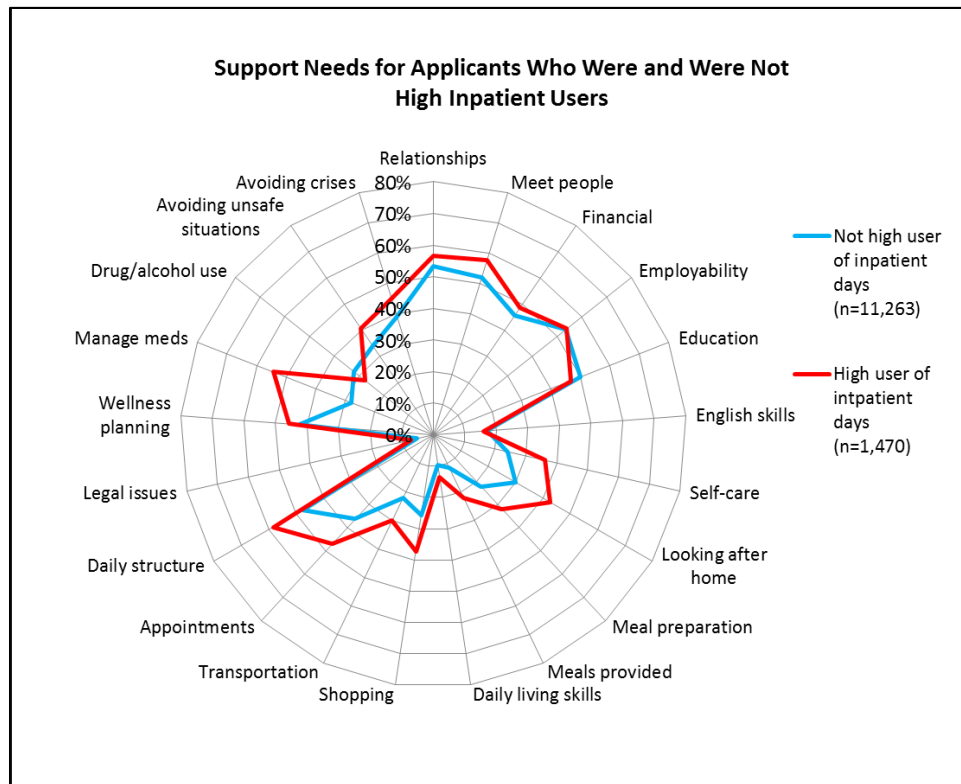
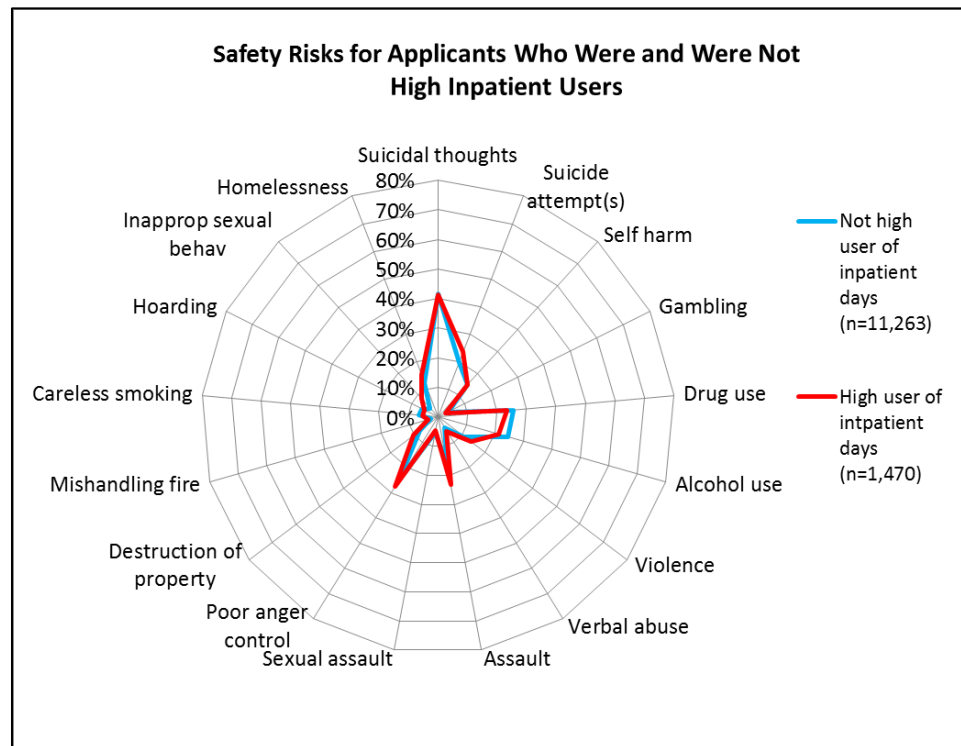
- reside in hospital or jail at time of application (31% versus 8%) and – associated with that – to be living with non-relatives (62% versus 47%).
- more likely to be homeless when they applied (57% versus 51%), but *less* likely to be residing in a shelter or to be of no fixed address (18% versus 28%). Among those who reported being homeless, one quarter resided in hospital compared to 4% of other homeless applicants.
- have a primary diagnosis of a psychotic disorder (63% versus 31%) but less likely to have a co-occurring mental health diagnosis (21% versus 26%) or substance use problem (31% versus 37%) (see Figure 4.7).

In sum, a substantial minority of applicants with high inpatient use were people with psychotic disorders who were hospitalized frequently or long term, with no other home when they applied.

Applicants with high inpatient use were more likely than other applicants to:

- report having ten or more support needs (40% versus 29%).
- request 24 hour or daily support (39% versus 18%).
- identify support needs in managing medications and in functional needs such as looking after the home, self-care and meal preparation (see Figure 4.8a).
- identify a need for meals be provided for them (twice as likely as other applicants).
- report safety risks (79% versus 72%). However, differences in the prevalence rate of individual risk behaviours was relatively small between this group and other applicants (see Figure 4.8b).

Applicants with high inpatient use were more likely than other applicants to request only shared accommodation than other applicants (15% versus 5%) and less likely to request *only* a self-contained unit (32% versus 50%). This finding fits the fact that high-support housing is often shared accommodation.

**Figure 4.8a****Figure 4.8b**

N=12,733 applicants 2009-2015

## 4.6 Alternate Level of Care (ALC) and Health Links

Patients are given an ALC designation when they occupy a hospital bed, but they no longer require that level of intensity of resources and services. Most people in this situation have needs that can be met better in other accommodation with appropriate support. ALC patient days are an inefficient use of system resources and may prevent access to care for other system users.

Health Links is a recent approach intended to achieve better care for people who live with complex chronic illnesses, many of whom also have high social needs. Health Links is a province-wide Ministry of Health and Long Term Care initiative in collaboration with various LHINs. In Toronto Central LHIN two Health Links teams, named FOCUS and LINK, were established. In this analysis, Health Links applicants comprise those who were screened by Access Point staff as meeting the relevant LHIN criteria for Health Links, and who were then referred to a Health Links team.

The Health Links and ALC clients are of strong interest to the LHINs, hospitals and others because they are high service users. For such reasons these groups are analysed here, even though these groups involve very few applicants, and Health Links referral practices were still emerging during the 2014-2015 period.

A small number of supportive housing applicants were identified as ALC applicants (66 persons) or Health Links applicants (93 persons). These were respectively 0.5 percent of the total 12,733 supportive housing applicants and 1.5 percent of the 6,153 who entered the waiting list from 2014 onward when Health Links referrals to The Access Point began. Details of the characteristics of Health Link applicants are presented in [Table 17](#). However, due to very small cell counts, data on the ALC group are not presented in a tabular format.

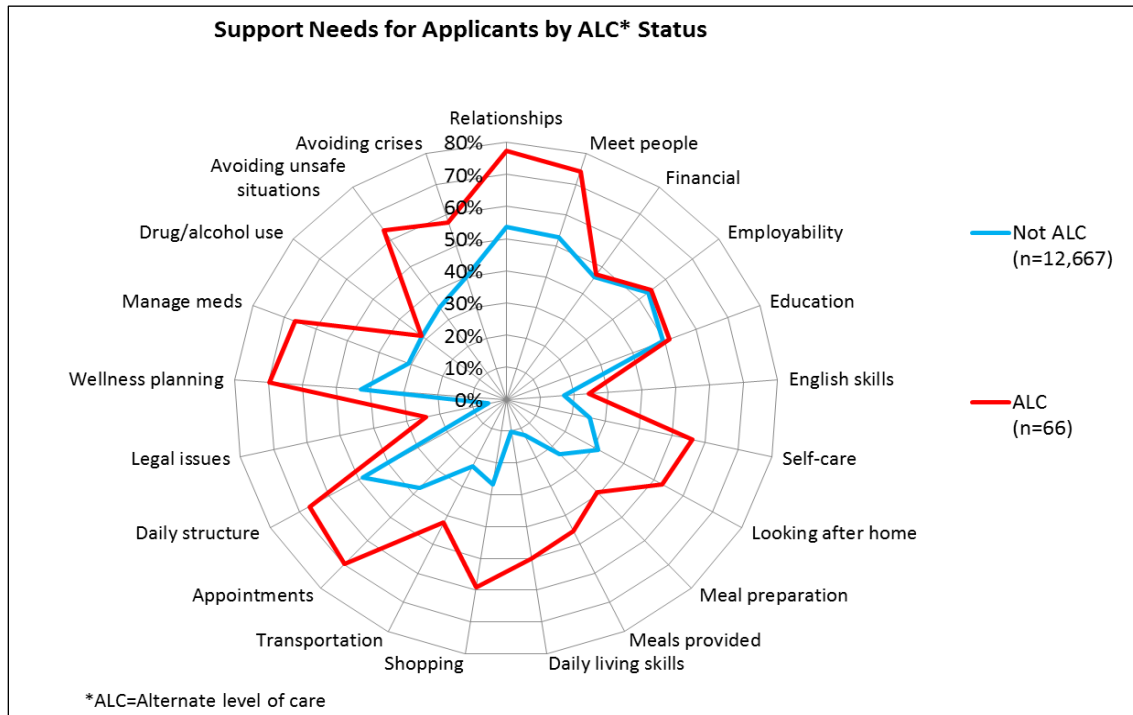
The ALC and Health Links populations are similar in some respects but quite dissimilar in others.

ALC applicants were more likely than non-ALC applicants to:

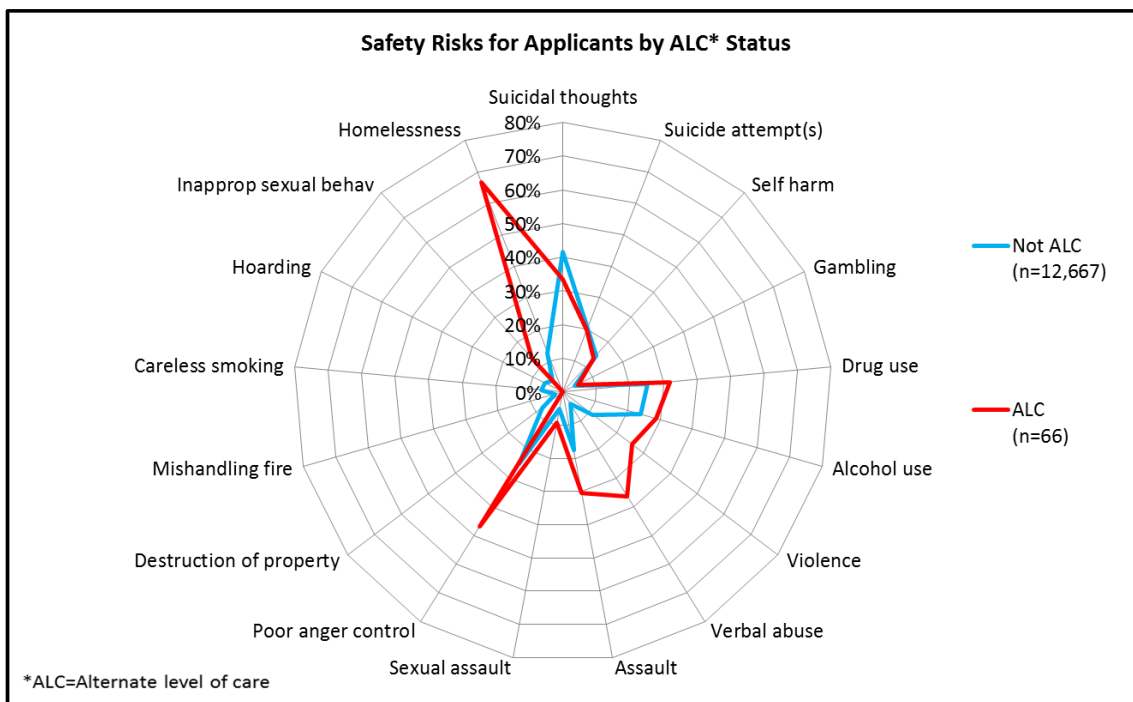
- be older (44% are aged 55 years or more versus 24% of non-ALC)
- require an interpreter (8% versus 1%)
- receive ODSP as their primary income source (75% versus 51%)

The majority of ALC applicants were homeless (70% versus 52%) and lived with non-relatives (70% versus 49%). This is as expected, since the ALC designation involves being in hospital and having no suitable housing to be discharged to.

Health Links applicants had fewer distinct socio-economic characteristics than ALC applicants. They were not different from other applicants in their age distribution. They were not any more often homeless than others. They, like ALC applicants, were more likely than others to require an interpreter (8% versus 2%).

**Figure 4.9a**

12,733 applicants 2009 to 2015

**Figure 4.9b**

12,733 applicants 2009 to 2015

Clinically, the ALC and HL applicants could be distinguished from other applicants:

- Twice as many ALC applicants as others had a psychotic disorder diagnosis (67%), while mood disorders (18%) were correspondingly rarer among them.
- As expected, nearly half of ALC applicants had spent over 50 days in hospital during the prior two years due to mental health issues (versus 11% of non-ALC).
- Among Health Links applicants, psychotic disorders (44%) were more common than among non-Health Links applicants (33%).
- Health Links applicants were more likely than others to have secondary mental health diagnoses (55% versus 37%), concurrent disorders (44% versus 32%), dual diagnosis (12% versus 6%) and neurological disorders (14% versus 5%). This reflects the clinical complexity inherent in the Health Links definition.
- ALC applicants were also more likely to have concurrent disorders (35% versus 24%), dual diagnosis (14% versus 6%) and neurological conditions (12% versus 3%).

ALC and Health Links applicants more often applied for Intensive Case Management as well as housing (compared to others) and far more often applied for Assertive Community Treatment:

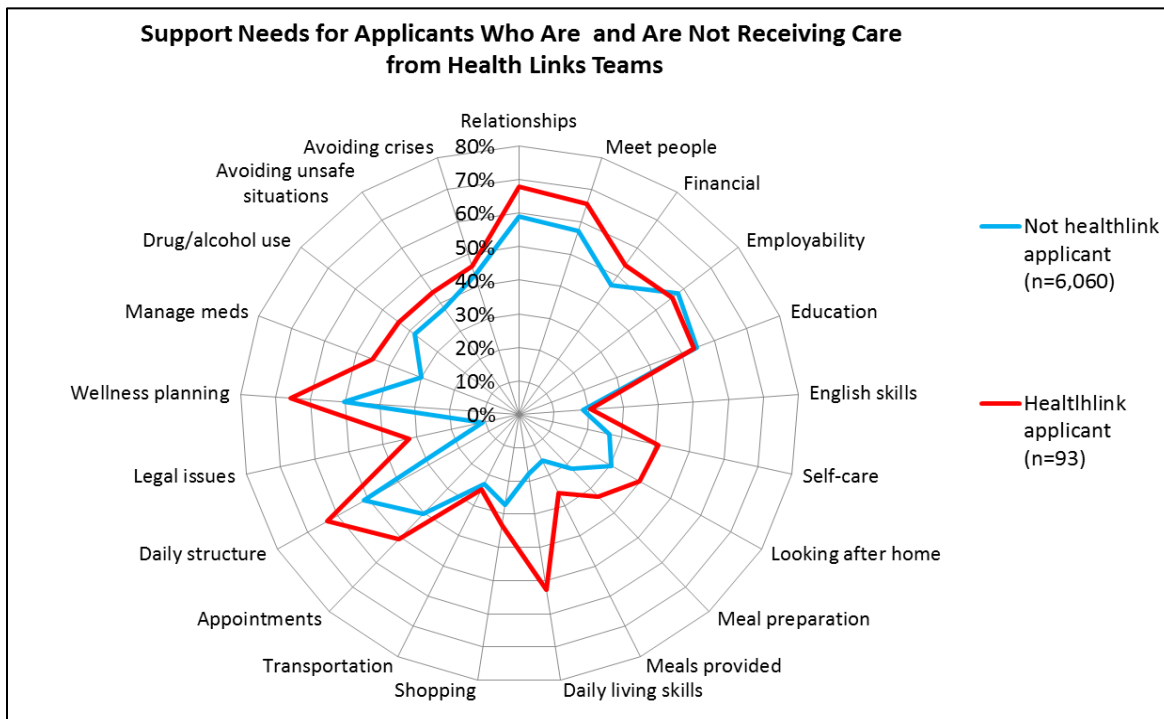
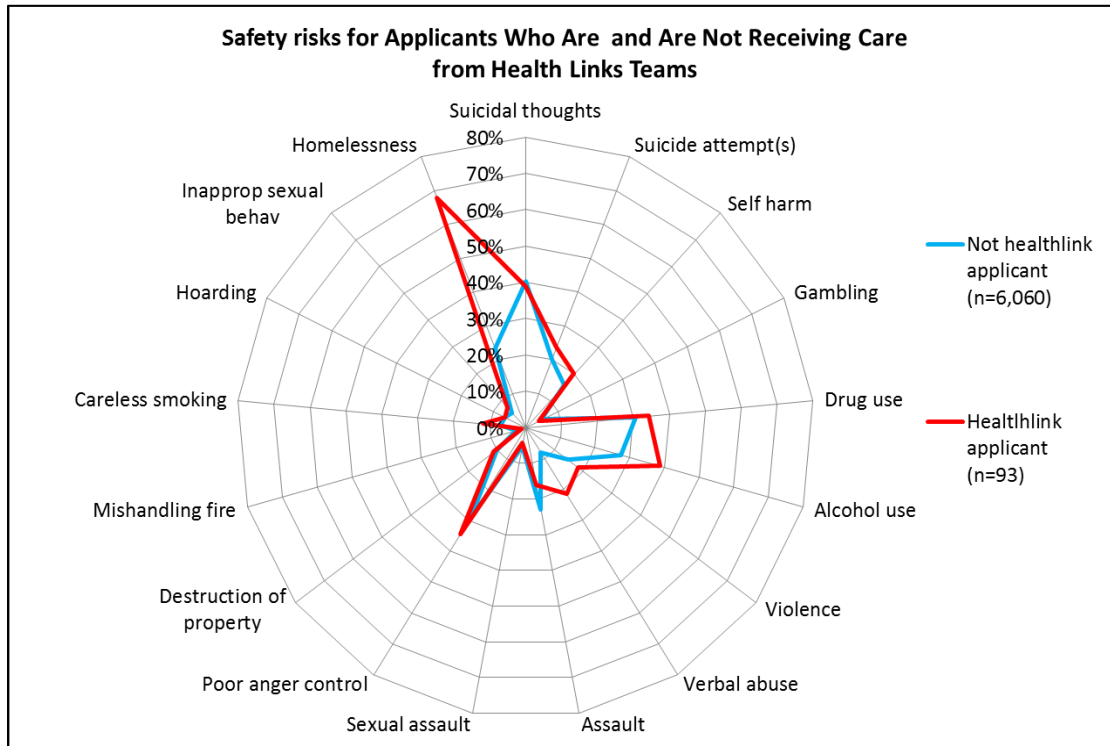
- 42 percent of ALC applicants applied for ICM (versus 25% of others doing so) and 38 percent applied for ACT (versus 5%).
- 47 percent of Health Links applicants applied for ICM (versus 34% of others) and 23 percent for ACT (versus 7%).

Reflecting their complex physical and mental health needs, far more ALC applicants requested wheelchair accessible housing (15% versus 1% of other applicants).

Support needs and safety risks were higher for ALC applicants (see Figures 4.9a and 4.9b):

- Over two thirds of ALC applicants were in the high needs group (10 to 22 support needs), compared to less than one third of other applicants.
- Support needs for the ALC group were higher than for other applicants across the support need categories, except support for drug and alcohol use, employability, education and English skills.
- ALC applicants far more often requested 24-hour support (26% versus 7%) or daily support (35% versus 13%).
- 58 percent of ALC applicants were in the high safety issues group (with 3 to 17 safety issues), compared to 37 percent of non-ALC.
- ALC applicants were much more likely than non-ALC applicants to have history of verbally abusing others (36% versus 4%), problems controlling anger (47% versus 25%), inappropriate sexual behaviour (14% versus 4%), violence against others (26% versus 11%). They also identified a higher risk of homelessness (67% versus 13%).
- ALC applicants were also more likely to have criminal justice involvement than other applicants (39% versus 25%).



**Figure 4.10a****Figure 4.10b**

12,733 applicants 2009 to 2015

Health Links applicants likewise have higher support needs and safety risks than other applicants (see Figures 4.10a and 4.10b), but to a lesser degree than the ALC group:

- 56 percent of Health Links applicants were in the high needs group (with 10 to 22 needs) compared to 36 percent of other applicants.
- Support needs were higher among Health Links applicants than among others for functional needs such as adding structure to their day (63% versus 51%), self-care (41% versus 26%), meal preparation (33% versus 22%), meal provision (26% versus 15%) and daily living skills (53% versus 18%).
- 56 percent of Health Links applicants were in the high safety issue group (with 3 to 17 issues) compared to 44 percent of non-Health Links applicants.
- Health Links applicants were more likely than non-Health Links applicants to have a history of alcohol use resulting in harm (39% versus 28%), verbally abusing others (22% versus 8%), and history or risk of homelessness (68% versus 24%).

## 4.7 Comparison of complex need groups

The analysis of characteristics and needs of complex needs groups points to some distinct clusters of applicants. This subsection highlights the main ways in which these several complex needs groups differ from each other. It should be borne in mind that there is overlap between these groups. For example, a person with support needs relating to substance use may also have criminal justice involvement and/or high inpatient use.

*Gender:* Applicants with substance use challenges, those with criminal justice involvement and those who were homeless and residing in hospital were all more like to be male than other applicants (respectively 64%, 70% and 69% versus 57% overall).

*Psychosis diagnosis:* Psychotic disorders were most common among ALC applicants (67%), those with high inpatient use (63%), those who were homeless and residing in a hospital (67%) and also Health Link applicants (44%). By comparison, the overall prevalence of psychotic disorders within the total sample was 33 percent. This diagnosis was less common among applicants with substance use challenges (26%).

*Co-occurring diagnoses:* Co-occurring mental health diagnoses were more common among Health Link applicants (55%) and people who were homeless and residing in jail/prison when they applied (41%) than among all applicants (25%).

*Substance use:* Just over a third of all applicants (36%) reported having substance use challenges. This was more prevalent among applicants with criminal justice involvement (54%), high ED use (50%) and homeless applicants who resided in jail when they applied (75%).

*High Inpatient use:* Overall, 12 percent of applicants had high inpatient use (50+ inpatient days in the previous two years). High inpatient use was more common among ALC applicants (48%), those with high ED use (24%), and homeless applicants residing in hospital when they applied (43%). It was less common

among applicants with substance use challenges and among people who were homeless and in jail/prison when they applied (3% and 5% respectively).

*Criminal justice involvement:* While 25 percent of all applicants had criminal justice involvement, it was more prevalent among applicants with substance use problems (40%) and among ALC applicants (39%).

*Support needs:* Needs related to managing alcohol and drug use and managing or avoiding crises were more common among applicants with substance use challenges, criminal justice involvement, high ED use or ALC status. In contrast, functional support needs related to in-home activities of daily living were more common among applicants with high inpatient use, people who were homeless, those residing in hospital when they applied and ALC and Health Link applicants.

The populations described above may be broadly clustered into three groups:

*(i) Applicants with substance use challenges, criminal justice involvement, or high hospital ED use:*

The three groupings of applicants with substance use challenges, criminal justice involvement, and high usage of hospital emergency departments had diagnostic profiles similar to each other, with similar rates of psychotic disorders and high rates of substance use problems. They also tended to have fewer functional support needs and more needs related to managing crisis and/or substance use. They more commonly requested occasional support.

*(ii) Applicants with high inpatient use or applying while homeless and in hospital:*

Applicants with high inpatient use, and those who were homeless and residing in hospital when they applied, were more likely than others to have a psychotic disorder and somewhat less likely to report substance abuse challenges. In addition, they were more likely to report more functional needs related to in-home activities of daily living such as self-care, meal preparation, and looking after the home. They were also more likely to request 24-hour or daily support.

*(iii) ALC and Health Link applicants:*

Health Link and ALC applicants had a combination of characteristics found in groups **i** and **ii** above. Compared to other applicants, the ALC and HL applicant groups both had high rates of functional needs and high rates of psychosis. Both had higher rates of co-morbidities (concurrent disorders, dual diagnosis and/or cognitive disorders). The ALC group (unlike Health Link clients) was more likely to have high inpatient use and criminal justice involvement and high support needs related to managing crises. The ALC group was more likely to request 24-hour or daily support while the Health Link group more commonly requested occasional support.

## 4.8 Summary and implications: Applicants with complex needs

### 4.8.1 Summary

- Many applicants reported substance use challenges, with more than one third identifying this as a problem and more than 40 percent reporting the presence of a concurrent disorder or problematic current substance use.
- Applicants' reporting of substance use challenges was associated with criminal justice involvement, high hospital emergency department (ED) use, and being homeless while residing in jail or a shelter or having no fixed address. It was also associated with support needs and safety issues related to managing crises.
- Having criminal justice involvement at the time of application was associated with being male, younger in age and homeless. It was also associated with having support needs related to managing crises and substance use problems. What most distinguished those with justice involvement was reporting past violence towards others and past problems controlling anger.
- There was considerable overlap between applicants reporting substance use challenges and those reporting criminal justice involvement, with respect to diagnosis, homelessness status, support needs, and housing preferences.
- Common features shared among applicants reporting high hospital use, homeless applicants residing in hospital, ALC applicants and Health Links applicants included the presence of a psychotic disorder, higher functional needs and preference for higher intensity (24-hour or daily) support.
- High ED utilization was associated with the presence of a personality disorder, substance abuse, past suicide attempts and self-harm behaviours, suicidal ideation, and with support needs related to avoiding unsafe situations.

### 4.8.2 Implications: Applicants with complex needs

#### Substance use

- a) **There is great need to provide more housing options and suitable support to people with problematic substance use, through evidence-based interventions, more provider capacity and targeted housing.**

The prevalence of alcohol and drug use problems, and their association with criminal justice involvement, high hospital emergency use, and homelessness, underscore the need for strategies targeted at meeting the needs of this service population. Among these is integrating substance abuse interventions within the support services delivered by supportive housing providers. Provision of more staff training on evidence-based interventions targeting these issues may increase providers' ability to house and support these applicants. For example, Integrated Dual Disorders Treatment (IDDT) for concurrent disorders is an evidence-based

effective approach,<sup>27</sup> and is the recommended way to address co-occurring mental health and substance abuse conditions in the Pathways Housing First model.<sup>28</sup> In IDDT, addictions services and mental health supports come from the same team of providers. IDDT provides a harm reduction framework and incorporates psychotherapeutic modalities including motivational interviewing, cognitive behavioural therapy (CBT), Stages of Change, and self-help groups. While CBT and group interventions may remain the focus of concurrent disorder specialists, motivational interviewing and knowledge of the Stages of Change should be core clinical skills that all housing support staff should be trained in and able to provide.<sup>29</sup>

There is also a need to make available more specialized addiction-targeted supportive housing. This would include more housing with a low-barrier assessment process, few preconditions and a Housing First approach to placement. This would also be paired with an ability to offer types of support that respond to the complex, related safety risks. Feedback from providers indicates that people with active and severe addictions can sometimes be destabilizing to other tenants and impinge on their tenancy rights, a concern that is congruent with the concerns expressed by residents,<sup>30</sup> especially in congregate housing. There is a need for expansion of specialized addictions programs, including programs with less stringent intake criteria than SHPPSU – congruent with changes now emerging among SHPPSU providers.

### **Criminal justice involvement**

#### **b) The prevalence of criminal justice involvement among applicants points to a need for assessments and services that are targeted to needs related to risk of re-offense.**

Support services and assessments must address criminal behaviour risks as well as mental health. The safety risks reported by Access Point applicants with criminal justice involvement – problematic alcohol and drug use, physical assault and violence towards others – are consistent with correlates of criminal justice involvement identified in the research literature.<sup>31</sup> Addressing applicants' needs in these matters as well as in mental health is essential for personal recovery and to avoid further criminal justice involvement.<sup>32</sup> Other research points to using comprehensive assessments, which include information on individual pathways to criminal justice involvement, clinical needs, strengths and protective factors, and social and community support needs. These can be a basis for developing individualized treatment and service plans. Recognized, existing tools that are not widely used by mental health and addictions supportive

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<sup>30</sup> See also Dream Team (2015), *Towards a New Bill of Rights: The Voice of Tenants in Permanent Supportive Housing*, 29-31.

<sup>31</sup> Sirotych, F. (2008). Correlates of crime and violence among persons with mental disorders: An evidence-based review. *Brief Treatment and Crisis Intervention* 8: 171-184. Retrieved from: <http://btci.edina.clockss.org/cgi/reprint/8/2/171.pdf>

<sup>32</sup> Substance Abuse and Mental Health Services Administration. (2017). *Guidelines for Successful Transitions of People with Mental or Substance Use Disorders from Jail or Prison: Implementation Guide*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from: <http://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998>.

housing providers<sup>33</sup> can be introduced to supplement and complement providers' existing assessment methods and tools, to guide program placement and service delivery.

### Homelessness

- c) **The high percentage of applicants residing in shelters or who are otherwise homeless points to the importance of coordinating the mental health supportive housing system with the municipal systems of housing and homeless-related services.**

Many people applying to The Access Point for supportive housing are residing in emergency shelters or have no fixed address. The population served by The Access Point and participating Health-funded providers therefore overlaps considerably with the population served by the municipally funded and administered system of homeless-related services and housing.

The overlap and intersections between the two systems extend beyond homeless shelter users seeking housing through The Access Point. The Streets to Homes program offers rapid access to housing with time-limited follow-up supports; Habitat Services is jointly funded; "alternative" housing providers house a population with comparable homeless histories and substance use issues. Homeless applicants are at least one fifth of placements into municipally funded and administered social housing, while LHIN-funded mental health supports have been introduced in some municipal housing.<sup>34</sup> New Ministry of Housing initiatives<sup>35</sup> reinforce the municipal role in housing and supporting populations, including people experiencing chronic homelessness or discharged from provincial institutions that are among The Access Point applicants.

This suggests a need for more coordination between the mental health and addictions supportive housing system, including The Access Point, and the municipally funded and administered systems of homeless-related services and social housing. While recognizing that both systems face pressures of large needs and constrained resources, better coordination can help serve people effectively and efficiently. This would be congruent with the provincial priority<sup>36</sup> of greater collaboration between service managers and LHINs in supportive housing.

- d) **Many homeless applicants in shelters or with no fixed address have urgent housing needs but often report only moderate support needs and request only occasional support. This may reflect their need and preference for low-barrier, less intrusive supports and services.**

The shelter/NFA homelessness group has a somewhat distinct balance of housing and support needs. This group includes people who are staying in homeless emergency shelters, who have no fixed address, or who reside in temporary living situations when they apply. Their housing-related needs are relatively urgent, but their support needs and in some cases safety risks are typically lower than for other applicants.

The mental health and addictions supportive housing system, including The Access Point, is not well designed to meet these urgent housing needs in a timely way. Prioritizing on the basis of

<sup>33</sup> In particular, the Level of Service Inventory-Revised – a validated 54-item need assessment that identifies psychosocial problem areas in an individual's life and predicts criminogenic risk – is a useful resource.

<sup>34</sup> See Suttor (2016), *Taking Stock of Supportive Housing for Mental Health and Addictions in Ontario*; social housing placement data from Housing Connections at p. 44.

<sup>35</sup> Ministry of Housing (2017), *Home for Good (HFG): Expression of Interest*.

<sup>36</sup> Ontario (2017), *Ontario Supportive Housing Policy Framework*.

homelessness has been suggested in recent official reports to the Ontario government.<sup>37</sup> However, in Toronto the large numbers of homeless applicants, exceeding the available housing openings, means that this is not possible. Any such approach would create a great disadvantage to other applicants. Yet there is a need to provide homeless applicants with more rapid access to supportive housing than is possible at present through The Access Point system.

### High hospital use

#### e) **Evidence-based support models should be targeted at applicants with high use of acute care services.**

The findings show an association between high ED utilization, the presence of a personality disorder, safety issues and support needs related to past suicide attempts, self-harm and avoiding crises. Evidence-based service interventions that can help to reduce these adverse events may be incorporated into the services that support staff offer or provided as adjunctive interventions. For example, there is growing evidence to support the efficacy of dialectical behaviour therapy (DBT) for reducing suicide attempts, self-harming behaviour and use of emergency and inpatient services among individuals with borderline personality disorder.<sup>38</sup> There is also evidence to support incorporating components of DBT into the delivery of case management services, as a way to decrease suicide attempts, suicidal ideation and related use of crisis services.<sup>39</sup>

Similarly, the prevalence of psychotic disorders among ALC and HL applicants, homeless applicants residing in hospital, and those with high inpatient use, point to the role of evidence-based interventions for individuals with psychosis. For example, cognitive behavioural therapy (CBT) as an intervention for psychosis has been found to reduce hospital admissions,<sup>40</sup> positive symptoms and depressive symptoms,<sup>41</sup> and some of these benefits are found when CBT is used by case managers under clinical supervision.<sup>42</sup>

#### f) **Flexible support models may be considered for applicants with high inpatient use.**

In addition to incorporating specific psychosocial interventions into the services that providers offer, flexible community support models of care may be utilized to support applicants with high inpatient use. For example, flexible assertive community treatment (FACT) service models which combine ACT and ICM community care models within one multidisciplinary team have been

<sup>37</sup> The 2016 Ontario Provincial Auditor's report recommended that the Ministry evaluate whether homeless applicants get priority access to supportive housing. Office of the Auditor General of Ontario (2016), *2016 Annual Report*, p. 401.

<sup>38</sup> Kliem, S., Kröger, C., & Kosfelder, J. (2010), Dialectical behavior therapy for borderline personality disorder: a meta-analysis using mixed effects modelling. *Journal of Consulting Clinical Psychology* 78(6): 936–951.

<sup>39</sup> Linehan, M.M., Karslund, K.E., Harned, M.S., Gallop, R.J., Lungu, A., Neacsiu, A.D., McDavid, J. Comtois, K.A., Murray-Gregory, A.M. (2015), Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *JAMA Psychiatry* 72(5): 475–482.

<sup>40</sup> National Collaborating Centre for Mental Health (2014), *Psychosis and schizophrenia in adults: treatment and management*. National Institute for Health and Care Excellence, London. Retrieved from <http://www.guideline.gov/content.aspx?id=47863>.

<sup>41</sup> Rathod, S. & Turkington, D. (2005), Cognitive-behaviour therapy for schizophrenia: A review. *Current Opinion in Psychiatry* 18(2): 159-163.

<sup>42</sup> Turkington, D. Munetz, M., Pelton, J., Monesano, V., Sivec, H.J. et. al. (2014), High-yield cognitive behavioral techniques for psychosis delivered by case managers to their clients with persistent psychotic symptoms: An exploratory trial. *Journal of Nervous Mental Disorders* 202(1): 30-34.

found to decrease inpatient utilization among individuals with psychosis<sup>43</sup> and, more generally, among individuals with mental health conditions.<sup>44</sup> These teams provide individual case management for clients with low support needs and shared caseloads with an intensive full ACT approach for clients with current acute care needs, affording step-up and step-down service intensity as needed. FACT may work particularly well for applicants with higher inpatient utilization that request 24-hour or daily support; it would enable service providers to house some people with these needs in scattered unit supportive housing, providing a high level of support initially and reducing support over time. FACT may help to avoid bottlenecks, because residents do not need to move to different housing or change their case managers as their support needs decrease over time.

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<sup>43</sup> Sood, L., Owen, A., Onyon, R., Sharma, A., Nigriello, J., Markham, D. & Seabrook, H. (2017). Flexible assertive community treatment (FACT) model in specialist psychosis teams: An evaluation. *British Journal of Psychiatry Bulletin*, 1-5. Retrieved from:

<http://pb.rcpsych.org/content/pbrpsych/early/2017/01/06/pb.bp.116.053967.full.pdf>

<sup>44</sup> Firn, M., Hindhaugh, K., Hubbeling, D., Davies, G., Jones, B., & White, S.J. (2013). A dismantling study of assertive outreach services: Comparing activity and outcomes following replacement with the FACT model. *Social Psychiatry and Psychiatric Epidemiology* 48(6): 997-1003.



## 5. Process and outcomes

Who gets housed sooner and who waits longer? In what ways is this associated with certain characteristics, support needs or safety risks? This section analyses these questions in several ways.

The first subsection provides context, explaining the application and referral process. Key statistics on numbers of applicants were provided in section 1.1.

Subsection 5.2 deals with wait times. This includes an overview and an analysis in terms of key parameters from earlier sections of this report, such as diagnosis, substance use, homelessness, high hospital use, and criminal justice involvement. There is also a special analysis of the people who wait longest for housing.

Subsection 5.3 deals with service request outcomes. When The Access Point refers a person to a provider for an available housing unit, he or she may get housed, may refuse the provider's offer of housing, or may be declined by the provider. These are alternative outcomes, and this analysis considers what characteristics and needs are associated with such different outcomes.

The final subsection (5.4) presents implications and conclusions from this process and outcomes analysis.

### 5.1 Context: The application and referral process

The Access Point has a standardized application and screening process to determine eligibility for supportive housing and to match applicants to available housing vacancies. This process is illustrated in Figure 5.1.

The Access Point utilizes a first level screening approach,<sup>45</sup> which involves initial screening of service requests from referral sources and matching to available housing providers. Supportive housing providers in turn assess applicants for specific vacancies, verify eligibility and make the final admission decision.

- The process begins with a referral source completing a service request (Step A). Referrals sources complete and submit a common application form, which collects basic demographic, clinical, service need and housing preference information. A referral source may initiate multiple service requests through the submission of the same application. For example, they may request supportive housing from each of the three supportive housing programs (Mental Health Supportive Housing, Supportive Housing for People with Problematic Substance Use, and Mental Health and Justice Initiative).

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<sup>45</sup> Rush, B. & Saini, B. (2016). Review of Coordinated/Centralized Access Mechanisms: Evidence, Current State, and Implications, Report submitted to the Ontario Ministry of Health and Long-Term Care. Retrieved from: <http://www.addictionsandmentalhealthontario.ca/coordinated--centralized-access.html>

- The Access Point receives and processes the application and reviews the eligibility of the applicant for each service requested against common eligibility criteria (Step B). The Access Point uses self-developed tools to determine eligibility and the level of housing support required.
- At this initial screening stage, The Access Point determines which supportive housing programs an applicant is eligible for and what level of support is needed, and then places the applicant on the respective wait lists for each program (Step C). For example, if an applicant applies to the MSHS and MHJI supportive housing programs and is eligible for both programs, the applicant is placed on separate waitlists for MSHS and MHJI housing.

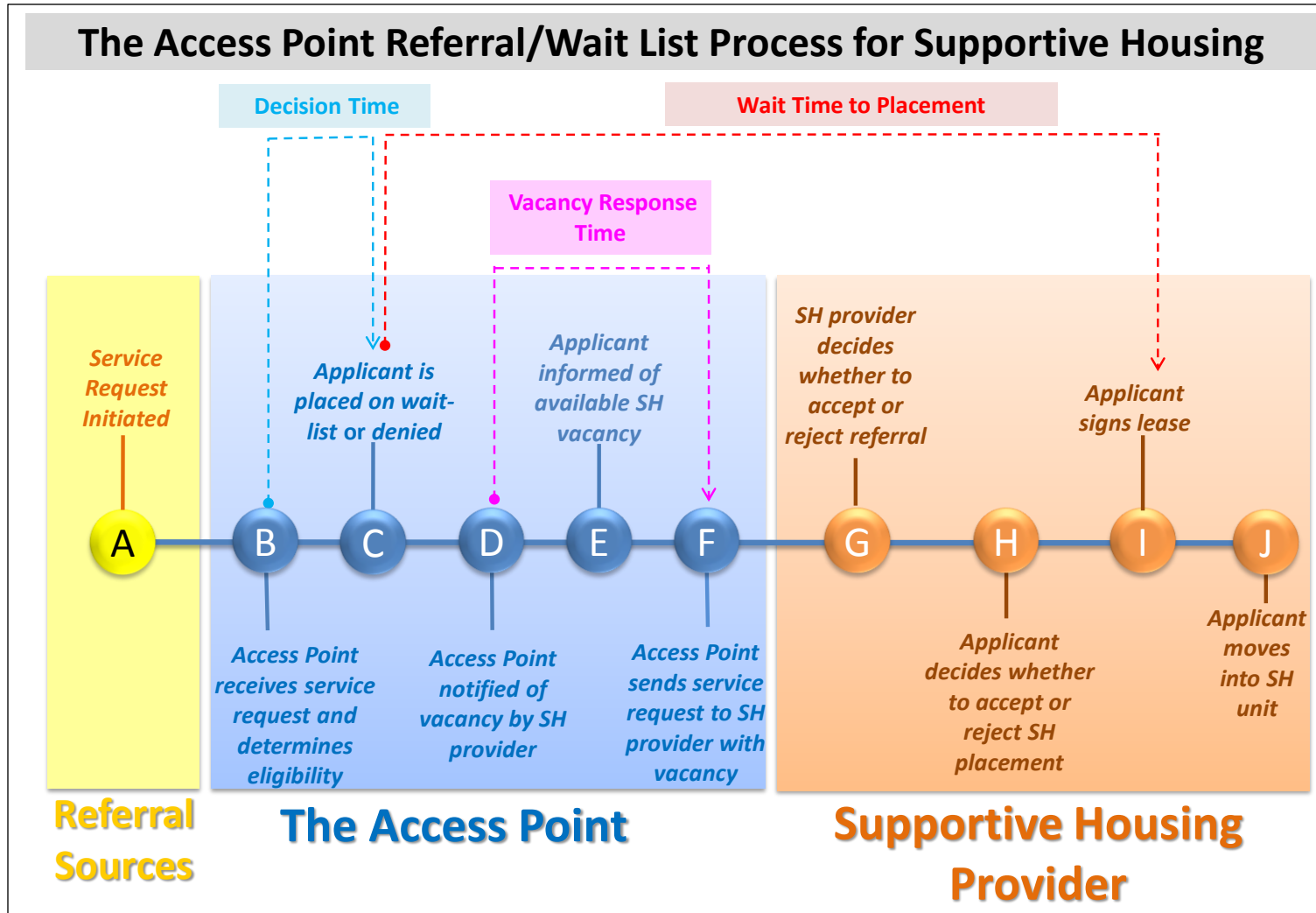
*The time between the receipt of the service request and eligibility determination by The Access Point is referred to as the Decision Time (Step B to Step C).*

- Applicants begin their wait for housing once placed on the relevant wait lists of the housing programs for which they are eligible. In most instances, applicants wait until The Access Point receives notification by a supportive housing provider of a housing vacancy (Step D).
- The Access Point then matches the first eligible applicant on the waitlist for the vacancy based on applicants' reported housing preferences (e.g. unit location, congregate versus self-contained unit) and informs the first eligible applicant of the match (Step E).
- If the first eligible applicant provides consent, The Access Point sends the applicant's service request to the service provider with the housing vacancy (Step F). If the applicant cannot be reached or does not provide consent to have his or her service request sent to the housing provider, The Access Point identifies the next eligible applicant on the wait list for the vacancy. Applicants are selected chronologically from the wait list for the housing program for which they are eligible. This process is repeated until an eligible applicant is identified and provides consent to be referred to the housing provider.

*The interval between the provider notifying The Access Point of a vacancy, and the service request being sent to the provider, is referred to as the vacancy response time.*

In some instances, a push process is utilized whereby a service request is sent to a housing provider that is known to have ongoing vacancies. In these circumstances, notification of a specific vacancy (Step D) does not occur, and the service request is sent directly to a housing provider based on the housing provider's eligibility criteria for these ongoing open vacancies. This push process is employed with housing providers that have a large volume of units with higher turnover rates, such as large boarding home operators (e.g. Habitat).

Figure 5.1



This diagram is adapted from Toronto Central LHIN (n.d.), "Coordinated Access to Supportive Housing and Access 1 Wait List Process" (Presentation slides).

- After a service request is sent to a housing provider, the provider assumes responsibility for contacting the applicant, confirming eligibility and notifying the applicant and The Access Point of whether the applicant will be accepted into the available housing vacancy. Specifically, the housing provider reviews the information from the common application form, conducts an intake assessment, verifies an applicant's eligibility for the housing vacancy and makes a determination of whether or not to offer the vacancy to the applicant (Step G). If the service provider declines the service request, The Access Point is notified, and the applicant's service request is maintained in the same position on the wait list for the service/program they requested. If the service provider accepts the service request, the applicant is offered the housing vacancy by the provider.
- After visiting the available housing unit, the applicant may either accept or refuse the housing offer (Step H). If the applicant refuses the housing offer, the housing provider notifies The Access Point and the applicant's service request is returned to the same position on the wait list. An applicant may refuse up to three housing offers, after which they are returned to the bottom of the wait list. An applicant however can modify their service request at any time (e.g. request a different type of housing or housing location).
- If the applicant accepts the housing offer, the applicant is admitted to the specific supportive housing opening (Step I) and signs a rental agreement with the housing provider before moving in to the housing unit (Step J). In this report, the completion of Step J is referred to as placement in supportive housing.

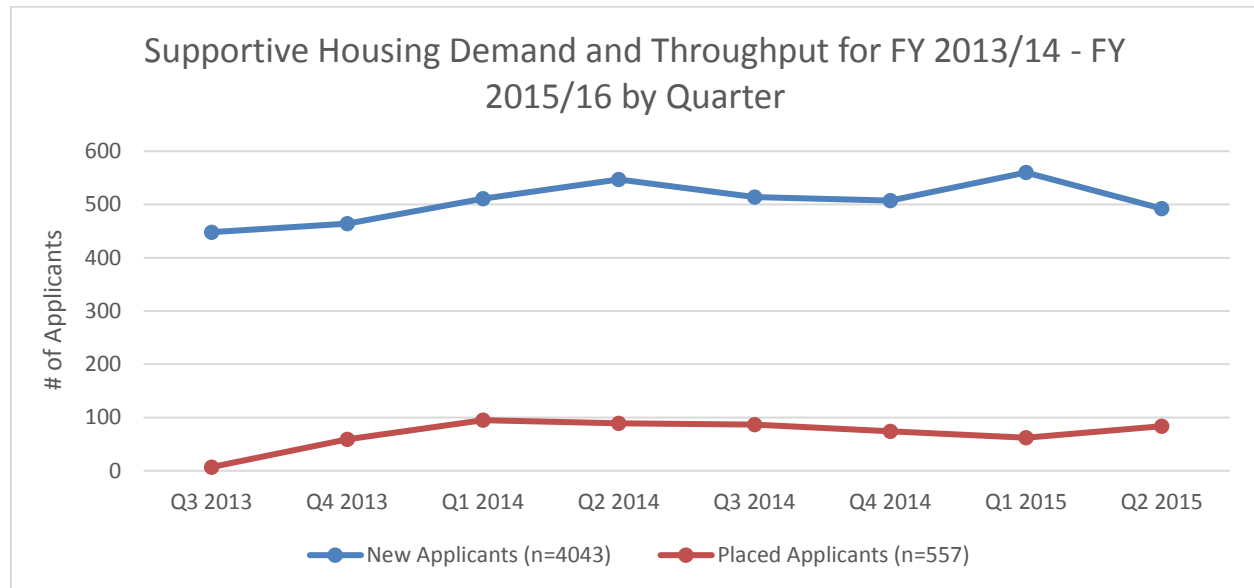
*The time between an applicant being placed on a wait list for housing (Step C) and admission or placement into supportive housing (Step I) is the wait time to placement.*

Though the vast majority of housing applicants are placed in housing through the process described above, some applicants waiting for housing are placed directly into housing by a housing provider. That is, the housing provider admits an applicant directly from a housing wait list based on an existing partnership arrangement with other service providers. For example, an applicant receiving case management by one organization may be given direct access to a supportive housing unit operated by a housing provider because of a partnership between the case management and housing providers. Where this occurs, The Access Point is informed that the applicant was placed into housing and the applicant's existing service request is closed.

## Demand for supportive housing and throughput

Between October 1, 2013 and September 30, 2015, 4043 applicants within the sample used in this study were put on the supportive housing waitlist. Within the same period, 557 applicants were placed in supportive housing.<sup>46</sup> Figure 5.2 illustrates the number of new applicants put on the waitlist and the number placed by fiscal quarter. The rate of new applicants and applicants placed over time has been relatively stable, though demand for supportive housing far outstrips throughput.

**Figure 5.2**



## 5.2 Wait times

To what extent have wait times varied for applicants with different characteristics and needs? What are the characteristics of applicants on the waitlist who wait the longest for housing? These questions are addressed below. This section examines the wait times of applicants placed in supportive housing by characteristics of the applicant; extent of support needs; and support intensity received (24-hour, daily, occasional). There is also a comparison of applicants in the top 10 percent of the waitlist to those in the bottom 90 percent in order to identify the characteristics of those applicants waiting the longest.

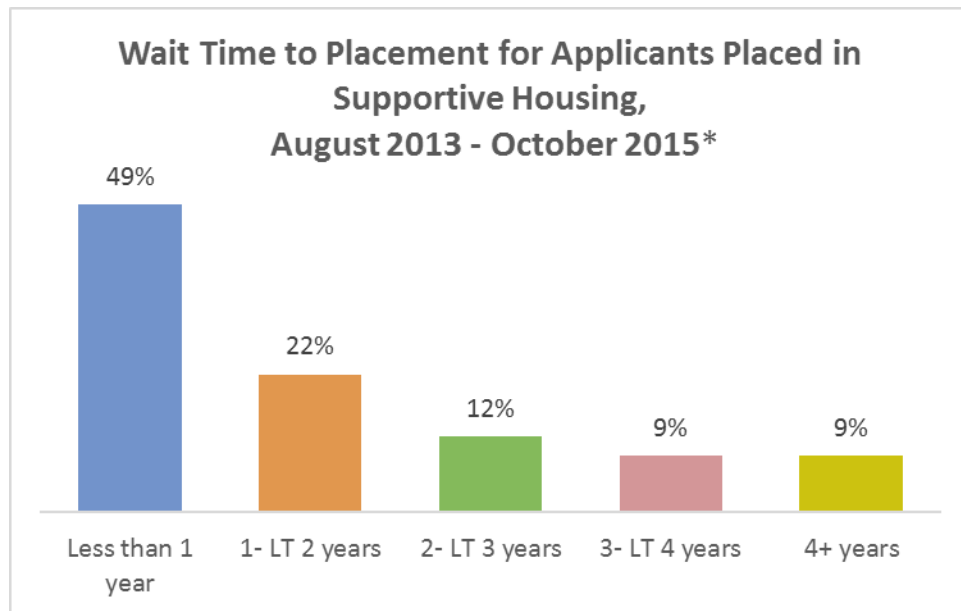
### Overview of wait times

Between August 2013 and October 2015, there were 772 unique applicants placed in supportive housing. Of these applicants, 642 (83%) had data available on wait time to placement. Wait time was

<sup>46</sup> Reliable wait time data was not available prior to August 2013. In addition, 17 percent of applicants placed after August 2013 did not have wait time data available. We excluded cases referred or placed prior to August 2013 and cases with missing placement dates (N=130) among those placed after August 2013.

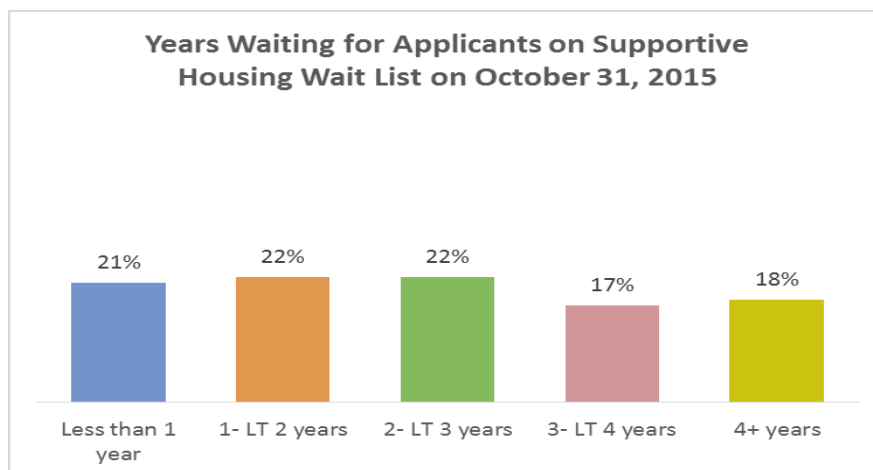
calculated from the date that an applicant was found to be eligible for supportive housing by The Access Point to the date they were admitted into supportive housing and signed a lease with a housing provider (Step C to Step I). The median wait time to placement was 393 days, with a range between 0 and 4802 days. Nearly half of applicants placed were placed in less than one year. Figure 5.3 below illustrates the distribution of wait times to placement for applicants placed after August 2013.

**Figure 5.3**



*N=642 applicants placed, excludes 130 (17%) applicants with missing wait time data. LT= "less than."*

**Figure 5.4**



*N=7767 applicants waiting for supportive housing on October 31, 2015.*

Among applicants on the supportive housing waitlist at the end of the study period (N=7767), nearly 60 percent have been waiting for housing for two or more years and those waiting longest (top 10% on the waitlist) have been waiting 4.5 years or longer. Wait time for those still waiting for housing was calculated from the date that an applicant was found to be eligible for supportive housing by The Access Point to October 31, 2015. The distribution of wait times for applicants on the waitlist at the end of the study period is illustrated in Figure 5.4.

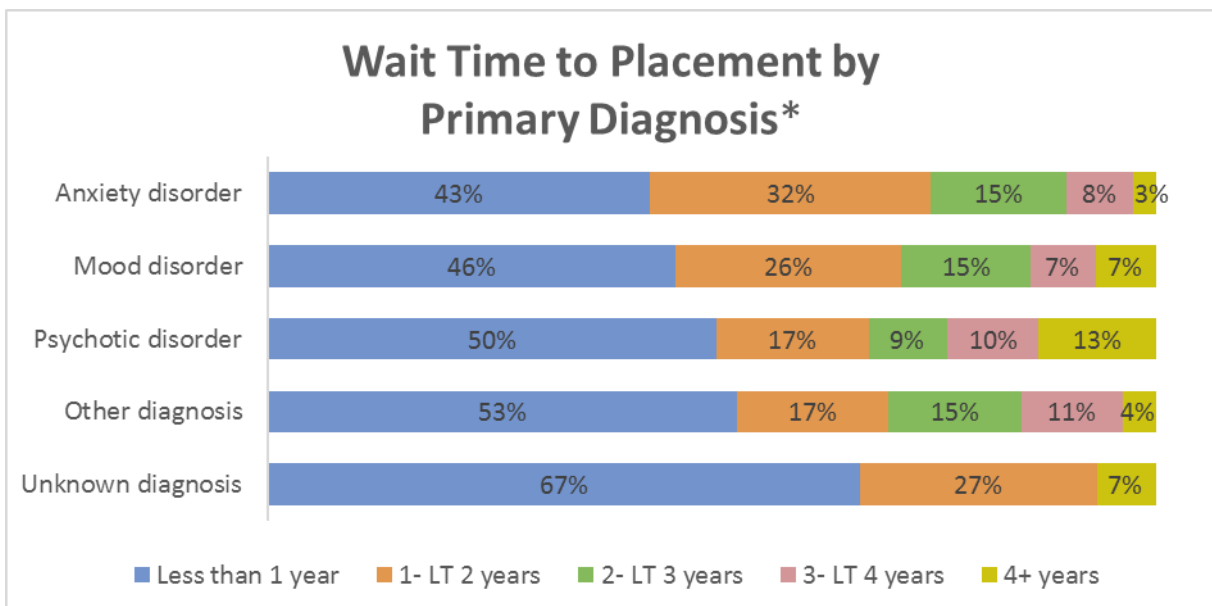
## Wait times to placement by applicant characteristics

### ***Diagnosis:***

The wait times for supportive housing were examined by diagnostic grouping as reported at the time of application (see Figure 5.5). The differences in time to placement across diagnostic groups was not statistically significant, but showed the following patterns by primary diagnosis:

- Anxiety disorder: median wait time of 427 days. Compared to other applicants, they were more likely to be placed in one to two years
- Mood disorder: median wait time of 461 days
- Psychotic disorder: median wait time of 357 days
- Other diagnoses: median wait time of 284 days
- Primary mental health diagnosis not known: this group had the shortest wait time with a median of 249 days. More than 90 percent were placed within two years

**Figure 5.5**

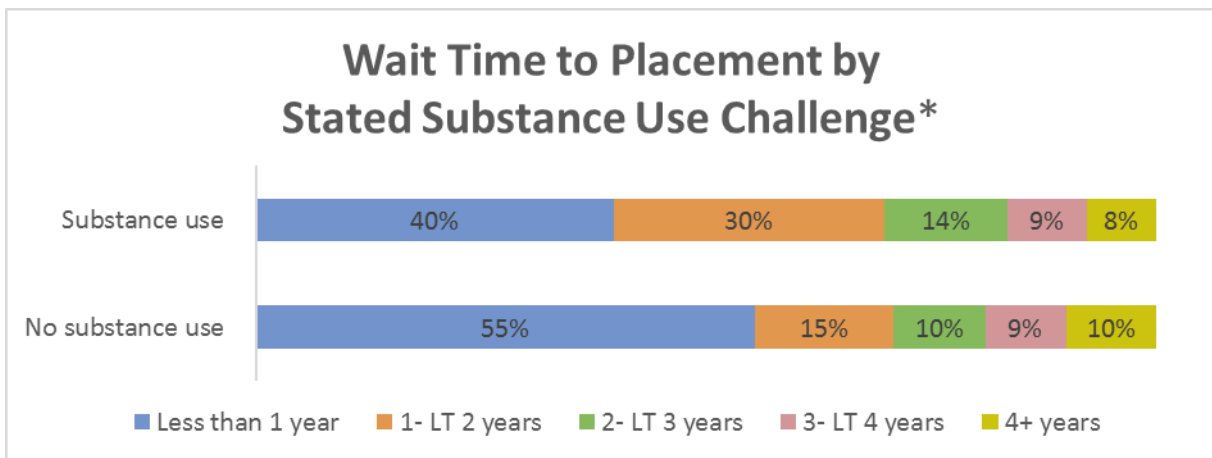


\*N=642 applicants placed between August 2013 and October 2015.  
Excludes 130 (17%) applicants with missing wait time data.

### ***Substance use challenges:***

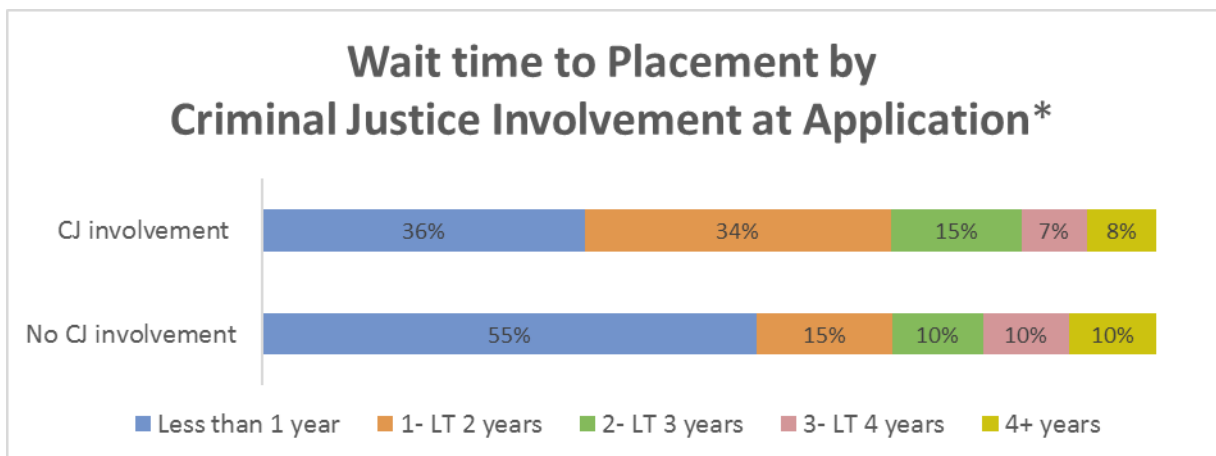
Applicants with reported substance use issues had a longer time to placement than other applicants: median 489 versus 256 days (see Figure 5.6). Applicants with no substance use needs were more likely to be placed in less than one year, while applicants with substance use needs were more likely to be placed in housing one to two years after being found eligible for supportive housing. The two groups were otherwise similar in their wait times.

**Figure 5.6**



*N=642 applicants placed between August 2013 and October 2015.  
Excludes 130 (17%) applicants with missing wait time data.*

**Figure 5.7**



*\*N=642 applicants placed between August 2013 and October 2015.  
Excludes 130 (17%) applicants with missing wait time data.*



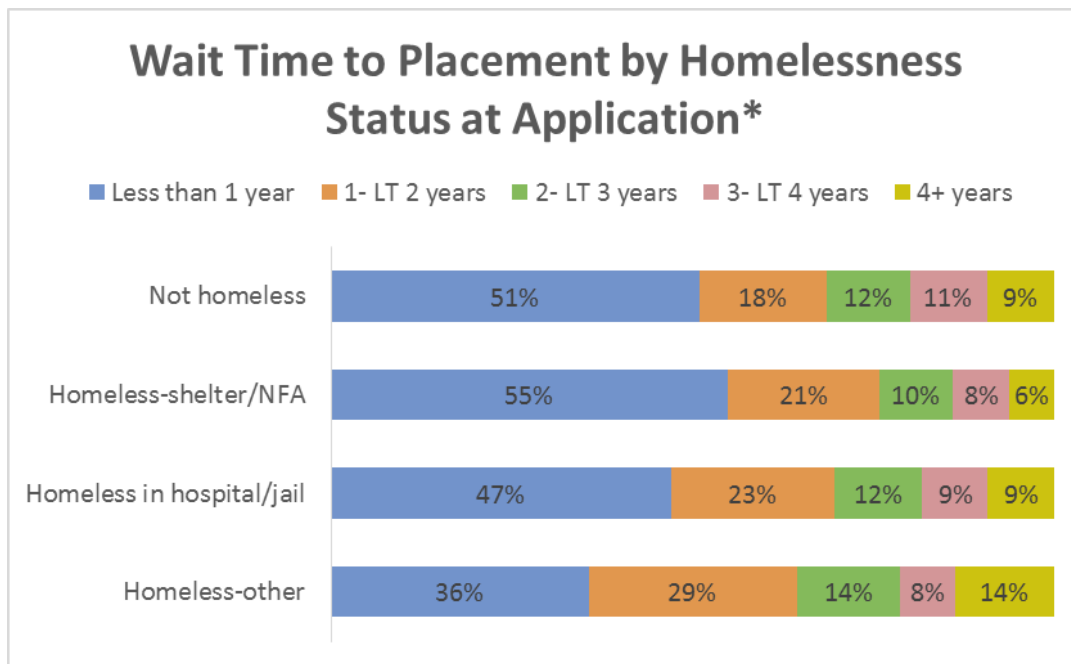
***Criminal justice involvement:***

Similarly, people with criminal justice involvement when they applied had longer wait times to placement than other applicants: median 494 versus 249 days (see Figure 5.7). Applicants with criminal justice involvement were more likely to be placed in housing one to two years after being put on the waitlist, while those with no criminal justice involvement were more likely to be placed within one year. However, 70 percent of both groups were placed in housing within two years.

***Homeless status:***

There was little difference in wait times among applicants on the basis of homelessness status at the time a person applied (see Figure 5.8).

- Among applicants who were not homeless when they applied, the median wait time to placement was 343 days.
- Applicants who were homeless and residing in an institution, such as a hospital or jail, had a median wait time of 391 days.
- Applicants who resided in a shelter or had no fixed address when they applied had the shortest wait to placement, with a median wait time of 265 days. Compared to other applicants, they were more likely to be placed within one year of application.

***Figure 5.8***

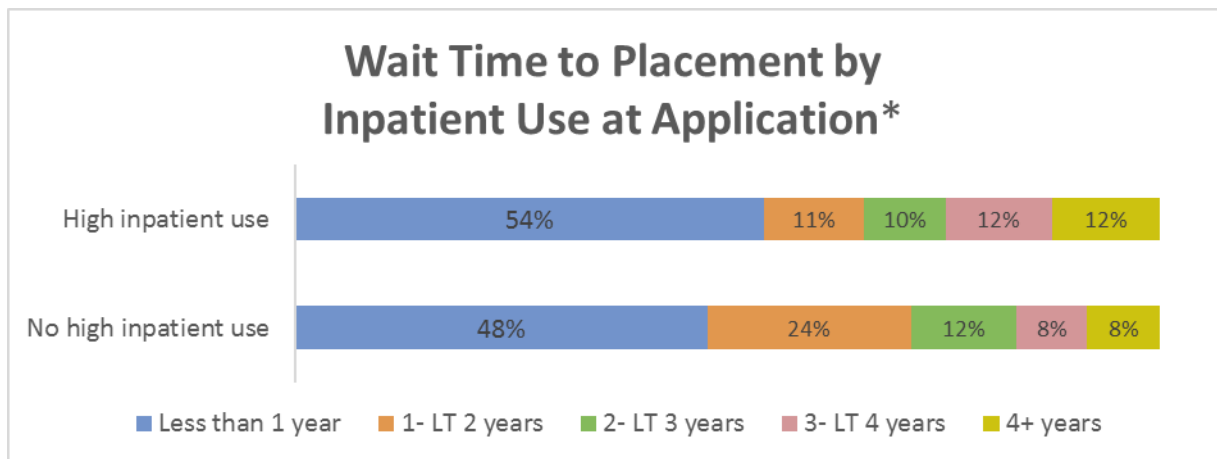
*\*N=642 applicants placed between August 2013 and October 2015.  
Excludes 130 (17%) applicants with missing wait time data.*

- Applicants who reported being homeless and who resided in a setting other than an institution or shelter had the longest wait to placement, with a median wait time of 535 days. Compared to other applicants, they were less likely to be placed within one year and more likely to be placed one to two years after being put on the waitlist.

**High inpatient use:**

- Applicants with high inpatient use (50+ inpatient days in the past two years) had modestly shorter wait times to placement than other applicants: median 308 versus 420 days. Applicants with no or limited hospital use were more likely than the high hospital use group to be housed one to two years after being placed on the wait list. Overall, the differences in wait times between these two groups was minor (see Figure 5.9).

**Figure 5.9**



*\*N=642 applicants placed between August 2013 and October 2015.  
Excludes 130 (17%) applicants with missing wait time data.*

## Wait times by support needs and intensity

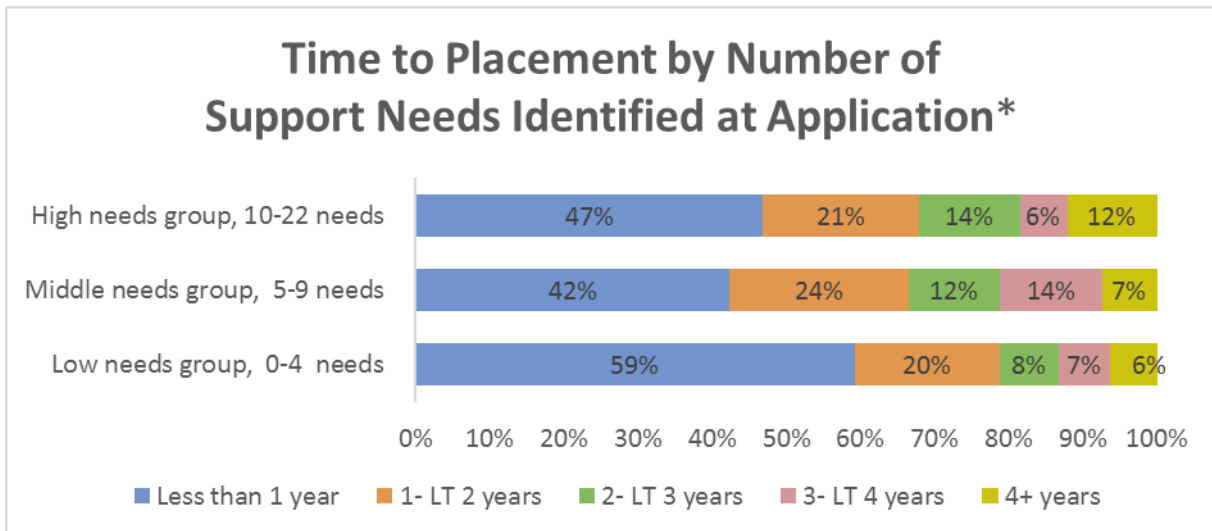
**Number of support needs reported:**

There were small differences in wait times to placement among applicants with low, medium and high needs. Those with low needs were more likely to be placed sooner, but the medium and high needs groups were similar to each other (see Figure 5.10).

- Applicants with low support needs (i.e. four or fewer support needs identified when they applied) had the shortest median wait time: 224 days to placement. Nearly 60 percent were placed within the first year.

- Applicants with a medium level of support needs (i.e. five to nine support needs identified when they applied) had a median wait time of 457 days.
- Applicants with high support needs (i.e. ten or more support needs identified when they applied) had a median wait of 439 days. They were modestly more likely to be placed after four years.

**Figure 5.10**



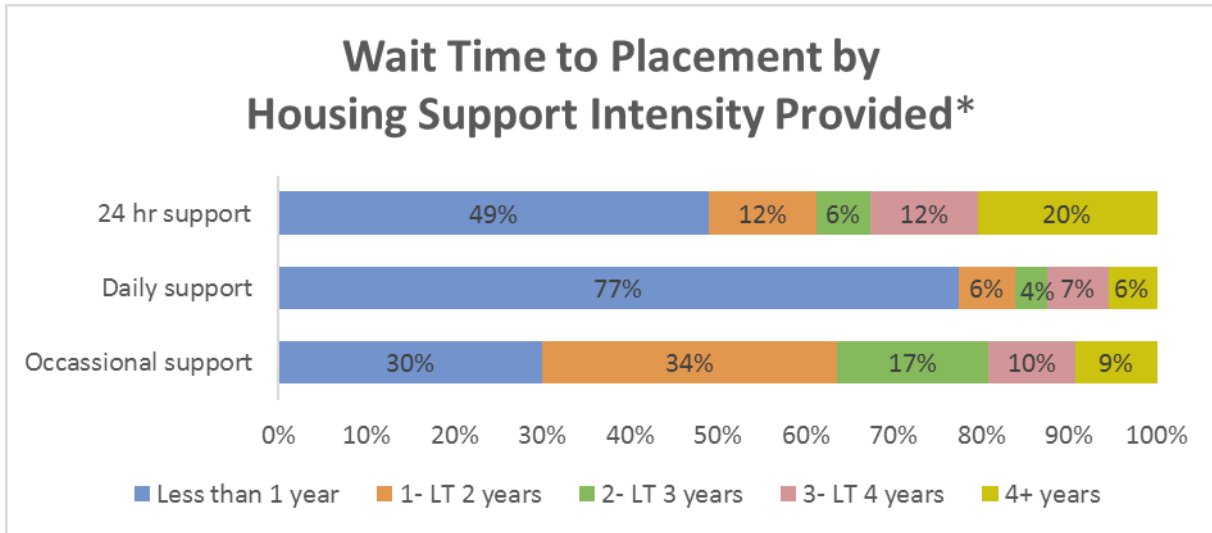
*\*N=642 applicants placed between August 2013 and October 2015.  
Excludes 130 (17%) applicants with missing wait time data.*

### **Support intensity provided:**

There were notable wait time differences for housing with different support intensity (see Figure 5.11). People were placed earliest in housing with daily support.

- Applicants placed in housing with 24-hour support had a median wait time to placement of 383 days. Nearly 50 percent of this group was placed within one year.
- Applicants placed in housing with daily support had the shortest wait time with a median of 274 days. Nearly 80 percent of these applicants were placed in less than one year.
- Applicants placed in housing with occasional support had the longest wait to placement with a median wait time of 578 days. 30 percent of these applicants were placed within one year.

The shorter wait times for housing with daily support may be the result of the availability of boarding homes, which offer rapid placement and often have high turnover.

**Figure 5.11**

*\*N=579 applicants placed between August 2013 and October 2015.*

*Excludes 193 applicants with missing wait time or support level data.*

*\*The specific level of support that applicants were placed within was not available for 63 applicants. These applicants were excluded from the above analysis.*

### Wait times of partnership applicants

It might be expected that partnership applicants would have a shorter wait time to service than other applicants by virtue of being given direct access to a housing unit by a supportive housing provider. Although partnership applicants had a shorter median wait time to placement than non-partnership applicants (median 294 versus 421 days), the difference was not statistically significant.

### Characteristics of applicants with the longest wait times

This subsection examines the characteristics of applicants waiting for supportive housing (as of October 31, 2015) who have the longest wait times. This category is defined here as those at or above the 90<sup>th</sup> percentile – in other words, the 10 percent of applicants who have waited the longest (1,661 days or longer). The 775 applicants in the longest-wait group are compared to the 6,992 applicants who were still waiting but had shorter wait times.

[Table 18](#) displays the characteristics of each of these groups, which were derived from their applications for supportive housing.

#### **Characteristics:**

Compared to other applicants, applicants with the longest wait time were:

- more likely to be over 34 years of age (83% versus 69%). Gender distribution was similar for both groups.
- less likely to be homeless at application (32% versus 50%). They were also less likely to be living in a shelter or have no fixed address (15% versus 26%) and more likely to be residing in a congregate living environment (18% versus 9%) or in non-congregate subsidized housing (16% versus 10%) when they applied for supportive housing.
- more likely to be receiving ODSP income (64% versus 50%) and were less likely to receiving Ontario Works (10% versus 23%).

***Diagnostic, substance use, hospital and correctional profile:***

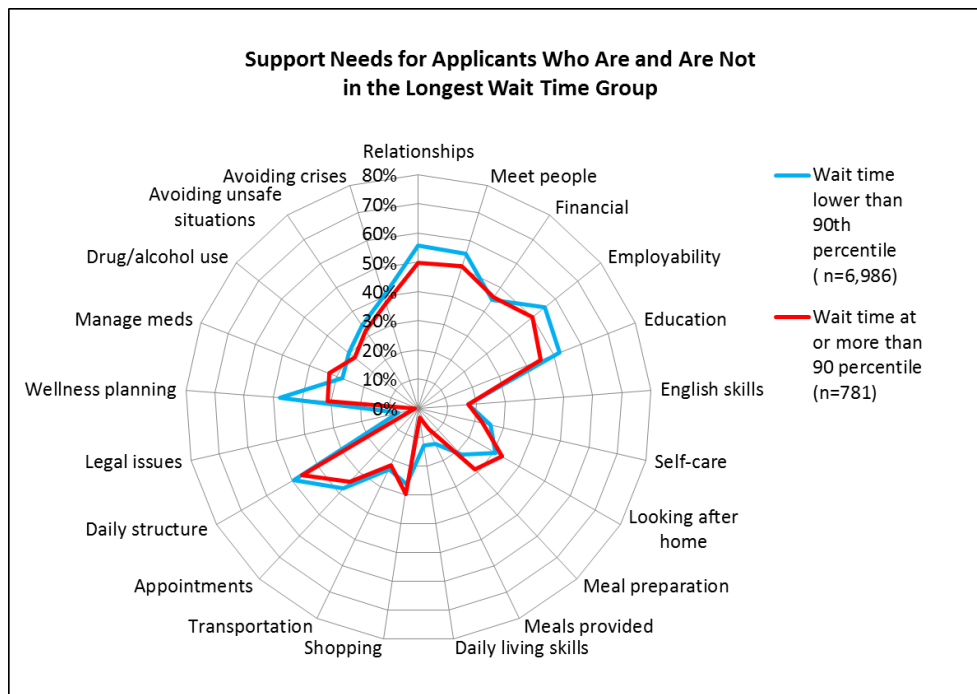
Applicants who had been waiting the longest were:

- more likely to have a primary mental health diagnosis of psychosis (47% versus 30%), while the shorter wait time group more commonly had diagnoses of mood disorders (41% versus 27%) or anxiety disorders (17% versus 11%).
- less likely to have co-occurring mental health conditions (18% versus 33%).
- less likely to have substance use challenges (29% versus 35%).
- more likely to have been hospitalized in the past two years for mental health reasons (44% versus 39%) but less likely to have any criminal justice involvement (18% versus 24%).

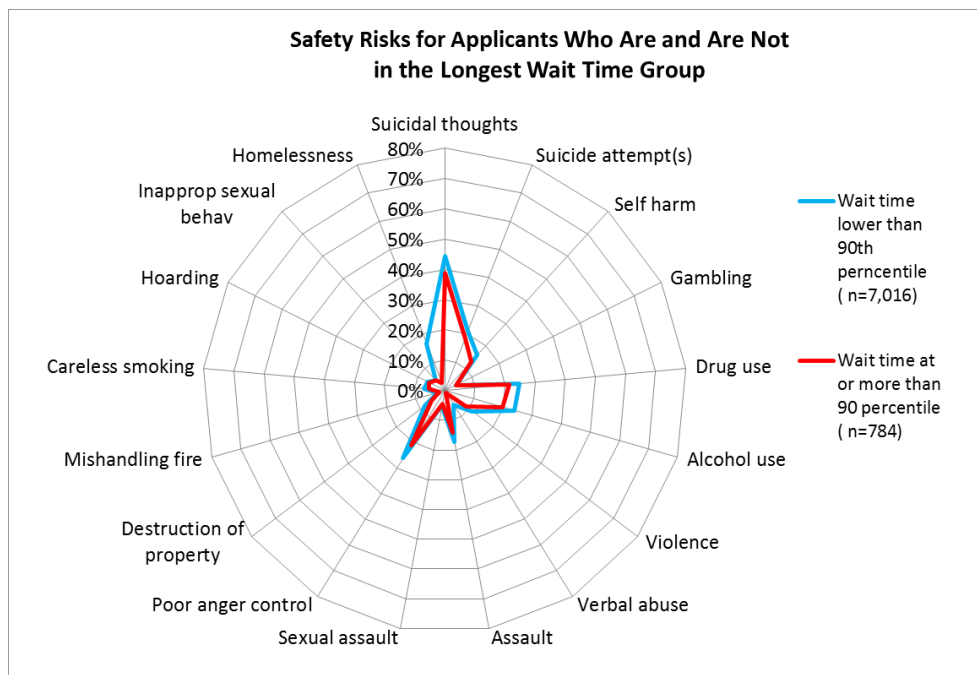
***Support needs and safety risks:***

- Applicants with the longest wait times were less likely to identify ten or more support needs when they applied (25% versus 31%). There were only modest differences between groups in their reported support need profiles (see Figure 5.12a).
- Applicants waiting the longest also reported a smaller number of risk behaviours: 30 percent with three or more risk behaviours compared to 39 percent of those with shorter wait times. The longest-wait group was less likely or no more likely to report each individual safety risk.
- The largest group difference in safety risks was in regard to homelessness, which was less common among applicants with longer wait times (5% versus 16%) (see Figure 12b).
- Support intensity requested was comparable between the longest-wait applicants and others.

There were few differences in housing preferences between the two groups. Applicants waiting the longest were more likely to apply for self-contained supportive housing units only (67% versus 54%) and less likely to apply for either shared or self-contained units (28% versus 40%).

**Figure 5.12a**

*N=7767 applicants waiting for supportive housing on October 31, 2015 (excludes applicants with missing wait time data and applicants not providing consent for participation in waitlist analysis).*

**Figure 5.12b**

*N=7767 applicants waiting for supportive housing on October 31, 2015 (excludes applicants with missing wait time data (n=25) and applicants not providing consent for participation in waitlist analysis).*

The above findings indicate wide variation in how long applicants wait.

The Access Point attributes this variation to a number of factors: i) direct access accorded some applicants through existing partnership arrangements between providers; ii) the large prevalence of boarding homes within the supportive housing system, which have higher turnover and provide faster access to housing for applicants willing to share housing or bedrooms; iii) a combination of targeted program criteria, applicant needs/preferences, and characteristics of the housing stock (e.g. location, accessibility, tenant mix and suitability), which results in a high number of matching criteria for available units. This suggests that the waitlist is akin to a waiting pool from which applicants are selected, rather than a chronological waitlist with those at the top being placed first.

### **5.3 Outcomes: Placed, declined, refused**

#### **5.3.1 Outcomes: Introduction**

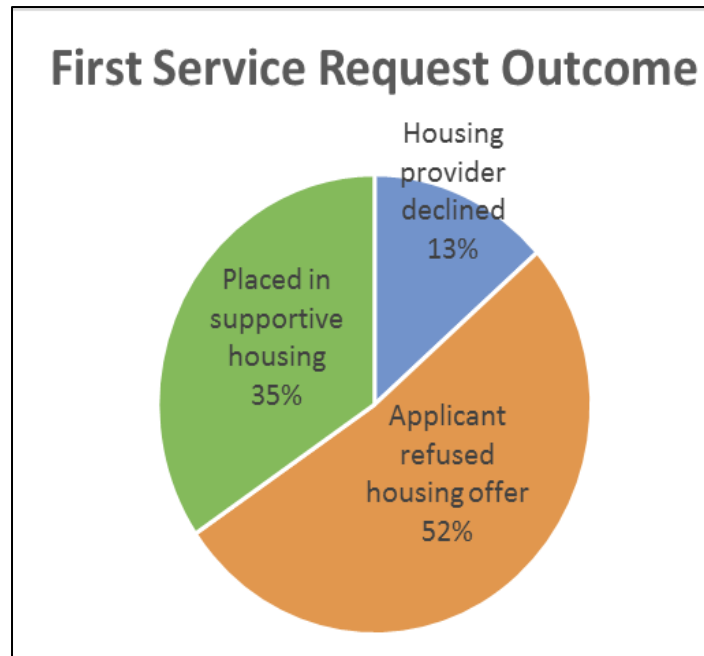
To better understand the service request outcomes of applicants to supportive housing, data on applicants' first service outcome were analyzed. The focus is twofold:

- Comparing the characteristics and needs of applicants who had their service request declined by a housing provider, and applicants who refused a supportive housing provider's offer of a housing unit, to those who were successfully placed in supportive housing
- Analysing the reasons for applicants being declined by providers or refusing a housing offer. This analysis includes the characteristics of applicants in relation to the reason for service provider decline or applicant refusal

People who refused a housing offer or were declined by a provider on their first service request outcome may have been successfully housed on a subsequent referral to a supportive housing provider. This analysis does not capture those outcomes. The analyses were conducted on applicants with a first service request outcome after August 2013, as consistent data on the reasons for declines and refusals were collected by The Access Point from that point onwards.

Between August 2013 and October 2015, 1,870 applicants had at least one outcome related to a service request for supportive housing. Using applicants' first service request outcome as a point of reference, 252 (13.5%) of these applicants had a service provider decline service, 972 (52%) refused a housing offer by a housing provider and 646 (34.5%) were successfully placed in supportive housing (see Figure 5.13).

Over this two-year span, service provider declines decreased from 17 percent of applicants during the period August 2013 to July 2014, to 11 percent of applicants during the period August 2014 to July 2015. In contrast, applicant refusals increased from 47 percent to 57 percent during the same period. Repeated service provider declines and client refusals were not common among this group of applicants. Of the 1870 applicants with a service request outcome, only 33 (2%) had two or more service provider declines and 94 (6%) applicants refused two or more supportive housing offers.

**Figure 5.13**

*N=1870 applicants with a service outcome between August 2013 and October 2015.*

### 5.3.2 Applicants declined by the housing provider

#### Characteristics and needs of applicants declined by the provider

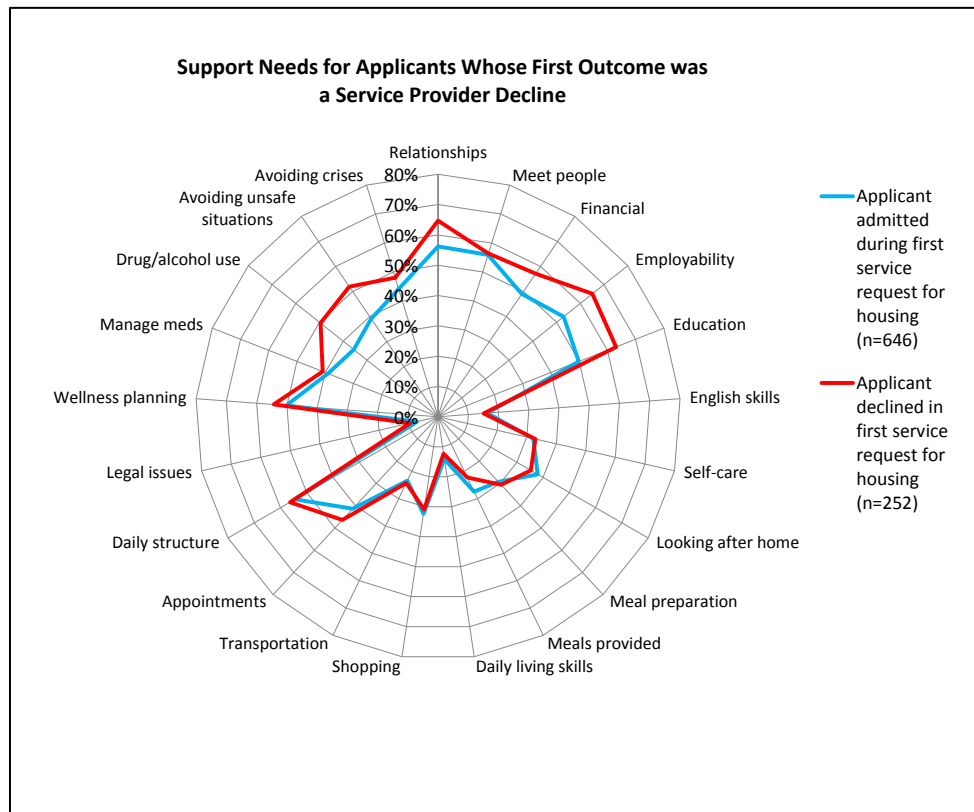
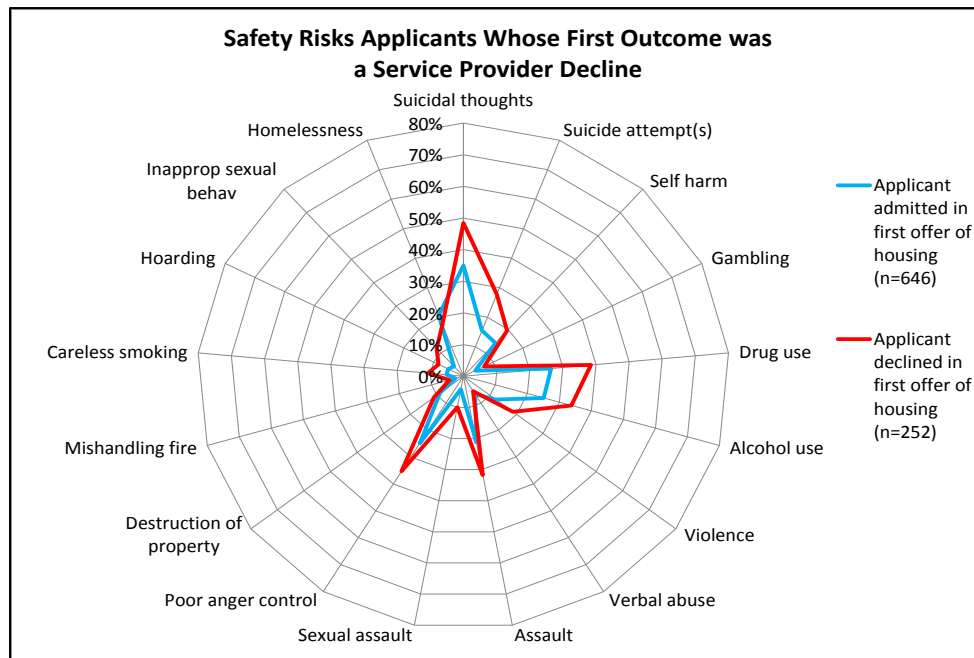
This subsection compares the characteristics of applicants whose first service request for supportive housing was declined by a provider, to applicants whose first service request resulted in placement.

[Table 19](#) provides the demographic, clinical, service preference and needs profile of applicants who had a service provider decline as the first service request outcome.

Compared to applicants who were successfully placed in supportive housing, those whose first service request was declined were more likely to:

- be homeless at application (73% versus 62%)
- have a secondary mental health diagnosis (40% versus 26%)
- have a concurrent disorder (41% versus 26%)
- report having a substance use problem (55% versus 39%)
- report current and/or recent criminal justice involvement (48% versus 32%)
- apply for Mental Health and Justice housing (37% versus 21%)



**Figure 5.14a****Figure 5.14b**

*N=898 applicants whose first service request outcome occurred between August 2013 and October 2015.*

Applicants who were declined also had some distinct support needs and more safety risks (see Figures 5.14a and 5.14b). Compared to others, they were more likely to:

- identify support needs related to avoiding unsafe situations (52% versus 39%) and managing drug and alcohol misuse (50% versus 36%)
- identify three or more safety issues (54% versus 38%)
- report safety issues of suicidal thoughts (48% versus 35%) and/or suicide attempts (28% versus 15%)
- report safety issues of drug use resulting in personal harm (38% versus 26%)
- report safety issues of sexually assaulting others (10% versus 4%) or engaging in inappropriate sexual behavior (12% versus 4%)

Other differences between the two groups were modest.

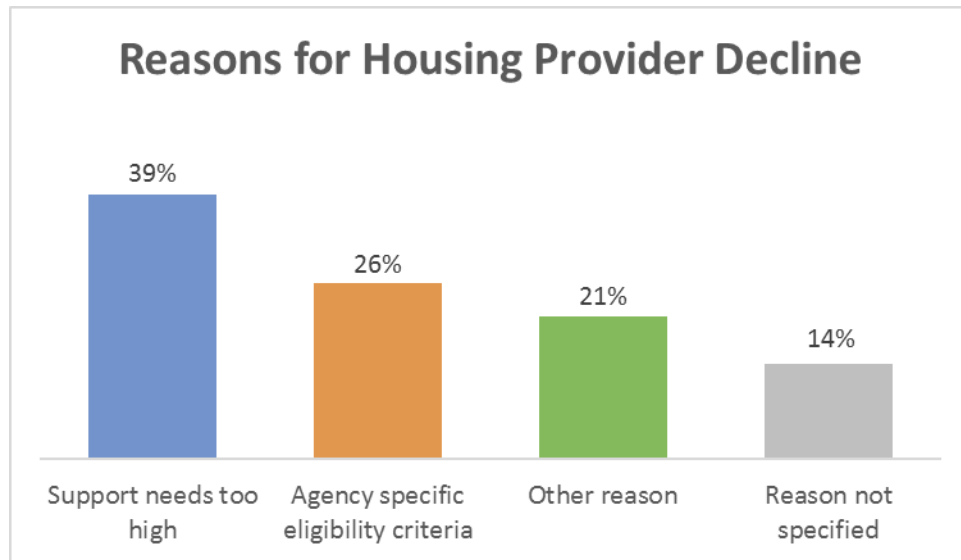
### **Reasons for housing provider declines**

The main reasons applicants had their service request for supportive housing declined may be clustered into the following categories (see Figure 5.15):

- Support needs too high (39%)
- Agency specific eligibility criteria (26%)
- Other reason (21%)
- Reason not specified (14%)

Agency specific eligibility criteria pertain to particular providers; these may include diagnosis, homelessness status, gender, age, roommate compatibility, presence of pets, and housing history of the applicant.

Other, less common reasons for a service provider decline include: support needs too low, housing arrears, applicant moved out of catchment area, applicant could not be located or is in hospital, applicant was a previous client of the housing provider, applicant has no goals, unit cannot accommodate an applicant with mobility issues, private landlord partner declined rent supplement, housing provider's support partner declined the applicant, or the housing agency filled the unit with another applicant.

**Figure 5.15**

*N=252 applicants whose first service request was declined by a housing provider between August 2013 and October 2015.*

***People declined because their support needs were too high:***

To better understand the characteristics of applicants who were declined by a housing provider because their support needs were too high (see [Table 20](#)), this group was compared with applicants whose first service request outcome was a placement into supportive housing.

Applicants who were declined because their support needs were too high had characteristics and needs similar to applicants declined by a provider for any reason. However, the applicants declined for this reason were even more likely to have substance use problems, criminal justice involvement, and safety risks relating to harm to self or others. Compared to those who were placed in housing, applicants declined because their support needs were too high were more likely to:

- be homeless (82% versus 62%) when they applied and residing in hospital (18% versus 8%)
- have a concurrent disorder (46% versus 26%) or a substance use problem (60% versus 39%)
- have current or recent criminal justice involvement (56% versus 32%)
- have an application for Mental Health and Justice housing (47% versus 21%)
- identify support needs related to avoiding unsafe situations (58% versus 39%), managing drug and alcohol misuse (57% versus 36%) and increasing employability (68% versus 53%) (see Figure 5.16a)
- identify three or more safety risks (62% versus 38%)
- identify safety issues pertaining to (see Figure 5.16b):
  - past suicide attempts (28% versus 15%)
  - drug use that resulted in harm to self (44% versus 26%)

- physically assaulting others (41% versus 21%) or difficulty controlling anger (43% versus 25%)
- sexually assaulting others (13% versus 4%) or engaging in inappropriate sexual behavior (18% versus 4%)
- fire-related matters such as mishandling fire (8% versus 3%) or careless smoking (15% versus 5%)

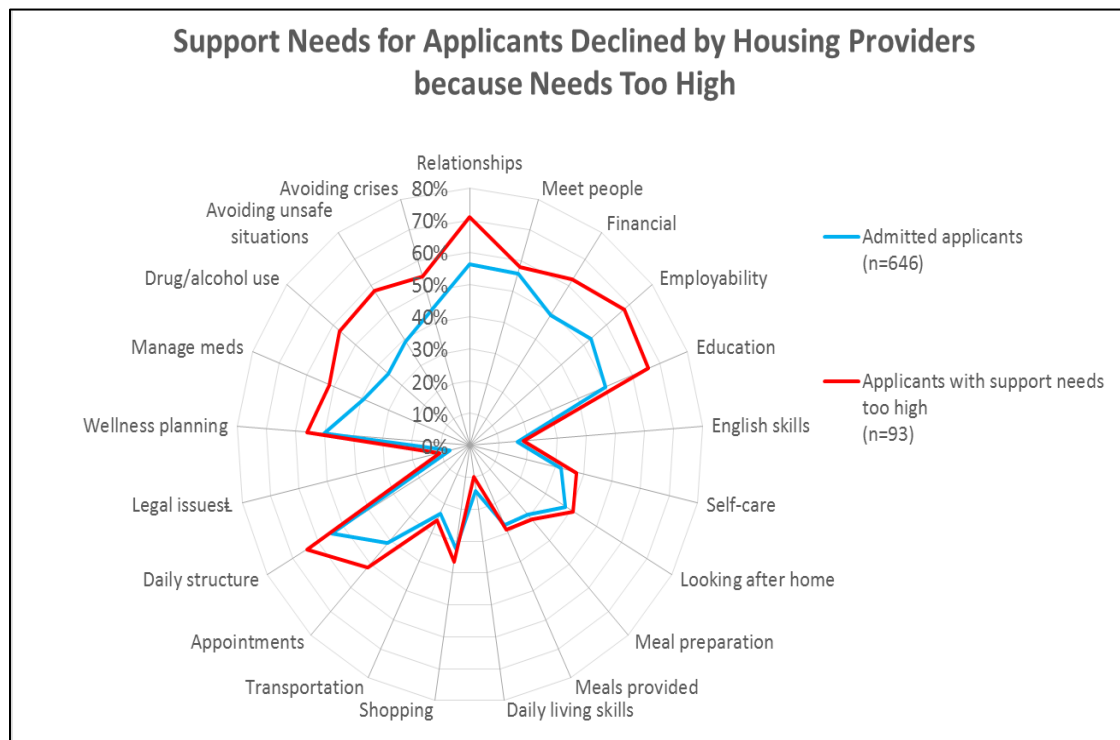
### 5.3.3 Applicants who refused a supportive housing offer

#### Characteristics and needs of applicants who refused a provider's offer

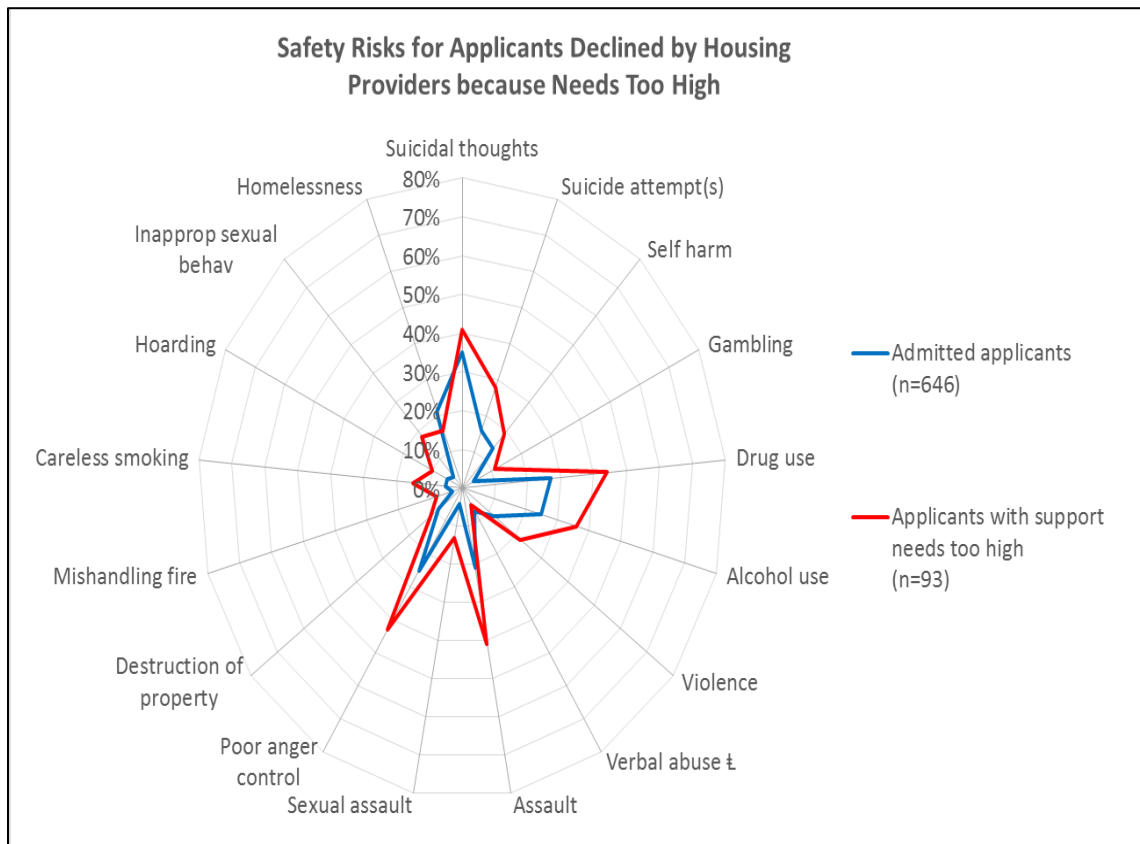
This section compares the characteristics of applicants who refused their first offer of housing from a provider to those whose first service request resulted in a housing placement.

[Table 21](#) provides the demographic, clinical, service preference and need profile of applicants whose first service request outcome was refusal of a supportive housing offer by a provider.

**Figure 5.16a**



*N=739 applicants whose first service request outcome occurred between August 2013 and October 2015.*

**Figure 5.16b**

*N=739 applicants whose first service request outcome occurred between August 2013 and October 2015.*

Applicants who refused a housing offer were more likely to:

- have a secondary mental health diagnosis present (42% versus 26%)
- request *either* a shared or self-contained unit (70% versus 56%)

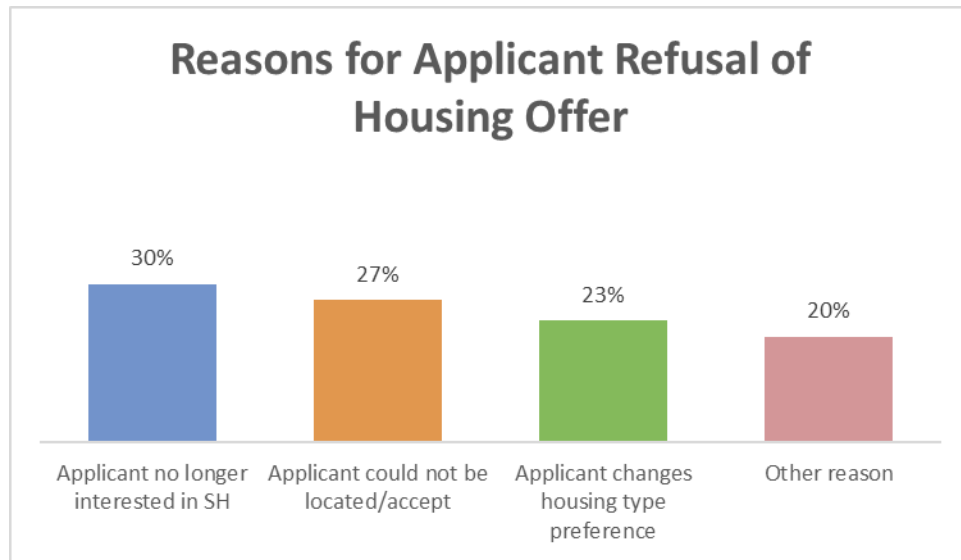
Applicants who refused a housing offer were less likely to request only a self-contained unit (20% versus 30%).

Other differences between those that refused a housing offer and those that were placed were small.

#### **Reasons for applicant refusal of a supportive housing offer**

The reasons applicants refused an offer of housing by a supportive housing provider may be grouped into the following categories (see Figure 5.17):

- Applicant changed housing type preference (23%)
- Applicant could not be located or was unable to accept a housing offer (27%)
- Applicant did not accept the unit once they were able to visit it (30%)
- Other reasons (20%)

**Figure 5.17**

*N=972 applicants who refused the first housing offer of a housing provider between August 2013 and October 2015.*

Applicants who could not be located or who were unable to accept a housing offer included people who could not be found after the provider made a housing offer, deceased persons, and applicants who were incarcerated or had a long-term hospitalization when the offer was made. Applicants no longer interested in supportive housing also included people who had found housing elsewhere. The “other reasons” group included applicants who did not like the unit offered, those who were offered another type of housing by the provider, and those who did not follow the provider’s intake procedures, including the information required from them at the time of placement and leasing.

In general, differences between groups were small. Details of the characteristics of applicants in each of these four groups are presented in [Table 22](#).

***Applicants who changed housing type preference:***

Applicants who refused a housing offer because they changed their housing type preference were more likely to be male and living in a market rent apartment or house when they applied. With respect to support needs, this group of applicants was more likely to require support with self-care and with literacy (see Figure 5.18). This group was less likely to have current or recent criminal justice involvement or to have an application for Mental Health and Justice Housing.

***Applicants who could not be located or were unable to accept a housing offer:***

Applicants who could not be located after a housing offer or could not accept the housing offer due to incarceration, long-term hospitalization or death were more likely to be male, younger in age (16-34), homeless and residing in a detention/correctional facility or in a hospital at time of application, and to have current or recent criminal justice involvement. They were also more likely to have an application

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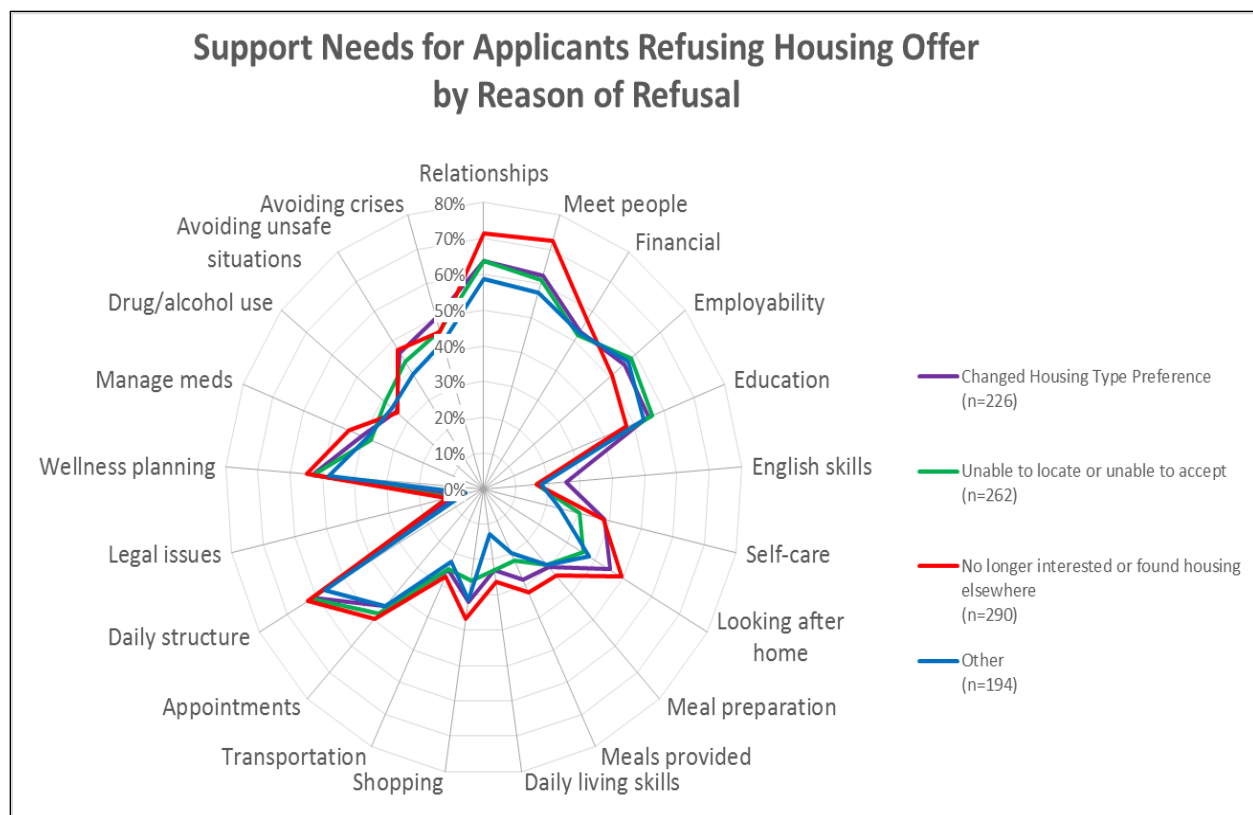
for Mental Health and Justice housing and to request “either” shared or self-contained housing. While all applicants refusing a housing offer were more likely to have requested “either” shared or self-contained, this request was most prominent among this specific subgroup (78% versus 62% to 72% of other applicants refusing a housing offer).

Applicants who could not be located or accept a housing offer were less likely to be residing in a self-contained dwelling or a boarding home; in other words, they were more likely to be in institutional settings, shelters or to have no fixed address when they applied. They were also less likely to request assistance with looking after the home.

***Applicants no longer interested in supportive housing:***

Applicants indicating that they were no longer interested in housing were more likely than other applicants refusing a housing offer to be female, to request daily support and to have high support needs (i.e. to have ten or more support needs). They were also more likely to request assistance with functional support needs such as meal preparation, shopping, looking after the home and daily living skills. In addition, they were more likely to request support with developing relationships and meeting people.

**Figure 5.18**



*N=972 applicants who refused their first housing offer between August 2013 and October 2015.*

***Applicants stating other reasons for refusing a housing offer:***

Applicants in this group were more likely to be female than other applicants refusing their first housing offer, to be living in a market rent apartment or a house or a boarding home when they applied, and to request a family unit and occasional housing support. They were also more likely to identify four or fewer support needs in their application. Compared with other applicants refusing their first housing offer, they were less likely to be residing in a hospital or correctional facility when they applied, to request a shared or self-contained unit, to request daily support, and to have ten or more support needs. They were also less likely to identify functional needs such as self-care, having meals provided and support with daily living skills. These applicants were less likely to have a history of homeless or risk of homelessness.

### **5.3.4 Closed without placement**

Some applicants withdraw their housing application and consequently are removed from the wait list without being placed in housing. Since January 2009, 1,986 (16%) applicants had their service request(s) closed without any placement in supportive housing.

[Table 23](#) compares the characteristics of this group to those placed in supportive housing.

Overall, there were few differences in the characteristics of applicants placed and those closed without placement. Those who were closed without placement were more likely to:

- report a primary mental health diagnosis other than an anxiety, mood, psychosis or personality disorder (22% versus 11%)
- request a self-contained unit only (41% versus 30%)
- report fewer support needs; less than one quarter (24%) reported ten or more support needs compared to nearly one third (31%) of placed applicants; but there was little difference between groups in the prevalence of individual support needs (see Figure 5.19)

They were less likely to:

- report a primary mental health diagnosis of psychotic disorder (32% versus 45%)
- report the presence of a secondary diagnosis (6% versus 15%)
- have an application for MHJ housing (6% versus 15%)

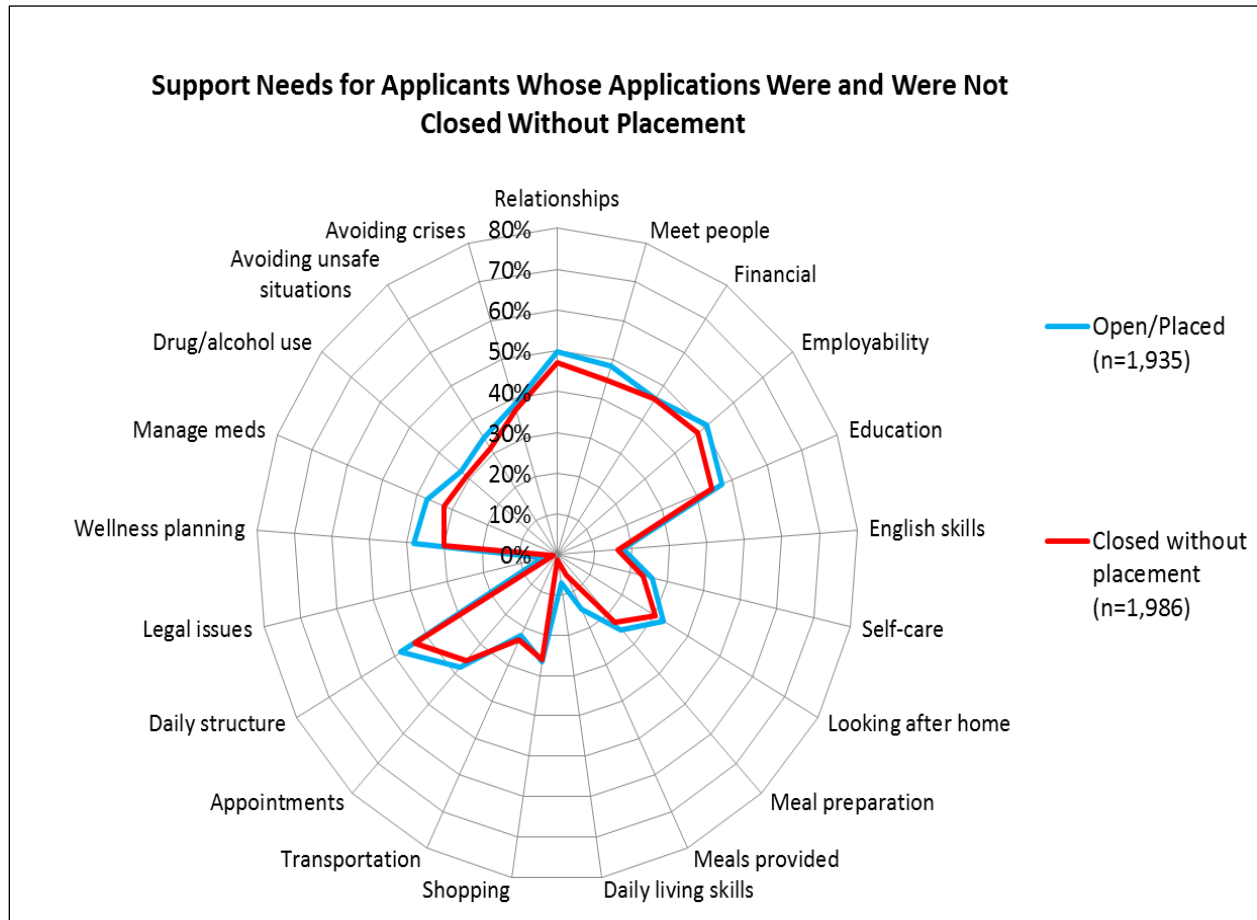
Differences in the prevalence of support needs across 22 need domains were modest (see Figure 5.19). Similarly, there was also little difference between the two groups with respect to safety risks.

It should be borne in mind that virtually any access system will have some cases that drop off without any known outcome. This analysis does not flag any notably different characteristics among the “closed without placement” group, except that they tend to have less common mental health diagnoses and



relatively fewer support needs. This analysis therefore does not point to the presence of an underserved or high-needs group that withdraws from the waitlist.

**Figure 5.19**



*N=3921 applicants whose application was closed, 2009-2015.*

## 5.4 Summary and implications: Wait times and outcomes

### 5.4.1 Summary

- Demand for supportive housing far outstrips available supply. Between October 2013 and September 2015, over 4,000 new applicants were placed on the wait list, while less than 600 were placed in supportive housing.
- Nearly half of applicants placed in housing were placed in less than one year. Among applicants still on the supportive housing waitlist at the end of the study period, however, nearly 60

percent (4,431) had been waiting for housing for two or more years and those waiting longest (top 10% on the waitlist) had been waiting 4.5 years or longer.

- Applicants' wait time from application to placement in housing did not substantially vary on the basis of mental health diagnosis, homelessness status at application, inpatient hospital use or partnership status.
- Applicants who reported substance use challenges, criminal justice involvement, or greater support needs waited disproportionately longer for housing.
- Wait times differed notably by the intensity of housing support in which applicants were placed. Those placed in housing with daily support had much shorter wait times. As noted, this reflects the availability of units in boarding homes with high turnover and therefore more rapid placement.
- The ten percent of applicants who waited longest reported lower support needs and less urgent housing needs. They identified fewer support needs and safety risks and were less likely to report substance use challenges or criminal justice involvement. These applicants were also less likely to be homeless when they applied and were more likely to request self-contained housing only.
- There is wide variation in how long people wait for supportive housing. This may be the result of direct access for some applicants through partnership arrangements; boarding homes which have higher turnover and therefore faster access; and the inherent complexity of matching people with specific needs and preferences to particular housing and supports. This variability suggests that the waitlist is akin to a waiting pool from which applicants are selected, rather than a chronological waitlist with those at the top being placed first.
- Among applicants who were declined by housing providers, nearly 40 percent were identified as having support needs too high for the provider to meet. These applicants were considerably more likely to be homeless, to have substance abuse challenges and criminal justice involvement, and to have safety risks involving harm to themselves or others.
- More than half of applicants who were offered supportive housing refused the first offer made. The reason varied: 23 percent had changed their housing preference; 27 percent could not be located, were institutionalized, or were otherwise unable to accept; 30 percent were no longer interested; 20 percent other reasons. Regardless of the reason for refusal, these applicants were more likely to have requested 'either' a shared unit or a self-contained unit in their application.

#### **5.4.2 Implications: Wait times and outcomes**

- a) The number of people applying far exceeds the available housing and support. This points to a need for policy response at different levels – from broad investment to operational practices.**

The system of mental health and addictions supportive housing and the housing availability within it are too small to meet the needs. Wait times from application to placement can be expected to increase, given the ongoing numbers of new applicants and scarcity of available

openings. Any prioritized access for specific categories of applicants is likely to materially lengthen wait times for other applicants. This will continue unless steps are taken to expand the available supply of supportive housing and, where possible, the turnover and availability of units in the system. The strong evidence of unmet need points in the same direction as other reports that have identified the scale of need or have called for additional supportive housing.

This shortfall calls for several types of policy responses. Some fall within the scope of The Access Point's processes, while others are broader, involving the priorities and practices of participating providers, LHIN priorities, and broad policy and funding decisions of the provincial government.

**b) Long wait times confirm the great need to expand the system.**

An expanded system of mental health and addictions supportive housing is needed. The long waits primarily relate to this system shortcoming, rather than to The Access Point's policies and procedures. Expanding the supportive housing system will require additional Ontario government funding for housing support services, rent subsidies, and capital or loan funds for housing development and acquisition. This would build on recent steps in that direction.<sup>47</sup>

**c) Applicants' diverse situations and long waits point to a need for multiple housing and support options. Availability within existing supportive housing could be increased by funding more supported, rent-subsidized alternatives that supportive housing tenants can move on to.**

The shortfall of supportive housing supply compared to needs is a strong reason to take steps to foster more turnover and availability in existing supportive housing by providing options that residents in this housing sector can move on to. This means facilitating the movement of supportive housing residents to other forms of housing, while adhering to the principle of permanent, secure tenure and rental subsidies. This is not an argument for "flow" without regard to secure tenure, suitable supports and affordable rents.

The feasibility of such steps is confirmed by the experience in the United States. Studies there have suggested that as many as 40 percent of residents no longer required the housing supports to live independently in the community, and were capable of transitioning to other forms of housing.<sup>48</sup> Some local jurisdictions in the US have adopted "moving-up" or "moving-on" strategies, which assist supportive housing tenants that no longer require housing supports to move to more independent housing. These strategies typically involve arrangements with social housing providers or provision of long-term rent subsidies in private rental. In addition they often cover related costs such as moving, security deposits and furniture. They may also require flexible step-up/step-down supports and offer rapid re-entry to supportive housing if required. These initiatives are not about limiting security of tenure or the principle of housing choice,<sup>49</sup> but rather providing affordable options to supportive housing residents who want to move on.

<sup>47</sup> See Ontario news release (Feb. 8, 2017): <https://news.ontario.ca/mohltc/en/2017/02/ontario-providing-faster-access-to-mental-health-services-for-thousands-of-people.html>.

<sup>48</sup> Tempel C. (2013) *Moving on from supportive housing: Creating successful exists*. Paper presented at the National Alliance to End Homelessness Conference, Washington D.C. Retrieved from: [http://b3cdn.net/naeh/e9e96a83affb80593a\\_sqm6bpvhk.pdf](http://b3cdn.net/naeh/e9e96a83affb80593a_sqm6bpvhk.pdf)

<sup>49</sup> Corporation for Supportive Housing (2015). *Improving Community-wide Targeting of Supportive Housing to End Chronic Homelessness: The Promise of Coordinated Assessment*. Retrieved from: [http://www.csh.org/wp-content/uploads/2015/01/TargetingSHthoroughCA\\_Jan15.pdf](http://www.csh.org/wp-content/uploads/2015/01/TargetingSHthoroughCA_Jan15.pdf); Corporation for Supportive Housing (n.d.) *Moving On Toolkit*. Retrieved from: <http://www.csh.org/moving-on/>; Corporation for Supportive Housing (2015). *Improving*

The prerequisite for expanding this approach in the Ontario context is to provide more funding for portable rent subsidies and rent supplement. These are far less available in Ontario than in most affluent countries including the US.<sup>50</sup>

Creating opportunities for flow across the support intensity continuum can also reduce wait times for high support housing. One approach to explore may be transitional housing within some dedicated sites. Amendments to the Residential Tenancies Act in 2017 expanded the permitted length of tenancy in transitional housing to four years. Some applicants who require high support at the time of applying, may over time require lower levels of support and be transitioned from high support sites to other supportive housing. In addition, the use of multi-disciplinary teams (e.g. FACT teams), which have the capacity to increase or decrease service intensity, can create more flexibility in responding to changes in individual needs.

**d) There is a need to find ways of giving priority to applicants with higher or more urgent needs and to continue moving towards systematic assessment of individual applicants' needs using standardized screening and assessment tools.**

Several findings point to a need for more systematic prioritization among Access Point applicants. These include: longer wait times for some applicants with more complex needs (e.g. co-occurring addiction, criminal justice involvement); the similarity of wait times regardless of homelessness or acute care utilization; and only modest differences in support needs, acute care utilization and homelessness, between the longest-wait applicants and others. A system that prioritized high-need, high-cost homeless populations would show larger wait time differences, with lower needs among people waiting longer.

There are distinct and valid reasons for giving priority to applicants with high or complex support needs, with high safety risks, with high hospital use, being discharged from hospital, or experiencing homelessness that destabilizes health. The system should also serve people with moderate needs. These are all valid but often competing priorities that benefit different individuals. Serving the applicant population fairly and adequately requires that priority for available housing be predicated on a multi-dimensional definition of urgency and of need.

This diversity of needs and urgency points to a need to triage applicants at an early stage. For example, some individuals could be identified as needing urgent placement, some could be linked to alternative housing and service options and others may be able to wait longer. In its ICM-ACT function, The Access Point has moved explicitly in this direction – for example with referrals to short-term case management. In Access Point housing referrals, some triaging is implicit in the complex process of matching applicants to suitable openings. Given the large and rising waiting list, The Access Point should continue to move in the direction of becoming a gateway to a range of housing and support options. This must be a collaborative endeavor between The Access Point and participating providers.

More use could be made of standardized, evidence-based screening and assessment protocols and tools, as a basis for assigning relative priority on the waitlist. A number of tools have been

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Community-wide Targeting of Supportive Housing to End Chronic Homelessness: The Promise of Coordinated Assessment. Retrieved from: [http://www.csh.org/wp-content/uploads/2015/01/TargetingSHthoroughCA\\_Jan15.pdf](http://www.csh.org/wp-content/uploads/2015/01/TargetingSHthoroughCA_Jan15.pdf)

<sup>50</sup> Most affluent countries have universal means-tested housing allowances. The USA provides vouchers to recipients equating to 9 percent of low-income households (US HUD funded 2,074,111 households with vouchers as of 2009 (<https://www.huduser.gov/portal/picture/picture2009.html>), i.e. 9 percent of lowest-quintile households in a country with 116.7 million households as of the 2010 US census).

developed for this purpose, including the Vulnerability Index - Service Prioritization and Decision Assistance Tool (VI-SPDAT), the Transition Age Youth Triage Tool, the Vulnerability Assessment Tool and others. The Access Point is now exploring the utility of such tools, and this research reinforces the need to do so. Such tools can support Access Point staff in ensuring suitable matching to appropriate supportive housing.

- e) The priority going to partnership applicants with lower needs points to a need to review such arrangements to ensure they give suitable priority to applicants with higher or more urgent needs.**

Partnership placements involve a housing provider offering an available housing unit to an applicant, in partnership with a support provider. While The Access Point is notified of these placements, it does not initiate them. Partnership applicants were less likely to be homeless, have recent hospitalizations or criminal justice involvement when they applied (see Section 2.5). They also reported fewer support needs (see Section 3.4) and had a lower median wait time to placement as compared to other applicants. Given that partnerships accounted for one fifth of all placements into supportive housing in the study period, there is a need to consider how to ensure they give suitable priority to applicants with higher or urgent needs. The Access Point could work with the Mental Health and Addictions Supportive Housing Network and partnership providers to move in this direction, using data-driven targeting strategies. This would entail: a review of competing objectives; giving priority to high need applicants; providing support agencies with assured housing access for their clients; and enabling housing providers with low support staff funding to ensure adequate support for people they house. It may also require adjustments to funding conditions that restrict the use of particular units to particular client/resident populations, as well as increases in funding to enhance the capacity of providers to support individuals with higher service needs.

- f) Enhancing providers' capacity to support people with problematic drug/alcohol use and criminal justice involvement is needed to reduce provider declines of housing applicants.**

The profile of applicants declined by service providers due to support needs being too high resembles the profile of applicants with substance use problems and criminal justice involvement (see Section 4.3). This group's reported support needs do not differ materially from other applicants, except that they are more likely to report needs related to managing substance use and avoiding crises/unsafe situations. The finding that people declined by providers have high prevalence of criminal justice involvement, substance use and behavioural challenges has implications for provider capacity and staff training. Providers may not feel that they have adequate capacity to successfully house and support these applicants. Provision of more staff training on evidence-based interventions that target these issues may increase service providers' confidence in supporting applicants with this clinical profile.

- g) Low-barrier access for homeless people with problematic drug/alcohol use, criminal justice involvement and behavioural challenges is needed to prevent exclusion from supportive housing.**

To ensure provision of supportive housing to applicants with problematic drug/alcohol use and/or criminal justice involvement, there is merit in moving more toward a Housing First approach in housing access (i.e. a low-barrier assessment process and eligibility or selection

criteria), as one part of the spectrum of housing and support models. This would minimize the unintentional exclusion of some of the most marginalized and costly homeless service populations.

**h) Providing specialized services to support applicants with complex care needs should be pursued as a way to reduce service provider declines.**

To support providers in meeting the needs of applicants with problematic drug/alcohol use, criminal justice involvement, and related risks, funding may be needed to enhance staff skills and local system capacity in this regard. Specifically, this could include the provision of 24-hour outreach and crisis response. It could include flexible, individualized, on-demand step-up/step-down services. It could include additional evidence-based interventions, such as integrated dual diagnosis treatment for concurrent disorders, or dialectical behavior therapy for self-injurious behaviours and emotional dysregulation.

**i) Rapid housing for most vulnerable applicants may serve to reduce rates of applicant refusals of housing offers.**

In nearly a quarter of “applicant refused” cases, the reason provided was that the applicant had changed their housing preference. Many applicants’ housing situations or needs may change between the time of applying and being offered housing. A prioritization process which would more rapidly place the most vulnerable homeless applicants may achieve a reduced rate of refusal associated with such changing situations. Rapidly housing those homeless applicants who have a history of cycling through institutional settings and shelters may also potentially reduce future hospitalization and incarceration rates.

**j) More systematic research is needed on the role of housing preferences, social compatibility, neighbourhood/location, and physical health factors in applicants’ refusals of housing offered.**

Choice of home – where to live and with whom – is a big decision for anyone, regardless of disability. Feedback from Access Point staff suggests that many factors shape clients’ refusals, including personal connections to a local community, proximity to health care and services, personal safety and avoiding risks. The feedback indicates that when applicants refuse offers of housing, this choice is affected by specific characteristics of the building, neighbourhood and location, compatibility with fellow residents, and physical health factors such as ability to handle stairs.

More systematic analysis is needed of housing characteristics, social compatibility factors, safety or risk factors, and geographic location as factors in housing preferences and refusals. This analysis would be assisted by more systematic tracking of the type, characteristics and location of housing that is offered in each case, and integrating variables such as physical health/mobility limitations into the client database.

The implications of general geographic location and neighbourhood characteristics require more analysis than was possible in this study, due to the limited geographic data available. Given the service area of 630 km<sup>2</sup> in a city of 2.7 million population with widely divergent neighbourhood conditions, such spatial factors may play a larger role than is usually recognized from a health services perspective.

## 6. Implications

This section consolidates in one place the implications of the research findings. These implications are also set out with slightly more elaboration in the concluding parts of sections 2 through 5.

For a summary of the findings, the reader should refer to the concluding parts of sections 2 through 5, or the executive summary.

### **Broad implications**

**1) Applicants have high levels of homelessness and housing need, and this is an under-served population in terms of affordable housing.**

Most people applying to The Access Point for supportive housing have a high level of housing need. Half of them self-identify as being homeless or in temporary accommodation at the time of application. Many live in various forms of congregate housing. Many applicants were literally homeless, with one quarter staying in shelters or having no fixed address, and others residing in institutions including hospitals and jails/prisons.

The population applying to The Access Point is very under-served in terms of housing, compared to other Toronto residents. Just 9 percent of applicants are in subsidized rental housing, compared to 8 percent of the total City of Toronto population and approximately one quarter of low-income renters in the city.<sup>51</sup>

**2) Most applicants identify large needs for more than just housing, including health- and housing-related supports.**

The vast majority of supportive applicants identify needs related to health, in-home, and out-of-home daily activities. The presence of needs across multiple domains confirms that applicants to The Access Point require the assistance of support workers and not just social/affordable housing or rent subsidies.

**3) The number of people applying far exceeds the available housing and support. This points to a need for policy responses at different levels – from broad investment to operational practices.**

People typically wait multiple years for supportive housing, even though they have very high mental health or addiction challenges, severe or urgent housing needs, as well as high use of hospitals, homeless-related services and the criminal justice system. The system of mental health and addictions supportive housing, and the housing availability within it, are too small to meet the needs.

Wait times from application to placement can be expected to increase, given the ongoing numbers of new applicants and scarcity of available openings. Any prioritized access for specific categories of applicants is likely to materially lengthen wait times for other applicants. This will continue unless steps are taken to expand the available supply of supportive housing, and where possible the turnover and availability of units in the system. The strong evidence of unmet need points in the same direction as other reports that have identified the scale of need or have called for additional supportive housing.

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<sup>51</sup> Details of these ratios are in section 2 of this report.

This shortfall calls for several types of policy responses. Some fall within the scope of The Access Point's processes, while others are broader, involving the priorities and practices of participating providers, priorities of the LHINs, and broad policy and funding decisions of the provincial government.

**4) The long wait times confirm the great need to expand the system.**

An expanded system of mental health and addictions supportive housing is needed. The long waits primarily relate to this system shortfall rather than to access policies and procedures. Expanding the supportive housing system will require additional Ontario government funding for housing support services, rent subsidies, and capital or loan funds for housing development and acquisition. This would build on recent steps in that direction.

**5) Applicants' diverse situations and long waits point to a need for multiple housing and support options. Availability within existing supportive housing could be increased by funding more supported, rent-subsidized alternatives that supportive housing tenants can move on to.**

The shortfall of supportive housing supply compared to needs is a strong reason to take steps to foster more turnover and availability in existing supportive housing, by providing options which residents in this housing sector can move on to. This means facilitating the movement of supportive housing residents to other forms of housing, while adhering to the principle of permanent, secure tenure and rental subsidies. This is not an argument for 'flow' without regard to secure tenure, suitable supports and affordable rents. The feasibility of such steps is confirmed by the experience of other jurisdictions (see references in section 5), which indicates that large proportions of supportive housing residents could live in other forms of assisted independent housing in the community. These steps require arrangements with other (non-supportive) social housing providers or long-term rent subsidies in private rental. They may also require flexible step-up/step-down flexible supports, rapid re-entry to supportive housing if required, and supplementary assistance at the time of moving. The fundamental prerequisite for expanding this approach in the Ontario context is to make available more portable rent subsidies and rent supplement funding.

**6) Applicants' diverse characteristics and needs confirm the need for a system with a range of support intensity (24-hour, daily, occasional), and a variety of types of support.**

The diversity of applicants' support needs, varying from one group to another, is strongly evident in the study findings. Some people identify a need for only occasional support, while others need quite high levels, including 24-hour support. Applicants are also diverse in the types of support they need and in their safety risks. Different groups of applicants have different needs (e.g. avoiding crises, practical household support, meals, personal care).

These findings point to the need for a diversity of approaches in providing housing with support, and to expanding the mental health and addictions supportive housing system on that basis.

The large identified needs for support on the social determinants of health confirms the importance of these as part of the range of support that providers offer or help residents to



connect with. These include supported employment, peer support, and social-recreational activities.<sup>52</sup>

### **Two groups with high or complex support needs**

- 7) Among the diverse applicants, there is a notable distinction between two large groups with high or complex support needs: people with psychosis diagnoses and functional support needs, and people with problematic substance use, criminal justice involvement, and related safety risks.**

These two groups and this distinction are a generalization from more specific findings on characteristics, support needs and safety risks. Not all applicants are in one of these groups, but the size of each of these and the differences between them are notable.

Applicants with psychosis diagnoses more typically identify a need for support with activities of daily living and medication management. This group has more history of hospital use and more frequently request 24-hour support. However, problematic drug/alcohol use is less common and there are fewer safety risks and less homelessness in this group.

Applicants with problematic substance use and/or criminal justice involvement are more often homeless in shelters or with no fixed address, and more often have mood and anxiety disorders as a primary mental health diagnosis. This group reported higher safety risks than the group with psychosis diagnoses, or than applicants in general. These risks pertain especially to substance use resulting in harm, managing crises, and harm to self or others. The need in this group is for low-barrier access (i.e. few preconditions) and associated outreach.

- 8) The group of applicants with problematic substance and/or criminal justice involvement are not as well served by the supportive housing system as other applicants are, in terms of access outcomes.**

People with problematic substance use and/or criminal justice involvement are more likely to be declined by providers when referred to an available unit, and to be declined because of high support needs associated with problematic drug/alcohol use, criminal justice involvement, and safety risks. They are less likely to be placed within one year of application. In this respect they are less well served by the supportive housing system than applicants in general.

- 9) Many homeless applicants in shelters or with no fixed address have urgent housing needs but often report only moderate support needs and request only occasional support. This may reflect their need and preference for low-barrier, less intrusive supports and services.**

The shelter/NFA homelessness group has a somewhat distinct mix of housing and support needs. This group includes people who are staying in homeless emergency shelters or have no fixed address, or are residing in temporary living situations when they apply. Their housing needs are relatively urgent, but their support needs and in some cases safety risks are typically moderate. (Not all homeless applicants are in the group with high substance use and related safety risks.)

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<sup>52</sup> Marshall, T. Golderg, R. W., Braude, L., Doughert, R. H., Daniels, A.S., Ghose, S.S., George, P., & Delphin-Rittmon, M.E. (2014), Supported employment: Assessing the Evidence. *Psychiatric Services* 65(1): 16-23.

The mental health and addictions supportive housing system, including The Access Point, is not well designed to meet these urgent housing needs in a timely way. Prioritizing on the basis of homelessness has been suggested in recent official reports to the Ontario government. However, in Toronto the large numbers of homeless applicants compared to available housing means that this is not possible as a general approach. Yet there is a need to provide homeless applicants with more rapid access to supportive housing than is possible at present through The Access Point system.

**10) Homeless applicants also include people with significant use of hospitals and correctional facilities, for whom more rapid access to housing could reduce use and costs of such institutions.**

“Applicant refused” patterns within the system indicate significant involvement in jails or prisons by persons on the waiting list, as well as stays in hospitals. This, in turn, points to the potential benefits of supportive housing as a way to reduce such institutional stays and costs. More than one quarter of refusals of a housing offer involved applicants who were incarcerated, hospitalized, or could not be located, many of whom were also in hospital or prison/jail when they applied. This may support an inference (although further research is needed) that a subset of homeless applicants tends to cycle through such institutional settings and shelters while they are on the waiting list for supportive housing. Rapidly housing these applicants has the potential to reduce incarceration and hospitalization. This would require a prioritization process to flag and place such applicants when they apply to The Access Point. This implication is consistent with other research, as noted in section 5.

**11) The distinct needs of applicants with psychosis, and those with personality disorders, reinforce the value of implementing evidence-based support models for each of these groups.**

The prevalence of psychotic disorders among alternate level of care (ALC) and Health Link applicants, homeless applicants residing in hospital, and those with high inpatient hospital use, point to the importance of evidence-based interventions for psychosis (e.g. CBT). Incorporating these interventions into the services of support staff in supportive housing, or providing them separately as adjunctive interventions, can help ensure a stable housing situation for this group of applicants. In many cases this involves relatively high support; but flexible assertive community treatment (FACT) offers a way to combine lower and higher support intensity and to flex these as needed.

Applicants with a primary diagnosis of personality disorder had the highest number of support needs, and issues relating to self-harm, substance use, and violence. Their presence as a group of applicants flags the importance of serving them well in supportive housing and in the mental health system more generally. Other research shows benefits from providing clinical support interventions such as Dialectical Behavior Therapy (DBT) for borderline personality disorder, and/or ensuring these applicants are connected with specialized services. Incorporating these interventions into the services of support staff or case managers within supportive housing, or providing them separately as adjunctive interventions, can help ensure a stable housing situation for this group of applicants (see also section 4). There may be a need to consider

targeted partnerships between housing providers and specialized supports; and, given the long waiting lists, availability of sufficient services to this group is an important concern.

### **Substance use, homelessness, and criminal justice involvement**

#### **12) The many applicants with problematic substance use and the “provider declined” patterns point to a need for enhanced provider capacity in this regard, including evidence-based interventions.**

The prevalence of problematic substance use, and the finding that provider declines<sup>53</sup> are associated with related risks pertaining to substance use, criminal justice involvement, and managing crises, has implications for provider capacity. Feedback from The Access Point and providers suggests that providers may not have adequate capacity or specific skills to successfully house and support these applicants. More staff training on interventions which target these issues may increase providers’ ability to house and support these applicants, and the research literature points to specific evidence-based support interventions (see section 4). There is a need to integrate substance abuse interventions as part of providers’ core support services. This need applies equally to housing with occasional support, given the prevalence of related safety risks among applicants with substance abuse and/or criminal justice involvement.

Supporting people with safety risks pertaining to substance use, self-harm or violence is a challenge in the current system. Feedback suggests that it is not acknowledged sufficiently as a funding and support need, and that to enhance capacity in this area additional resources will be required. Enhanced local system capacity will also be needed, such as 24-hour outreach and crisis response, as well as flexible, individualized, step-up/step-down services.

#### **13) The prevalence of problematic substance use and criminal justice involvement among applicants also points to a need for more supportive housing and services targeted to this population.**

The prevalence of substance use, criminal justice involvement, and related safety risks point to a need to make available more specialized addiction-targeted and mental health and justice supportive housing. This would include more housing with a low-barrier assessment process access, few preconditions, and a Housing First approach to placement and supports, to minimize the unintentional exclusion of homeless people with problematic drug/alcohol use and/or criminal justice involvement.

Feedback from providers and the documented concerns of residents indicates that people with addictions or repeated justice involvement can sometimes be destabilizing to other tenants and impinge on their tenancy rights.<sup>54</sup> These issues can be more pronounced in congregate housing, which is a large part of the existing supportive housing stock. This issue constrains the ability of some providers to house people with active addictions or recurrent involvement in the justice system.

This reinforces the need for specialized housing targeted to people with substance use and criminal justice involvement, as part of the housing spectrum. This would include more housing

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<sup>53</sup> This refers to cases where a provider declines to house an applicant who is referred to an available opening.

<sup>54</sup> See also Dream Team (2015), *Towards a New Bill of Rights: The Voice of Tenants in Permanent Supportive Housing*, 29-31.

with low-barrier access, few preconditions, and a Housing First approach to placement and supports. Such an approach would reduce the unintentional exclusion of homeless people with problematic drug/alcohol use and/or criminal justice involvement.

**14) The prevalence of criminal justice involvement among applicants points to a need for assessments and services that are targeted to these needs.**

Support services and assessments must address criminal behaviour risks as well as mental health. Addressing applicants' needs in these matters as well as in mental health is essential for personal recovery and to avoid further criminal justice involvement.<sup>55</sup> Other research points to the value of comprehensive assessments, which include criminal justice related and social supports information, as a basis for developing individualized treatment and service plans. Existing tools that are well recognized, but not widely used by mental health and addictions supportive housing providers,<sup>56</sup> can be introduced to supplement existing assessment methods, to guide placement and supports.

**15) The high percentage of applicants residing in shelters or otherwise homeless points to the importance of coordinating the mental health supportive housing system with the municipal systems of housing and homeless-related services.**

Many people applying to The Access Point for supportive housing are residing in emergency shelters or have no fixed address. Thus, the population served by The Access Point and participating providers overlaps considerably with the population served by the system of homeless-related services that is municipally funded and administered. Such overlaps occur in the Streets to Homes program, municipally funded 'alternative' housing, homeless placements into municipal housing, LHIN-funded mental health supports in municipal housing, and the routine practice of having shelter users apply to The Access Point.

This overlap of populations served points to a need to pursue more collaboration and coordination between the mental health and addictions supportive housing system, including The Access Point, and the municipal systems of homeless-related services and social housing. While recognizing that both systems face large pressures of needs exceeding capacity, as well as constrained resources, better coordination is likely to serve people more effectively and in a more efficient way.

### **Prioritizing and matching**

**16) Applicants' diversity in support needs, safety risks, housing or homeless situations, and degree of urgency necessitates prioritizing applicants on more than one dimension, with some triaging.**

The diversity of support needs and safety risks has implications for prioritization, as does the diversity of housing and homelessness needs. There are distinct reasons for giving priority to

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<sup>55</sup> Substance Abuse and Mental Health Services Administration. (2017). *Guidelines for Successful Transitions of People with Mental or Substance Use Disorders from Jail or Prison: Implementation Guide*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from: <http://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998>.

<sup>56</sup> In particular, the Level of Service Inventory-Revised, a validated 54-item needs assessment that identifies psychosocial problem areas in an individual's life and predicts criminogenic risk.

applicants with high support needs, high safety risks, high hospital use, or homelessness that destabilizes health. The system should also serve people with moderate needs.

These are all valid, but also potentially competing priorities that benefit different individuals. To serve the applicant population fairly and adequately requires that priority for housing involve a multi-dimensional definition of urgency and high need.

This diversity of needs and urgency points to a need to triage applicants at an early stage. For example, some individuals could be assessed as needing urgent placement, others could be connected to different housing and service options, while others still may be able to wait longer. This triaging would build on approaches The Access Point has started taking in its ICM-ACT access functions. Given the large and rising waiting list, The Access Point should continue to move in the direction of ensuring that its system serves as a gateway to a range of housing and support options.

Moving in this direction requires striking the right balance between allocating resources to early assessment and triaging, while avoiding a costly up-front needs assessment for applicants who will not be placed quickly and whose situation and needs will evolve. Moving in this direction must be a collaborative matter between The Access Point and participating providers.

**17) There is a need to continue moving towards systematic assessment of individual applicants' needs, using standardized screening and assessment tools.**

The complexity of applicants' needs and urgency, the complexity of prioritization, and the need for more early assessment all point to the need to integrate the use of evidence-based assessment and screening tools into the practices of The Access Point. This direction is already underway, and the findings of this study reinforce the importance of understanding needs systematically. This can support Access Point service navigator staff in ensuring suitable matching to appropriate supportive housing, and can also help reduce the incidence of "provider declined."

Various tools exist for this purpose, which are familiar to The Access Point and various participating providers. These are noted in earlier sections of this report. Effective assessment will also require systematically recording information on met versus unmet support needs as part of The Access Point application and client database.

**18) The mental health and addictions supportive housing system requires clear, shared definitions of support intensity (24-hour, daily, occasional), to facilitate matching of applicants to housing with the best use of resources.**

This research and related feedback from Access Point staff have confirmed the lack of consistent definitions for different levels of support intensity (i.e. 24-hour, daily, occasional). Consistent definitions are needed, shared and understood by Access Point staff, participating providers, and agencies that refer people to The Access Point. Such consistent definitions could be reflected and embedded within standardized screening and assessment tools. This approach would help in grappling with the complexity of matching and could decrease the incidence of "provider declined" outcomes. There is a need for renewed analysis and consultation to arrive at a clear, shared typology and definitions of support level, intensity, etc. Such definitions would also be helpful to providers as they adjust their support resources when a resident's needs change over time.

**19) Adjustments are needed to access priorities, including partnership placements, to ensure that applicants with higher needs are not disadvantaged.**

While the multiple dimensions of need and urgency were noted above, it remains important to give significant priority to applicants with high or complex needs. It was evident especially in the findings on “longest wait” applicants and partnership applicants that this is not consistently the case. There were only modest differences in support needs, acute care utilization and homelessness, between the longest-wait applicants and others. A coordinated access system that prioritizes high-need applicants would be expected to show larger differences, with lower needs among people waiting longest. The findings also indicate that partnership placements do not prioritize higher-need applicants. Given that partnership arrangements constituted one fifth of all placements, there is a need to ensure they give suitable priority to applicants with higher or more urgent needs.

It should be acknowledged that providers and their residents have a legitimate interest in ensuring the safety and housing stability of existing residents, and that placement of high-need applicants can present challenges in this regard, especially but not only in shared/congregate housing. Nevertheless, there is a need to ensure that in the mental health and addiction supportive housing system due priority is given to applicants with high needs to ensure fair probability of placement.

### **Housing types**

**20) The preference for self-contained units suggests a need to reconsider the role of congregate /shared housing. This could include conversion to short-term housing, to different support intensity, or to independent dwelling units.**

Few applicants prefer shared/congregate housing. Feedback from Access Point staff confirms that many who request shared units do so to maximize their housing options and get faster access (given the higher turnover in this housing stock).

Feedback from Access Point staff suggests that shared/congregate housing can mean less successful placement. The feedback indicates that providers may be less able to accept applicants whose safety risks are likely to have impacts on other residents and overall support requirements; and applicants are more likely to turn down shared housing when it is offered.

Further expansion of the supportive housing system should be in the form of self-contained units – whether scattered in the private rental apartment stock or in dedicated buildings.

The weak preference for shared/congregate housing points to some questions about the appropriate role of this housing in the system, while bearing in mind the important role it plays in rapid access. There may be opportunities to position some congregate housing more explicitly as transitional or short-term supportive housing. There may be benefits from reconfiguring some of the properties into self-contained housing, despite the large capital and operating costs involved. Shifting to a different support intensity may also be a good option in some cases.

## **Research and analysis**

### **21) There is great potential to expand use of Access Point administrative data for needs analysis and system planning, including linking it to other databases.**

The present research confirms the information-rich resource which The Access Point client database provides. It has been used in various ways by The Access Point itself, but there is potential to expand its use and integrate it with other datasets, to support needs analysis and service planning.

For The Access Point and the LHINs that fund it, this confirms the importance of continuing to invest in the IT infrastructure and research capability (while respecting client data confidentiality). Expanded use of the data for research, needs analysis and service planning would be assisted by developing fuller documentation on the database for researchers to use. It would be enriched by systematically recording variables which are generally known to staff of The Access Point but were not fully integrated into the database (as of the dates used for this research). Such additional data includes immigration, cultural and linguistic variables; type of housing and geographic location an applicant is referred to; accessibility-related matters such as stairs; etc.

### **22) More systematic research is needed on applicants' evolving housing and support situations while they are on the waiting list.**

The large numbers of applicants, the prevalence of urgent needs and homelessness, and the high incidence of applicant refusals when housing is offered, point to potential benefits from more analysis. An important aspect of this would be to track and understand applicants' evolving housing situations and evolving support needs while they are on the waiting list. Feedback from Access Point staff indicates that this information is updated in various ways through the periodic contact that applicants (or their workers) have with them while they are on the waitlist. Integrating this data into the client database would enable more systematic understanding and analysis of these evolving situations and needs. This would, in turn, support efforts to ensure that The Access Point functions as a system that helps applicants in various ways while they are on the waiting list, including linking them to alternative types of support and a range of housing options.

### **23) More systematic research is needed to understand the role of housing preferences, social compatibility, neighbourhood/location, and physical health factors in applicants' refusals of housing offered.**

Choice of home – where to live and with whom – is a big decision for anyone, regardless of disability. Feedback from Access Point staff suggests that many factors shape clients' refusals, including personal connections to a local community, proximity to health care and services, personal safety and avoiding risks. The feedback indicates that when applicants refuse offers of housing this is affected by specific characteristics of the building, neighbourhood and location, compatibility with fellow residents, and physical health factors such as ability to handle stairs.

More systematic analysis is needed of housing characteristics, social compatibility factors, safety or risk factors, and geographic location as factors in housing preferences and applicant refusals in the Access Point system. This would involve systematic tracking of the type, characteristics and location of housing that is offered in each case, as well as data on physical health/mobility limitations, and current supports, and analysis of these.

There is also a need for fuller analysis of the impacts of general geographic location and neighbourhood characteristics on applicant choices and refusals of offers. This is unavoidably important in a diverse service area of 630 km<sup>2</sup>, 2.7 million population, and widely divergent neighbourhood conditions. These dimensions need to be better recorded, tracked, and analyzed.

**24) There is a need to better understand the housing and support needs of applicants already in self-contained housing, including those living with family and those in regular social housing.**

For the one quarter of applicants who resided in self-contained or congregate dwellings at application, more needs to be understood in a systematic (not just case-specific) way about their housing situation and needs and how this relates to support needs. These applicants are a diverse mix of people living on their own (with or without subsidy), with family or with others. Although they are “housed” when they applied, their situation is not necessarily stable or affordable, and this report has shown that many have fairly high needs.

For applicants living with family, such analysis could help show to what extent the need is for appropriate supports, for independence from the family of origin or for family-friendly supportive housing. For those in social/subsidized housing, there may be possibilities of providing supports in that context. Some applicants in independent dwellings may need supports; some may need housing subsidies. Better understanding of these matters could enable The Access Point to link people to services while they are on the waiting list, or ensure their existing situation is stable.



## Appendix 1. Methodology

### Research objectives

The research objectives as approved by the Community Research Ethics Office were:

1. To identify the characteristics of service applicants for supportive housing and/or community support services (i.e. intensive case management (ICM) or assertive community treatment (ACT)). Sub-analyses will explore how dimensions of applicant characteristics (e.g. demographic, clinical, living situations, housing preference, service need) relate to each other;
2. To compare the characteristics of applicants for supportive housing and community support services in different program streams and across time;
3. To examine if specific clusters of service applicants who share common characteristics would emerge among service applicants waiting for supportive housing and/or community support services;
4. To examine the characteristics, wait times and service placement outcomes of applicants with multiple co-occurring chronic medical conditions and those with a higher proportion of service needs identified at referral;
5. To examine characteristics, wait times and service placement outcomes for service applicants for supportive housing and community support services on the waitlists who had previous high utilization of acute care services, such as emergency department and inpatient services;
6. To examine factors associated with homelessness and with being at-risk of homelessness. Sub-analyses will explore potential differences in the characteristics of homeless applicants based on their current living environments (e.g. residing in shelter, residing in hospital, no fixed address); Sub analyses will also examine whether wait times and service placement outcomes differ for applicants who are homeless as compared to the general population of service applicants;
7. To examine factors associated with service application outcomes (i.e., individuals who did not obtain housing/services due to refusing housing/services offered; and individuals whose application was declined by service providers, etc.). Factors related to health equity will also be explored by focusing on potentially disadvantaged populations (e.g. newcomers, individuals whose preferred language of service is other than English);
8. To examine factors associated with longer wait times for supportive housing and community support services. Sub-analyses will also examine factors related to health equity by exploring whether some potentially disadvantaged populations (e.g. newcomers, individuals whose preferred language of service is other than English) have longer wait times to access supportive housing or community support services;
9. To examine characteristics, wait times and service placement outcomes associated with varied referral sources for supportive housing and community support services;
10. To identify the number, characteristics, and wait times of applicants receiving priority access to services compared to applicants who do not receive priority access to services;

11. To identify the characteristics and service placement outcomes of applicants waiting for service who receive short term case management and to examine whether the provision of short term case management reduces the need for long term community support services.

## **The sample**

The data source for this project was the administrative database of supportive housing applicants used by The Access Point. The database includes information from the application on persons (age 16 or older) who applied for supportive housing from January 2009 through October 2015.

When a person applies for supportive housing, the applicant – or a staff person at a referring agency or a family member on the person’s behalf – inputs requested information into the application ([https://hub.roxysoftware.com/referralForm\\_0.php](https://hub.roxysoftware.com/referralForm_0.php)). This information is stored in The Access Point database. Subsequently, staff at The Access Point contact the applicant to clarify or expand on information from their application. After housing is offered, the service request outcome (decline, refuse, accept, other) and the date of this outcome are entered into the database by The Access Point staff. This information was used to calculate wait times.

To anonymize the dataset for research, Access Point staff removed any identifying information that could potentially be used to identify applicants. Data in this report are aggregate and frequencies fewer than 5 are suppressed to protect applicant privacy. The anonymized dataset was stored in a secure server at CMHA Toronto and accessed by the researchers through a virtual private network (VPN).

Applicants may apply to The Access Point for more than one type of supportive housing. For example, an applicant may apply for general supportive housing and for addiction-targeted housing, which would appear as two service requests for the same applicant in The Access Point database. To ensure that the sample only included unique applicants, we selected one service request per applicant. For applicants who have not been placed, the applicant’s first service request was included. For applicants who have already been placed, we included the service request linked to their placement.

The final sample includes a total of 12,733 persons who had been placed in supportive housing or who were still waiting for supportive housing as of October 2015. The original sample was reduced by excluding 9 percent of applicants who were deemed ineligible by The Access Point (e.g. if they did not have a diagnosed or suspected mental illness) and 10 percent who had not consented to their information being used for research. Figure A.1 below provides a detailed outline of the composition of the sample selected for this study.

Analyses of past wait times and placement outcomes was based on applicants placed between August 2013 and October 2015. Wait time and outcome data prior to August 2013 (when The Access Point implemented a new client management database) were less reliable. During this period there were 772 unique applicants placed in supportive housing. For the past wait times analyses, 130 (18 percent) of the 772 applicants were excluded due to missing wait time data. Past wait times were calculated from the date an applicant was found to qualify for supportive housing to the date they were admitted into supportive housing. One analysis examining the support intensity that applicants were placed within

was based on 674 rather than 772 applicants since 98 applicants were excluded due to not having information on the intensity of support of the unit in which they were placed. An analysis examining the service outcomes of applicants was based on applicants' first service outcome. Between August 2013 and October 2015, 1870 applicants had at least one outcome related to a service request for supportive housing.

Analyses of applicants on the wait list at the end of the study period (October 31, 2015) were based on 7767 unique individuals (25 applicants were excluded due to missing wait time data). Wait times for this group were calculated from the date applicants were found to qualify for supportive housing by The Access Point to October 31, 2015.

### **Indigenous individuals**

Indigenous persons compose 5 percent of the unique individuals in the database of applicants used in this analysis. In accordance with Tri-Council Policy,<sup>57</sup> analyses focusing on Indigenous applicants have not been undertaken, as the research team has not yet consulted with appropriate representatives of the Indigenous communities.

### **Variables**

Variables were mostly derived from responses to the application.

Variables derived from individuals' applications were:

- Referral source
- Service program stream requested (e.g. MHSH, SHPPSU, MHJ)
- Demographic variables (e.g. age, gender, language)
- Socio-economic variables (e.g. primary income source, type of residence, type of homelessness)
- Housing preferences (e.g. shared versus self-contained units; intensity of support requested)
- Mental health clinical variables (e.g. primary mental health diagnosis, co-occurring conditions, use of acute care services for mental health reasons)
- Support needs (e.g. requires support for managing medication, preparing meals, etc.)
- Safety issues (e.g., history of suicide attempts/self-harm, violence, substance abuse, etc.)

Variables added by The Access Point staff after supportive housing units are offered included:

- Service request outcomes (e.g. placed in service, applicant refused service or agency declined applicant)

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<sup>57</sup> Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans 2 - Chapter 9 Research Involving the First Nations, Inuit and Métis Peoples of Canada: <http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9>.

- Past wait times for service request outcomes

### Constructed and composite variables

In addition to examining variables that were derived directly from questions on the application, the research team also constructed certain variables from those measured in the application, and recoded some answers. For example, there is a composite variable for substance use, and consistent treatment of inconsistent answers on whether a person in an institution is living alone or with others.

For a more detail description of these variables, please consult the online application available from: [https://hub.roxysoftware.com/referralForm\\_0.php](https://hub.roxysoftware.com/referralForm_0.php).

Residence type and living arrangement categories used in The Access Point application form originate from data elements in the Ontario Common Assessment of Need (OCAN) tool. The OCAN categories of shared or congregate housing are not all clearly defined. For this study, the OCAN residence type categories were aggregated as follows:

OCAN/CDS Residence Type Categories	New Residence Type Categories
No fixed address	No fixed address
Hostel/shelter	Shelter
Correctional/probation facility	Correctional/probational
General hospital	Hospital
Psychiatric hospital	
Other specialty hospital	
Long-term care facility	Rooming or Boarding house or other congregate
Retirement home/seniors residence	
Supportive housing - congregate living	
Supportive housing - assisted living (developmental)	
Rooming/boarding home	
Approved Homes/Homes for Special Care	
Domiciliary hostel	
Municipal non-profit	Self-contained – subsidized
Private non-profit housing	
Private house/apt. - other/subsidized	
Private house/apt. - owned/market rent	Self-contained – market
Other	Other/unknown
Unknown or missing	

Applicants were considered to be in a self-contained unit if they lived in private non-profit housing, municipal non-profit housing, private house or apartment (client owned/market rent), or private house/apartment (other/subsidized).

Applicants residing in hospitals, correctional facilities, shelters and other shared or congregate accommodation responded very inconsistently about whether they were living on their own or with non-relatives (or with others). All such applicants were recoded as living with non-relatives for purposes of analysis.

There were a number of categories in the OCAN/CDS living arrangement data element that had low counts. In order to protect the privacy of applicants, some of these categories were collapsed and a new living arrangement variable was created. The OCAN/CDS Living Arrangement data categories were mapped to the following data categories of the new living arrangement variable:

<b>OCAN/CDS Living Arrangement Categories</b>	<b>New Living Arrangement Categories</b>
Self	Self
Children	With spouse and/or children
Spouse/partner	
Spouse/partner and others	
Parents	With parents or relatives
Parents and children	
Relatives	
Non-relatives	With non-relatives or others
Other	
Unknown	Unknown

A composite homelessness variable was constructed based on two questions asked at the time of application. The first is Residence Type, discussed in section 2.3, and the second is a direct question – “Are you currently in temporary housing or homeless?” The relationship between the categories of the composite homelessness variable to these two questions are as shown below.

All who were residing in a shelter or had no fixed address when they applied are in an “NFA/shelter homeless” category. People who self-identified as homeless and were in hospital or correctional facilities when they applied are counted here in categories named “homeless hospital” and “homeless jail/prison” respectively. A third homeless category consists of all others who self-identified as homeless – people living in various forms of shared or independent accommodation.

Homelessness by Type								
Residence type		Self-identified Not Homeless		Self-identified as Homeless or in Temporary Housing			Total	
a	Correctional/probational	38	1%	328	5%	Homeless Jail/prison	366	3%
b	Hospital	157	3%	867	13%	Homeless Hospital	1,024	8%
c	No fixed address	0	0%	1,413	21%	Homeless NFA/Shelter	1,413	11%
d	Shelter	0	0%	2,002	30%		2,002	16%
e	House or apt subsidized	930	15%	187	3%	Homeless Other	1,117	9%
f	House or apt in market	2,373	39%	546	8%		2,919	23%
g	Rooming /Boarding House	706	11%	243	4%		949	7%
i	Supportive congregate	333	5%	142	2%		475	4%
j	Other	648	11%	864	13%		1,512	12%
k	Unknown/Do not know	956	16%	0	0%		956	8%
Total		6,141	100%	6,592	100%		12,733	100%

Consistent with OCAN/CDS data, mood disorders are consolidated in a single category, as differences between more specific mood disorders (depression, bipolar, etc.) are not reported consistently across all applications. The psychotic disorder category includes schizophrenia and other psychotic disorders.

### Data quality and limitations

Some variables from the application were excluded from the analysis due to high percentage of missing data (e.g. variables on ethno-cultural and immigrant status).

There are other data limitations. Most notably, data are self-reported. The consequences are that for some variables there is a high non-response rate, and/or a high frequency of “don’t know” or equivalent. Due to this self-reporting, applicants may understand questions differently; some questions may be hastily considered or skipped. In addition, the variables at time of application were captured months or even years before the applicant was offered housing.

Data on applicants’ physical health was not included because questions on the application form did not distinguish between different physical health disorders and so data were too crude to be included. Data on applicants’ other supports and use of health services (e.g. family physician, psychiatrist) were not reported on because they only began being consistently collected in 2012. In addition, there were no data on supply of housing units or geographic areas of housing units. Moreover, responses to some variables (e.g. primary mental health diagnoses) offered response items that did not allow us to disaggregate desired categories (e.g. mood disorders).

### Waiting List Analysis – The Access Point – March 2018

## Data analysis and graphing

### Unadjusted analysis

To describe and compare groups, descriptive statistics and socio-demographic characteristics were compared using chi-squared tests and effect sizes measured using Phi/Cramer's V. Past wait time was divided into categories based on the number of years between qualification date (i.e. the date The Access Point found an applicant was eligible for supportive housing) and the date applicants were admitted into supportive housing. Group comparisons were done using chi square tests, which is the same approach used with other categorical variables (although this variable could only be examined for the subset of applicants who had already been placed).

### Adjusted analysis and predicted probabilities

Multinomial logistic regression models were used to examine predictors of applicants being placed in housing with each of three support intensities: 24-hour, daily, and occasional. Two models with the same sample (n=674) were used. The first model included sociodemographic characteristics (age, gender, primary mental health diagnosis, substance use issues, developmental disability, hospital use over the past two years, primary income source, criminal justice involvement, and homelessness) as predictors. The second model included applicants' requested support intensity (24-hour, daily, occasional) and 22 support needs listed on the application that the applicant coded as present or not as predictors and examined their relationship to being placed in units with each of these three support intensities.

Multinomial logistic regression models in this report yielded relative risk ratios. We endeavoured to make these results more tangible by computing predicted or expected values for hypothetical or prototypical cases.<sup>58</sup> These were then used to determine the likelihood of being placed in units with different support intensities for applicants who requested each of 24-hour, daily and occasional support. Other predictors in this model were support needs, which were held or fixed at their mean values; this was appropriate since the values were coded as 0 (no need) and 1 (need is present), meaning that the variable means resembled proportions (Long & Freese, 2006; Williams, 2012; Hanmer & Ozan Kalkan, 2012)<sup>3,59</sup>.

Data analysis commenced in early 2016 and was completed in early 2017. It was conducted using SPSS version 23 and Stata SE 13.

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<sup>58</sup> Long and Freese (2006), *Regression Models for Categorical Dependent Variables Using Stata* [Stata Press]

<sup>59</sup> Hanmer, M.J., Ozan Kalkan, K. (2012) Behind the Curve: Clarifying the Best Approach to Calculating Predicted Probabilities and Marginal Effects from Limited Dependent Variable Models. *American Journal of Political Science* 57 (1) 263–277. Accessed from:  
<https://gvpt.umd.edu/sites/gvpt.umd.edu/files/pubs/Hanmer%20and%20Kalkan%20AJPS%20Behind%20the%20Curve.pdf>



Figure A.1

15 Composition of sample of supportive housing applicants who applied to The Access Point in Toronto, Ontario from January 1 2009 to October 31, 2015.

	# INCLUDED SERVICE REQUESTS	SERVICE REQUESTS
Service requests to the AP for supportive housing or intensive case management from inception of the programs in Toronto, Ontario (January 1 2009) until October 31, 2015	37,554	
		99 Service requests excluded due to input errors (e.g., inaccurate dates that led to wait times less than zero, or no service outcome data)
Service requests to the AP for supportive housing or intensive case management until October 31, 2015 with input errors removed	37,455	
		4,163 Service requests excluded due to applicant not checking the consent checkbox that states, "I have read and understand this form and consent to the collection, use and disclosure of Personal Health Information as described in the form."
Service requests to the AP for supportive housing or intensive case management until October 31, 2015 with input errors removed and service requests for which the applicant did not check the consent box	33,292	
		31 Service requests excluded due to applicants' text box entries that asked that their information not be shared with anyone outside their direct service staff, researchers, or anyone
Remaining service requests after exclusions due to input errors or no consent provided	33,261	
		13,288 Service requests excluded because unique applicants had multiple service requests (earliest service requests were included, later service requests were excluded) by program (SH vs ICM-ACT)
Service request per unique applicants (earliest service request kept)	19,973	
		13,288 Service requests excluded because unique applicants had multiple service requests (earliest service requests were included, later service requests were excluded) by program (SH vs ICM-ACT)
Service request per unique applicants (earliest service request kept)	19,973	
Service request per unique applicants (most recent service request) by program		
Intensive case management	6179 (30.7%)	
Supportive housing	9918 (49.3%)	
Intensive case management + supportive housing	3870 (19.4%)	
Missing program (i.e., regular Mental Health Supportive Housing, Substance use focused housing, Mental health and Justice)	6 (0%)	
<b>Unique applicants to supportive housing</b>		
	# INCLUDED APPLICANTS	# EXCLUDED APPLICANTS
Unique applicants applied to AP for supportive housing	13,788	
		942 Excluded unique applicants not deemed eligible by AP
Unique supportive housing applicants deemed eligible by AP staff	12,846	
		7 Excluded unique applicants outside of eligible age range (16-100)
Unique supportive housing applicants deemed eligible aged 16-100 years with age data	12,839	
		106 Excluded unique applicants with missing or inaccurate dates of application (i.e., year 2103)
Unique supportive housing applicants deemed eligible aged 16-100 years who applied from Jan 1 2009 to Oct 31, 2015	<b>FINAL SAMPLE 12,733</b>	