Seeking Supportive Housing:

Characteristics, Needs and Outcomes of Applicants to The Access Point

Toronto Mental Health and Addictions Access Point
Waiting List Analysis, March 2018

Canadian Mental Health Association Toronto

Wellesley Institute
advancing urban health

The Access Point

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Prepared for The Access Point, Toronto

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KEY MESSAGES

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.

Highlights of the Research Findings

- Demand for supportive housing far outstrips supply. In a recent two-year period, over 4,000 new people applied while less than 600 were placed in supportive housing.
- Most applicants have long wait times. Nearly 60 percent (4,431) of applicants on the waitlist 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.
- Support needs vary, e.g. looking after the home, meal preparation, managing medications, avoiding crises, and addressing drug or alcohol use. The vast majority of applicants needed support in more than one of these areas.
- Applicants have high levels of housing need as well as great need for supports. More than half of them (52%) self-identified as homeless or in temporary housing when they applied.
- A large majority of applicants stated a preference for self-contained supportive housing units. Only six percent specifically requested shared accommodation.
- Applicants were diverse in their living situation, health and clinical issues:
    - Homeless applicants included 11 percent (of total applicants) residing in shelters, 7 percent in hospital, 3 percent in jail, and 16 percent with no fixed address.
    - One-third of applicants had mood disorders and another third had psychotic disorders, with anxiety and various other diagnoses among the rest.
    - Over one-third of all applicants reported problematic substance use.
    - One-quarter of applicants reported current or recent criminal justice system involvement.
    - One in every eight applicants reported high hospital inpatient use for mental health reasons (50 or more inpatient days in the two years before they applied).

- Support needs varied across the above applicant characteristics. However, two broad groupings were evident: people with psychosis diagnoses, higher hospital inpatient use, and functional support needs; and people with problematic substance use, criminal justice involvement, and needs related to managing crises.
- One-fifth of people who were placed in a supportive housing unit were selected by the housing provider rather than drawn from the wait list. These "partnership applicants" were less likely to report being homeless and reported fewer support needs on average.
- 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.
- Applicants' wait times from application to placement in housing did not vary substantially based on mental health diagnosis, homelessness, inpatient hospital use or partnership status. But people with problematic substance use, criminal justice involvement, or more support needs tended to wait longer.
- Applicants are not always placed in the support intensity they request when they apply. This is attributable both to the more numerous openings in boarding homes that provide daily support, and to the absence of clear system-wide definitions of support intensity.
- Diverse needs and limited openings make it challenging to match applicants to suitable housing. Half of applicants offered supportive housing refused the first offer made.
- Applicants declined by housing providers because their support needs were too high were more likely to report problematic substance use, criminal justice involvement and homelessness.

Implications of the Research

- Long wait times and a growing waitlist confirm a great need to expand the supportive housing system, and also to create more openings by providing rent-subsidized options for supportive housing tenants to move on to.
- A range (or continuum) of support intensity and housing options is needed, reflecting the diverse needs and preferences of supportive housing applicants. Support approaches should be evidence-informed to meet the needs of distinct applicant groups.
- Given applicants' stated preferences for self-contained housing, system expansion should favour self-contained units. Some shared/congregate properties should be converted to short-term housing, to different support intensity, or to independent dwelling units.

- The large presence of homeless applicants points to a need for better coordination of the mental health supportive housing system with the municipally-led systems of homelessness services and housing.
- The supportive housing system needs clear definitions of support intensity (occasional, daily, 24-hour) and related program standards, to facilitate suitable placements and ensure best use of resources.
- Support services should shift toward models that can flex up and down, to meet changing individual needs, and to reduce the likelihood of bottlenecks and mismatched supports.
- Providers need enhanced capacity to house and support applicants with problematic substance use and criminal justice involvement. More housing targeted to these populations may also be needed.
- 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 in terms of greater or lesser urgency or alternative service responses.
- Partnership placements (e.g. 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.

INTRODUCTION

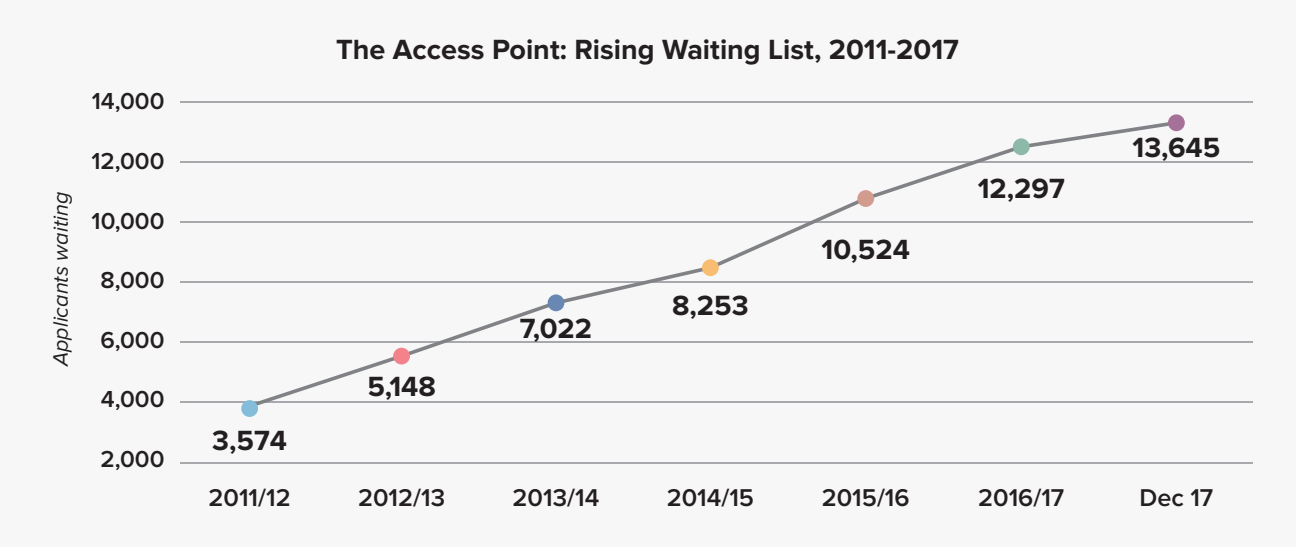
Currently in Toronto over 13,000 people are on the waitlist for mental health and addictions supportive housing. Understanding this population and how to meet their needs addresses an often overlooked health equity gap. This report is an analysis of the waitlist for mental health and addictions supportive housing in Toronto. It examines the characteristics of applicants, their support needs and housing preferences, and the patterns of wait times and outcomes of applying. Understanding the unique needs of this population will enable policy-makers to coordinate investments to ensure better outcomes. Further, it will provide an opportunity to develop program standards, common definitions and criteria and identify options to better meet client needs.

Most of the data are extracted from the administrative database of The Access Point, the coordinated access system for this supportive housing. This report summarizes a more detailed technical report which is also available.

Context

This analysis has been undertaken in a context of program pressures and policy change. The escalating waiting list is front and centre (Figure 1). 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 is related concern about homelessness associated with mental illness and addictions.

Figure 1



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

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 addictions in the City of Toronto (population 2.7 million, the inner half of the 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.

The housing to which people apply through The Access Point is funded by the Ontario Ministry of Health and Long Term Care and the LHINs. There are 29 participating non-profit supportive housing providers. The Access Point is jointly trusteed 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, operated by the City of Toronto.

The participating 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 targeted, for example, to people coming out of long-term hospital stays, with addictions, experiencing chronic homelessness, and with criminal justice involvement.

Scope and purpose of the research

The objectives of the research are as follows.

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 wait times and service request outcomes[1] for supportive housing;

4. To examine the relationships between applicant characteristics, needs, and service request outcomes;

5. To identify operational and policy implications of the findings.

1 Service request outcome refers to an applicant being placed in housing, refusing the offer of housing, or being declined by the supportive housing provider when referred to it.

Research methods

The extracted database for this study consists of application information on persons (age 16 or older) who applied for or were placed in supportive housing between January 2009 and October 2015, as well as wait time and service outcome data. To anonymize the dataset for this research, staff of The Access Point removed any information that could potentially be used to identify applicants. The final sample consists of 12,733 unique individuals. This excludes applicants who were ineligible for supportive housing or who had not consented to their information being used for research.

The database captures applicants' information as it was provided in their application, and data on wait times and outcomes of their application. The database and analysis do not cover applicants' evolving needs and situation, or any more refined assessments of needs carried out at a later time. It does not include data on the characteristics and location of supportive housing into which applicants were placed.

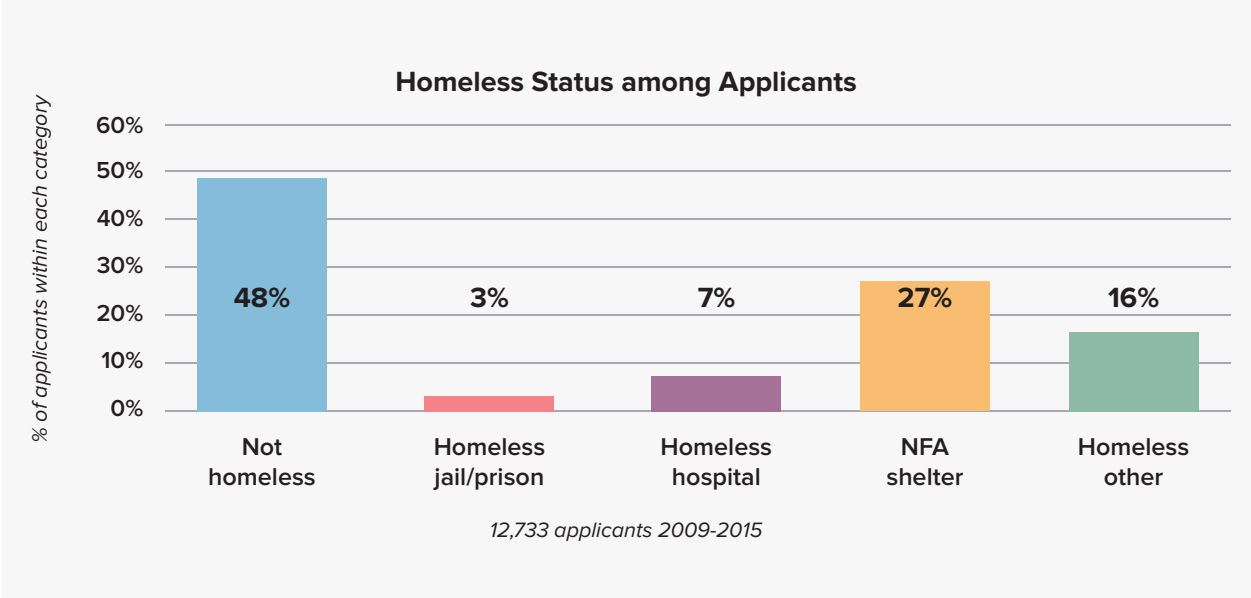
Interim findings were presented to key stakeholders, including groupings of providers and funders, the Integrated Access Steering Committee, Access Point staff, and people with lived experience of mental health conditions and/or addictions and homelessness. The implications and conclusions were developed 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 funders or participating providers.

KEY FINDINGS

Applicant characteristics

- A majority of applicants were male (59%), with a similar proportion found in most age groups. Applicants were fairly evenly spread across the 25-64 age groups, with a peak at age 45-54 and smaller numbers of youth or seniors.
- Most applicants had income sources that signal very low incomes. Most received social assistance, including half with ODSP (Ontario Disability Support Program) and one-fifth Ontario Works; 12 percent had no source of income while various smaller categories comprised the rest.

Figure 2



- More than half of applicants self-identified as homeless when they applied (Figure 2). This included 11 percent (of all applicants) being in a shelter, 16 percent having no fixed address (NFA), 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.
- Mood disorders and psychotic disorders were the most common primary mental health diagnoses reported by applicants (each 34% of all applicants). Next most common were anxiety disorders (14%), with various other diagnoses among the rest.

- Many applicants reported substance use challenges, with 36 percent identifying this as a problem and more than 40 percent reporting the presence of a concurrent disorder or problematic current substance use.

Support and Housing Needs

Support Needs

The specific support needs that people identified when they applied to The Access Point were analysed individually 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. These six domains are shown in Figure 3.

Of 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 are defined as low needs, medium needs and high needs in this analysis.

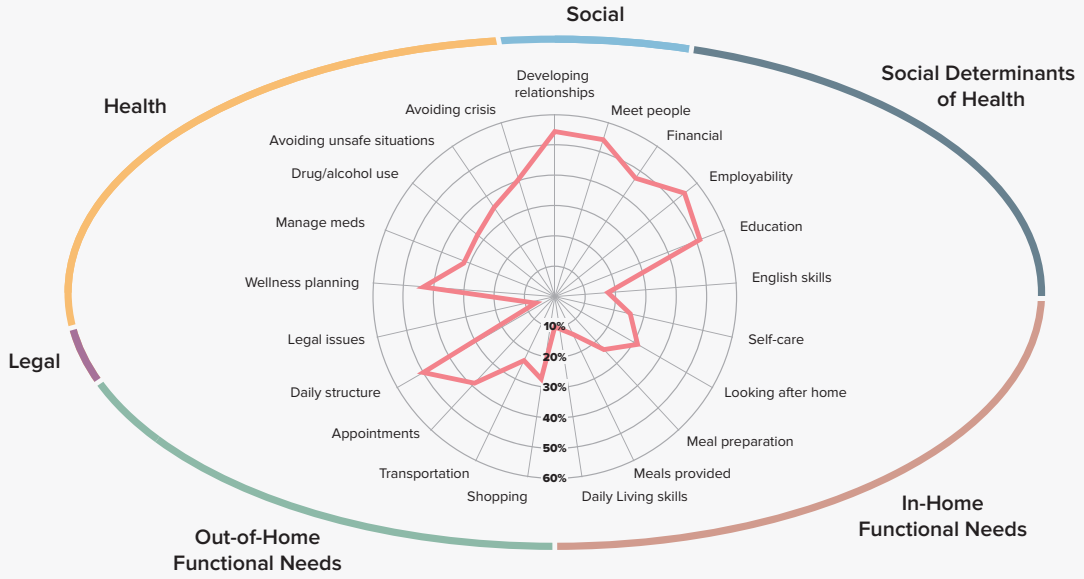
- Applicants most frequently identified support needs in the health and social determinants clusters (each representing 75% of applicants), followed by out-of-home activities of daily living (66%), social (63%), and in-home activities of daily living (46%).
- Applicants had high rates of needs in multiple domains. For example, over half of applicants with direct health-related support needs also had social support needs; and 40 percent of applicants with in-home support needs also had out-of-home support needs. Very few applicants had need in single domains.

Safety Risks/Issues

When people apply, they are also asked about safety issues they have struggled with at the time of application, which can help indicate the types of support they may need (Figure 4). For the 17 safety issues captured 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.

- The most common safety risk was suicidal thoughts (42%), with suicide attempts also common (20%).
- 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.
- A variety of other safety issues were cited by smaller shares of applicants.

Figure 3



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, each one labelled. Where the coloured line is further from the centre (wider), this indicates a higher frequency of that particular support need. Near the top of this graph, for example, developing relationships is further from the centre than avoiding crises. This indicates that more applicants cited a support need in developing relationships than in avoiding crises.

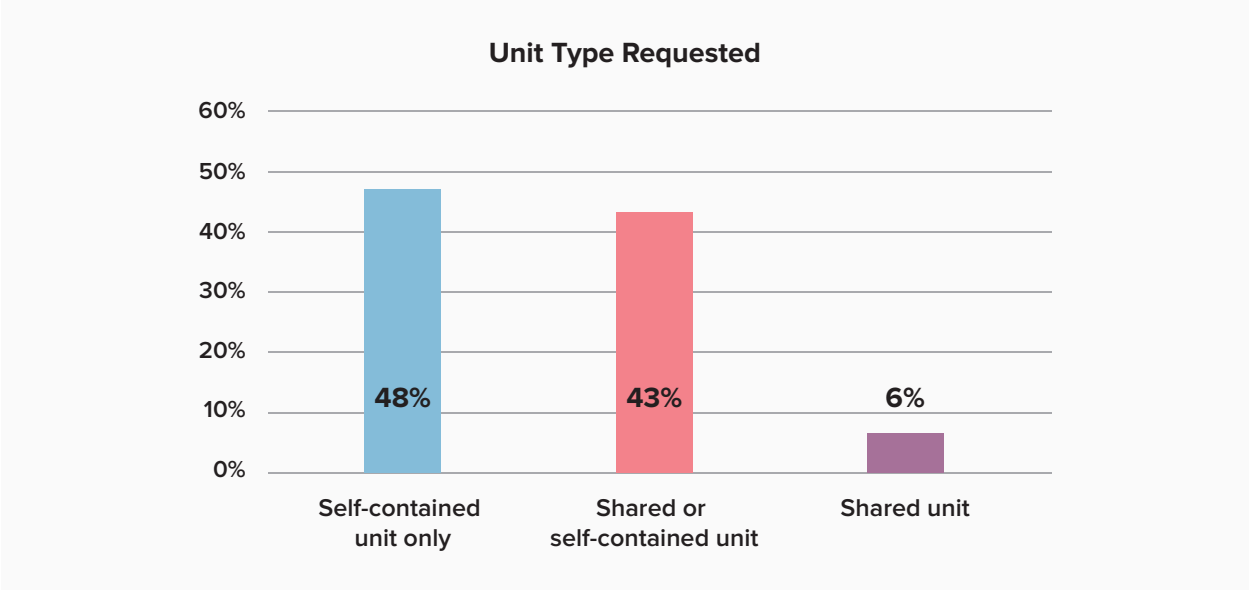
Figure 4

Housing needs and preferences

When people apply to The Access Point they are asked about the type of housing they prefer. They may choose from a range of shared and/or self-contained types of accommodation.

- A large majority of applicants stated a preference for self-contained supportive housing units: 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 (Figure 5). 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 inpatient use, and more functional and support needs.

Figure 5



Profiles of Five Service Groups

This section focuses on five applicant groups:

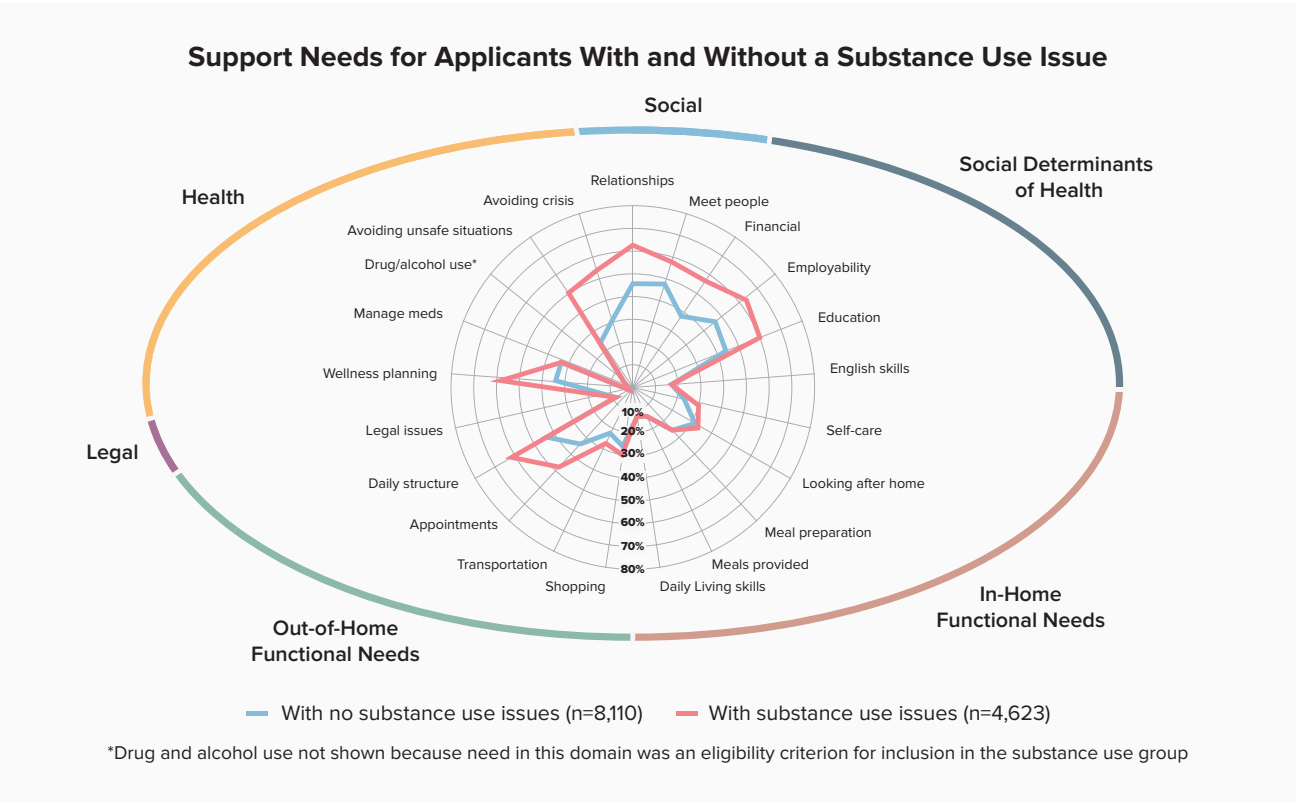
- people with co-occurring substance abuse and mental health problems
- those with criminal justice involvement
- people with high inpatient use
- homeless people
- people given priority access through partnership arrangements.

The focus on these groups responds to priorities previously identified by the LHINs, to specialized supportive housing programs targeted at specific service populations, and to partnership arrangements between housing and community support providers. These five groups are defined in this study using variables from the data collected when people apply to The Access Point (details available in the technical report). The groups examined here overlap. For example, some applicants may be experiencing homelessness and have high hospital inpatient usage.

Applicants with Problematic Substance Use

Over one-third of people applying for supportive housing between 2009 and 2015 (4,623 of 12,733, or 36%) reported a need for support with drug and alcohol use.

Figure 6



Compared to other applicants at the time of application, people reporting substance use challenges were:

- More likely to be homeless (62% versus 46%) and to be residing in a jail (5% versus 1%) or to have no fixed address or reside in a shelter (33% versus 23%)
- More likely to have current or recent criminal justice involvement (40% versus 16%)
- Twice as likely to identify 10 or more support needs when they applied (45% versus 22%)
- More likely to request support dealing with crises (55% versus 31%), avoiding unsafe situations (51% versus 25%) and wellness planning (57% versus 35%) (Figure 6).

Applicants with substance use problems were similar to other applicants in the types of housing units and support intensity they requested.

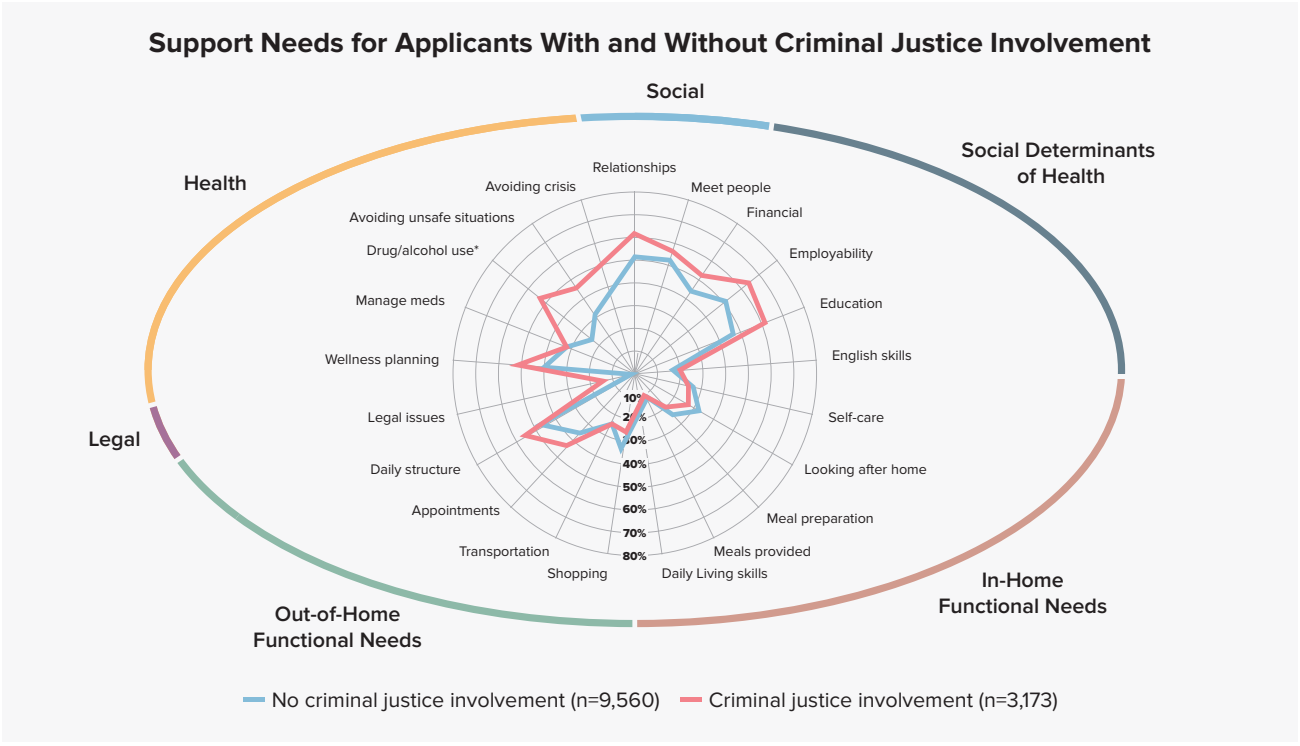
Criminal Justice Involvement

Fully 25 percent of applicants (3,173) reported current or recent criminal justice involvement.[2] Compared to other applicants, at the time of application, more of the people in this group:

- Were male (70% versus 53%) and younger (62% versus 46% under age 45)
- Were homeless (72% versus 45%); they were more likely to be in a shelter or NFA (35% versus 24%) and three times as likely to be in a correctional facility or hospital (21% versus 7%)
- Reported support needs related to avoiding unsafe situations (45% versus 31%), managing crises (51% versus 36%), or substance use problems (53% versus 25%) (Figure 7); this group was more than twice as likely to have a co-occurring substance abuse/dependence diagnosis (41% versus 18%)
- Reported past physical violence towards others (36% versus 12%), problems controlling anger (37% versus 21%), drug use resulting in harm (42% versus 20%) or alcohol use resulting in harm (36% versus 20%) (Figure 8).

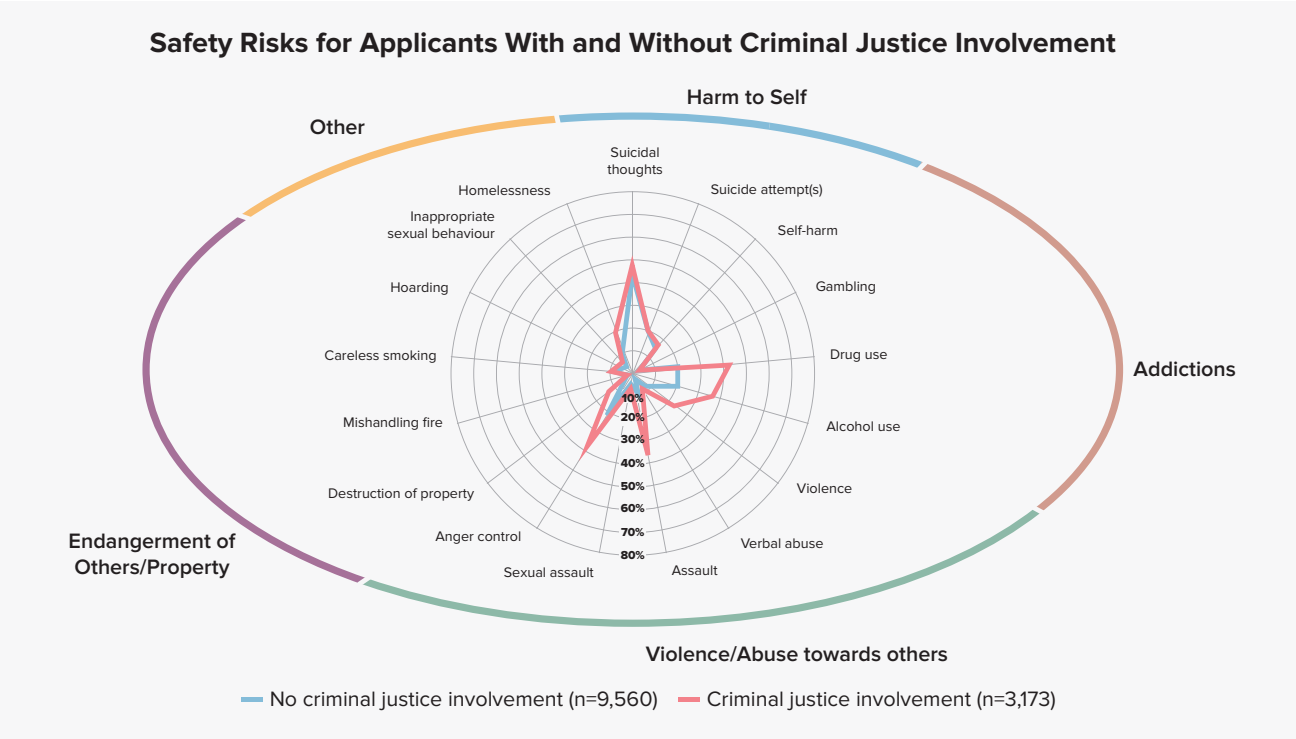
There was relatively little difference in housing preferences between justice-involved and other applicants. The support intensity requested was also similar.

Figure 7



2 Criminal justice involvement is a composite variable defined as the presence of one or more of the following, as captured in the application data: facing current criminal charges, residing in a correctional or detention facility, being on probation or parole, being under the purview of the Ontario Review Board (ORB) after being found not criminally responsible or unfit to stand trial, being held in a forensic mental health hospital pending a disposition by the ORB, or being screened as eligible for Mental Health and Justice housing by The Access Point.

Figure 8



Applicants with High Inpatient Use

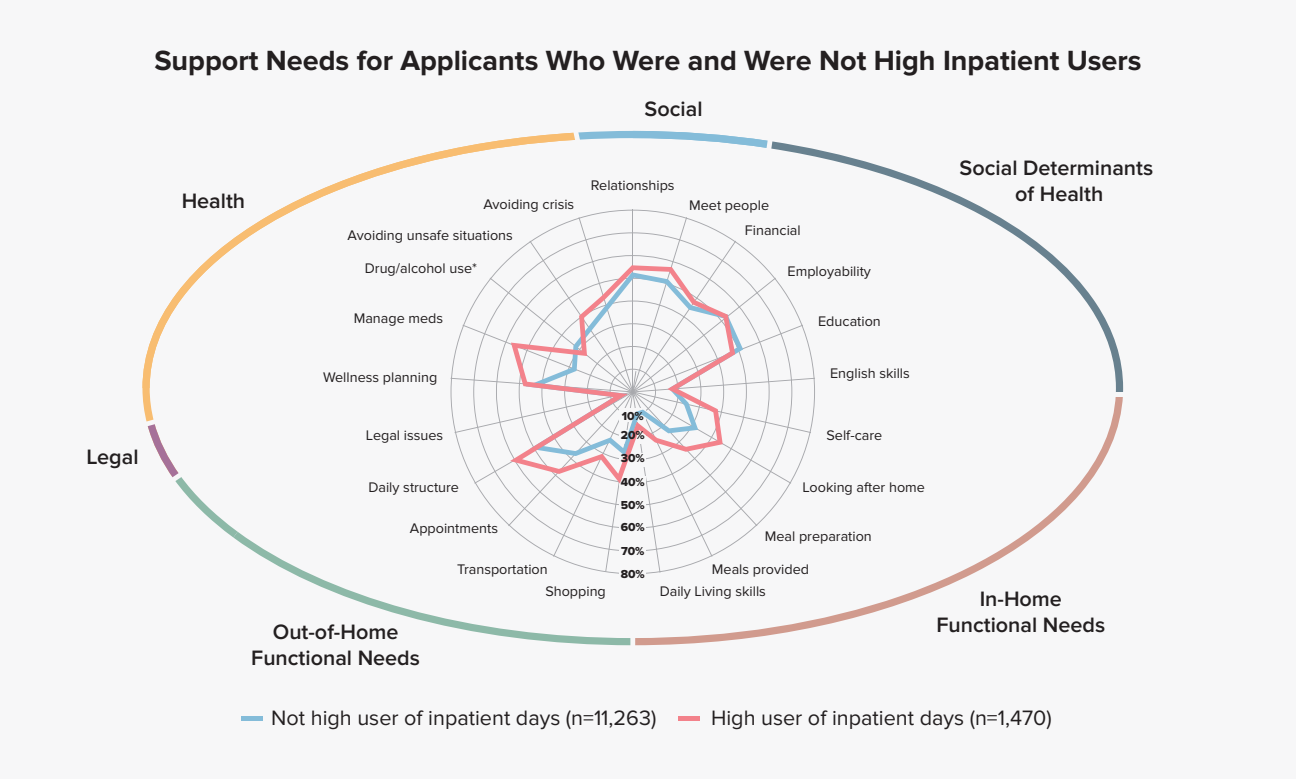
When they apply for supportive housing, people are asked how many days in the previous two years they had spent in hospital for mental health issues. The average days reported was 27, with wide variation. High inpatient use is defined as 50 or more inpatient days for mental health reasons in the prior two years. Fully 41 percent of applicants reported some such inpatient days and 12 percent of were in the high use category.

Compared to other applicants, at the time of application, more of the people in the high inpatient use group:

- Resided in hospital or jail (31% versus 8%)
- Were homeless (57% versus 51%); but this group was less likely to be residing in a shelter or have no fixed address (18% versus 28%)
- Had a primary diagnosis of a psychotic disorder (63% versus 31%). But they were less likely to have a co-occurring substance use problem (31% versus 37%)
- Reported ten or more support needs (40% versus 29%)
- Identified support needs in managing medications and in functional needs such as looking after the home, self-care, and meal preparation (Figure 9).

These applicants were more likely to request 24 hour or daily support (39% versus 18%) and only shared accommodation (15% versus 5%). They were less likely to request only a self-contained unit (32% versus 50%). This reflects the fact that high-support housing is often shared accommodation, and people are advised accordingly when they apply to The Access Point.

Figure 9



Homelessness

Half of all applicants were homeless or in temporary housing (6,592 of 12,733 or 52%). Four categories of homelessness were constructed by combining applicants' residence type and answers about homelessness: shelter/NFA (no fixed address), homeless and in hospital, homeless and in jail, and homeless-other. The latter consists of people who self-identified as homeless while residing in some form of self-contained or congregate housing. People's living situations often change during the period they are on the waiting list, but the data in this study capture only their status at the time of application.

The characteristics of applicants in each homeless category were compared to non-homeless applicants.

- Shelter/NFA applicants more often reported receiving Ontario Works than non-homeless applicants (27% versus 16%); homeless and in jail applicants were more likely to report no source of income than non-homeless applicants (36% versus 10%).
- Homeless applicants in hospital more often had a psychotic disorder as their primary mental health diagnosis (67% versus 27% to 35% for other homeless and non-homeless categories).

Figure 10

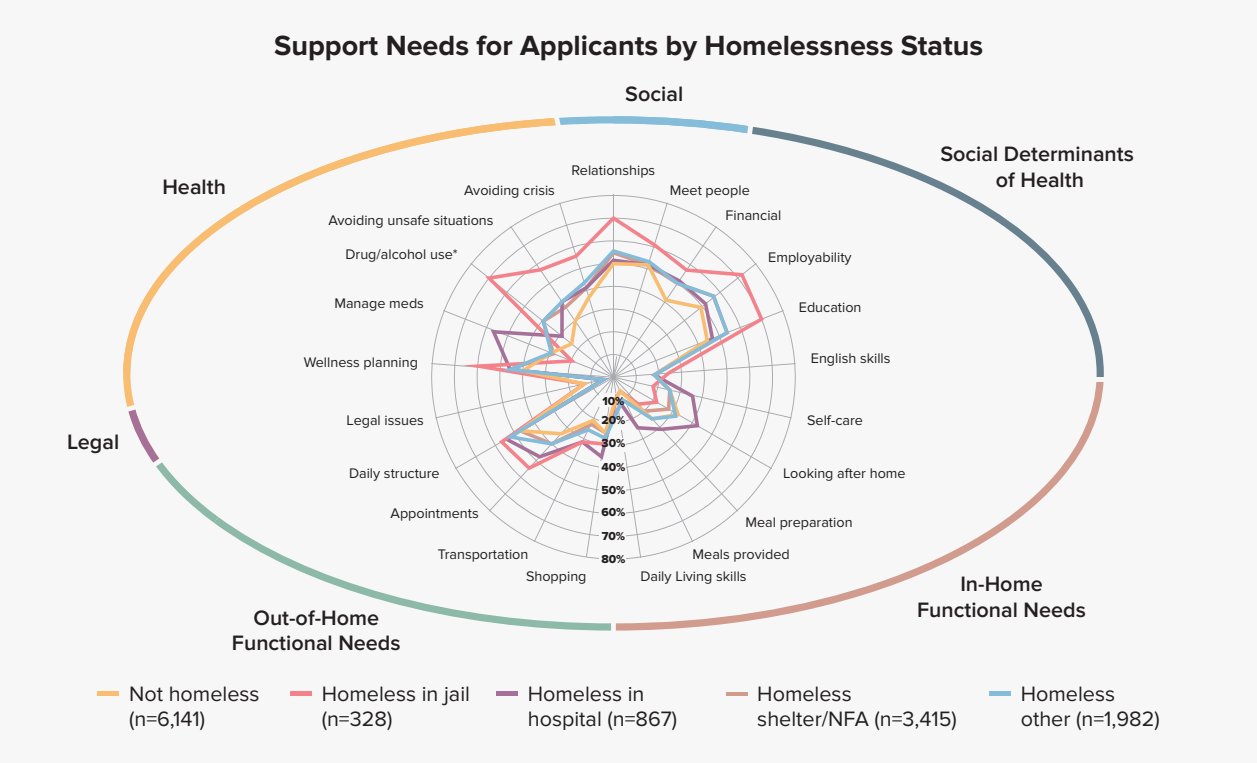
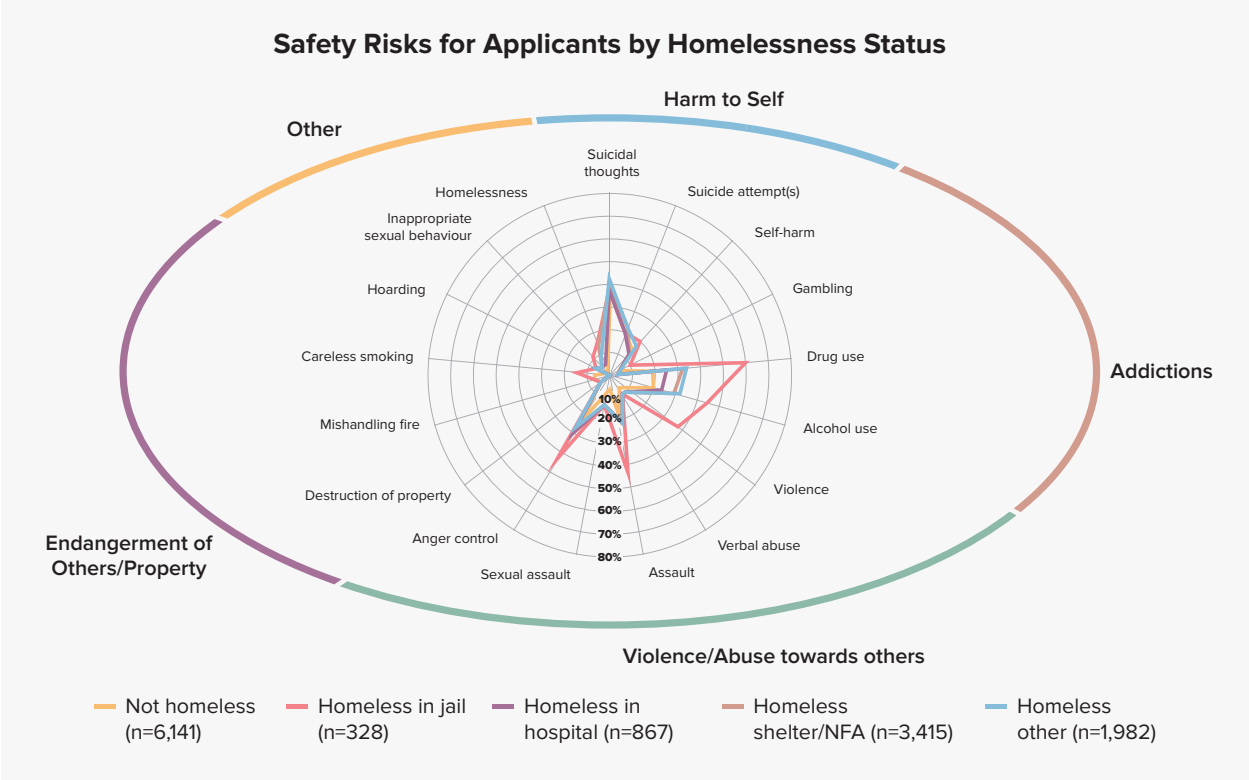


Figure 11



- Problematic drug and alcohol use is more prevalent among homeless applicants, except those in hospital. 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%). 'Homeless–other' applicants were similar. Among homeless applicants in jail/prison, 75 percent had identified drug/alcohol problems, and 55 percent a substance abuse/dependence diagnosis.
- Criminal justice involvement was also more prevalent among homeless applicants. Not only those in jail/prison, but also 33 percent of shelter/NFA and homeless-in-hospital applicants had such involvement, as did 28 percent of 'homeless–other' (versus 15% of non-homeless).
- Homeless applicants in jail were more often (45%) in the high needs group, citing 10 or more of the 22 housing-related needs, and so were other homeless applicants (between 31% and 36%) – compared to 27 percent of non-homeless.
- Homeless applicants in jail/prison had high support needs on adding structure to the day, avoiding crises, getting to appointments and obtaining employment; they had the highest needs in regard to drug and alcohol use and avoiding crises and unsafe situations. This group had a higher frequency of safety issues, especially in regard to drugs and alcohol causing harm, and violence against others (Figure 11).
- Homeless applicants in hospital had high support needs on managing medications, self-care, looking after the home, preparing meals, and accessing transportation (Figure 10).
- Shelter/NFA applicants had a relatively low number of support needs but a notable presence of safety risks associated with drugs/alcohol.
- Homeless applicants in hospital were far more likely than others to request 24-hour or daily support. Homeless applicants in jail/prison were most likely to request occasional support.
- Homeless applicants in hospital were least likely to request self-contained units and most likely to request shared units. Shelter/NFA and 'homeless–other' applicants were less likely than non-homeless to request only self-contained units. This reflects the fact that shared accommodation has more openings, and people are advised of that when they apply.

Partnership Applicants

Partnership applicants are usually identified by the supportive housing provider and given priority access to a 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 in place for people with high needs. The Access Point began collecting reliable data on partnership applicants in August 2013.

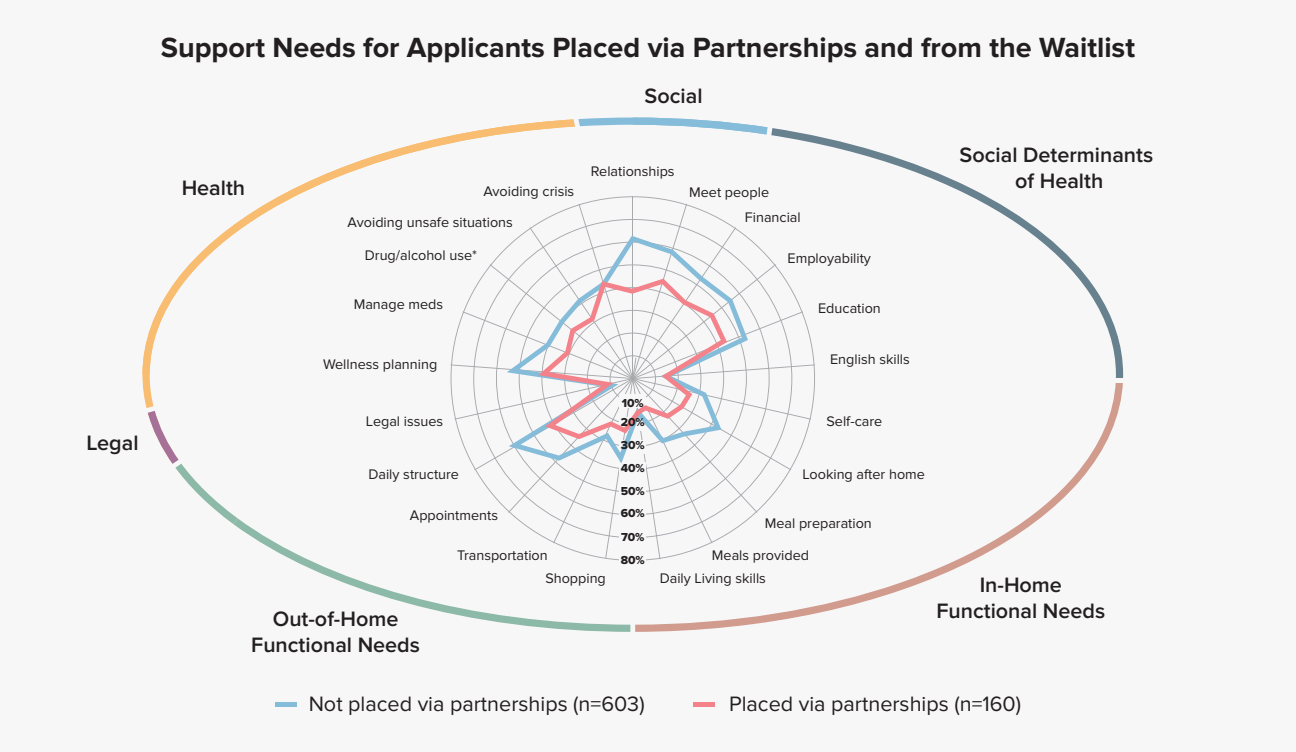
Between August 2013 and October 2015, 772 applicants were placed in supportive housing, and 169 (22%) of these were partnership applicants.

Partnership applicants:

- Were less likely to report being homeless when they applied (56% versus 68%).
- 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%).
- Reported fewer support needs than non-partnership applicants (Figure 12 below). However, there was no difference between groups with respect to reported safety risks.

These applicants were more likely to request self-contained units (43%) and less likely to request shared units only (4% versus 12%) or either shared or self-contained (43% versus 61%).

Figure 12



Characteristics and support needs among two diagnostic groups

Among the diverse applicants, two notable groups are evident in the analysis: people with psychosis diagnoses and functional support needs, and people with problematic substance use, criminal justice involvement, and related safety risks. Not all applicants are in one of these groups.

- Applicants with psychosis diagnoses more typically identify a need for support with activities of daily living and symptom/medication management. This group has more history of high inpatient use and more frequently request 24-hour support. They were also more commonly found among alternative level of care (ALC) inpatients. 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 are more often homeless in shelters or with no fixed address, more often have criminal justice involvement 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.

Wait times and outcomes

Demand for supportive housing, wait times and service request outcomes were examined among applicants placed or waiting for housing between 2013 and 2015. This shorter reference period was used as more reliable wait time and outcome data were available after August 2013.

Certain steps in the application and referral process are important in understanding this section. When a provider has an opening (housing vacancy), it notifies The Access Point, which then "matches" the first eligible applicant on the waitlist to that vacancy based on the individual's preferences and needs, and refers the person to the provider. The provider then carries out its own intake assessment and may either offer the unit or decline the application. If it offers the unit, the applicant may accept or refuse. A more direct referral process is used for housing with high ongoing openings, such as boarding homes.

The most prominent findings about wait times were as follows:

- Demand for supportive housing far outstrips available supply. Between October 2013 and September 2015, 4,043 new applicants were placed on the wait list while only 557 were placed in supportive housing (Figure 13).
- Nearly half of applicants placed in housing were placed in less than one year (Figure 14). 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 (Figure 15). Moreover, those at the top of the wait list (90th percentile) had been waiting for 4.5 years or longer.
- Applicants' wait time from application to placement in housing did not substantially vary based on 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 (Figures 16a-16c).

These 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.

These findings also suggest that the system – including The Access Point, providers, and the funded mix and range of housing and supports – does not give adequate priority to applicants with complex or high needs.

Figure 13

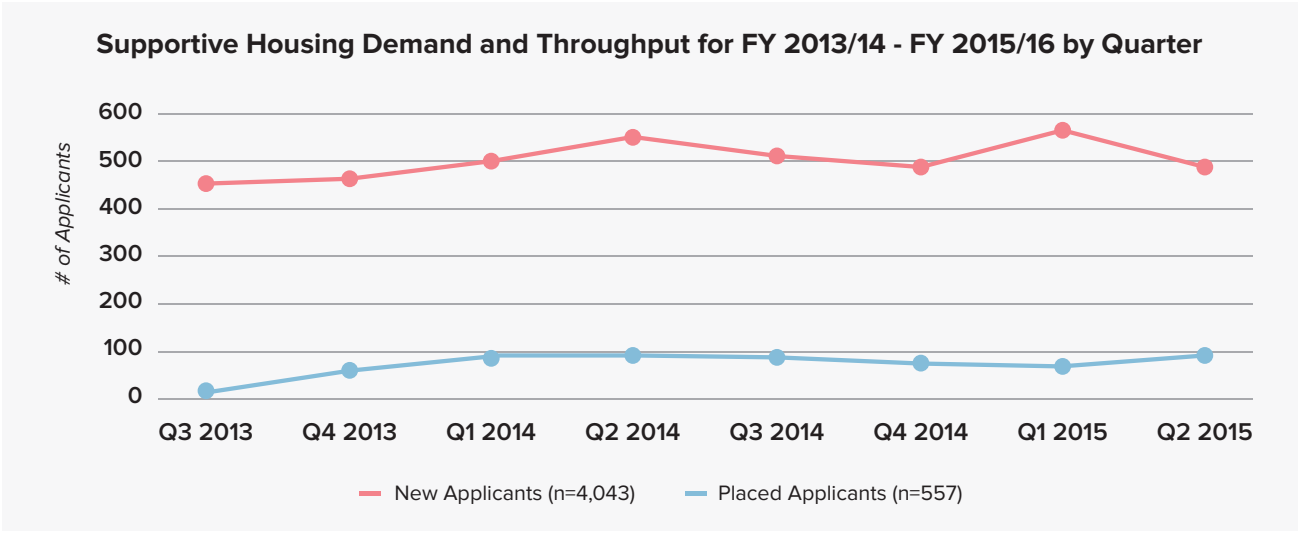
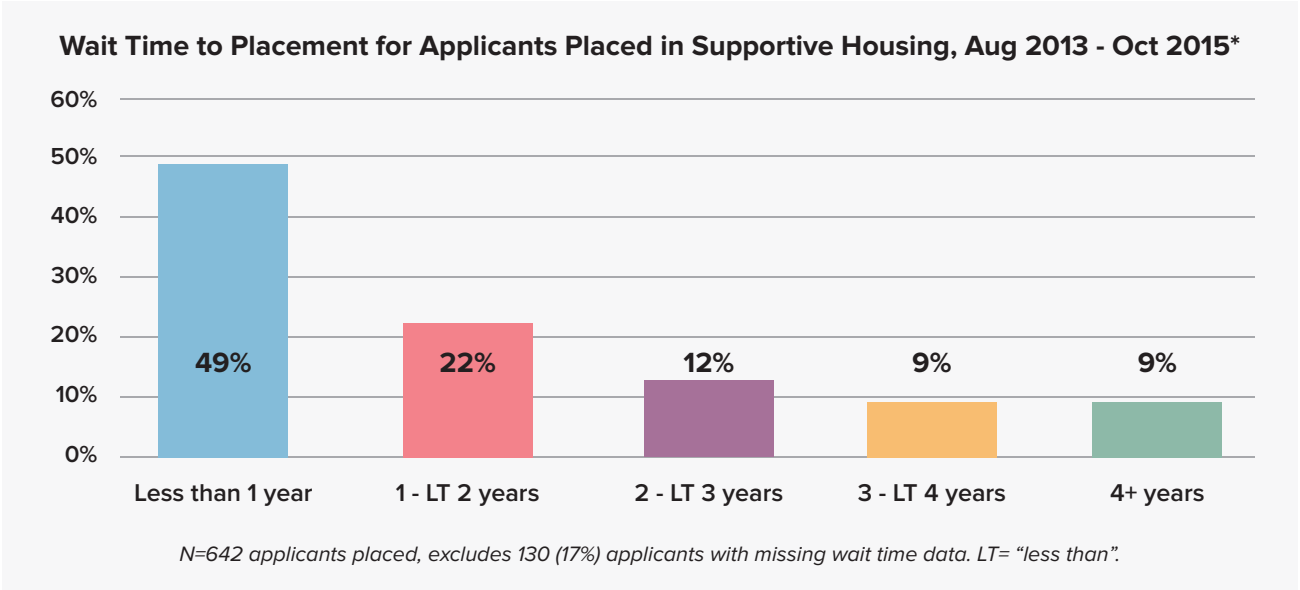
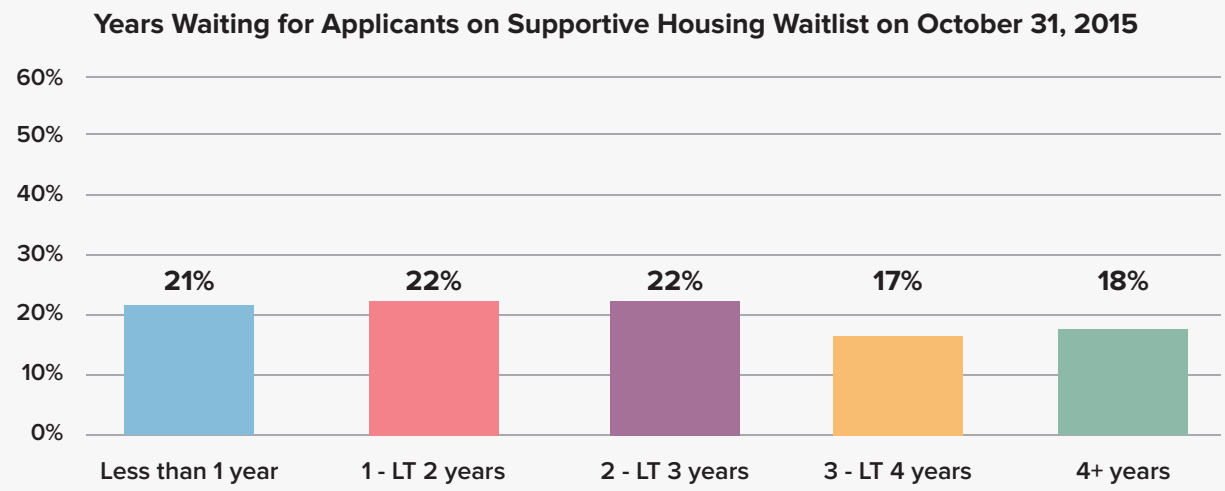


Figure 14



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

Figure 15



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

- 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 difference to the more detailed screening completed at the point of application, as well as the assessments done by staff when people are being matched to available housing. The difference between requests for daily support and placements in daily support is largely driven by 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 may reflect their need and/or preference for low barrier services and supports. Their 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 these than of other applicants requested self-contained units.

Figure 16a

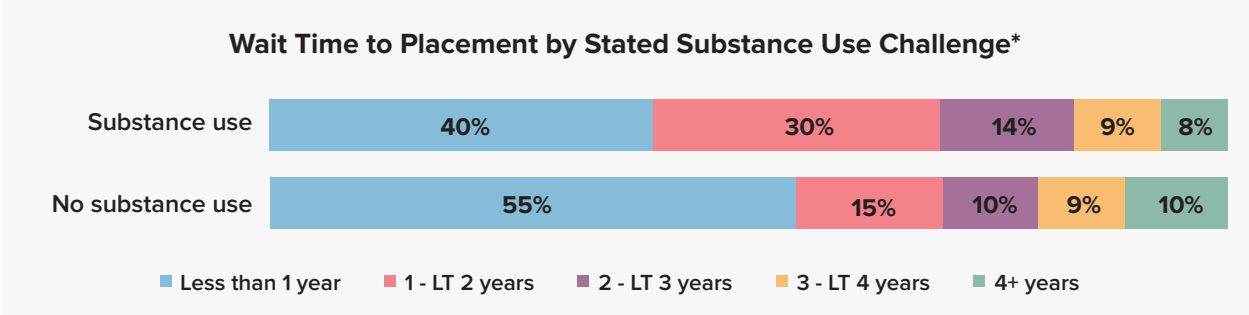


Figure 16b

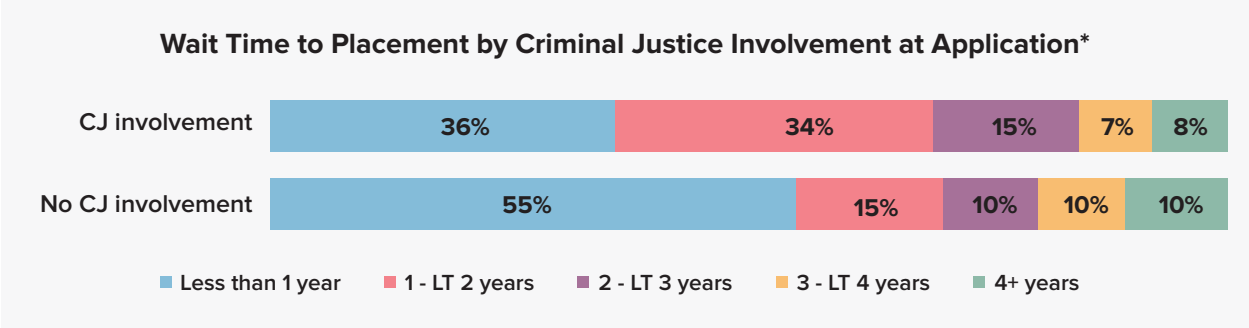
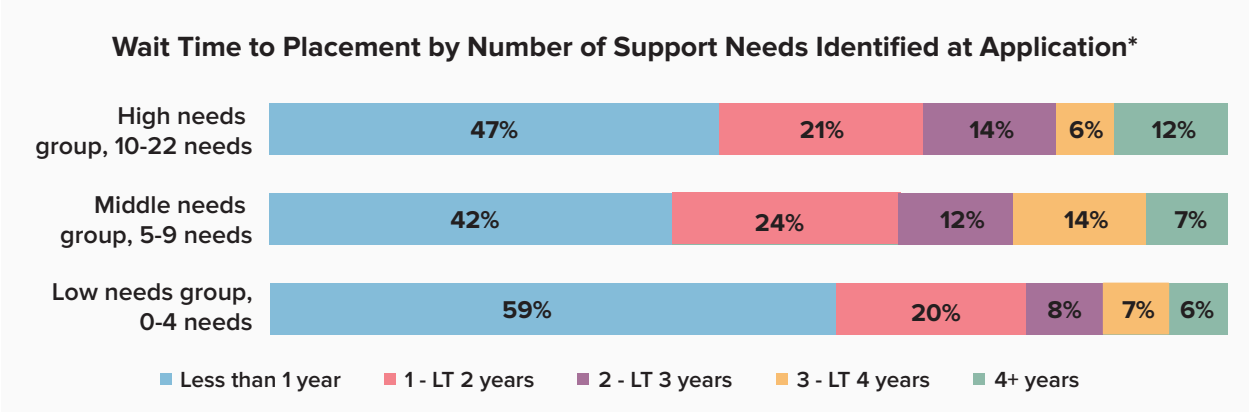
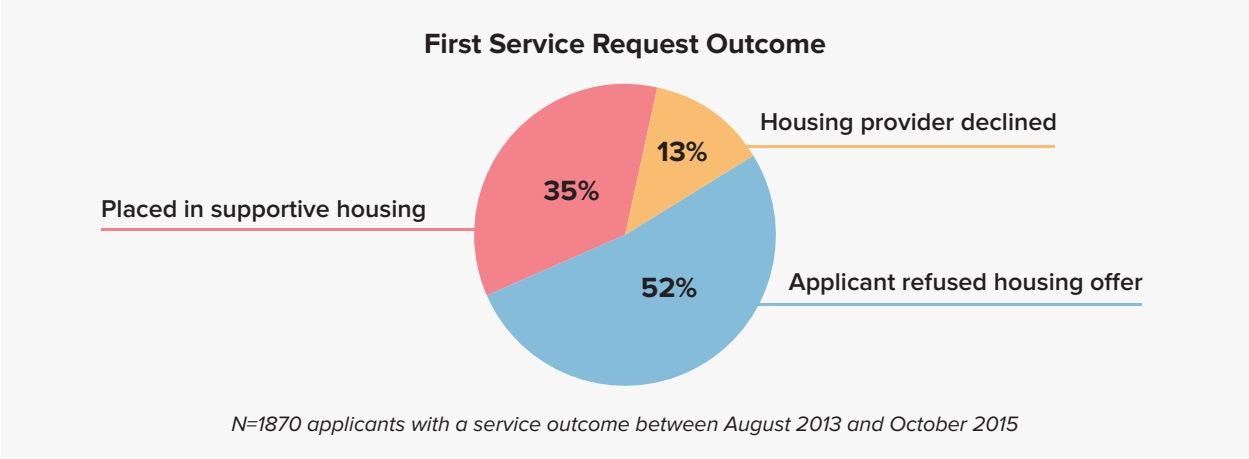


Figure 16c



*Note to figures 16a to 16c: *N=642 applicants placed between August 2013 and October 2015. Excludes 130 (17%) applicants with missing wait time data.*

Figure 17



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

- More than half of applicants who were offered supportive housing refused the first offer made (Figure 17). 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 did not accept the unit once they were able to visit it; 20 percent cited 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. (Given that the largest percentage of vacancies occur in shared housing and in boarding homes, applicants are encouraged to consider shared housing as an option.)
- 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, to have support needs related to managing crisis, unsafe situations and substance use (Figure 18), and to have safety risks involving harm to themselves or others (Figure 19).

Figure 18

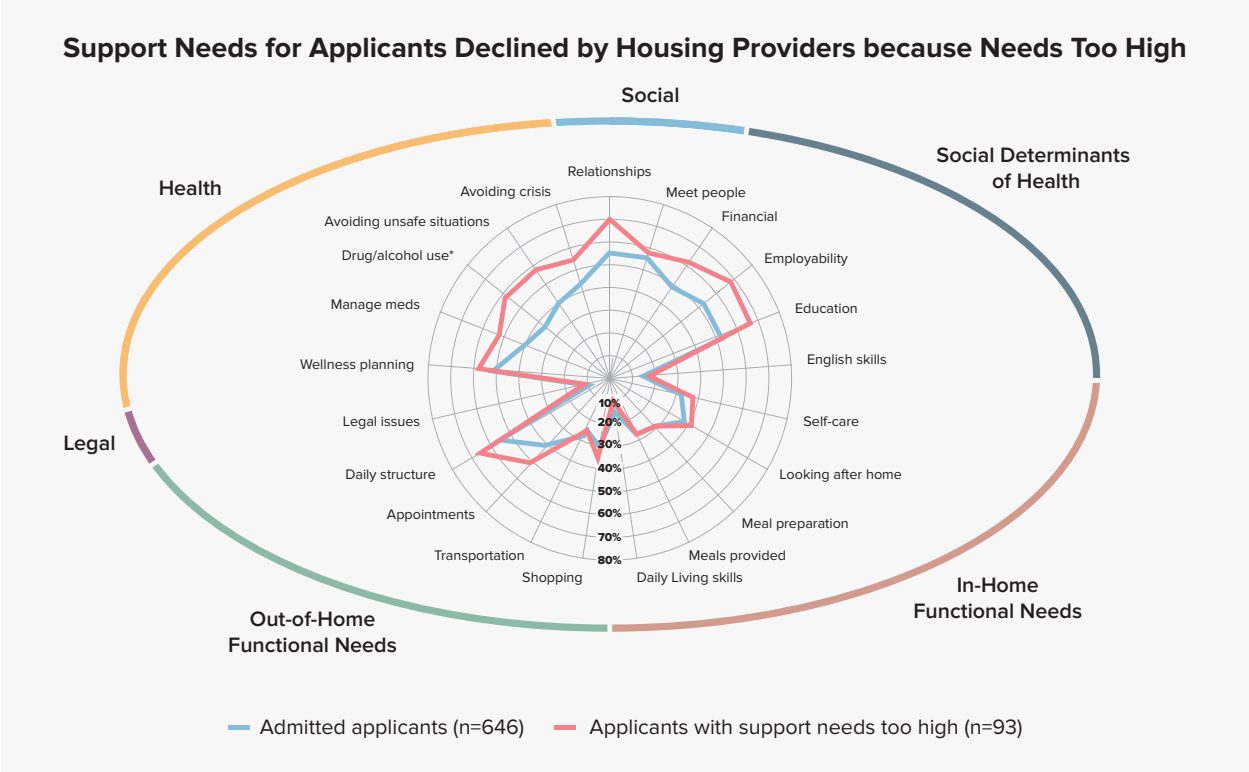
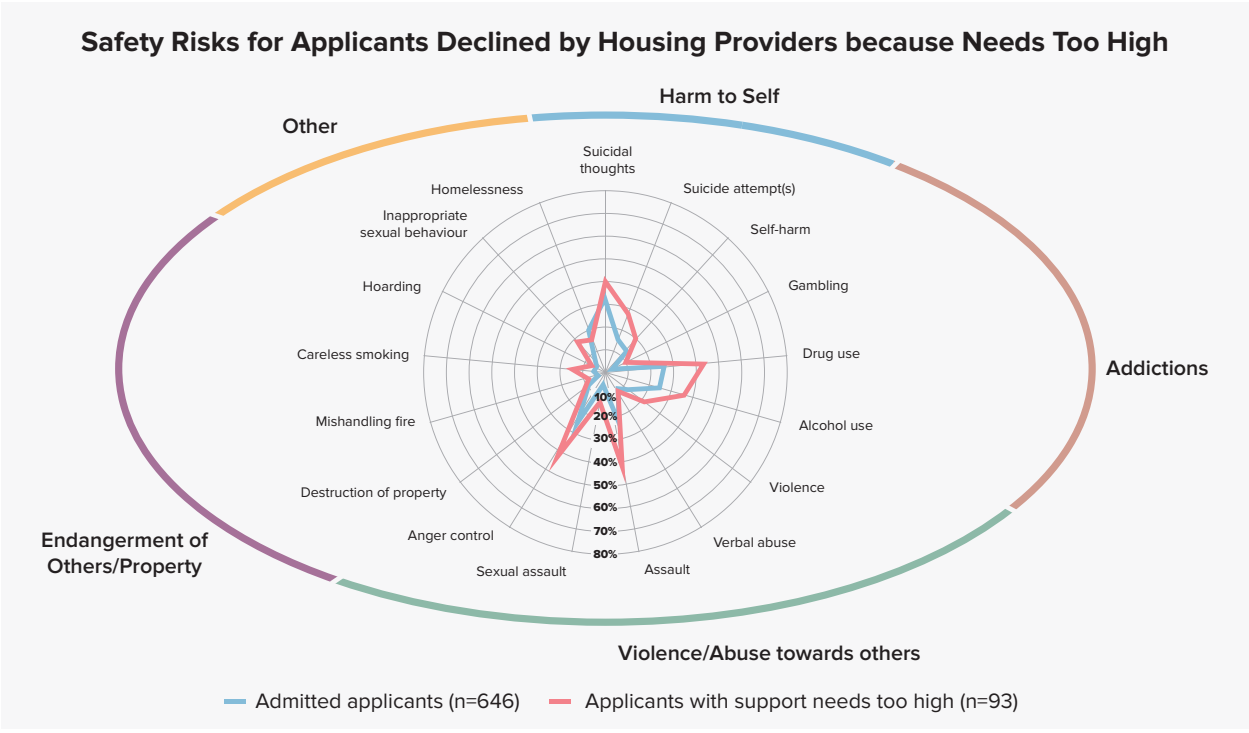


Figure 19



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

IMPLICATIONS

This section outlines the key implications of the research findings. A more detailed version of the implications and study findings is available in the technical report, which also provides references to supporting research literature.

1. Applicants have high levels of homelessness and housing need, and this is an under-served population in terms of affordable housing. Most applicants identify large needs for more than just housing, including health- and housing-related supports.

Half of applicants self-identify as being homeless or in temporary accommodation. Many live in various forms of congregate housing and very few are in subsidized housing. Many applicants are literally homeless, with one-quarter staying in shelters or having no fixed address, and others residing in hospitals and jails/prisons.

At the same time, a large majority of supportive housing applicants identify needs related to health, in-home, and out-of-home daily activities. The presence of needs across multiple domains confirms that applicants require supports and not just social/affordable housing or rent subsidies.

2. 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, and high use of hospitals, homeless-related services, and the criminal justice system. The system of mental health and addictions supportive housing and the openings 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. This calls for several changes in policy and practices, including expanding the supply of supportive housing, increasing the turnover and availability of units in the system where possible, and moving toward more triaging (see implications 3, 4 and 10).

3. 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 arise from insufficient system capacity rather than access policies and procedures. Expanding the supportive housing system will require additional Ontario government funding for housing support services, rent subsidies, and capital funding, building on recent program expansion.

4. Availability within existing supportive housing could be increased by funding more rent-subsidized alternatives that supportive housing tenants can move on to.

The shortfall of supportive housing supply compared to needs underscores the value of fostering more turnover and availability in existing supportive housing. This necessitates providing options to which residents can move on to, while adhering to principles of permanent, secure tenure and deeply affordable rents. The feasibility of this is confirmed by experience (see references in technical report) showing that many supportive housing residents could live in other forms of assisted independent housing in the community.

Such options require arrangements with other (non-supportive) social housing providers or private landlords. They may require flexible step-up/step-down supports, rapid re-entry to supportive housing if required, and assistance at the time of moving. Most fundamentally, these options require more Ontario funding for portable rent subsidies and rent supplement.

5. The many applicants with problematic substance use and the 'provider declined' patterns point to a need for enhanced provider capacity to support these clients, using evidence-based interventions.

Problematic substance use is common among applicants, and many provider declines[3] are associated with related risks pertaining to substance use, criminal justice involvement, and managing crises. Feedback on these findings suggests that providers may not have adequate capacity or specific skills to successfully house and support these applicants. More staff training on interventions targeting these issues can help address that gap, using specific evidence-based interventions and integrating this as part of providers' core support services.

Supporting people with criminal justice involvement and/or safety risks pertaining to substance use, self-harm or violence is challenging. Feedback suggests that it is not acknowledged sufficiently as a funding and support priority. Building up capacity in this area will require additional resources for providers, enhancing capacity for 24-hour outreach and crisis response, and adopting flexible, individualized, step-up/step-down supports.

3 This refers to cases where a provider declines to house an applicant who is referred to an available opening.

6. 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 these populations.

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. Substance use and risks related to justice involvement are part of the diversity of applicants' needs that call for a corresponding range of housing and support models.

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. These issues may be more pronounced in congregate housing, which is a large part of the existing housing stock. This constrains the ability of some providers to accommodate people with active addictions.

This reinforces the need for specialized housing targeted to people with substance use and criminal justice involvement, as part of the housing spectrum. Included in this would be more housing with low-barrier access, few preconditions, and a Housing First approach to placement and supports. This would reduce the unintentional exclusion of homeless people with problematic drug/alcohol use and/or criminal justice involvement.

7. The high percentage of applicants who are 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 providers overlaps considerably with the population served by the system of homelessness services (including shelters and housing supports) that is municipally funded and administered.

This points to a need to pursue more collaboration and coordination between the Health-funded housing system, including The Access Point, and the municipal system of homeless-related services and social housing. While recognizing that both systems face large pressures of insufficient capacity and constrained resources, better coordination will serve people more effectively and in a more efficient way.

8. 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 best use of resources.

The difference between the support intensity requested and the support intensities of units in which applicants were placed, and related feedback from staff of The Access Point, suggest a lack of consistent definitions for different levels of support intensity (e.g. 24-hour, daily, occasional). There is a need for renewed analysis and consultation to arrive at a clear, shared typology and definitions of support level, intensity, and related matters. This work combined with the use of standard screening tools would allow for a better analysis of the gap between applicant needs and the level of support available in current supportive housing units. Such definitions would also be helpful to providers as they adjust their support resources when a resident's needs change over time.

9. 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 staff of The Access Pointconfirms 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. Shared housing can mean less successful placement, as providers may decline applicants whose safety risks are likely to have impacts on other residents, 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 housing points to a need for strategic decisions on its role in the system. Some congregate housing could be more explicitly repositioned as transitional or short-term supportive housing. Some of the properties can be physically converted into self-contained housing. Other shared housing could be shifted to a different support intensity (e.g. high support housing). Different decisions will be needed about boarding homes than about other shared houses.

10. 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 applicants' support needs and safety risks, and their housing and homelessness needs, has implications for prioritization. There are valid but different reasons for giving priority to applicants with high support needs, or those with high safety risks, or others with high hospital use, or experiencing homelessness that destabilizes health. The system should also serve people with moderate needs.

To serve the applicant population fairly and adequately requires that access system priority for housing involve a multi-dimensional definition of urgency and high need.

This diversity of needs and urgency, and the lengthening waiting lists, point to a need to triage applicants at an early stage. For example, some could be assessed as needing urgent placement, others could be connected to different housing and service options, and others may be able to wait longer.

Moving in this direction requires the right balance between allocating resources to early assessment and triaging, while avoiding resource-intensive needs assessment of 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. Given the limited amount of housing available, any prioritized access for specific categories of applicants will materially lengthen wait times for other applicants. Therefore, prioritization should proceed in tandem with investments to expand sector capacity.

11. The significant proportion of partnership applicants with less urgent needs points to a need to review such arrangements to target more applicants with higher or urgent needs.

The findings indicate that partnership placements do not prioritize higher-need applicants. Given that partnerships constituted one-fifth of all placements, there is a need to ensure they give suitable priority to applicants with higher or more urgent needs. The Access Point could work with the Mental Health and Addictions Support Housing Network and partnership providers to move in this direction, using data-driven targeting strategies. The solution must balance several objectives, including priority for high-need applicants; assured housing access for support agencies' clients; and appropriate support for clients placed in housing with lower support staff funding. It may also require adjustments to funding to enhance the capacity of providers to support individuals with higher service needs.