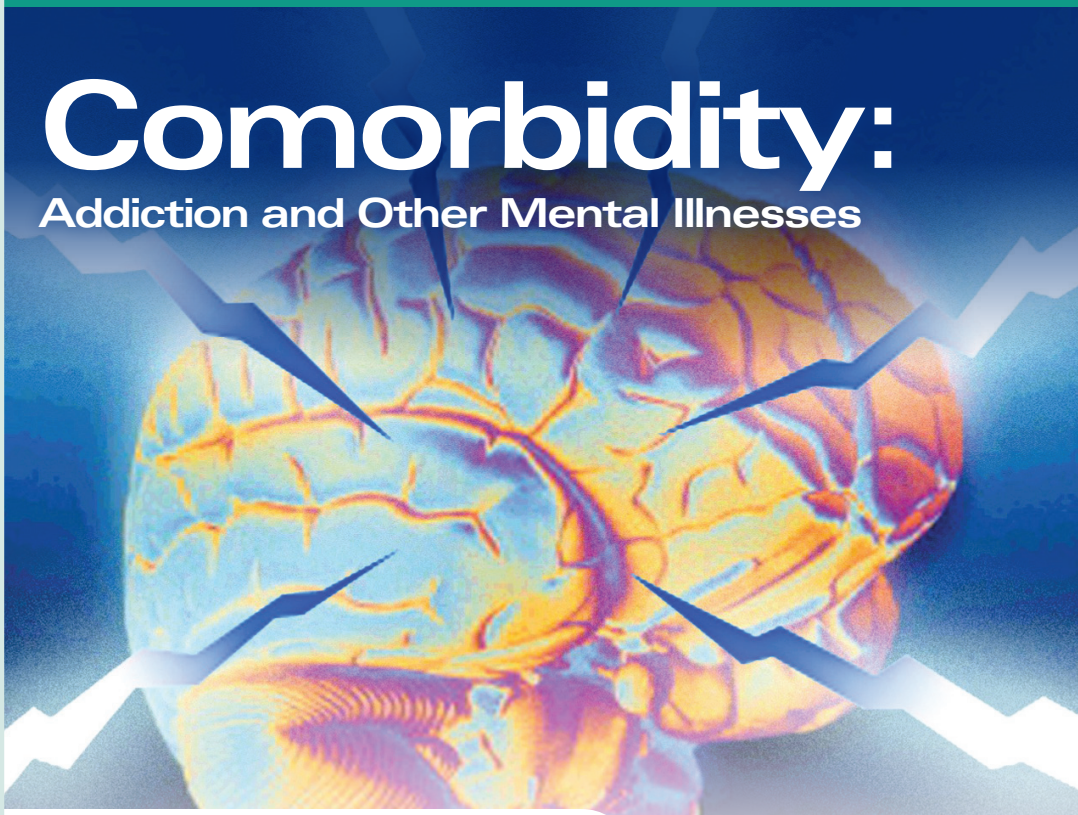
Is there a relationship between childhood ADHD and later drug abuse? See page 2.

NIDA NATIONAL INSTITUTE ON DRUG ABUSE

Research Report Series

Comorbidity:
Addiction and Other Mental Illnesses



from the director:

Comorbidity is a topic that our stakeholders—patients, family members, health care professionals, and others—frequently ask about. It is also a topic about which we have insufficient information, so it remains a research priority for NIDA. This Research Report provides information on the state of the science in this area. Although a variety of diseases commonly co-occur with drug abuse and addiction (e.g., HIV, hepatitis C, cancer, cardiovascular disease), this report focuses only on the comorbidity of drug use disorders and other mental illnesses.*

To help explain this comorbidity, we need to first recognize that drug addiction is a mental illness. It is a complex brain disease characterized by compulsive, at times uncontrollable drug craving, seeking, and use despite devastating consequences—behaviors that stem from drug-induced changes in brain structure and function. These changes occur in some of the same brain areas that are disrupted in other mental disorders, such as depression, anxiety, or schizophrenia. It is therefore not surprising that population surveys show a high rate of co-occurrence, or comorbidity, between drug addiction and other mental illnesses. While we cannot always prove a connection or causality, we do know that certain mental disorders are established risk factors for subsequent drug abuse—and vice versa.

It is often difficult to disentangle the overlapping symptoms of drug addiction and other mental illnesses, making diagnosis and treatment complex. Correct diagnosis is critical to ensuring appropriate and effective treatment. Ignorance of or failure to treat a comorbid disorder can jeopardize a patient's chance of recovery. We hope that our enhanced understanding of the common genetic, environmental, and neural bases of these disorders—and the dissemination of this information—will lead to improved treatments for comorbidity and will diminish the social stigma that makes patients reluctant to seek the treatment they need.

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

What Is Comorbidity?

When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid. Comorbidity also implies interactions between the illnesses that affect the course and prognosis of both.

continued inside

*Since the focus of this report is on comorbid drug use disorders and other mental illnesses, the terms "mental illness" and "mental disorders" will refer here to disorders other than substance use disorders, such as depression, schizophrenia, anxiety, and mania. The terms "dual diagnosis," "mentally ill chemical abuser," and "co-occurrence" are also used to refer to drug use disorders that are comorbid with other mental illnesses.

Childhood ADHD and Later Drug Problems

Numerous studies have documented an increased risk for drug use disorders in youth with untreated ADHD, although some suggest that only a subset of these individuals are vulnerable: those with comorbid conduct disorders. Given this linkage, it is important to determine whether effective treatment of ADHD could prevent subsequent drug abuse and associated behavioral problems. Treatment of childhood ADHD with stimulant medications such as methylphenidate or amphetamine reduces the impulsive behavior, fidgeting, and inability to concentrate that characterize ADHD. Yet, some physicians and parents have expressed concern that treating childhood ADHD with stimulants might increase a child's vulnerability to drug abuse later in life. Recent reviews of long-term studies of children with ADHD who were treated with stimulant medications (e.g., Adderal, Ritalin, Concerta) found no evidence for this increase. However, most of these studies have methodological limitations, including small sample sizes and nonrandomized study designs, indicating that more research is needed, particularly with adolescents.

Is Drug Addiction a Mental Illness?

Yes, because addiction changes the brain in fundamental ways, disturbing a person's normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug. The resulting compulsive behaviors that override the ability to control impulses despite the consequences are similar to hallmarks of other mental illnesses.

In fact, the DSM, which is the definitive resource of diagnostic criteria for all mental disorders, includes criteria for *drug use disorders*, distinguishing between two types: drug abuse and drug dependence. *Drug dependence* is synonymous with addiction. By comparison, the criteria for *drug abuse* hinge on the harmful consequences of repeated use but do not include the compulsive use, tolerance (i.e., needing higher doses to achieve the same effect), or withdrawal (i.e., symptoms that occur when use is stopped) that can be signs of addiction.

Addiction changes the brain, disturbing the normal hierarchy of needs and desires.

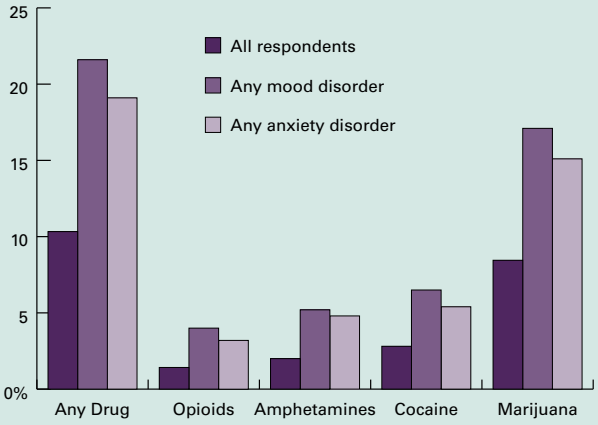
How Common Are Comorbid Drug Use and Other Mental Disorders?

Many people who regularly abuse drugs are also diagnosed with mental disorders and vice versa. The high prevalence of this comorbidity has been documented in multiple national population surveys since the 1980s. Data show that persons diagnosed with mood or anxiety disorders are about twice as likely to suffer also from a drug use disorder (abuse or dependence) compared with respondents in general. The same is true for those diagnosed with an antisocial syndrome, such as antisocial personality or conduct disorder. Similarly, persons diagnosed with drug disorders are roughly twice as likely to suffer also from mood and anxiety disorders (see page 3, "Overlapping Conditions— Shared Vulnerability").

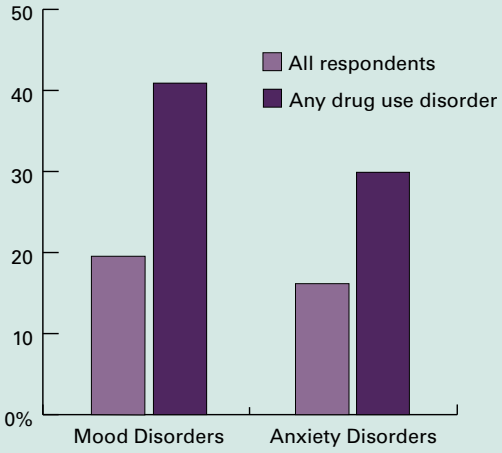
Gender is also a factor in the specific patterns of observed comorbidities. For example, the overall rates of abuse and dependence for most drugs tend to be higher among males than females. Further, males are more likely to suffer from antisocial personality disorder, while women have higher rates of mood and anxiety disorders, all of which are risk factors for substance abuse.

Overlapping Conditions—Shared Vulnerability

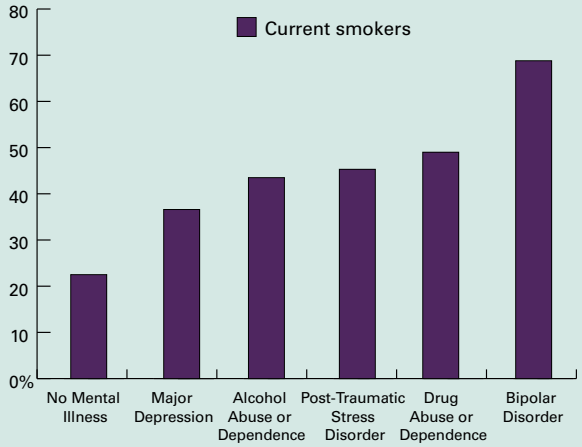
High Prevalence of Drug Abuse and Dependence Among Individuals With Mood and Anxiety Disorders



Higher Prevalence of Mental Disorders Among Patients With Drug Use Disorders



Higher Prevalence of Smoking Among Patients With Mental Disorders



Data in top two graphs reprinted from the National Epidemiologic Survey on Alcohol and Related Conditions (Conway et al., 2006). Data in bottom graph from the 1989 U.S. National Health Interview Survey (Lasser et al., 2000).

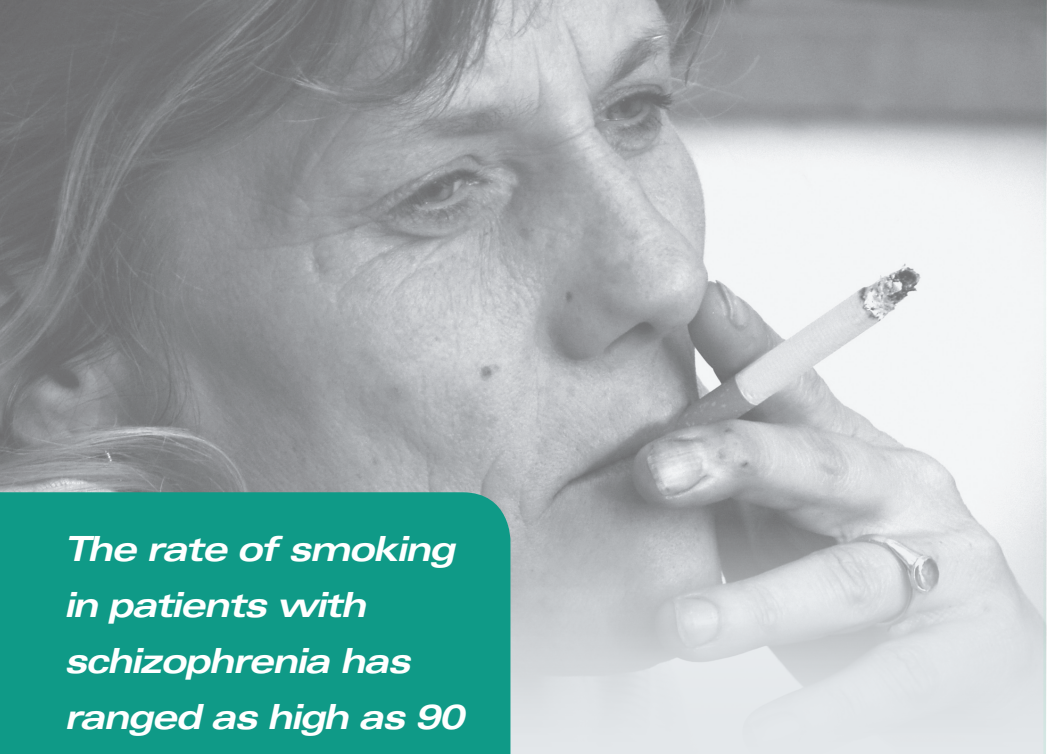
Because mood disorders increase vulnerability to drug abuse and addiction, the diagnosis and treatment of the mood disorder can reduce the risk of subsequent drug use. Because the inverse may also be true, the diagnosis and treatment of drug use disorders may reduce the risk of developing other mental illnesses and, if they do occur, lessen their severity or make them more amenable to effective treatment. Finally, because more than 40 percent of the cigarettes smoked in this country are smoked by individuals with a psychiatric disorder, such as major depressive disorder, alcoholism, post-traumatic stress disorder (PTSD), schizophrenia, or bipolar disorder, smoking by patients with mental illness contributes greatly to their increased morbidity and mortality.

Why Do Drug Use Disorders Often Co-Occur With Other Mental Illnesses?

The high prevalence of comorbidity between drug use disorders and other mental illnesses does not mean that one caused the other, even if one appeared first. In fact, establishing causality or directionality is difficult for several reasons. Diagnosis of a mental disorder may not occur until symptoms have progressed to a specified level (per DSM); however, subclinical symptoms may also prompt drug use, and imperfect recollections of when drug use or abuse started can create confusion as to which came first. Still, three scenarios deserve consideration:

1. Drugs of abuse can cause abusers to experience one or more symptoms of another mental illness. The increased risk of psychosis in some marijuana abusers has been offered as evidence for this possibility.
2. Mental illnesses can lead to drug abuse. Individuals with overt, mild, or even subclinical mental disorders may abuse drugs as a form of self-medication. For example, the use of tobacco products by patients with schizophrenia is believed to lessen the symptoms of the disease and improve cognition (see page 4, “Smoking and Schizophrenia: Self-Medication or Shared Brain Circuitry?”).
3. Both drug use disorders and other mental illnesses are caused by overlapping factors such as underlying brain deficits, genetic vulnerabilities, and/or early exposure to stress or trauma.

All three scenarios probably contribute, in varying degrees, to how and whether specific comorbidities manifest themselves.



The rate of smoking in patients with schizophrenia has ranged as high as 90 percent.

Smoking and Schizophrenia: Self-Medication or Shared Brain Circuitry?

Patients with schizophrenia have higher rates of alcohol, tobacco, and other drug abuse than the general population. Based on nationally representative survey data, 41 percent of respondents with past-month mental illnesses are current smokers, which is about double the rate of those with no mental illness. In clinical samples, the rate of smoking in patients with schizophrenia has ranged as high as 90 percent.

Various self-medication hypotheses have been proposed to explain the strong association between schizophrenia and smoking, although none have yet been confirmed. Most of these relate to the nicotine contained in tobacco products: Nicotine may help compensate for some of the cognitive impairments produced by the disorder and may counteract psychotic symptoms or alleviate unpleasant side effects of antipsychotic medications. Nicotine or smoking behavior may also help people with schizophrenia deal with the anxiety and social stigma of their disease.

Research on how both nicotine and schizophrenia affect the brain has generated other possible explanations for the high rate of smoking among people with schizophrenia. The presence of abnormalities in particular circuits of the brain may predispose individuals to schizophrenia, increase the rewarding effects of drugs like nicotine, or reduce an individual's ability to quit smoking. The involvement of common mechanisms is consistent with the observation that both nicotine and the medication clozapine (which also acts at nicotine receptors, among others) can improve attention and working memory in an animal model of schizophrenia. Clozapine is effective in treating individuals with schizophrenia. It also reduces their smoking levels. Understanding how and why patients with schizophrenia use nicotine is likely to help us develop new treatments for both schizophrenia and nicotine dependence.

Common Factors

Overlapping Genetic Vulnerabilities. A particularly active area of comorbidity research involves the search for *genes* that might predispose individuals to develop both addiction and other mental illnesses, or to have a greater risk of a second disorder occurring after the first appears. It is estimated that 40–60 percent of an individual's vulnerability to addiction is attributable to genetics; most of this vulnerability arises from complex interactions among multiple genes and from genetic interactions with environmental influences. In some instances, a gene product may act directly, as when a protein influences how a person responds to a drug (e.g., whether the drug experience is pleasurable or not) or how long a drug remains in the body. But genes can also act indirectly by altering how an individual responds to stress or by increasing the likelihood of risk-taking and novelty-seeking behaviors, which could influence the development of drug use disorders and other mental illnesses. Several regions of the human genome have been linked to increased risk of both drug use disorders and mental illness, including associations with greater vulnerability to adolescent drug dependence and conduct disorders.

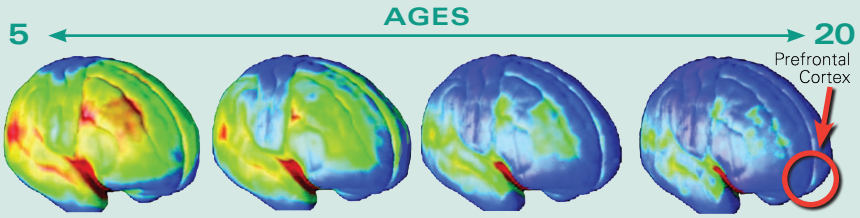
Involvement of Similar Brain Regions. Some areas of the brain are affected by both drug use disorders and other mental illnesses. For example, the circuits in the brain that use the neurotransmitter dopamine—a chemical that carries messages from one neuron to another—are typically affected by addictive substances and may also be involved in depression, schizophrenia, and other psychiatric disorders.

Indeed, some antidepressants and essentially all antipsychotic medications directly target the regulation of dopamine in this system, whereas others may have indirect effects. Importantly, dopamine pathways have also been implicated in the way in which stress can increase vulnerability to drug addiction. Stress is also a known risk factor for a range of mental disorders and therefore provides one likely common neurobiological link between the disease processes of addiction and those of other mental disorders.

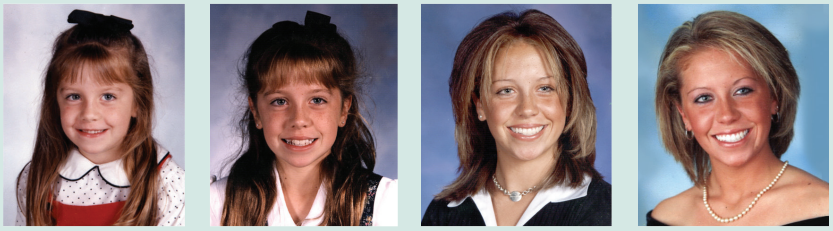
The overlap of brain areas involved in both drug use disorders and other mental illnesses suggests that brain changes stemming from one may affect the other. For example, drug abuse that precedes the first symptoms of a mental illness may produce changes in brain structure and function that kindle an underlying propensity to develop that mental illness. If the mental disorder develops first, associated changes in brain activity may increase the vulnerability to abusing substances by enhancing their positive effects, reducing awareness of their negative effects, or alleviating the unpleasant effects associated with the mental disorder or the medication used to treat it.

The brain continues to develop into adulthood and undergoes dramatic changes during adolescence.

One of the brain areas still maturing during adolescence is the prefrontal cortex—the part of the brain that enables us to assess situations, make sound decisions, and keep our emotions and desires under control. The fact that this critical part of an adolescent's brain is still a work in progress puts them at increased risk for poor decisions (such as trying drugs or continuing abuse). Thus, introducing drugs while the brain is still developing may have profound and long-lasting consequences.



Blue represents maturing of brain areas.



The Influence of Developmental Stage

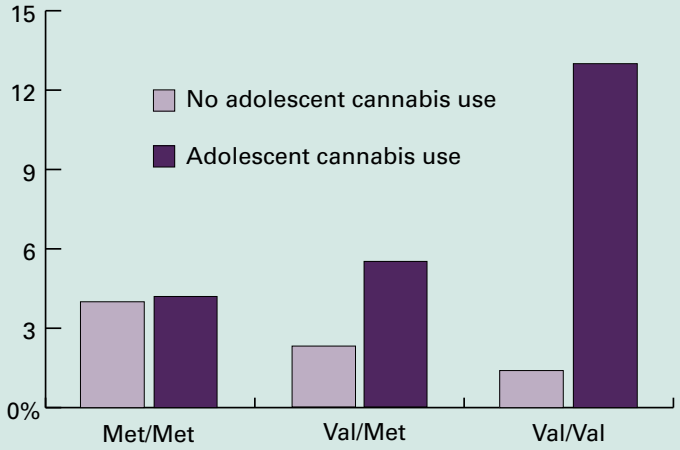
Adolescence—A Vulnerable Time. Although drug abuse and addiction can happen at any time during a person's life, drug *use* typically starts in adolescence, a period when the first signs of mental illness commonly appear. It is therefore not surprising that comorbid disorders can already be seen among youth. Significant changes in the brain occur during adolescence, which may enhance vulnerability to drug use and the development of addiction and other mental disorders. Drugs of abuse affect brain circuits involved in learning and memory, reward, decisionmaking, and behavioral control, all of which are still maturing into early adulthood. Thus, understanding the long-term impact of early drug exposure is a critical area of comorbidity research.

Early Occurrence Increases Later Risk. Strong evidence has emerged showing early drug use to be a risk factor for later substance abuse problems; additional findings suggest that it may also be a risk factor for the later occurrence of other mental illnesses. However, this link is not necessarily a simple one and may hinge upon genetic vulnerability, psychosocial experiences, and/or general environmental influences. A 2005 study highlights this complexity,

The high rate of comorbidity between drug abuse and addiction and other mental disorders argues for a comprehensive approach to intervention that identifies and evaluates each disorder concurrently, providing treatment as needed.

The Influence of Adolescent Marijuana Use on Adult Psychosis Is Affected by Genetic Variables

Percentage of Individuals Meeting Diagnostic Criteria for Schizophreniform Disorder at Age 26



Source: Caspi A, Moffitt TE, Cannon M, et al., 2005.

The above figure shows that variations in a gene can affect the likelihood of developing psychosis in adulthood following exposure to cannabis in adolescence. The catechol-*O*-methyltransferase gene regulates an enzyme that breaks down dopamine, a brain chemical involved in schizophrenia. It comes in two forms: Met and Val. Individuals with one or two copies of the Val variant have a higher risk of developing schizophrenic-type disorders if they used cannabis during adolescence (dark bars). Those with only the Met variant were unaffected by cannabis use. These findings hint at the complexity of factors that contribute to comorbid conditions.

with the finding that frequent marijuana use during adolescence can increase the risk of psychosis in adulthood, but only in individuals who carry a particular gene variant (see sidebar, "The Influence of Adolescent Marijuana Use on Adult Psychosis Is Affected by Genetic Variables").

It is also true that having a mental disorder in childhood or adolescence can increase the risk of later drug abuse problems, as frequently occurs with conduct disorder and untreated attention-deficit hyperactivity disorder (ADHD). This presents a challenge when treating children with ADHD, since effective treatment often involves prescribing stimulant medications with abuse potential. This issue has generated strong interest from the research community, and although the results are not yet conclusive, most studies suggest that ADHD medications do not increase the risk of drug abuse among children with ADHD (see page 2, "Childhood ADHD and Later Drug Problems").

Regardless of how comorbidity develops, it is common in youth as well as adults. Given the high prevalence of comorbid mental disorders and their likely adverse impact on substance abuse treatment outcomes, drug abuse programs for adolescents should include screening and, as needed, treatment for comorbid mental disorders.

How Can Comorbidity Be Diagnosed?

The high rate of comorbidity between drug use disorders and other mental illnesses argues for a comprehensive approach to intervention that identifies and evaluates each disorder concurrently, providing treatment as needed. The needed approach calls for broad assessment tools that are less likely to result in a missed diagnosis. Accordingly, patients entering treatment for psychiatric illnesses should also be screened for substance use disorders and vice versa. Accurate diagnosis is complicated, however, by the similarities between drug-related symptoms such as withdrawal and those of potentially comorbid mental disorders. Thus, when people who abuse drugs enter treatment, it may be necessary to observe them after a period of abstinence in order to distinguish between the effects of substance intoxication or withdrawal and the symptoms of comorbid mental disorders. This practice would allow for a more accurate diagnosis and more targeted treatment.

How Should Comorbid Conditions Be Treated?

A fundamental principle emerging from scientific research is the need to treat comorbid conditions concurrently—which can be a difficult proposition (see page 9, "Barriers to Comprehensive Treatment of Comorbidity"). Patients who have both a drug use disorder and another mental illness often exhibit symptoms that are more persistent, severe, and resistant to treatment compared with patients who have either disorder alone. Nevertheless, steady progress is being made through research on new and existing treatment options for comorbidity and through health services research on implementation of appropriate screening and treatment within a variety of settings, including criminal justice systems.

Medications

Effective medications exist for treating opioid, alcohol, and nicotine addiction and for alleviating the symptoms of many other mental disorders, yet most have not been well studied in comorbid populations. Some medications may benefit multiple problems. For example, evidence suggests that bupropion (trade names: Wellbutrin, Zyban), approved for treating depression and nicotine dependence, might also help reduce craving and use of the drug methamphetamine. Clearly, more research is needed to fully understand and assess the actions of combined or dually effective medications.

Behavioral Therapies

Behavioral treatment (alone or in combination with medications) is the cornerstone to successful outcomes for many individuals with drug use disorders or other mental illnesses. And while behavior therapies continue to be evaluated for use in comorbid populations, several strategies have shown promise for treating specific comorbid conditions (see page 8, "Examples of Promising Behavioral Therapies for Patients With Comorbid Conditions").

Most clinicians and researchers agree that broad spectrum diagnosis and concurrent therapy will lead to more positive outcomes for patients with comorbid conditions. Preliminary findings support this notion, but research is needed to identify the most effective therapies (especially studies focused on adolescents).

Examples of Promising Behavioral Therapies for Patients with Comorbid Conditions

Adolescents

Multisystemic Therapy (MST)

MST targets key factors (attitudes, family, peer pressure, school and neighborhood culture) associated with serious antisocial behavior in children and adolescents who abuse drugs.

Brief Strategic Family Therapy (BSFT)

BSFT targets family interactions that are thought to maintain or exacerbate adolescent drug abuse and other co-occurring problem behaviors. These problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behaviors.

Cognitive-Behavioral Therapy (CBT)

CBT is designed to modify harmful beliefs and maladaptive behaviors. CBT is the most effective psychotherapy for children and adolescents with anxiety and mood disorders, and also shows strong efficacy for substance abusers. (CBT is also effective for adult populations suffering from drug use disorders and a range of other psychiatric problems.)

Adults

Therapeutic Communities (TCs)

TCs focus on the "resocialization" of the individual and use broad-based community programs as active components of treatment. TCs are particularly well suited to deal with criminal justice inmates, individuals with vocational deficits, women who need special protections from harsh social environments, vulnerable or neglected youth, and homeless individuals. In addition, some evidence suggests the utility of incorporating TCs for adolescents who have been in treatment for substance abuse and related problems.

Assertive Community Treatment (ACT)

ACT programs integrate the behavioral treatment of other severe mental disorders, such as schizophrenia, and co-occurring substance use disorders. ACT is differentiated from other forms of case management through factors such as a smaller caseload size, team management, outreach emphasis, a highly individualized approach, and an assertive approach to maintaining contact with patients.

Dialectical Behavior Therapy (DBT)

DBT is designed specifically to reduce self-harm behaviors (such as self-mutilation and suicidal attempts, thoughts, or urges) and drug abuse. It is one of the few treatments that is effective for individuals who meet the criteria for borderline personality disorder.

Exposure Therapy

Exposure therapy is a behavioral treatment for some anxiety disorders (phobias, PTSD) that involves repeated exposure to or confrontation with a feared situation, object, traumatic event, or memory. This exposure can be real, visualized, or simulated, and always is contained in a controlled therapeutic environment. The goal is to desensitize patients to the triggering stimuli and help them learn to cope, eventually reducing or even eliminating symptoms. Several studies suggest that exposure therapy may be helpful for individuals with comorbid PTSD and cocaine addiction, although retention in treatment is difficult.

Integrated Group Therapy (IGT)

IGT is a new treatment developed specifically for patients with bipolar disorder and drug addiction, designed to address both problems simultaneously.

Exposure to Traumatic Events Puts People at Higher Risk of Substance Use Disorders

Physically or emotionally traumatized people are at much higher risk of abusing licit, illicit, and prescription drugs. This linkage is of particular concern for returning veterans since nearly 1 in 5 military service members back from Iraq and Afghanistan have reported symptoms of post-traumatic stress disorder (PTSD) or major depression. Recent epidemiological studies suggest that as many as half of all veterans diagnosed with PTSD also have a co-occurring substance use disorder (SUD), which could pose an enormous challenge for our health care system. Many PTSD programs do not accept individuals with active SUDs, and traditional SUD clinics defer treatment of trauma-related issues. Nevertheless, there are treatments at different stages of clinical validation for comorbid PTSD and SUD; these include various combinations of psychosocial (e.g., exposure therapy) and pharmacologic (e.g., mood stabilizers, anxiolytics, and antidepressants) interventions. However, research is urgently needed to identify the best treatment strategies for addressing PTSD/SUD comorbidities, and to explore whether different treatments might be needed in response to civilian versus combat PTSD.

Barriers to Comprehensive Treatment of Comorbidity

Although research supports the need for comprehensive treatment to address comorbidity, provision of such treatment can be problematic for a number of reasons:

- In the United States, different treatment systems address drug use disorders and other mental illnesses separately. Physicians are most often the front line of treatment for mental disorders, whereas drug abuse treatment is provided in assorted venues by a mix of health care professionals with different backgrounds. Thus, neither system may have sufficiently broad expertise to address the full range of problems presented by patients. People also use these health care systems differently, depending on insurance coverage and social factors. For example, when suffering from substance abuse and mental illness comorbidities, women more often seek help from mental health practitioners, whereas men tend to seek help through substance abuse treatment channels.

- A lingering bias remains in some substance abuse treatment centers against using any medications, including those necessary to treat serious mental disorders such as depression. Additionally, many substance abuse treatment programs do not employ professionals qualified to prescribe, dispense, and monitor medications.

- Many of those needing treatment are in the criminal justice system. It is estimated that about 45 percent of offenders in State and local prisons and jails have a mental health problem comorbid with substance abuse or addiction. However, adequate treatment services for both drug use disorders and other mental illnesses are greatly lacking within these settings. While treatment provision may be burdensome for the criminal justice system, it offers an opportunity to positively affect the public's health and safety. Treatment of comorbid disorders can reduce not only associated medical complications, but also negative social outcomes by mitigating against a return to criminal behavior and reincarceration.

Glossary

Addiction: A chronic, relapsing disease characterized by compulsive drug seeking and use and by long-lasting changes in the brain.

Antisocial Personality Disorder: A disorder characterized by antisocial behaviors that involve pervasive disregard for and violation of the rights, feelings, and safety of others. These behaviors begin in early childhood (conduct disorder) or the early teenage years and continue into adulthood.

Anxiety Disorders: Varied disorders that involve excessive or inappropriate feelings of anxiety or worry. Examples are panic disorder, PTSD, social phobia, and others.

Attention-Deficit Hyperactivity Disorder (ADHD): A disorder that typically presents in early childhood, characterized by inattention, hyperactivity, and impulsivity.

Bipolar Disorder: A mood disorder characterized by alternating episodes of depression and mania or hypomania.

Comorbidity: The occurrence of two disorders or illnesses in the same person, either at the same time (co-occurring comorbid conditions) or with a time difference between the initial occurrence of one and the initial occurrence of the other (sequentially comorbid conditions).

Conduct Disorder: A repetitive and persistent pattern of behavior in children or adolescents in which the basic rights of others or major age-appropriate societal norms or rules are violated.

Depression: A disorder marked by sadness, inactivity, difficulty with thinking and concentration, significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, and, sometimes, suicidal thoughts or an attempt to commit suicide.

Dopamine: A brain chemical, classified as a neurotransmitter, found in regions of the brain that regulate movement, emotion, motivation, and pleasure.

Dual Diagnosis/Mentally Ill Chemical Abuser (MICA): Other terms used to describe the comorbidity of a drug use disorder and another mental illness.

Major Depressive Disorder: A mood disorder having a clinical course of one or more serious depression episodes that last 2 or more weeks. Episodes are characterized by a loss of interest or pleasure in almost all activities; disturbances in appetite, sleep, or psychomotor functioning; a decrease in energy; difficulties in thinking or making decisions; loss of self-esteem or feelings of guilt; and suicidal thoughts or attempts.

Mania: A mood disorder characterized by abnormally and persistently elevated, expansive, or irritable mood; mental and physical hyperactivity; and/or disorganization of behavior.

Mental Disorder: A mental condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological or behavioral functioning of the individual. Addiction is a mental disorder.

Neurotransmitter: A chemical produced by neurons to carry messages from one nerve cell to another.

Post-Traumatic Stress Disorder (PTSD): A disorder that develops after exposure to a highly stressful event (e.g., wartime combat, physical violence, or natural disaster). Symptoms include sleeping difficulties, hypervigilance, avoiding reminders of the event, and re-experiencing the trauma through flashbacks or recurrent nightmares.

Psychosis: A mental disorder (e.g., schizophrenia) characterized by delusional or disordered thinking detached from reality; symptoms often include hallucinations.

Schizophrenia: A psychotic disorder characterized by symptoms that fall into two categories: (1) positive symptoms, such as distortions in thoughts (delusions), perception (hallucinations), and language and thinking and (2) negative symptoms, such as flattened emotional responses and decreased goal-directed behavior.

Self-Medication: The use of a substance to lessen the negative effects of stress, anxiety, or other mental disorders (or side effects of their pharmacotherapy). Self-medication may lead to addiction and other drug- or alcohol-related problems.

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NIH Publication Number 10-5771
Printed December 2008, Revised September 2010

Academic Emergency Medicine
Official Journal of the Society for Academic Emergency Medicine

ORIGINAL CONTRIBUTION

Injury-related Visits and Comorbid Conditions Among Homeless Persons Presenting to Emergency Departments

Bart Hammig, PhD, MPH, Kristen Jozkowski, PhD, and Ches Jones, PhD

Abstract

Objectives: The authors examined the clinical characteristics of homeless patients presenting to emergency departments (EDs) in the United States, with a focus on unintentional and intentional injury events and related comorbid conditions.

Methods: The study included a nationally representative sample of patients presenting to EDs with data obtained from the 2007 through 2010 National Hospital Ambulatory Medical Care Survey (NHAMCS). Descriptive and analytical epidemiologic analyses were employed to examine injuries among homeless patients.

Results: Homeless persons made 603,000 visits annually to EDs, 55% of which were for injuries, with the majority related to unintentional (52%) and self-inflicted (23%) injuries. Multivariate logistic regression analyses revealed that homeless patients had a higher odds of presenting with injuries related to unintentional (odds ratio [OR] = 1.4. 95% confidence interval [CI] = 1.1 to 1.9), self-inflicted (OR = 6.0, 95% CI = 3.7 to 9.5), and assault (OR = 3.0, 95% CI = 1.5 to 5.9) injuries.

Conclusions: A better understanding of the injuries affecting homeless populations may provide medical and public health professionals insight into more effective ways to intervene and limit further morbidity and mortality related to specific injury outcomes.

ACADEMIC EMERGENCY MEDICINE 2014;21:449–455 © 2014 by the Society for Academic Emergency Medicine

Homeless populations endure a much greater burden of health problems compared to the general population. Lack of access to primary health care, poor hygiene, and comorbid conditions inclusive of mental illnesses, polydrug use, and nutritional deficiencies have all been cited as contributory factors for this disparity.[1–4] Although several studies have examined health outcomes associated with homelessness using European samples, national studies among U.S. homeless are scant.[5,6] The majority of available research has been largely focused on geographically limited cohorts in major U.S. cities,[7–15] failing to provide a comprehensive examination of salient public health problems within homeless populations. Given the differences in health care systems and social care systems in the United States and European countries, it is useful to specifically examine U.S. homeless populations to better understand public health issues affecting this population.

Injuries are of particular concern for homeless persons. Several studies demonstrate that homeless individuals suffer a disproportionate burden of injuries compared to nonhomeless persons.[5,11,16,17] However, few studies have examined injuries by intent.[16] While cross-cutting approaches to injury prevention may be employed, many successful approaches are largely dependent on the intent (unintentional, assault-related, self-inflicted) of the injury and mechanism that caused the injury.[18] Therefore, a more precise understanding of the injuries affecting homeless populations may provide medical and public health professionals keener insight into more effective ways to intervene and limit further morbidity and mortality related to injuries. Therefore, we sought to examine the clinical characteristics of homeless patients presenting to emergency departments (EDs) in the United States with a focus on unintentional and intentional (assault

From the Division of Community Health Promotion, University of Arkansas, Fayetteville, AR.
Received September 6, 2013; revision received October 15, 2013; accepted November 13, 2013.
Presented at the American Public Health Association National Conference, Boston, MA, November 2013.
The authors have no relevant financial information or potential conflicts of interest to disclose.
Supervising Editor: Rebecca M. Cunningham, MD.
Address for correspondence and reprints: Bart Hammig, PhD, MPH; e-mail: bhammig@uark.edu.

doi: 10.1111/acem.12343
ISSN 1069-6563
PII ISSN 1069-6563583

and self-inflicted) injury events and related comorbid conditions.

METHODS

Study Design

This was a retrospective cohort study using data from the National Hospital Ambulatory Medical Care Survey (NHAMCS). The study received institutional review board approval.

Study Setting and Population

We analyzed ED visits made to a national sample of nonfederal general and short-stay hospitals in the United States from 2007 through 2010. The NHAMCS is maintained by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS). A multistage probability sample design was employed for the NHAMCS that involved 112 geographic primary sampling units, hospitals within the primary sampling units, EDs or outpatient departments affiliated with the hospital, and patient visits within the ED or outpatient department clinic. Data collection was via a patient record form (PRF) completed by trained hospital staff. A complete description of the National Ambulatory Medical Care Survey (NAMCS) and NHAMCS sample design has been provided elsewhere.[19,20]

Study Protocol

Homelessness was defined by the patient's response to an item on the intake form that ascertained patient's residence. On the 2009 and 2010 PRFs, response options included "private residence," "nursing home," "homeless," "other," or "unknown." In 2007 and 2008 PRFs, "other institution" was also a response choice. The sample was dichotomized into "homeless" or "all other," with the exception of "unknown" which remained as such.

Injury-related visits were attained by assessment of the patient's reason for visit, physician's diagnosis, and cause of injury, as indicated on the PRF. Response choices were dichotomized into "yes" or "no." Injuries were coded using the Supplementary Classification of External Causes of Injury and Poisoning (E-codes), International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). If the visit was related to an injury, then classification of the intent of the injury was completed from a checkbox item on the PRF responding to the question "Is this injury/poisoning intentional?" Response choices included "blank/unknown," "Not applicable (not an injury visit)," "Yes, self-inflicted" "Yes, assault," and "No, unintentional." Intent was derived from the E-coded cause of injury on the PRF. Hence, self-inflicted injuries were indicated by codes E950–959, assault-related injuries by codes E960–969, and unintentional injuries by codes E800–869 and E880–929.

Other variables included in the analyses included age, sex, race, primary source of payment, comorbid diagnoses of injury with a psychiatric disorder (ICD-9 codes 290, 293–302, 306–319) and/or a substance use disorder (ICD-9 codes 980, 291–292, 303–305), arrival by ambulance, hospital disposition, number of times patients visited the ED during the past year, season of the year, and geographic region.

Data Analysis

Sample weights were applied to the patient visits to produce national estimates. The sampling weights have been adjusted by the NCHS for nonresponse, geographic region, and hospital urban/rural and ownership designations, yielding an unbiased national estimate of ED visit.[20] To account for the sampling design of the NHAMCS, design variables were included to account for the clustered sample design. Standard errors were determined using STATA MP 11 software (StataCorp LP, College Station, TX). As stipulated by the NCHS, sample size estimates based on fewer than 30 unweighted cases, which had a relative standard error equal to or greater than 30%, or that had an item nonresponse rate greater than or equal to 30%, were deemed unreliable.[20] In addition, all of the records in the data files were included in the analysis to obtain the correct sample variance estimates. Because the NHAMCS are record-based surveys, population-based incidence and prevalence estimates cannot be calculated. Likewise, the incidence rate of injuries to homeless patients could not be calculated since the denominator data did not reflect the population who are homeless. Rather, the figures reported are the average annual ambulatory visits for injuries and other covariates among homeless and nonhomeless persons. All other reported estimates were also annualized. Bivariate and multivariate logistic regression analyses were employed to examine the relationship between residence (homeless or nonhomeless) and intent of injury, while adjusting for covariates. Covariates were included in the multivariate model if their p values were ≤ 1.0 on bivariate analyses, and/or it made empirical sense to include the variable (e.g., race) based on past research.[5,9,12] Goodness of fit of the logistic model was assessed by methods proposed by Archer and Lemeshow[21] that take into account sampling weights and cluster design of the survey data. Collinearity diagnostics among the independent variables were assessed using the Collin procedure in Stata. Finally, interaction terms were created and examined for each pair of covariates.

RESULTS

Between 2007 and 2010, approximately 603,000 homeless persons were treated in U.S. EDs annually. The majority of homeless persons seeking treatment were male (74%), aged 30 to 49 years (46%), and white (57%). In comparison, nonhomeless patients were more evenly distributed based on sex and age strata (see Table 1).

The majority of payments for services among homeless patients were from Medicaid or self-pay sources (59%), while among nonhomeless, private insurance was the dominant source of payment (40%). No notable differences were observed between homeless and nonhomeless patients based on hospital disposition or season of ED visit. However, homeless patients exhibited a higher prevalence of ED visits arriving by ambulance (44% vs. 15%), number of times the patient had visited the ED during the past year, and ED visits occurring in the western region (Table 1).

A descriptive analysis of comorbid conditions among patients presenting with injuries showed differing

Table 1
Comparison of Demographic Characteristics of ED Visits by Homeless and Nonhomeless Persons in the United States, 2007–2010

	Homeless			Nonhomeless		
Characteristic	Number*	95% CI	Percent†	Number*	95% CI	Percent†
Total visits	603	498–708	100	119,390	108,009–130,770	100
Age group, yr						
<18	—	—	<1	28,176	24,754–31,598	24
18–29	92	68–115	15	24,657	22,153–27,160	21
30–49	279	225–334	46	31,430	28,389–34,472	26
50+	224	177–271	37	35,127	32,034–38,219	29
Sex						
Male	448	361–536	74	65,499	59,023–71,974	55
Female	155	120–189	26	53,891	48,933–58,848	45
Race						
White	344	276–411	57	76,574	69,629–83,519	64
African American	141	109–174	24	24,737	20,492–28,982	21
Other	20	8–32	3	3,740	2,964–4,516	3
Unknown	98	61–136	16	14,339	10,530–18,149	12
Insurance						
Medicare	31	17–44	5	9,052	8,122–9,982	8
Medicaid	153	117–189	25	30,762	27,362–34,162	26
Self-pay	203	159–248	34	18,620	16,592–20,649	16
No charge	45	28–62	7	1,614	1,059–2,169	1
Private	25	12–38	4	47,211	42,420–52,002	40
Workers compensation	0	—	0	1,531	1,335–1,727	1
Other	60	30–91	10	3,660	3,004–4,317	3
Unknown	77	43–110	13	5,514	3,663–7,365	1
Ambulance arrival						
Yes	266	207–325	44	18,437	16,590–20,284	15
No	296	239–352	49	95,221	85,688–104,754	80
Unknown/missing	41	25–57	7	5,731	4,923–6,540	5
Admitted to hospital						
Yes	83	58–108	14	16,076	14,305–17,848	13
No	520	424–617	86	103,313	93,329–113,298	87
Number ED visits in past month						
0	145	106–184	24	32,742	28,355–37,128	27
1	65	40–90	11	19,091	16,357–21,826	16
2–3	78	56–101	13	12,751	10,859–14,643	11
4 or more	135	99–172	23	8,721	7,386–10,055	7
Unknown	179	125–233	30	46,085	28,849–53,320	39
Season						
Spring	160	116–205	27	31,600	27,260–35,940	27
Summer	150	110–190	25	30,677	26,744–34,610	26
Fall	161	108–213	27	27,875	24,204–31,547	23
Winter	132	92–173	22	29,237	25,527–32,947	25
Region						
Northeast	100	66–134	17	21,631	18,772–24,489	18
Midwest	85	52–119	14	26,498	20,277–32,719	22
South	148	93–203	25	48,522	41,510–55,533	41
West	270	185–345	45	22,739	16,941–28,536	19

*Average annual estimate in thousands.
†Percentages may not add to 100 due to rounding and/or missing data.

patterns between homeless and nonhomeless. Homeless patients exhibited a higher percentage of visits for injuries (55% vs. 34%, respectively), and the intent of injury patterns differed markedly as well. The majority of injury-related visits were unintentional for homeless and nonhomeless alike (52% vs. 77%). However, ED visits for self-inflicted injury visits were more prevalent among homeless patients (23% vs. 4%). Likewise, injury visits related to assaults were double that of nonhomeless patient visits (8% vs. 4%, respectively). An examination of select comorbid conditions revealed a higher prevalence among homeless patients as well. Among homeless patients presenting with injuries, 13% were diagnosed with psychiatric disorders, and 62% were diagnosed with substance abuse. In contrast, among nonhomeless patients presenting with injuries, 3% were diagnosed with psychiatric disorders, and 5% were diagnosed with substance abuse (see Table 2).

Results of multivariate logistic regression analyses revealed significant factors associated with ED visits among homeless patients. Demographic characteristics of being male (adjusted odds ratio [AOR] = 3.0, 95% confidence interval [CI] = 2.2 to 4.0), aged 36 years and older (AOR = 2.7, 95% CI = 2.0 to 3.6), African American (AOR = 1.7, 95% CI = 1.2 to 2.5), or living in the western region (AOR = 2.3, 95% CI = 1.4 to 4.0) were associated with homelessness among patients presenting to EDs in the United States. Also, having arrived by

Table 2
Comparison of Characteristics and Comorbid Conditions of Injury-related ED Visits Among Homeless and Nonhomeless Persons in the United States, 2007–2010

	Homeless			Nonhomeless		
Characteristic	Number*	95% CI	Percent†	Number*	95% CI	Percent†
Injury-related visit						
Yes	334	262–405	55	40,440	36,789–44,091	34
No	269	220–319	45	78,949	71,119–86,779	66
Intent of injury-related visit‡						
Unintentional	174	129–219	52	31,003	28,240–33,765	77
Self-inflicted	76	48–105	23	1,448	1,278–1,619	4
Assault	27	15–39	8	1,738	1,520–1,956	4
Unknown	56	36–76	17	6,252	5,479–7,025	16
Psychiatric Dx comorbid with injury‡						
Yes	44	25–64	13	1,135	994–1,276	3
No	289	223–355	87	39,305	35,751–42,860	97
Substance use comorbid with injury‡						
Yes	206	156–257	62	2,223	1,957–2,489	5
No	127	95–159	38	38,217	34,765–41,670	95

Dx = diagnosis.
*Average annual estimate in thousands.
†Percentages may not add to 100 due to rounding and/or missing data.
‡Estimates include injury-related visits only.

ambulance (AOR = 2.9, 95% CI = 2.2 to 4.0), having visited EDs multiple times during the past year (visited two to three times, AOR = 1.8, 95% CI = 1.2 to 2.5; visited four or more times, AOR = 3.6, 95% CI = 2.5 to 5.2), and payment methods (self-pay, AOR = 4.2, 95% CI = 2.7 to 6.6; Medicare/Medicaid, AOR = 1.6, 95% CI = 1.1 to 2.4) were associated with homelessness.

Intent of injury was associated with homelessness for each of the intent types (unintentional, self-inflicted, and assault-related) when controlling for other covariates included in the model. ED patients who were homeless had a higher odds of presenting with injury means related to unintentional (AOR = 1.4, 95% CI = 1.1 to 1.9), assault (AOR = 3.0, 95% CI = 1.5 to 5.9), and self-inflicted (AOR = 6.0, 95% CI = 3.7 to 9.5; see Table 3).

DISCUSSION

During the study period, over half a million homeless persons were treated in U.S. EDs on an annual basis. Descriptive findings coincide with those of previous reports indicating that older males made up a majority of patients who were considered homeless. As expected, Medicaid and self-pay were the main sources of payment identified among homeless patients who sought treatment in EDs in the United States. Although proportionally, Medicaid was used as a source of payment almost as frequently among homeless and nonhomeless patients, not surprisingly, private insurance was used in much higher proportions among nonhomeless patients.

Homeless patients also exhibited a higher prevalence of arrival by ambulance. Explanations for this finding include a lack of alternative transportation and/or lack of health insurance coverage among homeless patients. Lack of comprehensive health insurance coverage is associated with lack of access to care and poorer health outcomes among uninsured individuals, particularly homeless persons.[22] Although the incidence of homeless persons seeking treatment in EDs could not be ascertained in the present study, prior studies have indicated that homeless patients use EDs as a main source of health care.[6] Primary care access has been shown to be directly affected by private insurance status,[23] with Medicaid/Medicare and uninsured patients having difficulty in obtaining primary care services.[3] In turn, persons may delay treatment for illnesses or injuries and be noncompliant with therapy and may endure more serious health outcomes,[23] resulting in increased costs associated with treatment.[7]

Among patients presenting with injuries, substance use and psychiatric disorders were more prevalent comorbid conditions among homeless patients. A higher prevalence of these comorbid conditions has been well documented among the homeless, with over 60% experiencing mental illness and 80% lifetime drug/alcohol problems.[5,7,24,25] Prior research on psychiatric and substance abuse conditions have found them to be significant risk factors for injuries among homeless individuals.[8,15] Several studies have elucidated that injuries were more prevalent among homeless persons seeking treatment in EDs, yet few studies have examined intent. In addressing this gap, we found homeless patients to be at significantly greater odds of assault-related injury visits when compared to the nonhomeless patient populations. While we could not identify the specific manner of assault-related injuries, male and female homeless persons have been found to incur a high incidence of both physical and sexual assault victimization.[14,15] Assault-related victimization is a recurring problem among homeless populations and prevention of these crimes is difficult due to the vulnerability of the population. Typically, homeless persons may live in areas already inundated with violent crime,[26] have more limited access to shelter,[26] present with comorbid conditions that put them at greater risk,[15,27] and

Table 3
Visits Examining Homelessness Associated with Injury Intent in U.S. EDs

Characteristic	Crude OR (95% CI)	Adjusted OR (95% CI)
Intent of injury visit		
Not injury related	1.00	1.00
Unintentional	1.6 (1.3–2.1)	1.4 (1.1–1.9)
Assault	4.6 (2.9–7.3)	3.0 (1.5–5.9)
Self-inflicted	15.4 (10.5–22.7)	6.0 (3.7–9.5)
Age		
≤ 35 yr	1.00	1.00
> 35 yr	3.2 (2.6–4.5)	2.7 (2.0–3.6)
Sex		
Female	1.00	1.00
Male	3.5 (2.8–4.5)	3.0 (2.2–4.0)
Race		
White	1.00	1.00
African American	1.2 (0.7–2.0)	1.7 (1.2–2.5)
Other	1.5 (1.1–2.1)	0.9 (0.4–1.8)
Ambulance arrival		
No	1.00	1.00
Yes	4.6 (3.7–5.8)	2.9 (2.2–4.0)
Number of times visited ED in past year		
0	1.00	1.00
1	0.77 (0.5–1.1)	1.0 (0.7–1.5)
2–3	1.4 (1.0–1.9)	1.8 (1.2–2.5)
4 or more	3.5 (2.6–4.7)	3.6 (2.5–5.2)
Payment		
Other (private, etc.)	1.00	1.00
Self-pay	4.5 (3.3–6.2)	4.2 (2.7–6.6)
Medicare/Medicaid	1.9 (1.4–2.7)	1.6 (1.1–2.4)
Admitted to hospital		
No	1.00	1.00
Yes	1.04 (0.7–1.4)	0.6 (0.4–0.9)
Region		
Northeast	1.00	1.00
Midwest	0.7 (0.4–1.2)	0.6 (0.3–0.9)
South	0.7 (0.4–1.1)	0.6 (0.3–1.1)
West	2.6 (1.7–3.9)	2.3 (1.4–4.0)

engage in risky behaviors, such as commercial sex work.[27] Taken together, these circumstances increase a homeless person's risk of violent victimization. The common denominator for homeless victims of violence is that injuries incurred may result in an ED being their first point of contact with the medical system. Therefore, ascertainment of victimization status; referral to community resources; and linkages with psychiatric, public health, social work, and law enforcement officials may be crucial to prevent recidivism of assault-related injuries and homicides.[3,28]

While assaults among homeless people have received attention from the mainstream media,[29] and have been found to be a leading cause of morbidity and mortality among homeless persons residing in cities in the United States,[13,15] our findings indicate that self-inflicted injuries are also a pressing problem among homeless ED patients. Among the U.S. ED patient population, those patients presenting with self-inflicted injuries were at much greater odds of being homeless. Higher crude mortality rates among the homeless have been well documented.[9,10,30] However, specific causes of injury-related morbidity and mortality are not as well understood among U.S. homeless populations. Our findings on self-inflicted injuries are in accordance with findings using homeless study samples from other developed countries, which have found suicide and self-inflicted injuries to be a predominant mode of morbidity and mortality.[1,16,31–33] Feodor Nilsson et al.,[16] in a cohort of Danish homeless, found that males and females incurred significantly high rates of mortality by suicide. Likewise, a study examining homeless persons residing in the United Kingdom found that 68% of their sample reported past acts of self-harm, with a high propensity to have comorbid mental health conditions.[33] From our data, we were able to determine neither the method of suicide attempts nor the seriousness of the associated injuries. It should be kept in mind that our study was limited to ED visits; therefore, the manner and severity of suicide attempts and suicide completions warrant further study. However, we would be remiss if we did not acknowledge the methodologic difficulties in studying suicidal behaviors and underreporting of suicide mortality, which would likely be compounded in a homeless population.[34,35] Suicide is a complicated public health problem, with a variety of risk factors affecting persons at different life stages. This makes prevention difficult, particularly among vulnerable populations.[34] While our findings demonstrated a high degree of comorbidity with two known risk factors for suicidality (substance abuse and psychiatric illness), other risk factors must be considered when intervening in suicidal behavior among homeless persons. Social isolation, prior suicide attempts, hopelessness, economic struggles, and lack of access to mental health and substance abuse prevention services are also important considerations among homeless populations.[11,28,34,36] Therefore, prevention will require a coordinated effort among public service entities.

Among injured homeless patients, unintentional injuries represented the majority of diagnoses, followed by self-inflicted and assault-related injuries. Homeless patients also incurred higher odds of unintentional injuries when compared to the general patient population of ED visits, although the odds were not as pronounced as the associations observed with intentional injuries. The relationship between homelessness and unintentional injury risk is sparse. An analysis of injury conditions among hospitalized homeless patients in New York revealed that falls were the prominent cause of unintentional injury hospitalizations and were disproportionately higher among young and elderly age groups.[12] However, our data precluded us from identifying the causes of unintentional injury among the patient visits. Further studies are needed to examine the causes of unintentional injuries among homeless populations.

LIMITATIONS

Nonsampling errors, such as reporting and processing errors, as well as nonresponse, are inherent in all surveys. Given that resident status was self-reported, homelessness may have been underreported, which would have effectively biased estimates toward the null. However, the magnitude of these errors was kept to a minimum by procedures built into the survey operation.[19] For some variables, there was a high number of responses coded as "unknown." In particular, 17% of

injured homeless patients and 16% of injured nonhomeless patients did not have the intent of the injury indicated. While unlikely, it is possible that unknown cases were not equivalent across the three intent categories. We also were unable to determine if the ED visit was a repeat visit for the same injury. Identification of follow-up visits has been assessed in the NHAMCS, where 9.3% of all injuries treated in EDs were classified as follow-up visits from previous injury visits.[37] Since we estimated visits for injuries and not the true incidence of injuries, this limitation should not detract too much from our findings.

CONCLUSIONS

We found that homeless persons treated in EDs in the United States present with higher odds of unintentional, self-inflicted, and assault-related injuries. Given the prevalence of comorbid conditions and the complexity of the societal and health-related issues that affect homeless populations, prevention of injuries will continue to be problematic. EDs may represent a first point of contact for many injured homeless patients and therefore may be better able to serve the population by coordinating with respective public health, law enforcement, and social service agencies that may intervene to prevent injury recurrence.

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Criminal Behaviour and Mental Health
24: 18–35 (2014)
Published online 23 July 2013 in Wiley Online Library
(wileyonlinelibrary.com) DOI: 10.1002/cbm.1875

Psychiatric correlates of past incarceration in the national co-morbidity study replication

GREG A. GREENBERG, PHD[1] AND ROBERT A. ROSENHECK, MD[2], [1]VA New England Mental Illness, Research, Education and Clinical Center, VAMC West Haven, CT; Lecturer, Yale University Department of Psychiatry, New Haven, CT, USA; [2]VA New England Mental Illness, Research, Education and Clinical Center, West Haven, CT; Professor, Department of Psychiatry and Yale University School of Epidemiology and Public Health, New Haven, CT, USA

ABSTRACT

Background *Mental illness and substance abuse have been increasingly linked to criminal justice system involvement, but this relationship has mostly been by survey of prison populations and inferences of excess rates of disorder made by noting how these rates compare with national population-based surveys of mental disorders.*

Aims *The aim of this study is to examine associations between history of mental disorders, including substance misuse, with incarceration history within a single population-based data set.*

Methods *Data were from the National Comorbidity Survey Replication, a nationally representative household survey of respondents 18 years and older conducted between 5 February 2001 and 7 April 2003.*

Results *Multivariate regression analysis showed the strongest independent risk factors for a history of incarceration were being male [odds ratio (OR) = 6.3; $p < 0.001$], past receipt of welfare payments ($OR = 2.1$; $p < 0.001$), longer than 1 week of past homelessness ($OR = 2.1$; $p < 0.001$), not being from the northeast of the USA ($OR = 0.31$; $p < 0.001$) and a lifetime substance abuse or dependence diagnosis ($OR = 4.9$; $p < 0.001$). With the exception of welfare payments, these measures were also independently associated with longer (27 + days) incarceration.*

Conclusions *The socioeconomic associates of incarceration history were unexpected, and in line with other, differently conducted studies. The fact that only substance misuse disorders of all those assessed were independently associated with incarceration history was a surprise, given the multiplicity of prison surveys, which have shown higher rates of other serious mental disorders. Although we were unable to include measures of*

schizophrenia or similar psychosis and used impulse control disorders as surrogates for personality disorder, absence of a relationship between depression and incarceration when measured in the same way and over the same time among those previously incarcerated and those not, raises questions about the weight that should be put on the existing epidemiological perspective of mental disorder among prisoners. Published 2013. This article is a U.S. Government work and is in the public domain in the USA. Criminal Behaviour and Mental Health published by John Wiley & Sons Ltd.

Introduction

Worldwide, there is convincing evidence of an association, for men and for women, between severe mental illness and being in prison (Fazel and Seewald, 2012), and, albeit from fewer studies, of links between substance misuse and imprisonment (Fazel et al., 2006). More specifically in the USA, a Justice Department survey of the prevalence of all mental health disorders among criminal justice system detainees, reported that 56% of state prisoners, 45% of federal prisoners and 64% of jail inmates have some mental health problem (James and Glaze, 2006).

Many experts have suggested that reduction in psychiatric hospital bed numbers, in conjunction with the underfunding of community treatment programmes, may explain the high incarceration rates of severely mentally ill individuals (Engel and Silver, 2001; Jemelka et al., 1989; Lamb and Weinberger, 1998; White et al., 2006). Furthermore, living with mental illness in the community without access to comprehensive community care may increase the frequency of encounters with police and risk of subsequent incarceration (Lamb and Weinberger, 1998; Engel and Silver, 2001; Sellers et al., 2005).

It is also possible that the high incarceration rate among people with mental illness reflects co-morbid alcohol and/or drug use (Steadman et al., 1998; Swartz et al., 1998; Munetz et al., 2001; Erickson et al., 2008). Substance abuse is tied to greater risk for incarceration not only because drug use itself is a crime but because it raises the risk of violent behaviour (Boles and Miotto, 2003; Friedman 1999; Goldstein, 1985), participation in drug distribution systems (Boles and Miotto, 2003; French et al., 2004; Goldstein, 1985) and property crimes (Anglin and Speckart, 1988; French et al., 2004). It thus remains unclear whether mental illness alone increases incarceration risk or the observed risk reflects risks of association with substance abuse, which is more common in people with psychiatric disorders (Regier et al., 1990; Kessler et al., 1996).

Although the association of mental illness and substance abuse with risk of incarceration has been frequently studied in local populations, diagnostic assessments in past studies have been of uneven quality. The National Comorbidity Study Replication (NCSR) incorporated comprehensive sociodemographic measures, including data on past incarceration and sophisticated diagnostic measures in a representative national sample. Our aim was to examine correlates of past

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DOI: 10.1002/cbm

incarceration by using these data. Specifically, we wanted to determine the relative importance of mental illness and substance abuse over and above sociodemographic and economic factors associated with incarceration.

Methods

Source of data and sample

As described in detail elsewhere (Kessler and Merikangas, 2004), the NCSR is a nationally representative US household survey of respondents 18 years and older conducted from 5 February 2001 to 7 April 2003. Study procedures were approved by the human subjects committees of Harvard Medical School and the University of Michigan at Ann Arbour. The survey was limited to English speakers and excluded institutionalised individuals and those living in military bases. NCSR respondents were drawn by sampling within a multistage clustered area sample of households; there were four steps to the process: (1) primary stage sampling of US metropolitan statistical areas and counties; then sampling of (2) area segments within selected metropolitan statistical areas and counties; (3) housing units within the selected area segments; and (4) a random selection of eligible respondents from the sampled housing units. At every sampling step, all units had a greater than zero chance of being selected, with the probability of selection known (probability sampling). Sampling frames and sample selection procedures that are common to the University of Michigan Survey Research Center's National Sample design were used (Heeringa et al., 1984, 1994, 2006). Face-to-face interviews were conducted by professional interviewers from the Institute for Social Research at the University of Michigan.

The survey was carried out in two parts. Part 1 included diagnostic assessment of all respondents. Part 2 assessed risk factors for mental illness and substance abuse, demographic characteristics, service use and physical health status. So as to reduce study costs, only 5,692 of the 9,282 individuals who responded to part 1 were included in part 2. This substantial subsample included all part 1 respondents with a lifetime mental health or substance abuse disorder and a probability subsample of other part 1 respondents. The overall response rate was 70.9%.

Measures

Criminal justice system involvement

A measure was created to indicate whether an individual had ever been incarcerated since the age of 18 years. A second measure was constructed to represent cumulative incarceration of greater than 27 days among those with any reported incarceration. Although a cut-off of 1 month is commonly used to represent the distinction between short and longer periods of incarceration, 27 days was the only cut-off available in the NCSR data set.

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Sociodemographic characteristics

A series of dichotomous measures were created to represent sex, marital status, education (at least a high school degree), whether a language besides English was spoken at home while growing up, and whether the individual was born outside the USA. Race and ethnicity were represented by four mutually exclusive dichotomous measures (white, black, Hispanic, and other). In addition, four dichotomous measures represented the four US regions. A continuous measure of age was also created in which each unit represents a decade.

Economic characteristics

Economic status was assessed with a continuous measure of current annual household income (in $10,000 increments) and two dichotomous measures – one of past or current receipt of welfare payments and the other of current employment of 20 hours or more per week.

Homelessness

A dichotomous variable indicated whether an individual reported having one or more episodes of homelessness of at least 1 week since the age of 18 years.

Trauma

The first of four measures of trauma was a dichotomous indicator of lifetime participation in combat. We also used 48 items representing 26 types of trauma to create three measures that indicated whether an individual had ever experienced: (1) passive exposure to a traumatic environment (e.g. war zone or disaster) or event (e.g. being kidnapped or in a serious accident); (2) personal violence (e.g. being beaten up by a caregiver or spouse); and/or (3) exposure to death, trauma or injury of others.

Mental health and substance abuse

Diagnostic assessment of lifetime mental and substance abuse disorders was conducted using version 3.0 of the World Health Organization Composite International Diagnostic Interview (CIDI) (Kessler and Ustün, 2004) based on DSM-IV criteria. The CIDI is a structured diagnostic interview, here administered by non-clinicians trained in the interview technique. We created four dichotomous measures that reflected four diagnostic groups suggested by Kessler and associates (2006) as covering 16 lifetime mental health diagnoses: (1) anxiety disorders; (2) mood disorders; (3) disorders of impulse control; and (4) substance use disorders. Data on schizophrenia were not released because they were judged to be invalid. DSM-IV organic exclusion rules were used when making any diagnosis, and DSM-IV hierarchical rules were also applied (i.e. if a patient has two disorders of which one is a better explanation than the other, then the primary disorder or best-fitting diagnosis is adopted). Blind clinical re- interviews, using the structured clinical interview for DSM-IV, allowed demonstration of good concordance between structured clinical interview for DSM-IV and CIDI diagnoses of anxiety,

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mood and substance disorders. Disorders of impulse control could not be validated this way because of the absence of a gold standard clinical assessment for these disorders in adults (Kessler et al., 2005a; First et al., 2002). As these measures have been used with credibility in other published studies (Druss et al., 2007; Kessler et al., 2005b), we used them here. One additional dichotomous measure was created to indicate whether an individual was seriously mentally ill in the previous 12 months. This was based on a complex algorithm that used the following indicators and measures: DSM-IV diagnoses, history of suicide attempts and hospitalisations and the Sheehan Disability Scale (Kessler et al., 2005c; Leon et al., 1997).

Analyses

Firstly, we performed a series of bivariate chi-square and *F*-tests to examine whether a significant relationship existed between reported incarceration and each of the other measures. Secondly, we investigated the strength of the relationship between these measures with a series of bivariate logistic regressions with 'ever incarcerated' as the dependent variable and the odds ratio (OR) of each independent measure as the indicator of effect size. We then examined two multivariate logistic regression models. One model was used to identify the independent strength of the relationship between each measure and ever having been incarcerated, and the other to investigate the relationship between each measure and being incarcerated for 27 days or more compared with 26 days or less. Finally, we examined any interaction between substance abuse and psychiatric diagnosis in association with incarceration.

The bivariate logistic regression analysis was used to examine the strength of the relationship between each risk factor and incarceration, regardless of other factors. The multivariate logistic regression analysis, in contrast, was used to test for the unique relationship of each variable to the dependent measures over and above the effect of other independent variables, even those that were not significant in the bivariate analyses.

All analyses were performed using Sudaan (Version 9.0.3; Research Triangle Institute, Research Triangle Park, North Carolina), which uses sample design measures available in NCSR to adjust for the effects of weighting, clustering and non-responses on the precision of estimated variance. All significant tests in the logistic regression analyses were two-tailed with a *p*-value of 0.05, using Wald *F*-tests and based on coefficient variance-covariance matrices adjusted for design effects using the Taylor series method.

Results

Sample characteristics

Table 1 shows the relationships between sociodemographic characteristics and prior incarceration as well as those between mental health characteristics and

DOI: 10.1002/cbm

Table 1: Sample characteristics

	Not ever incarcerated (*N*/%)		Ever been incarcerated as an adult (*N*/%)		Chi-square/*F*-test	Bivariate logistic regressions all cases	
						Odds ratio	Confidence interval
Sociodemographic characteristics							
Race/ethnicity							
Black	575	12.4%	99	16.0%	0.049	1.34	1.02–1.77
Hispanic	500	10.8%	99	15.9%	0.048	1.56	1.05–2.31
Other	169	3.7%	26	4.2%	0.57	1.15	0.72–1.82
White	3383	72.1%	397	64.0%	0.0021	0.65	0.52–0.83
Age (in 10-year increments)	4.6 (0.04)		4.0 (0.07)		<0.0001	0.98	0.98–0.99
Male	1910	41.3%	476	76.6%	<0.0001	4.66	3.50–6.20
Married	2665	57.6%	307	49.5%	0.004	0.72	0.58–0.89
High school graduate	3902	84.4%	454	73.0%	0.0004	0.50	0.37–0.67
Language other than English at home when growing up	796	17.2%	120	19.3%	0.51	1.15	0.76–1.75
Born outside the USA	389	8.4%	27	4.4%	0.011	0.50	0.24–1.03
Region							
Northeast	885	19.1%	60	9.7%	<0.0001	0.45	0.31–0.66
Midwest	1091	23.6%	147	23.7%	0.94	1.01	0.81–1.26
South	1702	36.8%	224	36.1%	0.77	0.97	0.78–1.20
West	949	20.5%	190	30.6%	0.001	1.70	1.30–2.24
Economic characteristics							
Income (in $10,000 increments)	6.04 (0.17)		5.16 (0.23)		0.0004	0.96	0.94–0.98
Ever received welfare since 18 years old	669	14.5%	129	23.9%	0.0002	1.85	1.41–2.42
Employed full-time	2740	59.9%	410	66.4%	0.0114	1.33	1.06–1.65

(Continues)

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Criminal Behaviour and Mental Health published by John Wiley & Sons Ltd.
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DOI: 10.1002/cbm

Table 1: *(Continued)*

	Not ever incarcerated (*N*/%)		Ever been incarcerated as an adult (*N*/%)		Chi-square/*F*-test	Bivariate logistic regressions all cases	
						Odds ratio	Confidence interval
Community adjustment/trauma/mental health status							
Experienced longer than 1 week of homelessness since 18 years old	140	3.0%	108	17.6%	<0.0001	6.83	4.55–10.26
Trauma							
Ever participated in combat	204	4.4%	40	6.4%	0.048	1.49	1.01–2.20
Traumatic environment (such as, war zone or disaster) or experience (such as, kidnapped or automobile accident)	2204	47.7%	413	66.4%	<0.0001	2.17	1.66–2.84
Experienced personal violence against one self	1694	36.6%	393	63.3%	<0.0001	3.00	2.30–3.88
Witnessed or caused trauma to others on purpose or by accident	2979	64.4%	428	77.7%	<0.0001	1.92	1.38–2.68
Lifetime substance abuse or dependence DSM diagnosis	413	8.9%	306	49.3%	<0.0001	9.91	8.28–11.86
Lifetime drug abuse or dependence DSM diagnosis	210	4.5%	176	28.4%	<0.0001	8.33	6.55–10.61
Lifetime alcohol abuse or dependence DSM diagnosis	365	7.9%	286	46.0%	<0.0001	9.93	8.33–11.83
Lifetime mental health DSM diagnosis	1623	35.1%	344	55.3%	<0.0001	2.15	1.77–2.62
Anxiety disorders	1338	28.9%	260	41.9%	<0.0001	1.77	1.40–2.24
Panic disorder	207	4.5%	48	7.8%	0.0005	1.79	1.36–2.36
Agoraphobia (without panic disorder)	110	2.4%	23	3.6%	0.11	1.56	0.97–2.49
Agoraphobia (with panic disorder)	66	1.4%	8.0	1.3%	0.74	0.90	0.48–1.70
Specific phobia	565	12.2%	103	16.5%	0.0081	1.42	1.13–1.79
Social phobia	516	11.2%	119	19.2%	<0.0001	1.89	1.54–2.31

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Generalised anxiety disorder	355	7.8%	59	9.5%	0.029	1.26	1.04–1.53
Post-traumatic stress disorder (PTSD)	293	6.3%	67	10.8%	0.012	1.79	1.23–2.59
Adult separation anxiety disorder	262	5.7%	84	13.6%	<0.0001	2.62	1.98–3.46
Mood disorders	906	19.6%	172	27.7%	0.0002	1.58	1.28–1.95
Major depressive episode	830	18.0%	157	25.2%	0.0003	1.54	1.26–1.89
Dysthmia	175	3.8%	37	5.9%	0.018	1.60	1.11–2.31
Bipolar I or II	79	1.7%	32	5.1%	<0.0001	3.10	2.30–4.18
Mania	139	3.0%	47	7.5%	<0.0001	2.61	2.07–3.30
Impulse control disorders	580	12.5%	207	33.3%	<0.0001	3.49	2.88–4.22
Oppositional defiant disorder	195	4.2%	83	13.4%	<0.0001	3.52	2.64–4.69
Conduct disorder	149	3.2%	111	18.0%	<0.0001	6.55	5.30–8.11
Attention deficit disorder	159	3.4%	68	11.0%	<0.0001	3.45	2.69–4.44
Intermittent explosive disorder	299	6.5%	94	15.0%	<0.0001	2.57	2.04–3.25
Seriously or severely mentally ill	207	4.5%	85	13.7%	<0.0001	3.38	2.62–4.36
Weighted *N*	4627 (88.2%)		621 (11.8%)				

incarceration. Being male, single and having shorter education were prominent associations in respect of sociodemographics, as were being economically poorer, by the various measures and less well-adjusted to the community; histories of homelessness and incarceration were strongly associated. Exposure to trauma as an adult, according to any of the four categories, and all mental health diagnoses examined other than agoraphobia were also associated with incarceration history. The relationship between past incarceration and the two substance abuse diagnoses was particularly strong, with ORs of greater than 8.0. The ORs were highest for the impulse control disorders.

Multivariate analyses: ever been incarcerated

Table 2 shows that being male, younger and failing to graduate from high school were each independently associated with greater odds of having an offending history, but race/ ethnicity and recent immigrant status were not. Living in the northeast proved to be a protective factor, even after allowing for all the other sociodemographic variables.

Only one of the three economic characteristics – past or current receipt of welfare payments – was independently associated with incarceration history, but so too was a history of homelessness; unexpectedly, being employed was also independently associated (Table 2).

Among the trauma categories, only experience of personal violence was independently associated with greater odds of incarceration history. Among psychiatric diagnoses, we found that, after adjusting for all other measures, having had a substance abuse diagnosis was very strongly and independently associated with past incarceration, but no other psychiatric diagnostic type was independently associated.

Multivariate analyses: incarceration for over 27 days

Further examination showed that being black and male was associated with greater odds of a lengthier incarceration history, whereas the other sociodemographic variables had no independent effect on length of institutional stay (see right columns of Table 2); nor did receipt of welfare payments, but having a higher income was associated with lower odds of a lengthy incarceration.

Similar to the results for any incarceration, having experienced homelessness was associated with much greater odds of a lengthy incarceration history, but none of the trauma measures was independently related. Also similar to the results for any incarceration, substance abuse diagnosis was independently associated with greatly increased odds of longer term incarceration, but none of the three psychiatric measures was. In fact, a lifetime diagnosis of a mood disorder was associated with a reduced likelihood of longer-term incarceration.

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Table 2: Likelihood of incarceration

	Ever been incarcerated as an adult		Amount incarcerated over adult lifetime exceeds 27 days	
	Odds ratio	95% confidence interval	Odds ratio	95% confidence interval
Sociodemographic characteristics				
Race/ethnicity				
White	1.00		1.00	
Black	1.13	0.73–1.75	2.54†	1.21–5.34
Hispanic	1.06	0.65–1.72	1.60	0.42–6.04
Other	0.88	0.43–1.77	0.78	0.38–2.02
Age (in 10-year increments)	0.90†	0.81–1.00	0.91	0.78–1.05
Male	6.27§	4.31–9.14	2.41†	1.00–5.79
Married	0.87	0.66–1.16	0.80	0.42–1.56
High school graduate	0.66†	0.45–0.97	0.60	0.36–1.02
Language other than English at home when growing up	1.44	0.80–2.58	0.55	0.18–1.70
Born outside the USA	0.60	0.25–1.44	0.87	0.26–2.87
Region				
West	1.00		1.00	
Northeast	0.31§	0.19–0.50	0.80	0.25–2.51
Midwest	0.86	0.62–1.19	1.15	0.63–2.10
South	0.80	0.57–1.13	0.87	0.53–1.43
Economic characteristics				
Income (in $10,000 increments)	0.98	0.95–1.01	0.93†	0.86–1.00
Ever received welfare since 18 years old	2.12§	1.55–2.99	1.92	0.97–3.82
Employed full-time	1.36†	1.04–1.79	0.82	0.37–1.79
Community adjustment/trauma/mental health status				
Longer than 1 week of homelessness since 18 years old	2.13§	1.39–3.26	2.85‡	1.35–6.02
Ever participated in combat	0.72	0.52–1.00	1.57	0.71–3.48
Traumatic environment (such as, war zone or disaster) or experience (such as, kidnapped or automobile accident)	1.39	1.00–1.94	1.12	0.63–1.98
Experienced personal violence against one self	1.74‡	1.19–2.54	1.52	0.84–2.72

Witnessed or caused trauma to others on purpose or by accident	1.01	0.70–1.47	0.61	0.27–1.39
Lifetime substance abuse or dependence DSM diagnosis	4.89[§]	3.86–6.20	1.93[†]	1.07–3.49
Anxiety disorders	1.08	0.84–1.39	1.07	0.61–1.88
Mood disorders	0.82	0.61–1.11	0.58[†]	0.36–0.91
Impulse control disorders	1.20	0.81–1.75	1.65	0.94–2.91
Weighted *N*		5086		523

[†]<0.05;
[‡]<0.01;
[§]<0.001

Multivariate analyses: interaction of substance abuse and psychiatric illnesses

There are three interaction terms representing lifetime substance abuse diagnoses, and each of the three types of psychiatric illness showed no significant interactions in either model. Specifically, the results for the interaction terms for the multivariate model with ever been incarcerated as the dependent variable and main effects included the model were as follows: anxiety disorder [OR: 0.96, confidence interval (CI): 0.55–1.66], mood disorder (OR: 0.96, CI: 0.58–1.59) and impulse control disorder (OR: 0.66, CI:0.42–1.03). For the similar model in which incarcerated over 27 days was the dependent variable; the results were: anxiety disorder (OR: 1.38, CI: 0.52–3.68), mood disorder (OR: 0.80, CI: 0.24–2.62) and impulse control disorder (OR: 0.67, CI:0.21–2.09). These results suggest that the dually diagnosed do not experience increased risk of incarceration over and above the main effects of substance abuse and mental illness, separately.

Multivariate analyses: seriously mentally ill

In further multivariate analyses, firstly with ever incarcerated and secondly with length of imprisonment as the dependent variable, we substituted the dichotomous indicator of serious mental illness for the three dichotomous diagnostic indicators representing anxiety, mood or impulse control disorder. In neither case was illness independently related (OR 1.26, CI: 0.83–1.93; OR 1.61, CI 0.67–3.84, respectively).

Discussion

Our findings with respect to sociodemographic characteristics and incarceration history were unsurprising in that being male, young, without a high school degree

Published 2013. This article is a U.S. Government work and is in the public domain in the USA.
Criminal Behaviour and Mental Health published by John Wiley & Sons Ltd.
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and having had experience of personal violence or homelessness were all associated with having been incarcerated, all consistent with previous research (e.g. Bonczar, 2003; FBI, 2001; Fischer, 1988; Freeman, 1996; Lochner and Moretti, 2004; Holmes and Sammel, 2005; McDaniels-Wilson and Belknap, 2008; Snow et al., 1989; McCarthy & Hagan, 1991).

It might be assumed that the results of this study are not comparable with similar studies performed in other countries, because of differences between countries with respect to such factors as incarceration rates, availability of diversion programmes, criminal justice codes and access to mental health services. It appears, however, that several of our results are similar to studies conducted elsewhere. In particular, studies in general prison populations in other countries of behavioural health disorders have consistently found that the risk of having a serious psychiatric or substance abuse disorder is substantially higher for prisoners than the general population (Arboleda-Florez, 2009; Andersen, 2002; Fazel and Danesh, 2002; Fazel et al., 2006; Brugha et al., 2005; Jablensky et al., 1999). Unexpectedly, although neither race nor marital status was associated with greater odds of past incarceration, being currently employed was. One possible explanation for this is that, after adjusting for other factors such as education and substance abuse, individuals who have a record of incarceration have become in several ways more broadly representative of the general population, because of the very high incarceration rates in the USA.

Most unexpectedly, although substance abuse was found to be strongly and positively associated with past incarceration, the three measures of anxiety, mood and impulse disorders were not significantly associated, nor was having one of these three disorders together with a substance misuse disorder.

Also of interest is the finding that being from the northeast is associated with lower odds of past incarceration. Lower crime rates in the northeast, particularly for violent crime, have long been documented by other researchers (Lee et al., 2008 for a review) and in national crime statistics, such as those reported in the FBI's Uniform Crime Report (FBI, 2010). There have been two primary types of explanations for these differences: cultural and structural. Cultural proponents argue that higher violent crime rates in the southern states are due to a regional subculture that condones violence when there is adequate provocation. In contrast, those criminologists who use a more structural perspective make the argument that regional differences in structural deprivation and inequality better explain regional variation in crime rates (Lee et al., 2008; Felson and Pare, 2010). It is beyond the scope of this paper and the data available to us to attempt to suggest which approach better explains our results.

With respect to the employment finding, it is generally expected that employment will be found to be negatively associated with criminal activity and thus with incarceration, because employed individuals have more to lose if they are arrested, have less time to engage in illegal behaviours and less need to commit crime to overcome financial difficulties. In further analyses not

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presented here, we used a multivariate logistic regression to examine whether full-time employment was associated with a lengthy incarceration history (i.e. greater than 27 days) *among all cases*. We found that it was not. Employment does, therefore, appear to reduce the risk that an individual will commit more serious crimes, leading to longer incarceration, but the small positive association between full-time employment and any past incarceration remains unexplained.

A further finding that is of particular interest is that individuals who experienced homelessness were more likely to have been incarcerated than other individuals. Homelessness is associated with increased risk for incarceration because homeless individuals may commit crimes in an effort to survive with limited resources, but, equally, incarceration increases the risk of homelessness as it weakens community and family ties and also limits opportunities for employment and access to public housing (Kushel et al., 2005; Travis et al., 2001; Hopper et al., 1997; Metraux and Culhane, 2006).

With respect to diagnostic measures, our most original finding is of the strong association between past incarceration and substance abuse but the lack of any independent relationship between past incarceration and indicators of three psychiatric disorders (anxiety, mood and impulse disorders) or with serious or severe mental illness. Our study has certain methodological advantages, which may have contributed to this finding, in particular, the use of well-validated diagnostic measures, a wide variety of salient covariates (in multivariate analyses), a representative comparison group and a large national sample. The substance misuse component may in part be explained by the fact that, in contrast to psychiatric disorders, drug use itself is a crime, which may, in turn, lead to participation in illicit drug distribution systems and to property crimes; and because there are high rates of co-morbidity, people with psychiatric disorders may be incarcerated for their drug problems. The absence of association between the mental illnesses we measured, even when associated with substance abuse, and incarceration may underscore the importance of having more geographically matched comparison samples. Prior research has found co-morbid drug abuse to be one of the strongest risk factors for violence and/or criminal activity among persons with a severe mental illness (Fulwiler et al., 1997; Greenberg et al. 2011; Munetz et al., 2001; Swartz et al., 1998; White et al., 2006). Further, the combination of mental illness with substance abuse and non-compliance with medication has been shown to increase the risk of violent behaviour and incarceration beyond the risk directly due to mental illness or substance abuse alone (Mulvey, 1994; Räsänen et al. 1998; Steadman et al., 1998; Elbogen and Johnson, 2009), although there are dissenting findings (Sacks et al., 2009), whereas other studies only examined how substance abuse increases the risk of violence among individuals with a mental illness (Cuffel et al. 1994; Fulwiler et al., 1997; Swanson et al., 2006; Swartz et al. 1998). More importantly, the focus of our study was on the risk of past incarceration for any reason rather

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than on the risk of violent behaviour. Although several studies have examined the degree to which substance abuse increases the risk of criminal charges or incarceration among individuals with mental illnesses (Fowler et al., 1998; Munetz et al., 2001; White et al., 2006) or investigated the rates of co-morbidity and different types of offences among already incarcerated individuals (Abram and Teplin, 1990, 1991; Ellaj et al., 2004), there appears to be little research on whether being dually diagnosed significantly increases an individual's risk for incarceration beyond the main effects of mental illness and substance abuse. The only study we came across that directly examined this issue found that co-occurring disorders did not do so (Erickson et al., 2008).

Our study has several limitations. We relied on a cross-sectional rather than longitudinal study design, and previously incarcerated individuals were interviewed at unknown but presumably variable lengths of time since they were last incarcerated. Our analyses rest on the assumption that currently reported characteristics found to be associated with past incarceration were present in some form prior to incarceration and increased the risk of incarceration, but we cannot be certain of this. Incarceration is, however, a rare event and thus difficult to study prospectively, and we consider our assumptions in this respect to be at least plausible.

There are three other limitations of this study. Firstly, a more technical limitation is that NCSR data on obsessive compulsive disorder and schizophrenia were considered invalid and thus not available, whereas a measure of serious or severe mental illness was available. We would not, however, expect to find substantially different results for people with schizophrenia than for people with the psychiatric illness that were examined here since; although psychosis has previously been associated with incarceration, according to a substantial meta-analysis, pooled prevalence of major depression is much higher (Fazel and Seewald, 2012). Secondly, the survey depended on the respondent's memory, potentially reducing the validity of the data especially with respect to the symptoms of childhood disorders. Lastly, individuals actually residing in mental health facilities and prisons were excluded from the survey, perhaps removing from the study those with the most disadvantageous characteristics; however, the formerly hospitalised and incarcerated were included in the sample, and we thus believe it is unlikely that the results would have been substantially affected by inclusion of the currently institutionalised. A recent study of formerly hospitalised veterans did, in fact, find roughly similar results to ours (Erickson et al., 2008).

Despite these limitations, the NCSR is the largest national survey of which we are aware that includes well-validated measures of psychiatric and substance abuse disorders and information on past incarceration. Our results suggest that past incarceration and length of incarceration are associated with several sociodemographic and economic characteristics, and that substance abuse in particular is associated with greater risk of incarceration and lengthier

incarceration. Several non-substance abuse psychiatric disorders (anxiety, mood and impulse control) as well as serious or severe mental illness are not prominent independent risk factors as have often been assumed.

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Address correspondence to: Greg Greenberg, Northeast Program Evaluation Center, 950 Campbell Ave, West Haven, CT 06516, USA, Email: greg.greenberg@yale.edu

24: 18–35 (2014)
DOI: 10.1002/cbm

Services to Homeless People with Concurrent Disorders: Moving Towards Innovative Approaches

Submitted by:

Luba Serge
Deborah Kraus
Michael Goldberg
The Social Planning and Research Council of BC

April 2006

Acknowledgments

We would like to thank a number of people who have helped produce this report. Above all we would like to thank the people who work and who live in the projects that have been profiled in this study. They have been more than generous with their time and with the wisdom that they have shared so kindly with us. We hope that this research not only highlights the work that they are doing - for some on a personal level, for others professionally - but also celebrates their resolve, creativity, and courage.

We would like to thank the advisory committee, composed of Marcia Gibson, Mary King, Lorraine Chapman, and Jim Zamprelli. They all provided insightful comments and suggestions throughout the process.

We were also greatly aided by our project offices Lina Asfour and Jennifer Cottes. Both were extremely helpful in the process of completing this study.

We also would like to thank Deborah Hierlihy who prepared two case studies in Ontario.

This report was prepared for the Housing and Homelessness Branch of Human Resources and Social Development and received funding from the National Research Program of the National Homelessness Initiative. The research and recommendations are the responsibility of the authors of the report and do not necessarily reflect the views of the Housing and Homelessness Branch.

Luba Serge
Deborah Kraus
Michael Goldberg

April, 2006

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Appendices

1. Introduction

1.1 Purpose

The purpose of this study was to investigate innovative approaches to providing services for people with concurrent disorders (i.e. mental illness and substance use issues) who are homeless or at risk of homelessness.

1.2 Method and Approach

The methods used to gather the information for this research project involved:

- Conducting a literature review (see Appendix C);
- Preparing case studies to document eight programs and services that provide services to people with concurrent disorders (see Appendix A); and
- Conducting interviews with people living in housing or using services provided by six of the agencies participating in the case studies (see Appendix B).

A brief description of the methods is provided below.

1.2.1 Literature review

The researchers undertook a review of the literature from Canada, the US, UK, Europe and Australia, focusing on materials published since 1990. This included reports and articles published in English and French. The literature review provides an overview of treatment options for people with concurrent disorders. This includes non-residential programs, residential programs and other housing options. The focus is on programs targeted to people who are homeless. The literature review also addresses issues such as the definition of concurrent disorders, the prevalence of concurrent disorders, characteristics of individuals with concurrent disorders, and the connection between concurrent disorders and homelessness. (See Appendix C for the complete literature review.)

1.2.2 Case studies

The researchers documented eight programs that are providing (or planning to provide) services to people who are homeless or at risk of homelessness, and who have concurrent disorders.

For six case studies, (Walking to Wellness; Westview Dual Diagnosis Program; Mainstay Residence; Housing and Supports Peel; Housing with Outreach, Mobile and Engagement Services; and the HIV Project), face-to-face interviews were conducted on site with key informants and four residents or persons receiving services from the program.

Two other initiatives were documented using slightly different approaches. These were 5616 Fraser Street, which is still in the planning stages, and the Concurrent Disorders Program, which describes an aspect of a program that had recently been documented for another report[1]. Client interviews were not conducted for these two initiatives. It was intended that both interviews would be conducted by telephone. However, since one of the researchers lives in a city where one of the initiatives is located, the interview for that initiative was conducted in person.

In addition to the interviews with key informants, the researchers sought to obtain written documentation about each initiative, such as annual reports, policies, and evaluations, if available. Interview guides were used for all interviews. These are included in Appendix D. Table 1 below shows the programs documented as case studies.

TABLE 1.1: PROGRAMS DOCUMENTED AS CASE STUDIES

Project	**Sponsor group**	**Location**	**Type of interview**	**Resident/ Client Interviews**
1.Walking to Wellness	Nanaimo Mental Health and Addictions Services, Vancouver Island Health Authority	Nanaimo, British Columbia	On-site	Yes
2. Planned: 5616 Fraser Street Supported Housing Program	Triage Emergency Services & Care Society	Vancouver, British Columbia	On-site	No
3. Westview Dual Diagnosis Program	Phoenix Residential Society	Regina, Saskatchewan	On-site	Yes
4. Mainstay Residence	Main Street Project Inc.	Winnipeg, Manitoba	On-site	Yes
5. Housing and Supports Peel (HASP)	Supportive Housing Peel	Peel Region, Ontario	On-site	Yes
6. Housing with Outreach, Mobile and Engagement Services (HOMES)	Good Shepherd Non-Profit Homes	Hamilton, Ontario	On-site	Yes
7. Concurrent Disorders Program	Canadian Mental Health Association (Ottawa Branch)	Ottawa, Ontario	Telephone	No
8. HIV Project	Federation des OSBL d'Habitation de Montreal (FOHM) & Centre Dollard-Cormier	Montreal, Quebec	On-site	Yes

It was determined that all the initiatives should be operating in Canada. The researchers spoke with key informants throughout the country to identify projects that would be of interest. It was also felt that as much as possible, projects should be innovative or "best practices". While these two terms are somewhat difficult to define, the goal was to select

[1] Kraus, Serge, and Goldberg (2005) *Homelessness, Housing, and Harm Reduction: Stable Housing for Homeless People with Substance Use Issues* Ottawa: CMHC

case studies that were pioneering new approaches to serving people with concurrent disorders.

In Winnipeg, the Mainstay Residence is the main focus of the case study. However, the Co-occurring Mental Health and Substance Use Disorders Initiative (CODI), which can have an impact on the ability of Mainstay residents to access services, is also profiled within the case study and elements of this initiative are discussed in the report.[2]

1.2.3 Interviews with residents/people using services

The researchers conducted face-to-face interviews with four individuals from six of the projects where on-site interviews took place. An additional interview was also completed at one project, for a total of 25 interviews. The purpose of the interviews was to hear from the residents and individuals using the services what they like most and least about their housing, the kind of services and activities they are involved in, what their life was like before they became involved in the program, how their life changed since becoming involved in the program, and suggestions for other organizations interested in undertaking a similar project.

All the information from the 25 interviews is reported as a group. The information from these participants was not included as part of the case study of the program they were involved with in order to maintain confidentiality. An overview of the findings from these interviews is included in Section 5. More detailed findings are in Appendix B.

It should be noted that the information provided by the residents/people using the services is qualitative in nature. Therefore, when considering the information provided by the residents, it would not be appropriate to make generalizations that the findings would apply to the homeless population as a whole. A different study might have recruited individuals with different experiences who might have provided different points of view.[3]

1.2.4 Limitations of the research

One of the difficulties that this research confronted, as do similar projects that examine existing initiatives, is that of availability and comparability of data. It is clear that most community projects are stretched in delivering their services and do not have the resources or the capacity to undertake outcome studies. However, such information is critical as it would allow greater understanding about what is in place as well as better understanding on the targeting and design of new projects. The lack of systematic outcome measures also makes it difficult to recommend one approach over another.

[2] The Main Street Project Inc., sponsor of Mainstay, is a designated training site for CODI.

[3] Qualitative research is intended to provide in-depth knowledge about a specific topic based on the view of the participants. This is different from quantitative studies which involve the collection of statistical data from large, random samples for the purpose of generalizing findings to the larger population.

2. Overview of the literature review

The literature review focused on materials in English and in French published in Canada, the United States and Europe since 1990. A number of issues emerged that proved to be important in guiding subsequent phases of this research. These include the definition of concurrent disorders as well as which approaches are the most effective in addressing the needs of people with concurrent disorders.

2.1 Definition of concurrent disorders

According to Health Canada, concurrent disorders refer to the "*combination* of mental/emotional/psychiatric problems with the abuse of alcohol and/or other psychoactive drugs" (Health Canada 2002). Another recent and similar Canadian definition is used in the Interim Report of the Standing Senate Committee On Social Affairs, Science and Technology, *Mental Health, Mental Illness and Addiction.* This report states that "the term *concurrent disorders* most commonly refers to individuals who suffer from a mental illness and a substance use disorder at the same point in time" (Kirby and Keon 2004)[4].

However, the literature review reveals that information about concurrent disorders is far from being uniform and consistently defined. Definitions vary from study to study. Often, it is not clear what type of mental illness and substance use disorder is included in discussion of a concurrent disorder. The difficulty in assessment, the overlap in substance abuse and mental disorders, and the complexity of understanding the causal links is an issue that resurfaces in the literature (Farrell et al. 2003).

Since the 1980s, various terms have been used to describe the combination of mental health and substance use disorders. These have included dual diagnosis, dual disorders, comorbidity and co-occurring addictive and mental disorders. The terms chemically abusing-mentally ill (CAMI), mentally ill – chemically abusing (MICA) and substance abusing-mentally ill (SAMI), have also been used to describe this population.

Health Canada has expressed preference for the term concurrent disorders because it provides a distinction from other work in the field of developmental disabilities and mental health. In several parts of Canada, the term "dual diagnosis" is currently used to describe mental illness and developmental delay. In addition, "thinking of mental health and substance use problems as a plurality rather than duality is more consistent with the typical clinical presentation of abuse of multiple drugs, including alcohol, and often more than one psychiatric diagnosis" (Health Canada 2002).

[4] A bibliography is provided at the end of the literature review in Appendix C.

2.2 Prevalence of concurrent disorders

The concept of concurrent disorders is relatively recent – only gaining prominence in the last two decades. This may be explained by the closure of large psychiatric hospitals, a process of deinstitutionalisation that occurred not only in North America but in Europe and Australia as well. The increased availability of drugs in the community is an additional explanatory factor. This increased interest has been spurred by economics – health costs are significantly higher for this population, as well as recognition that "there may not just be a gap in service provision, but a chasm…." (Crawford et al. 2003).

However, the study of concurrent disorders is dominated by US literature, which may introduce biases that are country-specific. While the data from other countries is not as developed as that from the US, some of the literature indicates that characteristics and even treatment approaches are not necessarily transferable from the US.

In Canada, there are no national studies that estimate the prevalence of concurrent disorders. The Health Canada report on Concurrent Mental Health and Substance Use Disorders quotes literature summarized by US authors which estimates that between 40 – 60 percent of individuals with severe mental illness will develop a substance use disorder at some point during their lives (Health Canada 2002). The Standing Senate Committee On Social Affairs, Science and Technology, provides data from the 2002 Canadian Community Health Survey (CCHS) conducted by Statistics Canada. While there is no information about the number of individuals with a concurrent disorder per se, the survey found that one out of every 10 Canadians aged 15 and over (about 2.6 million individuals) reported symptoms consistent with mental illnesses and/or substance use disorders during the past year (Kirby and Keon 2004).

2.3 Concurrent disorders and homelessness

Individuals with a concurrent disorder are believed to be among the most visible and vulnerable of the homeless population (National Health Care for the Homeless 1998). In the US, it has been estimated that about one third of people who are homeless have serious mental illnesses, and that between 50 and 70 percent of homeless adults with serious mental illness have a co-occurring alcohol or other drug use disorder (Rickards et al. 1999; Conrad 1993; Tsemberis et al. 2003; Gulcur 2003). It has also been estimated that about 10-20 percent of homeless people in the US have a concurrent disorder (Buckner et al. 1993; National Health Care for the Homeless 1998).

A few limited studies in Canada are consistent with the US. For example, in British Columbia it was estimated that about 10 percent of shelter users had both substance use and mental health issues (Eberle et al. 2001). A 1998 study of Pathways to Homelessness in Toronto, estimated that approximately 66 percent of homeless persons had a lifetime diagnosis of mental illness (Mental Health Policy Research Group 1997; Kirby and Keon 2004). The City of Toronto has estimated that up to 20 percent of its homeless population suffers from severe mental illness and addictions (City of Toronto Mayor's Homelessness Action Task Force 1999). A Montreal study of the clients of twelve facilities dealing with persons with multiple problems found that 85 percent had mental

health issues, 75 percent were homelessness, 65 percent had problems with alcohol, and 53 percent had problems with drugs (Comité aviseur itinérance multiproblématique de la Régie régionale de la Santé et des Services sociaux de Montréal-Centre 1994).

The literature reports that individuals with a concurrent disorder who are homeless have more issues that need to be addressed than others with a concurrent disorder who are not homeless. Once homeless, they are likely to remain homeless longer than other homeless people. Most clients are unable to navigate the separate system of mental health and substance abuse treatment. In Toronto, for example, it was found that most mental health facilities were unable or unwilling to work with people who have an addiction, while addiction treatment facilities were not equipped to deal with people with a serious mental illness (City of Toronto Mayor's Homelessness Action Task Force 1999). Often they are excluded from services in one system because of the other disorder and are told to return when the other problem is under control (Dixon and Osher 1995; Drake et al. 2001; Drake et al. 1997; Rickards et al. 1999; Bebout et al. 1997).

Some of the specific issues facing individuals with concurrent disorders who are homeless include: a high risk of suicide; a high lifetime prevalence of injection drug use; high prevalence rates for HIV, hepatitis B and hepatitis C; high rates of contact with the criminal justice system; more isolated and disconnected from social support networks; more resistant to accepting help than their domiciled counterparts; and come from very dysfunctional family backgrounds (Prigerson et al. 2003; Susser et al. 1997; Klinkenberg et al. 2003; Hartwell 2004; Drake et al. 1991; Blankertz and Cnaan 1994).

Concern has been expressed that public mental health service systems are not versatile enough to meet the multiple needs of homeless individuals with concurrent disorders and have failed to engage most of this population in treatment (Reardon et al. 2003). However, it is also recognized that it is often difficult to engage this population, and they often enter the system only while in crisis. Because of non-compliance with medication and treatment plans, they tend to move in and out of services. Even when homeless individuals do enter specialized psychiatric and substance user treatment programs, dropout rates are high.

2.4 Recommended treatment approaches for people with concurrent disorders

According to the literature, one of the major barriers to dealing with concurrent disorders is that of two separate systems that have developed to deal with mental health and with addictions. The integration of these two systems is a major issue in the treatment of concurrent disorders, and becomes especially problematic with a homeless population that not only faces the barriers described above but also is confronted with navigating two, often incompatible, systems.

Historically, substance use treatment services for homeless people have been offered either sequentially or in parallel. In sequential treatment clients might be told they must receive treatment for their substance use disorder before they can be treated for their mental illness, or vice versa. This approach was found to be ineffective because it was difficult to stabilize one disorder without addressing the other (Hendrickson et al. 2004).

In a parallel approach, clients receive services from two or more systems simultaneously (Kraybil et al. 2003). According to Health Canada, having two separate systems of care has usually meant parallel or sequential services being delivered across the two systems with little or no coordination and less than optimal outcomes.

The Canadian literature indicates support for an integrated approach to treatment for individuals with concurrent disorders. For example, the Health Canada report (2002) recommends integrated treatment as a best practice, but suggests new ways of thinking about integration. The report proposes that there are many ways to better integrate an individual's treatment and support across units within the same facility or across community agencies, and that increasing collaboration blurs the distinction between the old terms of integrated treatment and sequential and parallel treatment.

The literature appears to indicate that homeless individuals with concurrent disorders do not accept an environment that is too restrictive or rigid, and heavily controlled residential treatment models in which housing and treatment are tightly bundled are associated with recruitment and retention problems. The literature appears to recommend that programs be flexible and encourage people with concurrent disorders to enter gradually without requiring abstinence (Bebout et al. 1997; Blankertz and Cnaan 1994). The literature states that programs segregated from the community result in rapid relapse rates when clients are discharged and suddenly reintroduced in to the community. Residential programs are most likely to be successful when they are located within clients' natural communities, and when they provide opportunities for community reintegration (Meuser et al. 2003).

2.5 The role of housing

There is consensus in the literature that housing is the cornerstone of care, particularly for people who are homeless and have concurrent disorders (Drake et al.1991). Numerous studies have reported that stable housing is nearly always central to attaining treatment goals and that housing must be part of any comprehensive treatment program. A study in Montreal of the trajectories of homeless persons who were substance users and in the process of stabilisation found also that housing was the cornerstone for stabilisation and that the ability to maintain the housing was the result of a more global process of rehabilitation (Mercier et al. 1999).

However, there appear to be differences of opinion and new ideas regarding what type of housing should be available and regarding the relationship between housing and treatment. For example, while studies have shown that most mental health consumers want to live in their own residence, several studies in which housing was provided for homeless mentally ill people in the mid-1990s demonstrated that substance abuse posed serious problems for their ability to maintain stable community housing (Schutt and Golfinger 1996, Hurlburt et al.; Bebout et al. 1997).

On the other hand, there are others who believe housing, and the stability that comes with having a stable living environment needs to come before treatment. For example,

Alverson et al. (2000) found that positive quality of life factors precedes rather than follows sobriety.

The predominant and more traditional approach to housing homeless individuals with severe and persistent mental illness in the US has been an approach that follows a Continuum of Care. Individuals who also use substances are expected to become more engaged in abstinence as they move along the continuum. The Continuum of Care approach has had limited success and has been criticized for several reasons (Tsemberis 2003; Dixon and Osher 1995; Gulcur 2003) including:

- difficulties in engaging individuals;
- the requirement that individuals change housing as they "progress" through the continuum may be counterproductive, even causing symptomatic relapse;
- consumers prefer to live in independent housing and have complained about the institutional qualities of many treatment-oriented housing settings;
- consumer choice or preference may be ignored;
- skills learned for successful functioning at one type of residential setting are not necessarily transferable to other living situations;
- it takes a substantial amount of time for clients to reach the final step on the continuum;
- individuals who are homeless are denied housing because placement is contingent on accepting treatment first;
- given the lack of data on how rapidly individuals should progress through the phases, time limits may seem arbitrary and a step-wise progression may not mirror the client's clinical course.

The "housing first" approach is an alternative to the continuum of care: housing is viewed primarily as a place to live, not to receive treatment. Central to this idea is that consumers will receive whatever individual services and assistance they need to maintain their housing choice. Proponents of this approach emphasize that it facilitates normal community roles, social integration, and increased independence and control for the client (Dixon and Osher 1995; Tsemberis and Asmussen 1999; Tsemberis et al. 2003).

2.6 Conclusion

Based on the literature, it is clear that more work needs to be done to integrate addiction and mental health treatment services for individuals with concurrent disorders. However, there are different ideas as to what integration means, and how it can best be achieved. Health Canada supports integration through the development of enduring *linkages* between service providers or treatment units within a system, or across multiple systems to facilitate the provision of services to individuals at the local level.

The literature review reveals that housing plays a critical role and is the "cornerstone of care". While some of the older thinking and literature advocated treatment before independent living, more recent research is demonstrating that homeless individuals with a concurrent disorder can maintain independent housing, providing appropriate supports are in place.

3. Overview of case studies

This section of the report provides an overview of the eight initiatives that were documented as case studies.

3.1 About the people

All the initiatives serve people with concurrent disorders. Most are single men and women, however, two programs, HOMES in Hamilton and HASP in Peel, reported that they also serve families with children and couples. The clients served at the time of the interviews ranged in age from 23 to 59 years old. A small percentage of clients in one program were reported to be transgendered.

Some of the initiatives are targeted specifically to people who are homeless or at risk. However, even if the initiatives are not targeted to this group, all the programs serve some clients who have experienced homelessness or lived in unstable housing situations.

Most of the initiatives reported serving individuals with a variety of ethnic/cultural backgrounds, including Caucasian, Aboriginal, Asian, East Indian and Vietnamese. While the majority of clients in most projects were Caucasian, 60% of the residents in the Mainstay Residence in Winnipeg were Aboriginal.

The key informants reported that schizophrenia, bipolar disorder, depression, obsessive compulsive disorder, anxiety disorders, and mood disorder are the most common mental illnesses among the people they serve. The people served also face a variety of other challenges, including personality disorder, history of trauma, brain injury, physical illness (e.g., Hepatitis C and HIV), a learning disability, and criminal record.

Most of the case study agencies reported that the substances used most often by their clients are alcohol, cocaine, marijuana, crack, and prescription drugs. Some agency key informants reported that poly-substance use is also common. Other types of substances used by program participants include crystal meth, and non-prescription drugs (e.g. antihistamines and gravol), ecstasy, and hallucinogens. Agency key informants reported a decline in the use of heroin, which is too expensive for their clients. Three case study agencies reported having clients involved in a methadone program. The Westview program in Regina reported that Talwin and Ritalin, considered the “poor man’s heroin”, is the most common intravenous drug that residents have used, although use has decreased lately. The Mainstay Residence in Winnipeg, reported having clients with a history of sniffing solvents (e.g., paint and paint thinner) as well as drinking products such as hairspray and mouthwash. They also note an increase in the use of cocaine, crack and crystal meth.

Agency key informants noted that some clients have complications from long histories of substance use, such as losses in their cognitive abilities, difficulties managing anger, and difficulties relating to others.

The 5616 Fraser Street project in Vancouver is planning to target its program to people in recovery who have been abstinent for at least 60 days before applying to the program.

TABLE 3.1: TYPE OF CLIENTS SERVED BY EACH CASE STUDY

Project	Type of clients
1.Walking to Wellness, Nanaimo	• Concurrent disorders • Multiple challenges and complex needs • Frequent users of acute services and had no successful engagement with mainstream services.
2. Planned: 5616 Fraser Street Supported Housing Program, Vancouver	• Single men and women with concurrent disorders who are in recovery and have stopped using drugs and alcohol for at least 60 days.
3. Westview Dual Diagnosis Program, Regina	• Single men and women in Regina who have a concurrent diagnosis of serious and persistent mental illness and substance abuse.
4. Mainstay Residence, Sponsored by Main Street Project Inc., Winnipeg	• Single men and women with a history of substance use (30%), mental health issues (20%), concurrent disorders (40%), or other issues (10%).
5. Housing and Supports Peel (HASP), Peel Region	• Mostly single men and women, but also families and couples. All live with a mental illness and are homeless or at risk of homelessness. Forty percent have a concurrent disorder.
6. Housing with Outreach, Mobile and Engagement Services (HOMES), Hamilton	• Mostly single men and women living with mental illness and who are homeless or at risk of homelessness. Less than one percent are transgendered. A small percent of tenants are couples or families with children. Almost 50% of tenants have a concurrent disorder.
7. Concurrent Disorders Program, Ottawa	• Persons with concurrent disorders who are homeless or at risk.
8. HIV Project, Montreal	• Single men and women who are homeless or at risk, have substance use issues and are HIV positive. Most have psycho-social problems.

3.2 About the housing

Three of the initiatives provide permanent housing (see Table 3.2). In two programs (HASP in Peel and HOMES in Hamilton) clients have access to units in dedicated buildings or units that are integrated within non-profit or private rental buildings that serve a mix of tenants (i.e. scattered sites). The HIV Project offers scattered site housing to its clients in buildings managed by the FOHM and owned by the City of Montreal or FOHM member organisations.

Three initiatives provide (or will provide) transitional housing[5] in dedicated buildings. 5616 Fraser Street will be purpose built to house 30 residents in self-contained units

[5] Transitional housing is defined as time limited housing (e.g. two to three years) often with support services and the expectation that the residents will move on to independent and permanent housing. The

(units include bathrooms and kitchens). The Westview Dual Diagnosis Program leases an entire 10-unit building from the landlord, with responsibility for day-to-day property management and rent collection assumed by Westview and "big ticket" items, such as roof replacement, remaining the responsibility of the owner. Mainstay Residence is a dedicated building adjacent to the Main Street Project facility in Winnipeg (which contains services such as a shelter and Detox centre). The Mainstay Residence has 22 private bedrooms and 6 rooms, each shared by two residents. Women are housed on a separate floor and meals are provided in a community dining room.

Clients in the remaining two initiatives have a variety of different housing options. In Ottawa, clients of the Concurrent Disorders Program can have access to the housing services available to other CMHA clients[6] and they can use CMHA as a reference for landlords. Landlords have been found to be more interested in clients who are addressing previously known substance use issues.

Clients in the Walking to Wellness project in Nanaimo choose where they want to live in the community, subject to availability and affordability, and program staff help their clients access the housing in the community. The program has some Rent Supplement funding for up to 15 units in private rental and non-profit housing. The program also has access to four bedrooms in a six-bedroom house, Crescent House, which is owned by Mental Health and Addictions (part of the regional Health Authority) and was formerly used as a step down facility for the hospital. Clients may use Crescent House in an emergency (e.g. if they get evicted from their housing), for respite, or if they need a temporary place to stay to avert an eviction. The team may also recommend that a new client stay in Crescent House to "stabilize" if they believe the client would get evicted from other housing options in the community. The length of stay is determined on an as-needed basis. The importance of Crescent House is underscored by the fact that all the participants in the program have spent at least some time there.

Westview Dual Diagnoses Program allows residents to stay up to five years – however they consider themselves a treatment facility and not transitional housing.

[6] CMHA-Ottawa Branch has a Housing Outreach Program, documented in Kraus, Serge, and Goldberg (2005) op.cit.

TABLE 3.2: TYPE OF HOUSING PROVIDED IN EACH CASE STUDY

Project	Type of housing	Type of unit	Number units	Type of provider	Scattered Site[7] vs. Dedicated[8]
1.Walking to Wellness, Nanaimo*	Mix of transitional and permanent .	Varies some shared some self-contained	4 bedrooms in Crescent House and funding for up to 15 rent supplement units	Non-profit and private	Dedicated and scattered
2. Planned: 5616 Fraser Street Supported Housing Program, Vancouver	Transitional supported housing	Self-contained	30 units	Non-profit	Dedicated
3. Westview Dual Diagnosis Program, Regina	(Transitional) – treatment facility**	Self-contained	10 units	Non-profit rents entire building from a private landlord	Dedicated
4. Mainstay Residence, Winnipeg	Transitional	Shared	34 beds in 28 rooms	Non-profit	Dedicated
5. Housing and Supports Peel, Peel Region	Permanent	Self-contained	218 units	Non-profit and private	Dedicated and scattered
6. Housing with Outreach, Mobile and Engagement Services (HOMES), Hamilton	Permanent	Some shared, some self-contained	181 units	Non-profit and private	Dedicated and scattered
7. Concurrent Disorders Program, Ottawa	Housing is not an integral part of the program but clients have access to CMHA housing services	NA	NA	NA	NA
8. HIV Project, Montreal	Permanent	Self-contained	10 units	Non-profit & public	Scattered

* Housing is provided for some of the 30 clients while the others are supported in whatever situation they find themselves – which can range from owner-occupied housing to prison. **Westview considers itself to be a treatment facility where residents may stay for 3 to 5 years.

3.3 About the services

3.3.1 Approach to substance use

The initiatives documented in this report have adopted different approaches to substance use. Five initiatives follow a harm reduction philosophy and accept clients "where they

[7] Clients are integrated in a building that serves a mix of tenants
[8] The entire building is dedicated to the target population or a similar clientele.

are at" in terms of their substance use[9]. Where housing is provided, clients may remain in their housing as long as their use does not contravene landlord/tenant legislation or interfere with other tenants. Generally, use in common areas is not tolerated and drug dealing is grounds for eviction.

Two initiatives (Westview and Mainstay Residence) expect their clients/residents to be abstinent or working towards abstinence. Drugs and alcohol are not permitted on the premises. However, there is some flexibility. While abstinence is a goal, participants are not automatically discharged for using drugs or alcohol. The Westview project illustrates an evolution in the approach to abstinence. From the onset, the project did not require strict adherence to abstinence but rather a commitment to this goal. Over time an approach incorporating elements of harm reduction has developed. For example, Westview will continue to work with a resident who has resumed substance use for a longer period than in the past, as long as the resident is not interfering with the progress of others: rather than abstinence, the goal might be to help the resident use less.

In Vancouver, 5616 Fraser Street, a planned project, will have a stronger expectation of abstinence. The program will be targeted to individuals with concurrent disorders who are in recovery and who have stopped using drugs and alcohol for at least 60 days. Part of the assessment process will be to determine a person's ability and commitment to live an alcohol and drug free lifestyle and to take an active part in both their mental health and addictions treatment plans. If the program sponsor believes a resident has relapsed, staff plan to issue a 48-hour eviction notice which will give residents 48 hours to decide if they wish to recommit to their recovery plan. Residents will be able to go to Triage's transitional housing (Princess Rooms) or its emergency shelter if they do not recommit.

[9] The definition of harm reduction used in this study is similar to that in Kraus, Serge, and Goldberg (2005) op.cit.. The definition is: *An approach aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence. A distinction is made between approaches that are primarily a "tolerance of consumption" and approaches that actively engage clients in making positive changes in their lives.*

TABLE 3.3. APPROACH TO SUBSTANCE USE

Project	Approach to substance use
1.Walking to Wellness, Nanaimo	Follows a harm reduction philosophy in all aspects of treatment and service delivery. The team accepts all clients "where they are at" regardless of their substance use, and aims to meet their needs with creative and relevant clinical responses. There are no program rules to limit substance use in buildings where clients have their own self-contained unit. Alcohol and drugs are not permitted on the property in Crescent House, a shared living environment. A resident must stay in their room if under the influence of a substance
2. Planned: 5616 Fraser Street Supported Housing Program, Vancouver	Residents will not be permitted to use substances – on or off the premises. The goal of the program is to meet the needs of clients who want to become abstinent and to help residents through the recovery process.
3. Westview Dual Diagnosis Program, Regina	The goal of the program is to lead clients towards abstinence and psychiatric stability while they maintain a level of independence in the community. Substance use is not permitted in Westview. The house is "dry" – providing an alcohol and drug free environment. However, the program is "damp". Residents are not supposed to use alcohol or drugs (on or off site), but it is also understood that relapse is part of the recovery process. If a resident shows overt signs of relapse, they must agree to follow through with a detox plan.
4. Mainstay Residence, Winnipeg	Residents are expected to be abstinent or working towards abstinence. Drugs, alcohol or inhalants of any kind are not permitted in the rooms or common areas of the building.
5. Housing and Supports Peel (HASP), Peel Region	The program goal is to eliminate homelessness for people with serious mental illness and addictions and to provide suitable accommodation. Abstinence is not a requirement and service recipients are not monitored for their substance use. Tenants are treated like anyone else living in a private residence. However, no landlord tolerates substance use in common areas or drug dealing on the property.
6. Housing with Outreach, Mobile and Engagement Services (HOMES), Hamilton	The program goal is to provide safe, secure, affordable and supportive housing for those with a history of homelessness and mental illness. Abstinence is not a requirement or expectation of individuals accepted into the program. Instead, the focus is on harm reduction: working with tenants to minimize harm to their physical health, minimizing risks to the individual's safety, education about the supports that are available, and helping them make their own decisions. Use of drugs and/or alcohol in private living spaces does not contravene tenancy rules for the housing provider – unless the use of substances interferes with the ability of others to enjoy or feel safe in their housing.
7. Concurrent Disorders Program, Ottawa	This is a harm reduction program. Clients set treatment goals in relation to where they are at in their stage of change. Relapse is expected.
8. HIV Project, Montreal	The program uses a harm reduction approach to substance use. There are no expectations in terms of abstinence. What happens in participants' apartments is up to them, as long as they do not disturb other residents.

3.3.2 Approaches to service delivery

The agencies are using several different approaches to the way in which they deliver and coordinate services to their clients. These include:

- An integrated approach to the delivery of both mental health and substance use services so that services address both issues concurrently (e.g., when providing counselling, staff would address both mental health and substance use issues).

- Multi-disciplinary teams that include a diversity of expertise such as social work, nursing, psychiatry, addictions, recreational/occupational therapy.

- Intensive case management (small caseloads, available to clients beyond regular work hours, work with clients for an extended period of time, and provide services in the clients' environment – on an outreach basis).

- Case management where clients are assigned to one key worker who is their primary contact. The case manager is responsible for addressing clients' immediate and basic needs and connecting them with services in the community.

- On-site staffing available 24 hours a day, seven days a week.

- Approaches that embrace principles of psychosocial rehabilitation and focus on the client's strengths.

- Coordination and partnerships with a range of service agencies, focusing on housing and referral to services as needed.

TABLE 3.4: APPROACH TO SERVICE DELIVERY USED IN EACH CASE STUDY

Project	Approach to service delivery
1.Walking to Wellness, Nanaimo	Assertive Community Treatment (ACT) is used: a multi-disciplinary team provides intensive case management services to clients in their own environment 8:30 a.m. to 9:00 p.m. six days a week. A 24-hour back-up crisis service system is available. The team includes two social workers, a registered psychiatric nurse and an assisted living worker who provides social, recreational, life skills, vocational and pre-employment support. Staff have training or experience in addictions, harm reduction, and psychosocial rehabilitation. The ACT team delivers mental health and substance use services concurrently and treats both mental illness and substance use as primary. The team also ensures that professionals who provide treatment or services to their clients use a consistent approach and recognize where each client is at with their mental illness and substance use.
2. Planned: 5616 Fraser Street Supported Housing Program, Vancouver	Will involve a multi-disciplinary treatment team, including a dually trained psychiatrist and case manager hired specifically for the program. Services will be coordinated with the resident's addiction counsellor. Treatment will focus on client strengths, an assertive approach (especially for relapse prevention and early intervention), group treatment, motivational interviewing, Cognitive Behavioural Therapy, and an emphasis on community integration and meaningful activities. On-site staff will be available 24 hours a day, 7 days a week.
3. Westview Dual Diagnosis Program, Regina	The approach to service delivery is based on "best practices" as defined by Health Canada and Psychosocial Rehabilitation Canada[10]and an integrated approach in the delivery of both mental health and addictions services. The services delivered by staff are intended to address both mental health and substance use issues concurrently. Each resident is assigned to a key worker to review their individual plans. The caseload ratio is one worker to 5 residents. On-site staff are available 24/hours a day. 7 days a week
4. Mainstay Residence, Winnipeg	The approach to service delivery includes 24-hour on-site staffing. Each resident is also attached to a member of a multi-disciplinary team. Case managers are trained in a wide range of areas including counselling, advocacy, relapse prevention, housing, money management, assessment, case planning, referrals, like skills development and community outreach. Staff link their clients to services outside the program to get them ready to move out of Mainstay. Mainstay is also a designated site for implementation of the Winnipeg Regional Health Authority's Co-occurring Mental Health and Substance Use Disorders Initiative (CODI). Residents with concurrent disorders have access to a Community Mental Health Worker who has received specialized training to work with individuals with concurrent disorders.
5. Housing and Supports Peel (HASP), Peel Region	Takes a holistic approach to providing mental health and substance abuse services with a focus on reducing harm and improving the well-being of service recipients. Practice the principles of psychosocial rehabilitation. Case management services are provided on the basis of 1 case manager for 10 clients.

[10] See Health Canada, Centre for Addiction and Mental Health. 2002. *Best Practices. Concurrent Mental Health and Substance Use Disorders.* Ottawa: Health Canada, and Roberts, Gary and Alan Ogborne 1999. *Best Practices Substance Abuse Treatment and Rehabilitation.* Ottawa: Health Canada, Office of Alcohol, Drugs and Dependency Issues.

Project	Approach to service delivery
6. Housing with Outreach, Mobile and Engagement Services (HOMES), Hamilton	HOMES embraces psychosocial rehabilitation and a recovery based approach in housing and supporting individuals with concurrent disorders. The focus is on the strengths of the individual and what challenges he or she wants to work on. The nature of the support provided by HOMES staff is intensive case management. Tenants who need 24 hour onsite support are housed in buildings owned by the sponsor group. Those requiring a lower level of support are housed in scattered units and are supported by a mobile team.
7. Concurrent Disorders Program, Ottawa	CMHA-Ottawa Branch uses an intensive case management approach. Workers have a limited case load and work with clients for a long period of time. The primary case manager develops an overall treatment plan with the client. Outreach workers seek to meet the target client group in locations where they are likely to be found. Their work consists of meeting people and convincing them that they have something to offer that could interest potential clients. Clients who need a longer period of support (i.e. more than a year) will be referred to the Assertive Community Treatment team that can undertake long-term intensive case management. Services are available seven days a week from 12 to 8 p.m. on weekdays and 9 a.m. to 5 p.m. on weekends. The Concurrent Disorders Program consists of a "training the trainers" education project that targets frontline staff and agencies as well as treatment groups for clients of CMHA. The groups are based on Stages of Treatment: engagement, persuasion, active treatment, and relapse prevention. These stages of treatment are based on the observation that people who change behaviours progress through a series of distinct stages, each stage characterised by different motivational states. The groups have two facilitators each: one is from CMHA and the other from an agency dealing with addictions. Meetings are held at various community sites.
8. HIV Project, Montreal	The approach for service delivery is centred on coordination and partnership with a range of services and agencies. The program revolves around the housing. Depending on needs, participants are referred to services in the community. All participants are clients of Dollard-Cormier, an agency that offers a wide range of services for people with substance use issues, including 24/7 emergency services, detox and a clinic for people with concurrent disorders.

3.3.3 Types of services

The clients of case study agencies have access to a full range of services to address their mental health; substance use; housing; and needs for social, recreational and vocational opportunities. Some of the above-noted services are available on-site, while others are available in the community. In addition, some services that are provided on-site by one agency may be available off-site with another agency. Most often, these include:

- Providing housing or helping clients access and maintain housing;
- Helping clients access services in the community and become integrated into the community;
- Helping clients manage their medications e.g. storing and monitoring their use;
- Counselling – both in groups and one-on-one;
- Helping clients to set goals, develop and implement personal plans;
- Providing training, assistance or support with lifeskills;
- Helping clients with budgeting or managing their finances;

- Assisting clients with volunteer, pre-employment, and employment opportunities;
- Providing social and recreational activities or helping clients engage in activities of personal interest;
- Dealing with crises and working with clients to prevent crises in the future; and
- Helping clients get to appointments, and if need be accompanying them.

A few of the case study agencies also reported providing meals and support to family members.

Some of the specific ways in which case study agencies support their clients in addressing their substance use issues include:

- Frequent engagement with their clients regarding their substance use (e.g., "motivation" and "lots of talking");
- Expecting residents to see substance use counsellors at local community agencies or to participate in concurrent disorders programs;
- On-site programs to help residents maintain a drug and alcohol free lifestyle, including support recovery groups, counselling and crisis intervention;
- In-house non-medical detox;
- Formal addiction assessments and referrals; and
- A variety of strategies to encourage participants to focus on reducing harm to themselves and improving their well-being.

4. Findings from the case studies

4.1 Introduction to the findings

In many respects the eight projects profiled in this study are not only unique but they also reflect the difficulty and challenges that confront the development of projects to address the needs of homeless persons with concurrent disorders. The early stages of the research underlined this: for example the literature review indicated that treatment of concurrent disorders was difficult since two systems to deal with mental health and addictions had been developed, and navigating the two was especially challenging for homeless persons. The scan of potential Canadian initiatives to be profiled revealed that agencies and services often were so overwhelmed with dealing with the overall homeless population that services targeting very specific populations were beyond their capacity.

The eight case studies represent a broad range of approaches to dealing with homeless or at risk persons with mental illness and problems of substance use. The case studies were examined to identify common elements and these have been organized into the following topics: development of the project/program, the target population, the overall approach to substance use and housing, and the integration of mental health and addictions services. The three final sections of this chapter deal with the impact of the programs/projects on residents' lives, reasons for success, and challenges.

4.2 Impetus to development of the project/program

Perhaps because of the complexity of the issue of concurrent disorders and homelessness, all of the projects that are profiled in this study are rooted in existing organisations, which, for the most part, are long-standing and have considerable experience in their field. In examining the impetus for the projects, three major themes emerge: a perceived gap in services being offered; systemic problems in the response to needs; and an over-utilisation of certain services by the target population.

4.2.1 Gap in services

Agencies such as Triage, the sponsor of the planned 5616 Fraser Street project in Vancouver, and Phoenix Residential Society, sponsor of Westview Dual Diagnosis Program, have been working with persons who have mental illness, are homeless or marginalized. Through their work these two agencies came to the conclusion that certain services were not available to their population. In the case of 5616 Fraser Street, Triage was already offering a range of services and housing, including an emergency shelter, transitional housing, supportive housing, as well as an outreach team. However, what was missing in this continuum were facilities for persons who wished to become abstinent. Triage clients would enter a recovery home after detox but because these are not designed for people with mental illness, they often would be asked to leave if they displayed symptoms such as talking to themselves. 5616 Fraser Street, currently under construction, will address the need for abstinence-based transitional housing for people with concurrent disorders.

In the case of the Westview Dual Diagnosis Program[11], Phoenix Residential Society was offering services such as group homes and support services, but there was a need for a treatment program that would help people with concurrent disorders learn how to maintain themselves in the community, using an approach that did not require strict adherence to abstinence but instead expects clients to commit to abstinence (participants are not automatically discharged for using drugs or alcohol).

Other projects grew out of gaps in addressing specific needs: HASP in Peel for example confronted the problem that many individuals in shelters had become "perpetual residents" because of their mental illness and substance use, while FOHM (Fédération des OSBL d'habitation de Montréal), a housing organisation, was approached by the Centre Dollard-Cormier, which works with persons who have addictions, to provide housing and supports for people who are homeless or at risk, with HIV/AIDS, and have substance use issues.

4.2.2 Systemic problems

A number of projects grew out of the recognition that two very separate systems, one to treat addictions and one for mental illness, were almost impossible to navigate by their clients. CODI (the Co-occurring Mental Health and Substance Use Disorders Initiative), which offers services to residents of the Mainstay Residence in Winnipeg, grew out of the recognition by the Winnipeg Regional Health Authority, Addictions Foundation of Manitoba, and Manitoba Health that individuals with concurrent disorders were often poorly served in both mental health and substance abuse settings. The initiative takes a systems integration approach (i.e. service providers are linked across programs and systems) to facilitate welcoming, comprehensive and continuous services. A consultant, Kenneth Minkoff, was hired to help implement the Comprehensive, Continuous, Integrated System of Care (CCISC) model that he had developed.[12]

The CMHA-Ottawa Concurrent Disorders Program grew out the realisation that a significant proportion of the client group, homeless persons who had mental illness, had concurrent disorders. Like many other agencies in Canada, their staff, as part of the mental health system were trained to work with mental illness, not addictions, while persons who were working with additions had not been trained to work with mental illness. CMHA clients with complex needs were not being well served in either system, and outcomes were not as good as they could have been. The concurrent disorders program was developed in conjunction with Kim Mueser[13] and includes both concurrent disorders groups for CMHA clients as well as a training program for agencies working with this population.

[11] As noted elsewhere, the terminology for concurrent disorders (i.e. co-occurring mental health and substance use) is variable. In the Regina case study, the term "dual diagnosis" is used in the same sense as "concurrent disorders". Elsewhere, notably in two Ontario case studies (HOMES and SHIP) the term "dual diagnosis" is used exclusively in reference to problems of developmental delays and substance use.
[12] See the literature review for more detail about Minkoff's work.
[13] See the literature review for more detail about Mueser's work.

It should be noted that both Walking to Wellness in Nanaimo and Phoenix Residential Society, sponsor of Westview Dual Diagnosis Program also recognised that there was a need, in developing their programs, for integration of the mental health and addiction systems and undertook means to integrate the two in their practice from the onset.

4.2.3 Over-utilisation of acute care

Finally, some projects profiled in the study were encouraged to develop the initiative through the realisation that persons with concurrent disorders were using expensive services on a regular basis and that better solutions could be found for them. Walking to Wellness in Nanaimo, which was developed with multiple partners (including the Nanaimo Mental Health and Addictions Services, Forensic Psychiatric Services, Ministry of Human Resources, RCMP (Royal Canadian Mounted Police), Corrections Services, and Addictions Services), was based on the realisation that persons with concurrent disorders were frequent users of acute services and did not engage with mainstream services. For example, the Nanaimo General Hospital had found that a small number of individuals were “frequent flyers” - using psychiatric beds on an emergency basis several times a year. The project’s goal is to help people become healthy and engaged so that they will transition to less intensive, mainstream services.

In developing an integrated program both CODI in Winnipeg and the CMHA-Ottawa Branch, recognised that the target clients were over-utilising the criminal justice system, primary health care, and the child protection and shelter systems. There were also high rates of housing instability as well as increased levels of HIV and other communicable diseases.

4.3 The target population

Half of the projects profiled in this study deal explicitly with a clientele that has concurrent disorders and is homeless or at risk while the other half of the projects profiled deal with a client group that is significantly but not exclusively persons with concurrent disorders.

TABLE 4.1: TARGET CLIENTELE

Project/program	*Target clientele*	*Proportion of clients with concurrent disorders*
Walking to Wellness, Nanaimo	Persons who have concurrent disorders and are homeless or at risk	100%
Planned : 5616 Fraser Street, Vancouver	Persons who have concurrent disorders and are homeless or at risk	100%
Westview Dual Diagnosis Program, Regina	Persons who have concurrent disorders and are homeless or at risk	100%
Mainstay Residence, Winnipeg, Manitoba	Problems with, mental illness, substance use, abuse and homeless or at risk	About 40%
HOMES Hamilton, Ontario	Mental illness and homeless or at risk	About 50%
HASP Peel, Ontario	Mental illness and homeless or at risk	About 40%
Concurrent Disorders Program, Ottawa (Agencies dealing with this population)	Persons who have concurrent disorders and are homeless or at risk	100%
HIV project Montreal, Quebec	HIV/AIDS, substance use, and homeless or at risk	Most have socio-psychological problems

It should be noted that while the Concurrent Disorders Program of the CMHA-Ottawa Branch deals with clients who have a concurrent disorder, the program also provides training to service agencies, as does CODI in Winnipeg which has completed work with 40 designated trainers who are responsible for sharing information that would be useful to others who work with persons with a concurrent disorder.

4.4 Overall approach to substance use and housing

As described in Chapter 3, three of the eight projects have an approach that is based on abstinence, while the other five adhere to harm reduction[14]. The provision of housing varies. Some such as HOMES, HASP, and the HIV Project offer housing as an integral part of the program. Two (Mainstay and 5616 Fraser Street) offer transitional housing and a third (Westview), where residents stay three to five years, is considered a treatment facility. The Concurrent Disorders Program does not offer housing but clients have access to CMHA housing services. Walking to Wellness is a hybrid – four rooms are available on an emergency basis, funds for up to 15 rent supplement units are available to participants, but clients can also live in their units or participate in the program from other facilities, including jail, a forensics facility or mental health housing.

[14] The definition of harm reduction used in this study is similar to that in the CMHC study *Homelessness, Housing, and Harm Reduction: Stable Housing for Homeless People with Substance Use Issues* by Deborah Kraus, Luba Serge and Michael Goldberg (2005). See footnote #8 for the definition.

4.4.1 The housing situation

In many respects, the initiatives illustrate the range of housing options and partnerships that can or need to be undertaken to house clients. While two projects, 5616 Fraser Street (planned) and Mainstay Residence have dedicated buildings to house clients and are owned by the project or its sponsor, the other initiatives have a range of means to provide housing, as illustrated by Table 4.2. For example, the Westview Dual Diagnosis program is also in a dedicated building but leases the building from a private landlord. Other projects, including HOMES, HASP, and Walking to Wellness use rent supplements in buildings owned by private and non-profit landlords to make housing affordable for their clients. HASP also has access to units owned by Supportive Housing in Peel (SHIP), the housing partner in the project, while clients of the HIV project in Montreal live in units owned by non-profit housing providers that are members of FOHM or public housing units administered by FOHM.

The lack of suitable housing or housing that is appropriate or accessible to clients is a major issue for a number of initiatives. For example, in the early months of operation of Walking to Wellness, the team found it both hard to stabilize and keep track of participants who were homeless or in unsafe housing (at that time ten of the thirty participants were homeless and others were living in low quality rooming houses). Crescent House, where four bedrooms are available to clients of Walking to Wellness, was acquired to provide a safe and stable home environment to help in the transition to greater stability. However, housing stability continues to be one of the biggest challenges for the program: clients get evicted because of drug use and related behaviours (e.g. noisy parties, drug dealing, damage to the unit, etc.). Housing is also a problem due to significant rent increases (25 to 30 percent) and a low vacancy rate.

In Winnipeg, the lack of suitable housing for clients to move to has resulted in some clients of Mainstay continuing to live in the project for years. HASP was developed in response to a similar problem in Peel: people were continuing to live in shelters because of their mental illness and substance use. They had become perpetual residents, unable to work or obtain housing. The partnership that led to HASP allows individuals with concurrent disorders to be housed and supported with individualized services.

4.4.2 Permanent and non-permanent housing

It is interesting to note from Table 4.2 that the three abstinence-based programs have a client group that is either coming from detox (the planned 5616 Fraser Street), waiting to get into a treatment program (Mainstay) or the initiative itself is considered a treatment facility (Westview). It could be that offering permanent housing, with the ensuing rights of tenants to control the environment within their unit, might not be compatible with an abstinence-based program.

TABLE 4.2: APPROACH TO SUBSTANCE USE AND HOUSING TYPE

Project	***Approach***	***Housing type***		
		Permanent	*Transitional*	*Housing not provided directly*
Walking to Wellness, Nanaimo	Harm reduction			✓ *
Planned: 5616 Fraser Street, Vancouver	Abstinence		✓	
Westview Dual Diagnosis Program, Regina	Abstinence – residents must commit to this goal		✓ **	
Mainstay Residence, Winnipeg	Abstinence		✓	
HASP, Peel Region	Harm reduction	✓		
HOMES, Hamilton	Harm reduction	✓		
Concurrent Disorders Program, Ottawa	Harm reduction.			✓
HIV Project, Montreal	Harm reduction.	✓		

* While housing is not an integral part of the program, the sponsor, Mental Health and Addictions, did acquire a six-bedroom house of which four bedrooms are available to the program and the length of stay is determined on an as-needed basis. Furthermore, rent supplement funding for up to 15 units is available.

** Westview does not consider itself to be transitional housing, but instead a treatment facility where residents can stay for 3 to 5 years.

Westview does not consider itself housing but a treatment facility. While the relationship between staff and clients is key to abstinence and relapse is understood to be part of the recovery process and a "learning experience", random urine tests and apartment checks are carried out to check adherence to abstinence. In 5616 Fraser Street, it is expected that because there will be 24-hour staffing and a close relationship with clients, staff will know if a resident is consuming again by changes in behaviour, attitude or thinking (e.g. withdrawing from staff, staying in one's room, etc.). However, the project's sponsors are still uncertain whether the provincial Residential Tenancies Act will apply in their project.

Eviction is one of the potential consequences of use in all three abstinence projects. In Westview, persons may be suspended for a period of 3 to 7 days and stay at the Salvation Army, while at Mainstay residents who use substances will be required to sleep in the shelter or the Intoxicated Persons Detention Area. It is planned that residents will be given a 48-hour eviction notice at 5616 Fraser Street. In all three projects, these periods of eviction are used as time away during which clients must decide if they wish to recommit to their recovery plans and to abstinence. Finally, in Walking to Wellness the four bedrooms in Crescent House (owned my Mental Health and Addictions), are dry and residents may be asked to leave the house for the day if they use a substance on site. However, the program does not impose restrictions on participants in the units with rent

supplement funding, nor are any such restrictions placed by Walking to Wellness on participants living elsewhere.

The projects that follow a harm reduction approach and that provide housing offer tenants leases and full protection under provincial tenancy acts, an approach that is similar to Housing First[15]. Both HASP and HOMES consider their housing attractive enough that clients will choose to stay over the long term. The HIV program in Montreal finds that offering permanent housing may help people reduce or even cease their consumption because they are "anchored" by their housing. Since residents have full occupancy rights, the program and the housing are less entangled and it is difficult to evict people for reasons other than those covered by law. This is seen as an advantage by the HIV project as offering permanent housing allows people to continue to live in their units even if they no longer need or desire the support services. HOMES, like the other projects profiled, is not quick to evict tenants. Issues such as the stage the individual has reached in dealing with mental health and addictions problems, recognition of the significant barriers that individuals face, and understanding that many individuals have not had responsibility for paying rent for many years are all taken into consideration by the agency. Both HASP and HOMES have certain behaviours, notably selling drugs on the property that do result in warnings and, if warnings are not heeded, they will take action to evict the residents.

4.4.3 Prescribed medication

Residents are expected to take their prescribed medications in the two projects that adhere to abstinence, 5616 Fraser Street and Mainstay. On the other hand, persuasion is used in Westview: if residents do not want to take their medications, they will be asked to see their psychiatrist to discuss their concerns as it is understood that it can take time for people to accept that taking medication may be a permanent part of their lives.

The approach to medications in harm reduction projects is generally one of persuasion: in HOMES the focus is on self-awareness and education, while CMHA tries to help clients understand the consequences of their choices, to support their decisions, and build an alliance that will help clients make better decisions in the future. In the HIV project, residents are expected to take their medication (although it should be noted that this can be for HIV as well as mental health issues). However, this is not a condition, rather, as in the other projects, persuasion is used, including the argument that the ability to continue to live in the apartment and have an autonomous life is related to taking medication.

4.5 Integration of mental health and addictions services and the role of partnerships

One of the issues that pushed projects to be developed, and one of the challenges facing all eight initiatives that are profiled is the integration of addictions and mental health services for their clients. In some cases specialized teams have been put into place to deal

[15] Housing First is the direct provision of permanent, independent housing to people who are homeless. Clients will receive whatever individual services and assistance they need and want to maintain their housing choice. For more about this approach see Kraus, Serge and Goldberg (2005).

exclusively with the clientele whereas in other initiatives the team is built using existing services in the community. However, all the projects rely on partnerships and community networks to some extent to meet the complex and broad needs of the client group.

4.5.1 Integration of services

The Four existing projects (5616 Fraser Street is in the development stage) that deal exclusively with persons with concurrent disorders have an explicit approach that treats substance use and mental illness simultaneously. For example, Walking to Wellness in Nanaimo has adopted a modified ACT model[16] to ensure that services are integrated (services are available 8:30 am to 9:00 pm 6 days a week instead of 24/7). These services are delivered regardless of where the clients live. Both mental illness and substance use are treated as primary since it is felt that it is essential to consider both at the same time as each one affects the other. It is also recognised that a person may be at one stage in addressing their mental illness and at another stage in addressing their substance use. One of the roles of the ACT team is to ensure that all the professionals who provide treatment or other services to their clients use a consistent approach and that everyone recognizes where each client is at with their mental illness and substance use.

The Concurrent Disorders Program of CMHA-Ottawa Branch also treats mental health and addictions concurrently. Basing the model on work undertaken by Kim Mueser, six key elements are included in the approach to integration: comprehensive treatment; assertive outreach; reduction of negative consequences; long-term perspective; motivational based treatment; and multiple psychotherapeutic modalities.
Outreach and assessment is undertaken in three main locations: hospital in-patient/ER departments, provincial court, and homelessness services such as shelters. All CMHA clients are assigned a case manager. If a client requires longer-term support, they are referred to the intensive case management services. Clients are encouraged to make use of "normal" services so they can become familiar with them. This will help the clients to further integrate into the community rather than becoming dependent on CMHA-Ottawa Branch services alone. One of the means used to integrate the approach to concurrent disorders is to have the concurrent disorders groups facilitated by staff from both CMHA and from an addictions partner agency.

Westview also treats both mental illness and substance use concurrently: two key workers on staff (each with a case load of 5 residents) undertake psychosocial rehabilitation, medication management, and group and individual counselling. Finally, 5616 Fraser Street, like CMHA, Westview and Walking to Wellness also will treat concurrent disorders simultaneously. Residents will work with an addictions specialist (clients will have at least 60 days of sobriety) and a multi-disciplinary treatment team will include a dually trained psychiatrist and a case manager, attached to a mental health team. Services will be coordinated with the resident's addiction counsellor.

[16] ACT comprises case management with a multi-disciplinary team of professionals who are responsible for providing services to clients. Caseloads are small, (typically a 1:10 ratio). Most services are delivered on an outreach basis and there is usually 24 hour coverage.

In Winnipeg, CODI has set systemic integration as a goal but with the underlying assumptions that mental health and addiction programs do not have to change nor be fully integrated or fall under unified administrative authority to be effective in delivering integrated services. Furthermore, clinicians, trained in either mental health or substance use treatment do not have to become experts in both specialties, but they do require a basic level of competency. Components of systemic integration undertaken by CODI include the Interagency Network (regular meetings of mental health and addictions clinicians) and training of persons responsible for assisting in the knowledge transfer process.

Projects not dealing exclusively with persons with concurrent disorders have a variety of approaches. For example, the HOMES project in Hamilton provides intensive case management services from housing support workers who also help link tenants to community support programs and interventions. Specific support to residents with concurrent disorders includes access to two psychiatrists who will consult with tenants over a short period, with a focus on looking at the impact of substance use on mental health, as well as Recovery Support Workers who have personal and professional experience with addictions. There is also a Dual Recovery Anonymous group that provides a 12-step approach for discussion about both substance use issues and mental health symptoms. At HASP in Peel, the case management function is provided by PAARC (Peel Addiction Assessment and Referral Centre) whereas a housing worker offers housing support. At the HIV project in Montreal, one worker co-ordinates services for the ten residents and links them to community agencies and departments, while at the Mainstay Residence case management is assumed by a primary transition worker who is part of a multidisciplinary team. The team has specialized skills in counselling, advocacy, relapse prevention, housing, money management, assessment, case planning, referrals, life skill development and community outreach.

4.5.2 The partnerships

All eight projects illustrate the importance of partnerships in developing and delivering services. In a number of cases, partnerships were instrumental in instigating the projects themselves. For example, Walking to Wellness grew out of need that had been identified by Mental Health and Addictions with several other agencies, including Forensic Psychiatric Services, the Ministry of Human Resources, Corrections Services, and Addictions Services. The Royal Canadian Mounted Police (RCMP) was approached as well, since it was often the police who brought the client group to the hospital. The initial proposal was a demonstration project to evaluate whether ACT would be an effective way to engage and work with the target population.

HASP is also the result of collaboration between agencies. When funds became available from the Ontario Ministry of Health and Long Term Care, Peel agencies collaborated to submit one proposal, which also resulted in enhanced communications between SHIP (Supportive Housing in Peel), the lead proponent, and mental health agencies, addiction programs, hospitals and organizations serving people with concurrent disorders.

Partnerships are critical to delivery of services as well. None of the projects that are profiled can deliver the range of support and expertise required on their own. For example, Westview residents must be under the care of a psychiatrist and the case manager at the Mental Health Clinic (part of the Regina Qu'Appelle Health Region) prepares a community support and rehabilitation plan. Formal partnerships with local agencies are in place to provide housing support workers for HOMES, while HASP is a result of formal agreements between numerous community agencies including SHIP, PAARC, and the Canadian Mental Health Association/Peel.

The Concurrent Disorders Program in Ottawa has very purposefully undertaken a partnership arrangement for delivery of simultaneous services. Each of the concurrent groups has two facilitators; one from CMHA the other from an agency dealing with addictions and meetings are held at various community sites. The Concurrent Disorders Program has learned that there will not be systemic changes until mental health and addictions agencies work together and bring about the necessary changes in unison. They also learned that working in partnerships with agencies dealing with addictions is more complex and challenging than developing or hiring such skills within their organisation.

To some extent this is also one of the early lessons of CODI. The project has resulted in discernable improvements for Mainstay. Doors have been opened giving easier access to clients to mental health counselling, psychiatric services, and psycho-geriatric assessments and fewer are "falling through the cracks". Furthermore, staff at different agencies have a better understanding of what services each agency can provide and what each agency requires before they can provide service. Training also has resulted in greater understanding and knowledge.

Similar conclusions have been found at HASP where collaboration has not only resulted in creative solutions for problems but there is recognition and appreciation of various agency mandates. An unforeseen benefit has been generosity among the partnering agencies: an unexpected year-end surplus was dedicated to clear up rent arrears among HASP tenants.

Partnership arrangements are key in expanding the services available. A small initiative like the HIV Project, with only one full time staff member, can offer a range of services because people have access to expertise available in the community. Therefore, while there is only one employee for this program, the worker sees herself as part of a much larger team that includes the various agencies that work in close collaboration.

4.6 The impact on residents' lives

One of the most challenging aspects for many initiatives dealing with fragile populations is the monitoring of outcomes or undertaking full evaluations and assessments of impact. The projects profiled in this study are no different and the information about outcomes is variable, however in general key informants did note changes in the lives of clients since they had become involved in the project.

4.6.1 How projects define of success

Key informants were asked how they defined success for their project. The definitions were varied, reflecting the diversity of approaches and rationales for the initiatives. Many of the projects referred to substance use in their definitions of success: for example, Walking to Wellness refers to reduced harm associated with substance use, which can include safer use (e.g., clean needles/not sharing needles), using less harmful substances, being able to talk about substance use, and reducing problems associated with drug use. 5616 Fraser Street plans to include the ability to remain abstinent as well as fewer and shorter relapses and learning from the relapses in their definition of success.

Other elements of success include housing stability. For example, this is the key for the HIV project in Montreal and an important factor for HOMES in Hamilton. Other key informants spoke of stability in general, that can include housing, quality of life, and reduced use of acute care. Some also spoke of re-establishing links with family and friends as well.

Some project key informants spoke about less quantifiable measures of success. For example, at CMHA-Ottawa Branch success is a moving target and, ultimately, is seen as meeting clients' needs. In the same way, Walking to Wellness sees success as any positive change in the lives of the participants, but also includes the question of sustainability of improvements as a consideration. The issue of sustainability was raised by Mainstay in Winnipeg. The initiative has been successful in providing a place where residents feel safe and supported. People stabilize and are able to make progress in achieving their goals. However, a significant number have been unable to maintain the positive changes when they move out: the ability to live somewhere stably for 6 months is considered a major accomplishment. One of the major factors for this instability has been the lack of sufficient support and a need for alcohol and drug free transitional housing, where people can live after they complete treatment. It is hoped that additional staffing will help address this situation.

4.6.2 Impact on housing stabilisation

The HIV project in Montreal has a particular focus on housing stabilisation. Residential stability is seen as the starting point for many other changes that occur in participants' lives; sometimes as people find stability in their housing situation, they begin to recognize other needs and seek support for these. On the other hand, Walking to Wellness found access to housing to be particularly challenging, and while some clients have been able to stabilize, for others this has proven to be more elusive. However, the project has found that clients are able to stay in their housing longer before getting evicted; it is taking less time for clients to find another place to live after they are evicted; the amount of time that any client is homeless has been reduced from months to a few days or not at all, and the quality of housing for all participants has improved since they became involved in the program.

Other projects also noted achievements in the housing situations of clients. For example, HASP reports a low unit turnover, while HOMES has only 3 percent evictions and less than 2 percent rent arrears.

4.6.3 Impact on substance use

Most projects report a change in substance use by clients. For example, in Walking to Wellness, two people have achieved long-term abstinence (3 years) and for most other participants there has been a noticeable decline in the level of harm that results from their substance use (e.g. longer periods of abstinence, use of less harmful substances, and safer use) as well as substance use having a less negative impact on their lives. Westview and Mainstay also find that there is a decrease in use, while the HIV project finds that people change their consumption habits - they may decide to consume less or switch to different substances, such as beer with lower levels of alcohol.

However, CMHA- Ottawa Branch has not noted a decrease in use and HOMES finds that it can appear that use increases. There are a number of reasons for this, including underreporting of substance use at intake, little privacy to consume when people lived on the street or in shelters, and being housed with a stable source of income. According to some key informants, people may find that they have more money available, which can have an impact on the amount or type of substances used.

4.6.4 Impact on physical and mental health

Many projects report better health with corresponding decreases in use of emergency services. For example, Mainstay has found that the health of residents improves as they are encouraged to take care of their medical and dental needs and because meals are provided, residents eat better and more nutritious meals. Similarly, Westview has found that there is better health with better access to health care, increased medications compliance, and fewer inpatient hospitalizations and less use of emergency services. HOMES, HASP, and Walking to Wellness all report parallel trends in reduced hospitalisations and improved health, including mental health.

The HIV Project reports a different tendency – the use of emergency services is seen as a sign of success. While clients were on the street they had difficulty taking care of their health and using health services. Most of the clients have been HIV positive for a long time and are very sick; often confronting serious problems that require emergency services (e.g., infections) so the use of emergency services is seen as a sign that they are beginning to take care of their health. Key informants reported that housing plays a role in stabilizing physical health – problems are more easily identified and compliance with treatment, including taking medication, is much easier than while living on the street or in a shelter.

4.6.5 Impact on income, employment and volunteer work

One of the changes that is noted for many clients of profiled projects is an increase or stabilisation of income. In many cases persons received no income and the project has

helped them apply and receive social assistance or other revenue, such as disability support. This is especially important for clients of the HIV Project, since the cost of medication can be as much as $2,000/month which is covered while they are on social assistance.

Some projects also provide employment or pre-employment support. For example, Walking to Wellness provides a pre-employment readiness program. They look for opportunities in the community, such as the SPCA, where participants can engage in volunteer or paid work. Participants can be hired as a recreation assistant or peer support worker or to do landscaping for Crescent House and other related sites. HOMES has also hired residents for security or for surveys and a vocational support worker is available for assistance finding paid and unpaid work opportunities, including access to a casual labour pool.

Getting a job is one of the main goals for some residents of the Mainstay Residence. Assistance is provided to help people connect to work opportunities and a few are employed directly. However, while some residents are definitely employable, they can easily lose their jobs if they go through a crisis. At the HIV Project, while all the participants are on social assistance, some participate in work programs, such as those at the local street journal. Although some speak of pursuing educational goals, none have followed through at this point.

A recently introduced incentives program has been initiated at Westview to encourage residents to engage more actively in programs and rewards for participation can include not only a "pizza night" or brunch but also eligibility to be hired to do janitorial work.

4.6.6 Impact on social networks

Project key informants spoke of better social networks for clients. For example, Walking to Wellness has found that people have better contact with family members, including parents, siblings and children, as did HASP. At the Mainstay Residence, staff help residents strengthen existing relationships and build new ones as some have no family. Some residents are disconnected because of the impact of residential schools. The HIV project has found that once people are stabilized, many express a desire to re-establish contact with family and social networks that they had before they began to consume substances. Having stable housing and a phone helps clients contact people in their network.

4.7 Reasons for success according to key informants

When asked the reasons for their initiative's success, all of the key informants spoke of the importance of the staff. For example, at Westview the way in which staff work with the residents and are able to connect with them is critical, as is having staff that are flexible, creative, can look at the needs of each client and provide support as needed. It was underlined that staff treat the residents with honesty and respect, giving residents a positive experience. The relationship that is established between staff and residents endures even after people leave. Former residents feel a connection and often phone and

stay in touch with the staff, while others continue to attend group meetings and participate in activities. The ongoing connection is felt to help former residents continue with their recovery - if they need help, they know they can always come back. A unique feature might be that the majority of staff at Westview have a history of substance use and are in recovery. The sponsor, Phoenix, believes these individuals are an asset to the program since they are able to see life through the eyes of their clients and are positive role models, instilling hope that change is possible.

Other projects, such as Mainstay noted the importance of the relationship between staff and the residents and the ability of staff to engage the residents. This relationship also extends to the sponsor organisation, Main Street, which has been in operation since 1972. Some clients have had a long history with the organisation, they trust it, and "it gives them hope".

The diversity of support offered was deemed important at the Concurrent Disorders Program in Ottawa. This can range from sending out a doctor or a nurse to the client to giving taxi chits. The range is wide enough so that a client cannot say: "You can't help me with that". At the HIV Project in Montreal, the availability of the worker was also seen as important to the success of the project. It was emphasised that a major element in working with participants is to establish trust and a positive relationship – something that is not always easy. Dealing with issues such as substance use, conflict or bringing in the police are all carefully weighed and considered in the light of the long-term relationship that is being developed and the goal of creating confidence. This is especially important in the way that workers speak to participants. For example judgemental statements such as "you consume too much", are not allowed.

Qualities of the staff and of the relationship between staff and clients were cited as reasons for success. For example, the key informant of the Concurrent Disorders Program spoke of staff being persistent and using a strength-based, client-directed service as important factors in the success of their initiative. The HIV Project key informant spoke of tolerance, consistency, and flexibility as important qualities of staff.
Walking to Wellness staff do whatever it takes to establish and maintain a relationship with each client. When the ACT team first starts working with new clients, they focus on getting to know them and meeting their basic needs for food and housing. They also help their clients get the medical and dental care they require and focus on health and safety. Their approach is to say, "Here's a program. We want it to work for you." The ACT team takes a very practical approach to addressing their clients' needs to show that they are helpful and can be trusted to make things better. They note that it can take a long time to establish a relationship with a client. Staff do what it takes to maintain the relationship on an ongoing basis. For example, they may take a participant to the Dairy Queen once a week, or go shopping with them for food. It all depends on what the participant wants and is able to accept. Over time, the ACT team expects that participants will increase their goals and what they want for themselves. The ACT team seizes opportunities as they arise to help their clients move ahead.

Flexibility was also noted as an important quality by other initiatives. For HASP this is

related to all partners involved in the initiative keeping flexibility in mind when working with clients and each other. This flexibility in the program and supports has allowed some clients with complex needs to stay in existing units. For HOMES, flexibility includes having a broad range of housing and supports available to respond to specific and changing needs of tenants.

Housing was another important feature for projects. For example, Walking to Wellness attributed their success to features related to housing: units at Crescent House and rent subsidies. While, housing has remained a challenge for clients, most are able to stay in their housing longer before getting evicted; it is taking less time to find another place to live after they are evicted; and the amount of time that any client is homeless has been reduced from months at a time to a few days at most, or not at all. It should be noted that the quality of housing for all participants has improved since they became involved in the program.

In the HIV project in Montreal, housing was seen as the starting point for many other changes that occur in participants' lives; sometimes as people find some stability in their housing situation, they begin to recognise other needs and seek support for these. HASP has noted that residents appreciate the sense of safety within their units as well as coming and going from their buildings, while HOMES pointed out that ensuring that tenants have choices about their housing, supports, and all aspects of their life was critical to their success.

Co-ordination and collaboration between agencies was felt to be key. 5616 Fraser Street anticipates that this will include the co-ordination of mental health and substance use services in a functional way, while at HASP this includes not only having partners work together to solve problems and find creative solutions but also a working style focused on inclusion not exclusion. The HIV Project also noted the importance of collaboration between agencies, the multidisciplinary nature of the teams and belief in the program. For CMHA-Ottawa Branch the integration of services has been pivotal to its success.

Finally some noted that having access to adequate funding was important (HASP). Other factors for success that were identified included setting abstinence as a goal (Westview), and the creation of support networks that residents can rely on to help them through the transition to a more independent living situation (5616 Fraser Street).

4.8 Challenges

Housing and related issues was raised as a major challenge by a number of project key informants. For example, Walking to Wellness finds that while some clients have been able to maintain their housing in the community, others continue to get evicted on a regular basis. The most common reasons for eviction are behaviours arising from drug use (e.g., bringing dealers into the building) or engaging in the sex trade. Furthermore, there are not enough "tolerant" landlords in the community, and some landlords of even the lowest quality housing in Nanaimo won't house some of their clients. Expanding the apartments available from other non-profit providers is an ongoing challenge for the HIV Project.

NIMBY (Not In My Back Yard) was a housing related issue mentioned by a number of key informants. For example, 5616 Fraser Street held several public information meetings for neighbouring residents yet there was strong opposition to the project. The main concern was that residents would relapse, commit crimes to raise money for drugs (e.g. break and enter into the neighbours homes), sell drugs in the community, and create problems in the neighbourhood. Some fears were due to the stigma of mental illness, and fears that people with mental illness and/or addictions are violent. HOMES also has confronted NIMBY problems but has relied on the good reputation of the sponsor to overcome difficulties. HASP has found that there have been complaints about tenants in the scattered units, typically related to behaviour (e.g., noise, sleeping or being intoxicated in hallways, allowing too many people into the unit, etc.) In some cases neighbours target them through a series of complaints when they find out that a tenant is with HASP.

Stigma also was raised as an issue by Westview. This is seen as one of the biggest barriers to recovery for individuals with concurrent disorders - stigma from society as well as from mental health professionals.

The lack of resources on the part of agencies and residents was noted. Westview pointed out that the underlying issue of poverty makes it difficult for residents to make fundamental life changes. Mainstay has found that achieving long-term success in the community has been difficult for clients because the resources to provide a sufficient level of support are not available.

Mainstay has found that while some residents move to an independent living situation, they usually get evicted within six months. For example, out of 142 clients who stayed at Mainstay in a twelve month period, 56 had resided at Mainstay more than once: the majority had been admitted twice, but one individual was admitted seven times. The main reasons clients return to Mainstay have been found to be lack of life skills; underdeveloped coping skills; and low self-esteem and subsequent lack of assertiveness.

The Main Street Project believes their new staff will help Mainstay residents acquire the necessary skills to be able to live independently in the community and to allow other members of the team to spend more time in the community with residents who have moved out.

Changes in clientele also were raised as challenges by Mainstay. There is an increasing number of younger (18 to 30 years old) crack users who are generally more affluent than traditional clients, are usually disrespectful, and some have drug induced psychoses that can be disruptive for the other residents. However, there are no other places for them to go. Another group that is challenging are people with a history of solvent use. Their use damages the central nervous system and causes cognitive brain damage. It is particularly difficult for this group to access resources because very few are targeted to serve them and most programs involve group work – something that is very hard for individuals with cognitive limitations. Furthermore, even if people gain access to specialized treatment

programs, there are no resources in the community to help them continue with their recovery.

Westview has found that while their funding has been stable, they need more resources to maintain programs and staff. The salaries they can afford to pay their staff are low compared to what other employers can offer which makes it difficult to attract and retain trained professional staff. Walking to Wellness has found that recruiting professional staff with the skills necessary for working on the street is a challenge.

A few projects, including 5616 Fraser Street, noted that ensuring that clients have access to the services they need will be a challenge. The CMHA Concurrent Disorders Program pointed out that systemic challenges include the inaccessibility of much of what is out there for clients. For example most of the addictions programs from the Ontario Ministry of Health are abstinence-based - in spite of recognition of harm reduction as a "best practice". There is a disconnect between what is recognised as "best" and what is funded.

5. Interviews with residents/individuals using the programs

The researchers conducted face-to-face interviews with 25 individuals who participated in this study. All of them were receiving services from six of the case study agencies where on-site interviews took place.[17] Most of the interviews lasted 45 minutes to one hour.

5.1 Characteristics

About three-quarters of the participants (19) were men and six were women. They ranged in age from 29 to 55 years old, but most were in their forties.

All the participants had issues with substance use – although some had stopped using substances at the time of the interview, and almost all the participants had a mental illness or mental health issue. Participants were also living with a variety of health issues including being HIV positive (one program was targeted to this population), Hepatitis C and diabetes. Participants identified themselves as having diverse ethnic/cultural backgrounds, including Canadian, Aboriginal, Quebecois, from the UK, Europe and Asia.

5.2 Past housing backgrounds

About two thirds of the participants (16) reported having been homeless for a period of time - some for a few years. Most had stayed in shelters or couch surfed with friends and family, while some had been "on the street" or in the "bush".

Five participants reported unstable housing histories, which included living in hotels, shared living arrangements, rooming houses and run down buildings. One individual had been living in a large apartment that was declared "illegal". Eight participants reported having spent some time in a psychiatric hospital/ward as a result of their mental illness. Five participants reported that they had spent some time in jail.[18]

5.3 Current housing

5.3.1 Type of housing

Some participants lived in housing that was owned or operated by the case study agency, and also received services provided by them. Others lived in housing owned and operated by private landlords or other non-profit societies. The case study agencies had helped the participants secure their housing and provided ongoing support to help them maintain it.

[17] These were the Walking to Wellness Program, Westview Dual Diagnosis Program, Mainstay Residence, Housing with Outreach, Mobile and Engagement Services (HOMES), Housing and Supports in Peel, and Concurrent Disorders/HIV Project. The researchers had planned to interview four individuals from each of the case study agencies. However, five interviews were completed at one location.

[18] Totals are greater then 25 because some individuals had been homeless and spent time in a psychiatric hospital and/or jail prior to becoming involved with the case study agency.

Most of the participants (17) were living in permanent housing. Eight were living in housing that is considered transitional because residents are expected to move out after a period of time. One of the buildings is actually considered to be a treatment facility where residents may remain for 3-5 years.

Six participants were in buildings operated by a private landlord. The rest were living in non-profit housing that was owned or operated by the case study agency or another non-profit agency. About half the participants (13) were living in units that were integrated within non-profit or private rental buildings that serve a mix of tenants. The rest (12) were living in buildings dedicated to the target group or a similar clientele (i.e. people with concurrent disorders or mental illness and in need of support). Seventeen participants had their own self-contained unit – either a bachelor/studio or one bedroom apartment. The remaining eight had a private bedroom in a building with shared living space (e.g. bathrooms and/or cooking facilities).

TABLE 5.1. TYPE OF HOUSING

Ownership/Management	Dedicated/scattered housing	Type of unit
19 non-profit 6 private landlord	13 scattered sites or integrated in buildings with a mix of tenants 12 dedicated buildings	17 self-contained units 8 shared living space

5.3.2 Length of time in current housing

Most participants (15) had been living in their housing for two years or more while 8 had been in their housing for less than one year. Of the 17 individuals in permanent housing, nearly two-thirds (11) had been in their housing for two years or more, and 5 had been in their housing for four years or more.

5.3.3 Satisfaction with housing

Participants were asked to rate their level of satisfaction with their housing. Five were very satisfied, eleven were satisfied, and four were not satisfied. There did not seem to be any association between the type of housing participants were living in and their level of satisfaction, except for a concern from one participant in a private rental building who thought the rent was too high.

When asked about what they liked most about the place where they were living, some participants simply appreciated having a roof over their head, while others mentioned the privacy of having their own unit or bedroom, safety, the location of their housing, affordability, and a sense of community within their housing.

When asked about what they liked least about the place where they were living, participants expressed concerns about maintenance issues (e.g., a broken security system, problems with the plumbing, and common areas that were run down and dirty), poor sound insulation between the units, concerns with other tenants, and the location.

5.4 Impact of the program

Most participants reported positive changes in their lives since becoming involved with the case study agency. For example:

- Most participants (21), when asked about their mental health, reported that they were feeling better since becoming involved with the case study agency.

- Most participants (18) reported that they were using less drugs or alcohol or had stopped using these substances altogether – 12 were using less and 6 had stopped. On the other hand, five participants indicated that their substance use had increased since becoming involved with the case study agency.

- Most participants (16) said they were in touch with members of their family. Eleven of them said that their relationships with their families had improved since becoming involved with the case study agencies.

- Most participants (16) reported that they haven't used any emergency medical services since becoming involved with the case study agency. Some of the reasons were that they have others to look after them, including a doctor, nurse or their support worker. Another four (4) reported that they were making much less use of emergency medical services.[19]

- About half the participants (13) reported that they were better off physically since becoming involved with the case study agency. They reported feeling better, eating better or sleeping better. Another five (5) participants indicated that even if they were not feeling better since becoming involved with the case study agency they were receiving help to address some of their health concerns.

- About half the participants (13) reported positive changes in terms of their incomes. Eleven participants reported that their incomes had increased or they had more disposable income since becoming involved with the case study agency because they had been able to obtain income assistance, increase the amount they received from income assistance due to disability or special nutrition requirements, obtain part-time employment, and reduce housing costs. Eight participants reported that the program was managing their funds to help them with budgeting or their funds were being managed by a trustee. Seven of them appreciated this service and the fact that their rent is paid and they have money throughout the month for groceries, coffee and cigarettes. As one person said, "Before, I was broke 2 hours after cashing my cheque". Ten participants stated that their income was the same since they had become involved with the case study agency. The main reason was that most of them were already in receipt of income assistance before becoming involved with the case study agency.

[19] This impact did not apply in the same way to those participants at the HIV project.

- Some participants (8) reported that they had made new friends since becoming involved with the case study agency.

5.5 Activities

5.5.1 Day-to-day activities

Participants were involved in a variety of activities on a day-to-day basis. These included: preparing their meals, cleaning their apartments, and attending to their health issues by going to medical appointments and taking their medications.

The participants also discussed visiting with friends - both inside and outside the building. Some spent time with their families. They mentioned going to the movies, for bike rides, walks, the park, coffee, listening to music, watching TV, feeding the ducks and geese, and reading the bible. Some participants were also involved in community activities, such as swimming at the "Y", and going to the library.

Eight participants reported that they were engaged in some part-time work. This included janitorial services for the case study agency for a few hours in any given month, working at a homelessness street journal, being part of a casual job pool, landscaping, yard work, painting and construction. One person reported that he sometimes makes money telling jokes. One participant provided peer counselling and another was a recreation assistant for the programs they were involved with. One participant was attending a job training program.

Two participants had attended a local community college while in the program and had received certificates to be community mental health workers.

Eight participants reported that they participate in group activities organized by the case study agency. Some of the activities included going to an amusement park in the summer, cooking classes, a camping trip, walking trips, bowling, swimming, going to the library, going for coffee, frisbee golf, karaoke, euchre, and going to hockey or baseball games.

5.5.2 Mental health programs

Twenty participants reported that they were participating in mental health programs. Some of the activities included attending drop-in programs in the community, group meetings and programs in their building, or receiving visits from their support worker. Some participants also reported that they would see a psychiatrist or nurse.

5.5.3 Substance use programs

Fourteen participants said that they were involved in programs to address their substance use. Some of the programs were provided on-site. Often, the participants reported attending Alcoholics Anonymous, Narcotics Anonymous, 12-step meetings or other group meetings. Others reported seeing a counsellor. Some support workers visited

their clients in their homes. One person reported being on a methadone program. Three participants reported that they participated in dual recovery or concurrent disorders programs rather than a program just for substance use.

5.6 Prior experience with treatment programs

Less than half the participants (11) had been to a treatment program before becoming involved with the case study agency. Another three participants reported that they had been involved in Alcoholics Anonymous and/or Narcotics Anonymous. Eleven participants had not attended a treatment program – although a few had been in detox. Some of the reasons for not trying a treatment program were that they didn't think they needed it and nothing was available.

Among the 11 participants who attended a treatment program, five individuals had found the programs helpful or somewhat helpful for varying periods of time. One person had spent 60 days in a hospital for cocaine use and hasn't used it since. However, this same person was drinking a significant amount of alcohol when he became involved with the case study agency. One person pointed out that although the program was pretty good, going to treatment can "bring a lot of pain out".

Five participants who went to a treatment program said that they didn't like it, and had some specific complaints. For example:

- One person quit because the therapist insisted he could become heterosexual. As he said, "I had struggled with my homosexuality for 10 years, and this was not helping".

- Another felt there was too much emphasis on guilt and shame, and not enough attention paid to nutrition.

- One participant thought there was both too much and too little going on. He reported that he couldn't keep up with the requirement to attend meetings every day at 9:00 a.m. and again from 1 p.m. to 2 p.m. He felt there was too much information. At the same time, there was nothing to do after the meetings.

- A fourth person was "turned off" by the counsellor who he felt was too closed minded. He also didn't like the requirement for regular attendance at Alcoholics Anonymous, Cocaine Anonymous, and Narcotics Anonymous meetings.

- Another person felt that the treatment program put too much stress on her. They made her look at things. She became a "depressed drunk". Although the programs showed her there were options, her addiction was too strong. She didn't think she could change and didn't think she needed to change.

One participant pointed out how the lack of decent affordable housing in an alcohol and drug free environment made it difficult to remain abstinent upon leaving a treatment program. He had tried a treatment program about 5 times in the last 10 years. Each time,

he would leave treatment and go back to where he could afford housing - where everyone was using - and he would start using again.

5.7 Factors responsible for changes

When asked about the factors most responsible for the changes in their lives, the most frequent response was the staff, the program, housing, and the participant's own motivation to change.

5.7.1 The staff

Fifteen participants reported that the staff who were working with them were responsible for the changes in their lives. They commented specifically on the quality of the relationships they had with the staff. As one participant said, "people need trust and positive healthy relationships to make positive changes in their lives". Other participants reported that the staff genuinely care and are really nice. They make sure you get to appointments. They try to help you help yourself. One person said, "They listen/hear me, including the nurses and workers. I feel as if there is a network that has been formed around me. I'm really lucky to be so well surrounded".

Other participants focused on the availability of staff, and appreciated the 24 hour staffing – that staff are onsite for support in case help is needed. Others said they appreciated being able to call the support worker any time.

5.7.2 The program

Nine participants said that the program itself was responsible for the changes in their lives. This included the safety and structure provided by the program and that the program provided a "home". As one participant said, "the program has given him hope".

5.7.3 Housing

Eight participants identified housing as a factor responsible for the changes in their lives. They noted that the housing provided safety and stability.

5.7.4 Motivation

Four participants identified their own motivation - desire to have a better life and do better – as the main factor responsible for the changes in their lives.

5.7.5 Employment

Two participants said that working had made a significant change in their lives and was very important to them.

5.8 Goals

Participants identified the following goals when asked about the kind of changes, if any, they would like to see for themselves over the next year:

- Working full-time or part-time or volunteering in the community.
- Improving their physical health and taking better care of themselves.
- Moving somewhere else – to get their own place – a regular apartment or just a bigger place. One person specified that he wanted to live in a different location (outside the downtown core). "A place to call home".
- Stopping their use of drugs or alcohol.
- Improving their relationships with their families.
- Engaging in a variety of self-improvement activities.
- Addressing some financial concerns.

5.9 Participants' recommendations

Participants were asked if they had any words of wisdom or advice for any other organization that might be interested in doing a similar project to the one like their case study agency. They were also asked to provide more comments about what features of the program they thought should be different and what should definitely stay the same. The following themes emerged about what is important to the participants.

5.9.1 Staff

Eleven participants discussed what was important to them in terms of staff. They believe programs need to hire staff who are empathic, honest, and who are able to listen, provide positive encouragement, be understanding, and non-judgmental. They also believe it is important for staff to get to know each resident and to establish relationships based on trust. As one participant said, the program needs to have "good support workers who do not pressure you and who you can trust and be truthful with". The personal touch is essential. They want "hands-on staff" and note that small projects make this possible. It was also noted that staff need patience and commitment, and "they need to really want to do it."

The participants also value staff who:

- Treat them with respect;
- Are able to get along with everybody;
- Are available when needed;
- Are vigilant about how they are doing – particularly if a client is unwell;
- Help them with practical day-to-day issues such as making sure they get to appointments, helping with transportation, and sorting out issues with government bodies and welfare cheques; and
- Understand both mental health and addictions.

5.9.2 The program

In addition to the qualities of staff, participants identified a need for programs to have *enough* staff. It is important that staff are available when needed and keep in touch with them (at least weekly) to make sure they are OK and have enough food to eat etc. Participants in buildings with 24 hour staffing appreciated that there was always someone available on-site that they could talk to. They also stated that they appreciate the counselling and support provided by staff and look forward to their visits. A few participants thought their program could use more workers. They noted that sometimes clients need more one-on-one time than is currently available.

Participants said they like support groups because they help people get to know each other, learn more about themselves and their issues, and can bring people closer together. On the other hand, one participant expressed concern that "when a group of addicts gets together, that some people could take the others down".

Participants expressed support for small projects where staff can know everyone by name. They expressed concern that a large project would feel like an institution. It was suggested that agencies should start small so they can address any start-up issues.

Participants indicated that the structure provided by programs is very important. Several participants commented on the need for structure in their day and the need to keep busy - to alleviate boredom and give the tenants more to do. One participant said that structure is particularly important for people coming off the street – to prevent self-defeating patterns. They thought it was important to provide on-site programs and activities as well as fun group outings. At the same time, the need to provide adequate supervision was also noted, particularly if some of the participants are unwell.

Most participants who had their finances managed for them thought this was very helpful so they have enough for rent and food throughout the month.

Participants also identified a need to ensure that clients have access to services they need in the community, including doctors, nurses and counsellors.

Other issues that were raised included ensuring that programs provide for privacy, flexibility, procedures for addressing conflicts and concerns (with the program and among the residents), and that programs recognize the need for some clients to be in touch with their spirituality, religion and cultural backgrounds.

5.9.3 Housing

Several participants discussed the importance of safe and affordable housing. As one person said, "Housing - if it's a safe place to live, that's the foundation of everything. If you are not relaxed where you are living, it puts stress on everything. You don't eat or sleep properly." Another participant said, "This is the only opportunity I see for people like me to get an apartment instead of living in just a room. Please tell others that this is a serious matter." He too discussed the need for safe housing to help people reduce the

stress in their lives – after which they may be able to address their alcohol and drug use. As he said, "Safe homes is a first step. Then focus on why people are doing drugs and alcohol. People need safety and support, but you can't baby them. You need to get the person's trust in order to help them."

Participants identified a need for:

- More affordable housing – "there shouldn't be such a long waiting list."
- Good quality housing, in a nice/safe area.
- Safe housing and for landlords to deal with safety issues such as proper locks and a security system the front door.
- Housing (units and common areas) to be well maintained.
- Consideration being given to the types of units available to participants (self-contained with a private bathroom and kitchen). There is a need to ensure privacy. Some participants expressed a desire for larger units. Some participants want to live in a building with on-site staffing and common space for socializing with other tenants.
- Procedures to address conflicts among tenants.
- Help acquiring furniture and household supplies.
- A public phone in all buildings.
- Buildings being designed to ensure that services are accessible (e.g., laundry room closer to the units and less expensive).
- Program sponsors to ensure that landlords and superintendents are able to deal with the clients if clients are going to be placed in private rental buildings. The landlords need to understand what it means to provide housing to people with a mental illness.
- Residents being able to stay as long as they want to (i.e. no limit on length of stay).
- Strategies being put in place so that if a tenant is evicted they will not become homeless. There should be a place for them where they can go and store their stuff. "Don't leave them high and dry on the street". They identified a need for short term options for people who are evicted and realistic rent repayment schedules when a tenant falls into arrears.

5.9.4 Substance use

Participants who are working hard to be abstinent appreciated rules that required abstinence in their housing. Some participants expressed concerns about living with others who are using substances. Even in buildings/programs where there is no requirement or expectation for participants to become abstinent, a few expressed concerns about overt drug use and the prevalence of drug activity in their building or area where they are living. One participant suggested that there should be separate places for people who use drugs and people who don't. Another suggested that "while staff are not pro-addiction, they could be more against addictions to put more onus on the individual to be accountable".

Participants also suggested that people who use substances receive more education on the harms that come from drugs. They further suggested more public education about why

people use drugs and alcohol so the public would recognize that not everyone is "bad" just because they do drugs.

5.9.5 Food and health

Participants commented on the need to provide good and nutritious food. One participant pointed out that nutrition and education about nutrition are particularly important in a person's first year of recovery as they have done so much damage to themselves from drugs and alcohol. Where meals are provided, participants suggested that the program sponsors hire a good cook, offer healthy food choices, and serve meals at times that recognize different sleep patterns (not everyone is ready for breakfast at 6 am). At the same time, it is clear that it is difficult to please everyone. One participant called for more perogies, hot dogs, hamburgers, fish and chips, pizza, less chicken, no spinach, and no asparagus.

Participants also suggested that programs place greater emphasis on helping their clients get exercise. They suggested that outings encourage people to be active e.g. baseball, skating, swimming, and picnics.

5.9.6 Employment

Participants noted the importance of employment. They recommended that programs help their clients find a job. This includes giving them the tools they need such as access to computers, access to programs that will help clients prepare for employment and learn how to look for a job, and opportunities for work experience.

5.9.7 Marketing

Participants thought it was important that programs such as the ones they were involved with be available to help more people get off the streets. They thought there should be information and pamphlets about each program and more counsellors on the streets to tell more people about the programs. One participant thought it would be a good idea to get someone who is living on the street, is well known, and has a serious addiction problem, to straighten out his life and become a champion for the program. He thought his would get others interested in the program. Others also suggested letting more people know that these types of program exists – "go to them".

6. Conclusions

The purpose of this study was to investigate innovative approaches to providing services for people with concurrent disorders who are homeless or at risk of homelessness. However, it became clear that there are few Canadian projects that specifically address the needs of this population. There is general awareness of the needs of this group and of the considerable obstacles they face in receiving the services they require. Nevertheless, some agencies that were contacted were too overwhelmed with dealing with the needs of the overall homeless population to address the needs of one subgroup. For others, the challenge of bringing together all the necessary services for this target population was overwhelming.

The literature review underscored this. The challenges of delivering effective services to people with concurrent disorders are not limited to Canada or North America. On the contrary, European countries as well as Australia have grappled with the issue and have found no single approach is optimal.

In the end, only three projects that deal exclusively with this population were identified, while a fourth is in the developmental stages.[20] In the other four projects that were profiled the clientele can include 40 to 50 percent persons with concurrent disorders. It should be noted, however, that agencies may not know with any certainty how many clients have concurrent disorders. While people may have indications of mental health issues, it can be difficult, sometimes because of the reluctance of the clients themselves, to have a confirmed diagnosis.

Thus while some projects are innovative and have undertaken means to deal with the complexity and challenge of providing services to homeless or at risk persons with concurrent disorders, the researchers believe that we are still far from a situation where "innovative" projects can be culled from a larger group of initiatives. Instead Canadian projects are struggling with difficult situations and with limited means. Nonetheless, some are managing to develop responses or elements of responses that are innovative and they should be commended and encouraged.

6.1 Program Outcomes

As in many other projects, there are no systematic and comparable data on project outcomes. Many of the projects profiled do not have the means to undertake evaluations, and as with many initiatives that deal with homeless persons, long-term outcomes are especially hard to monitor. Furthermore, each program sets different goals and defines success in its own way; at times these are closely linked to the reasons for initiating the projects in the first place. For example, the Concurrent Disorders Program provided by CMHA – Ottawa Branch and Westview define success as being able to provide an

[20] These include Walking to Wellness, Westview, the Concurrent Disorders Program and 5616 Fraser Street (planned).

integrated treatment approach for individuals with concurrent disorders. One of the initial goals of the Walking to Wellness program was to evaluate whether ACT (which includes a multi-disciplinary team with expertise in both mental illness and substance use) would be an effective way to engage and work with the target population. The goals of the HIV Project, HASP, and HOMES focus on housing stability and ending homelessness. Both 5616 Fraser Street and Westview have goals that involve helping their clients to become abstinent, whereas, Mainstay, which provides transitional housing, aims to offer a safe place where residents can receive support, stabilize and develop plans to re-establish themselves in independent housing in the community.

In all of these projects, the goals have been met. When interviewed, project key informants were very positive in terms of achievements, while acknowledging that there were still challenges.

Integration of mental health and substance use services

The integration of mental health and substance use services would appear to be variable. The three projects that deal exclusively with clients who have concurrent disorders, the Concurrent Disorders Program, Westview and Walking to Wellness, have managed to provide an integrated treatment program for people with mental health and substance use issues, resulting in better service for clients. Perhaps because persons with concurrent disorders are not the only client group, the process of integration of the two service streams – mental health and addictions – appears less systemic in the other projects. It will be interesting to see whether in the future, Mainstay that deals with a wide range of clients, will result in a more integrated approach because of its links to the CODI project in Winnipeg that seeks greater integration.

The Concurrent Disorders Program provides an interesting example of a successful approach to integration. As in other projects profiled, they work closely with organisations with complementary skills and knowledge – primarily in substance abuse – and have developed working relationships. For example, workers from both mental health and substance use backgrounds facilitate each group. This “cross pollination”, is undoubtedly an important and lasting method to break down some of the barriers between the two systems. Projects such as this are notable as well for having researched and used specialized resources (e.g. consulting with Mueser) to develop and monitor the program, including the use of a fidelity scale (developed by Mueser), which identifies elements that should be in place to have an integrated approach to concurrent disorders.

Housing

The projects that offer permanent housing would appear to be successful in stabilizing their residents. For example, HASP has found that tenants are remaining housed on a long term basis. The HIV Project and HOMES have observed positive outcomes for their clients as a result of stable housing – although there is no data regarding the average length of stay for tenants. A survey of HOMES tenants found a high level of satisfaction with the housing and supports offered through the program.

Walking to Wellness illustrates the challenge that housing can represent for this client group. Access to housing became a major issue in the early stages of the project and it would appear to have been resolved to some extent through some housing subsidies and emergency/respite rooms. Thus some of their clients have achieved housing stability, but this is still a challenge for others – people are still being evicted and having to find new places to stay. Nonetheless Walking to Wellness does report that the overall quality of housing has improved for all their clients.

Two of the projects that provide transitional housing, Mainstay and Westview, report that they are successful in being able to provide a place to live where the residents feel safe, supported and able to make progress in achieving their goals. However, it is not clear what happens to the residents after they move out. According to Westview, most of their clients who have moved out and are living successfully in the community continue to receive support. On the other hand, Mainstay finds that most of their clients have been unable to maintain positive changes when they move out, which appears to be related to the lack of good and affordable housing and ongoing support. Mainstay hopes this will change as a result of increased staffing.

This study also illustrate that there is no single ideal type of housing – a harm reduction approach, as Triage, sponsor of 5616 Fraser Street, has found is not suitable for all of their clients – some people need to live in a setting that is substance free to reinforce their hard-earned success in stopping use. None of the initiatives profiled that were abstinence-based provided permanent housing. Yet this too would seem to be a need: one participant spoke of going through treatment programs numerous times. However, once he left and was living in the housing that he could afford, there was high use by neighbours and he would find himself using again.

Substance use

Most of the programs report positive substance use outcomes for their clients, although most of this information remains anecdotal and is very much related to the overall goals of the project For example, Walking to Wellness reported that two clients achieved long term abstinence (3 years) while most of their other clients have reduced the level of harm resulting from their substance use. The HIV project also reports that their clients have changed their consumption habits – deciding to consume less or to switch to less harmful substances. Westview and Mainstay report a decrease in substance use among their residents, although no information exists about long-term abstinence. On the other hand, the HOMES program has found that it appears the use of drugs or alcohol has increased for clients; it is not clear whether this is a real increase or under-reporting by clients at intake.

Other improvements

The case study agencies reported other positive outcomes for their clients including improved self-care, improved mental health and medication stability, reduced

hospitalizations as a result of mental health issues, improved physical health, more contact with family and social networks. Some clients were better off financially.

While the interviews with key informants leave questions unanswered about elements such as long term impact and unmet needs such as permanent housing, the interviews with the program participants demonstrate that the projects have had positive impacts. Most of the participants were living with multiple challenges, including substance use, mental health issues, some with variety of health issues and most had been homeless for a period of time in their lives. Nevertheless, since becoming involved with the case study agency, most of the participants were stably housed, were feeling better, were using less drugs or alcohol and hadn't used any emergency medical services. About half said they were better off physically, had more income, and their relationships with their families had improved, confirming much of the information that had been provided by key informants about the impacts of their projects.

When asked about the factors most responsible for the changes in their lives, the most frequent response was the staff. The participants made it clear that they valued the quality of the relationships they had with program staff and appreciated that staff were available when needed. Participants also attributed the positive changes in their lives to the program, their housing and their own motivation to change. In terms of housing, participants identified a need for housing that is safe and well-maintained. As one participant said, a safe home is the first step in reducing stress and is needed before it is possible to address the other issues in their lives - such as substance use.

6.2 Factors to consider and recommendations

6.2.1 Integration of services

The literature is clear that the integration of services (treating mental illness and substance use simultaneously) is the most effective approach in working with clients who have concurrent disorders. Canadian studies, including work by Health Canada and the Standing Senate Committee On Social Affairs, Science and Technology, advocate integration of treatment. This study underlines the importance of access to the various components of treatment. The study also illustrates how difficult it can be to provide all of the components needed for this client group – including affordable, decent, permanent, and appropriate housing.

Many of the initiatives profiled in this study have undertaken means to provide clients with access to the services that they need. In a few cases there have been the resources and the means to integrate both addiction and mental health services. This would appear to be easier in cases where the targeted clientele has concurrent disorders. Westview, Walking to Wellness and CMHA all deal with both mental health and substance use simultaneous and in a planned and targeted way. The other projects would appear to do this on a more "ad hoc" basis – in a number of cases their priority has been to offer permanent housing and then the services, as needed, to maintain and stabilize residents. What is not clear is how much of the lessons from projects that deal exclusively with persons with concurrent disorders and that have developed means to integrate mental

health and substance use services, could be applicable to projects that have only a portion of their clientele in need of such services.

6.2.2 Partnerships

The initiatives profiled in this research illustrate how some of the obstacles in dealing with the mental health and addiction systems can be overcome by partnerships. Many of the projects profiled relied on partnerships with a range of community and governmental agencies to deliver services.

Critical to achieving this would seem to be an understanding of the issues and of the optimal approach. The projects that deal exclusively with a clientele with concurrent disorders perhaps best illustrate this understanding and the development of service delivery that integrates both treatment of addictions and mental illness simultaneously. Nonetheless all the projects have devoted considerable effort in bringing together the services required for their clients. Results from interviews with participants would confirm that the delivery of services is to a large extent seamless. This ongoing approach seems to be one that has been adopted by all the projects, and none of the residents interviewed spoke of lacking services or any disjuncture in their delivery.

Recommendation

This report identifies a need to move towards an integrated system of mental health and substance use services for homeless persons with concurrent disorders, and recommends that the federal and provincial governments take a leadership role in promoting and implementing the integration of mental health and substance use services. The initiatives that were profiled underlined that integration is not an easy process, and there is a need for effort, understanding and resources to achieve this. Nonetheless, some projects have managed to overcome the difficulties associated with dealing with two systems that have historically developed in separate streams. When the services are offered to people in a seamless manner, the study demonstrates that success is possible, as clients do move forward in their lives.

6.2.3 Approach to substance use

An element that emerges from this study is what appears to be a continuum in the application of abstinence and harm reduction approaches. It is interesting that programs may evolve over time. For example, Westview has adopted more of a harm reduction focus over time in an effort to better meet their clients' needs. While the case studies illustrate clear differences in the levels of tolerance of substance use, there also appears to be a grey area when it comes to how firmly the consequences of use are applied – for example evicting people from housing seems to be something that is not immediately undertaken but rather is the end of a process of discussion and persuasion.

Recommendation

It is clear that both abstinence-based and harm reduction approaches can achieve success. In developing new programs, this report recommends that policy makers move away from an either/or approach and acknowledge that both abstinence and harm reduction initiatives can meet the needs of different clients.

It is suggested that a client-centred approach, one that works with the goals set by the client might ultimately be more flexible and responsive to needs. This would be a way to perhaps end the cycle of people entering programs, leaving when they relapse, and trying again. Working with individual goals, while requiring much greater flexibility on the part of agencies, is a better response to needs and does not negate the possibility of abstinence or reduction of use.

6.2.4 Housing

The need for decent, affordable permanent housing is well-illustrated by the study. It is also clear that a range of options is required. While some residents underlined the need for decent and affordable housing, others spoke of the challenge of trying to remain abstinent in an environment where people were consuming. The need for permanent housing suitable for their clients was raised by projects such as Walking to Wellness, which is confronting a difficult housing market, Mainstay, which finds it difficult to help clients maintain what they gained once they move out of the residence, and the HIV Project which continues to try to expand its program into other non-profit housing projects. Furthermore, a number of participants underlined the importance not just of housing as such but also expressed concern about the quality and location of the housing. The experience with the private sector also led to the observation that these landlords need to be able to deal with the clients and better understand people with a mental illness.

One of the great challenges, as illustrated by Mainstay, is the ongoing support for people who have moved onto permanent housing after a transitional program. Housing stabilisation, as multiple studies on homeless populations have asserted, is critical and is the "cornerstone of care", for both those with concurrent disorders and others who are homeless.

The need for options raises the questions of how best to serve this client group in areas and regions where resources are limited and where the means to develop a range is not feasible. Outside of the major centres in Canada, it is not clear how much can be offered or if there are other means to offer the support and housing types that answer the range of needs that have been expressed by participants in this study – housing that is not only permanent, decent, affordable – but also housing that allows consumption and tolerates certain behaviours as well as housing that is abstinence-based.

Recommendations

The importance of housing must be recognized in any program that is created to address the needs of people with concurrent disorders. This includes housing where the residents

feel safe and where the housing providers understand their tenants. Again, it is clear that a range of options is necessary, including housing that is supportive, that incorporates a harm reduction approach and promotes stable tenancies for people with concurrent disorders, as well as housing that is alcohol and drug free.

The issue of transitional housing, especially in a context where suitable permanent housing is not available needs to be revisited and re-examined as a program and policy response. This issue was especially underlined in Winnipeg where there is a cycle of people getting support, getting better and then having the progress negated because neither long-term support nor suitable permanent housing is available. People also continued to live in Mainstay because there was nowhere else for them. However, this was not the only case – HASP was a response to a similar problem of people continuing to live in shelters because there were no alternatives for them.

6.2.5 Staff

Another critical factor for success that is strongly underlined in all the interviews is the importance of staff – the relationships that they form with the clients, and the qualities that are essential – being flexible, non-judgemental, honest, trustworthy, and having commitment and patience. However, one project noted the impact of limited resources on maintaining and attracting professional staff while a second pointed out that finding staff with skills necessary for working on the street was challenging.

The scope of the study did not allow for exploration of how to judge whether the staff had the required qualities, what training was required, and what means were used to retain staff over the long run. Since this is such a critical element of success – from the perspective of key informants as well as participants – it would be essential to better understand how to develop and enhance staff recruitment and retention.

Recommendation

Any program for people with concurrent disorders must recognize the importance of staff. Programs require sufficient funding to attract and maintain skilled staff, to provide ongoing staff training and to hire enough staff. At the same time, agencies need support and guidance to determine what kind of training and skills staff need to work effectively with people with concurrent disorders.

6.2.6 Activities

Most of the key informants spoke of recreational and occupational support. The need for these was underlined by participants who spoke of the importance of the structure provided by programs. There is a strong need for people to keep busy and prevent self-defeating habits from re-emerging. One of the questions that arises is how to provide for the integration of people with concurrent disorders into the community over the long term. Many of the participants made it clear that they wish to become productive members of society – through volunteer or paid employment. The challenge will be to give them what they need to support them in achieving their goals.

Recommendation

Programs for people with concurrent disorders must build in opportunities for the clients to engage in activities that are meaningful to them, and help them achieve their personal goals.

7. Further research

- *There is a need for better outcome data*. One of the greatest challenges posed by this study was the analysis of outcomes and trying to understand the effectiveness of the various programs and approaches undertaken by the initiatives profiled. As with all research on homelessness, the information on outcomes is very limited; often only anecdotal information is available. There is need to undertake research on identifying the best methods to gather data about outcomes with the view of collecting such data systematically in the future. The systematic collection of outcome data must recognise that the participating organizations will require additional funding. Organizations may also require some research expertise in setting up the data collection methods for such outcome research.

- *There is a need for data on medium and long-term change over time.* The information gathered in this study does not yield strong data on the stability over time of clients that were served. Information about medium and longer term outcomes in a sample of the individuals would allow comparison of outcomes and an ability to draw conclusions about what kind of intervention, for what kind of clientele is most effective.

- *Better understanding of long-term supportive environments.* Key informant and some participant interviews indicate that clients need environments that are supportive in the long run. It would be useful to better understand what an ideal environment would be. For example, is removing people from their previous neighbourhood a positive practice, since they are away from the influences that might lead to a relapse or do they also leave all support and social networks? How do people integrate into "mainstream" society? Are there specific supports that can help them?

- *Better understanding of organisations and the role of staff.* This is a key component and there is a need to know more about staff qualities, training, composition of teams, salaries, etc. needed for success.

- *A range of treatment and housing options.* This study points to the need for a range of options for this client group to ensure long-term stabilisation. However, it is not clear how realistic it is to expect such a range outside of the large urban centres. There is a need to better understand the options and possible means to deliver such a range, no matter where the potential client may live.

Appendix A - Case Studies

The case studies are presented in the following order:

Nanaimo, BC	Walking to Wellness
Vancouver, BC	5616 Fraser Street Supported Housing Program
Regina, SK	Westview Dual Diagnosis Program
Winnipeg, MB	Mainstay Residence
Peel Region, ON	Housing and Supports Peel (HASP)
Hamilton, ON	Housing with Outreach, Mobile and Engagement Services (HOMES)
Ottawa, ON	Concurrent Disorders Program
Montréal PQ	Fédération des OSBL d'habitation de Montréal (FOHM)

Name: Walking to Wellness - Intensive Case Management Services: Sponsored by Nanaimo Mental Health and Addictions Services, Vancouver Island Health Authority	Nanaimo, British Columbia

1. Background

This case study was prepared based on an interview with the Manager of Nanaimo Mental Health and Addictions Services, members of the Assertive Community Team (ACT) delivering services in the Walking to Wellness program, and additional written information provided by the key informants.

1.1 The sponsor

The Vancouver Island Health Authority provides a full range of health care services to approximately 706,000 people living on Vancouver Island, the Gulf and Discovery Islands, and residents of the mainland located adjacent to the Mt. Waddington and Campbell River areas. Services include hospital, community, and home care, as well as environmental and public health.[1]

1.2 Program goals and history

Walking to Wellness began in 2000 as a two-year demonstration project to serve people with concurrent disorders (mental illness and chemical dependence).[2] Nanaimo Mental Health and Addictions Services (Mental Health and Addictions) received funding from the BC Ministry of Health after responding to a request for proposals.

Mental Health and Addictions had submitted a proposal in partnership with several other agencies, including: Forensic Psychiatric Services; Ministry of Human Resources; Royal Canadian Mounted Police (RCMP); Corrections Services; and Addictions Services.

Project at a glance	
Sponsor name	Nanaimo Mental Health and Addictions Services, Vancouver Island Health Authority
Goals	Use the ACT model and harm reduction approach to help program participants: • Improve their overall recovery, quality of life and level of functioning; • Integrate into the community so they can live as normal and productive a life as possible; and • Transition to less intensive, mainstream services.
Target population	People with severe concurrent disorders, multiple challenges and complex needs who were frequent users of acute services and had no successful engagement with mainstream services.
Housing tenure	A range of housing options
Number of participants	Able to serve 30 clients at one time.
Factors for success	• The ACT model • Staff competence • Relationships established between the staff and participants • Crescent House, which provides safe and secure housing • Ensuring that clients have access to the services they need
Location	Nanaimo, British Columbia
Project start date	2000

[1] www.viha.ca/

[2] During the two year demonstration period, this program was known as the Concurrent Disorders Demonstration Project. After that, the clients named the program "Walking to Wellness".

The agencies had identified a need to provide services to individuals with concurrent disorders who were frequent users of acute services and had a history of non-engagement with mainstream services. The Nanaimo General Hospital had recognized that a small number of individuals were "frequent flyers" – accessing the hospital's psychiatric beds on an emergency basis several times a year, and creating havoc each time. Mental Health and Addictions thought it would be beneficial to work with these individuals in the community to try and avert the crises that resulted in their hospitalization.

Since it was often the police who brought these individuals to the hospital, Mental Health and Addictions approached the RCMP to see if they would be interested in collaborating. The RCMP had a strong interest in community policing, and assisted in bringing together other key players in Nanaimo. All these agencies had clients who were particularly challenging, and they wanted to find a better way to serve them. The request for proposals from the Ministry of Health served as a catalyst to develop a plan. The agencies decided on an approach that would involve creating an Assertive Community Treatment (ACT) team, and using the health system's existing 24-hour crisis response team. Another core element of the proposal was that the partner agencies would continue to work together as a management committee.

The goal of the demonstration phase of the program was to evaluate whether an ACT model would be an effective way to engage and work with the target population. The current goals of the program are to use the ACT model and a harm reduction approach to help program participants:

- Improve their overall recovery, quality of life and level of functioning; and[3]
- Integrate into the community so they can live as normal and productive lives as possible.

The ultimate goal of the program is to help the participants become healthy enough to transition to less intensive, mainstream services.

2. Program Description

2.1 The people

Walking to Wellness is able to serve 30 individuals at any one time. In April 2005, twenty-one program participants were men and 9 were women. Twenty-five participants were single individuals, four were living with another person as a couple, and one woman was living with her children.

[3] Vancouver Island Health Authority, "Walking to Wellness" Intensive Case Management Services – program outline and referral criteria.

Household Type	Men	Women	Total
Single individuals	18	7	25
Couples	3	1	4
Single parent with children	0	1	1
	21	**9**	**30**

Participants ranged in age from 28 to 59 years old, but most were in their 30s and 40s.

Most were Caucasian (26), two were Aboriginal and two were Asian. This is typical of mental health clients who are connected to the mental health system in Nanaimo, but is not necessarily reflective of need in the community.

All the participants have a severe and persistent mental illness, including schizophrenia and bipolar disorder. Most participants are also living with a variety of other challenges, such as a personality disorder, history of trauma, brain injury (acquired from chemical dependency or a physical injury), physical illness (e.g. Hepatitis C and HIV), learning disability or criminal record. At the start of the program, all participants were using drugs and/or alcohol, and many exhibited challenging behaviours because of their substance use.

When participants first became involved with the program, most had no source of income. However, all participants currently receive disability benefits through BC's income assistance program. Some receive income from the Canada Pension Plan (disability). About half the participants (13) also receive some earnings through employment.

2.2 The housing

The ACT team provides services to program participants regardless of where they live - even if the client is in jail.

Participants can choose where they want to live in the community – subject to the housing they want being available and affordable – and as long as they don't get evicted. The ACT team will help participants access the housing they want – or help them find other acceptable alternatives. While participants may access housing targeted to individuals with a mental illness, this housing is generally not suitable for Walking to Wellness clients who are actively using substances.

In the first 6 months of the program, the ACT team identified a lack of appropriate housing as a major issue. Ten participants were homeless, while others were living in low quality rooming houses. A few lived in non-profit housing and three participants were in their own homes, with their families, parents or spouse.

The ACT team found it challenging to stabilize participants who were homeless or in unsafe housing. It was also difficult to keep track of those who were homeless.

In order to address the housing needs of their clients, Mental Health and Addictions acquired Crescent House – a six bedroom house that had been used as a step down facility for the hospital. The goal was to provide a safe and stable home environment for residents to help them in their transition to greater stability. Four bedrooms were made available to clients of the program, while the other two bedrooms are used as general crisis beds for clients of other programs provided by Mental Health and Addictions or Forensic Psychiatric Services. This is the only housing that the Walking to Wellness program controls directly. The house is owned by the Vancouver Island Health Authority and is managed by the Island Crisis Care Society.

Crescent House may be used as an emergency place to stay, for example, if a client gets evicted from their housing. Crescent Housing may also be used for respite or if a client needs a temporary place to stay to avert an eviction. The team may also recommend that a new client stay in Crescent House "to stabilize" if they believe the client would get evicted from other housing options in the community. The length of stay in Crescent House is determined on an as needed basis. The importance of Crescent House is underscored by the fact that all the participants in Walking to Wellness have spent at least some time there.

In addition, to Crescent House, Mental Health and Addictions obtained access to rent supplement funding for about 15 units through the Supported Independent Living (SIL) program so that clients can access private rental and non-profit housing.[4]

In July 2005, Walking to Wellness participants were living in the types of places described below.

Number of clients	**Where living in July 2005**
2	Non-profit rental – a few months in their current units, but stable for a few years before that.
2	Rooming houses – for 6 to 12 months.
15	Private rental housing (10 have SIL funding) – for varying periods of time.
3	Ownership. One owns a condominium unit and 2 own their own trailers. They have been in their housing for more than 5 years. Some major interventions were necessary in the beginning to help the clients retain their housing.
2	Jail
1	Motel
2	Crescent House
2	Mental health housing (1) and a forensics facility (1)
Total 29	

[4] The Adult Mental Health Division of the Ministry of Health funds the shelter component. The Vancouver Island Health Authority is responsible for administering the program on Vancouver Island.

2.3 Access to the program/housing

Agency referrals

The ACT team meets monthly with the Community Clinical Team to select new clients to participate in the program, if there are vacancies. This committee includes a front-line worker from each of the partner agencies involved with the original proposal (Forensic Psychiatric Services, Ministry of Human Resources, RCMP, Corrections Services, and Mental Health and Addictions Services) as well as the Vancouver Island Health Authority Mental Health Housing Coordinator who coordinates all mental health housing and SIL units in the region.

Client acceptance

Once clients have been identified for the program and the ACT team has determined that they are able to accept a new client, a member of the ACT team approaches the individual to see if they are interested in participating. Participation is voluntary, but if they are interested, clients are asked to make a commitment.

Eligibility criteria

To be eligible for the Walking to Wellness program, clients must:

- Be an adult – 19 to 65 years of age;
- Be assessed as having a serious mental illness;
- Have a chemical dependence (substance use issue that is prone to relapse and impacts level of functioning); and
- Have a history of *no* successful engagement with mainstream services (e.g. consumers whose only contact with the mental health system was through acute services, and who were frequent users of these services).

Priority is given to consumers in most need.

Degree of "housing readiness"

Clients had a range of skills when they became involved in the program, but most were in chaotic situations as a result of their mental illness, substance use or both.

Program expectations

Participants are required to be in contact with a team member at least once/week face-to-face.

Program demand

At the outset of the program, the management committee identified about 200 clients whom they thought would be eligible for the program. However, they had to narrow the list down to 30 individuals.

The program does not maintain a waiting list per se, but in April 2005, 5-8 people were being considered for acceptance when there is a vacancy.

2.4 Substance use issues and policies

Substance use

Cocaine is the substance used most often by program participants. However, there has been an increase in the use of crystal meth. Both new and existing clients are starting to use this drug. Poly substance use is common among participants, and it is difficult for these clients to abstain from new drugs.

At the beginning of the program, there was heavy use of heroin, but within a short time, all these clients became involved in a methadone program.

It was noted that recovery from addictions is slower for clients who also have a mental illness, and recovery from mental illness is also impeded by drug use.

Policies and approaches relevant to housing the target group

Use of substances

In buildings where clients have their own self-contained unit, there are no program rules that would limit their substance use. If a participant's substance use creates a problem in the building, the landlord will usually call a member of the team. They may also proceed with an eviction.

In Crescent House, the building is dry. Alcohol and drugs are not permitted on the property. If a resident is under the influence, they must stay in their room. A client may be asked to leave the common areas of the house if their behaviour disturbs the other residents. If participants use a substance on site, they may be asked to leave the house for the day.

Role of staff in working with residents

Walking to Wellness is an outreach program, and staff are expected to spend all their time with clients in their environment. This includes taking clients places where they need or want to go, and accompanying them to their medical appointments.

When the ACT team first starts working with new clients, they focus on getting to know them and meeting their basic needs for food and housing. They also help their clients get the medical and dental care they require. The team takes a very practical approach to addressing their clients' needs to show that they are helpful and can be trusted to make things better. They note that it can take a long time to establish a relationship with a client. Clients may not be willing to engage at first, although the desire for help is usually there at some level.

The ACT team is very welcoming to new participants. Their approach is to say, "Here's a program. We want it to work for you." The team does not step in right away to try and address the mental illness or addiction. They focus on health and safety. For example, they would ask the participant, "Have you eaten today? How do you feel? Are you living in a safe place?" The ACT team understands that until basic needs are met, the participants will not be able to move to the next level.

Staff do what it takes to maintain the relationship. This could include taking a participant to the Dairy Queen once a week, or going shopping with them for food. It all depends on what the participant wants and is able to accept. These activities provide an opportunity for team members to assess the functionality of their clients.

Over time, the ACT team expects that participants will increase their goals and what they want for themselves. The ACT team seizes opportunities as they arise to help their clients move ahead.

While the program requires that clients and staff have contact at least once a week, in fact they generally have much more interaction than that. Clients tend to be very involved in the different meetings and group activities offered through the program. In addition, clients are crisis prone, which can require a great deal of time and interaction with the ACT team. There is no limit to the amount of time a member of the ACT team is available to a client. If a client needs someone from the team 3 times a day, a person from the team is there.

Legal issues

The RCMP is a partner in this project and is willing to work with the ACT team. They have a good working relationship. In addition, because of their involvement with the project, the RCMP knows all the clients. The RCMP is usually the first agency to respond to a crisis. If they need to pick up a client, they call the team, and will hold the client until a team member comes. The team has found that the RCMP treat their clients well. Nevertheless, if a client breaches a condition of probation, there will be legal consequences.

2.5 Exits from housing and/or programs

Participation in the Walking to Wellness program is voluntary. Clients who are interested in participating are asked to make a commitment.

2.6 Services

Approach to service delivery

Walking to Wellness uses an ACT approach to service delivery in that a multi-disciplinary team provides intensive case management services to clients in their own environment. Unlike a true ACT model where a team would be available on a 24 hour basis – 7 days a week, the Walking to Wellness team is available 8:30 a.m. to 9:00 p.m. 6 days a week. The program sponsors believe this is sufficient, given that a 24-hour back-up crisis service system is available.

The program also follows a harm reduction philosophy in all aspects of treatment and service delivery. The team accepts all clients "where they are at", regardless of their substance use, and aims to meet their needs with creative, diverse and relevant clinical responses.[5]

At the beginning of each year, clients prepare a community plan. The ACT team helps the participants identify concrete goals, how they are going to achieve them, and what support they want from the team. The clients fill out a form that has three columns: What I Want To Achieve, What I Need To Do About It, and How Am I Doing. The ACT team and clients discuss these goals and "how things are going" on an ongoing basis throughout the year.

The ACT team expects the process of recovery to take a minimum of two to five years before any healthy, sustainable improvements in functioning will be made. Therefore, the program nurtures a voluntary long-term partnership between participant and staff based on the participant's needs/goals.

Types of services

The following are examples of some of the services provided by the ACT team.

Mental health and addictions services

The program treats both mental illness and substance use as primary, assessing for phases of treatment (addressing their mental illness) and stages of change (where clients are in addressing their substance use, e.g. pre-contemplation, contemplation, preparation, action, and maintenance). The ACT team notes that a person may be at one stage in

[5] Creativity can include developing a plan to ensure that a client has food in the fridge, and making sure that used needles are not left on the premises where the participant is living.

addressing their mental illness and at another stage in addressing their substance use. The ACT team believes it is essential to consider a client's mental illness and substance use at the same time, because each affects the other. They also note that it is easier to stabilize a person's mental illness than their substance use.

Participants are invited to complete a Mental Illness Drug & Alcohol Screening (MIDAS) form[6] every 6 months, which allows clients to self-report on their recovery. This form opens the door to conversation, and over time, helps participants become more aware of their substance use issues and the relationship between their substance use and mental health.

It is important to note that the ACT team delivers mental health and substance use services concurrently – often while just "hanging out". The team also ensures that all the professionals who provide treatment or other services to their clients use a consistent approach and one that recognizes where each client is at with their mental illness and substance use. As an example, the team will ensure that psychiatric medications prescribed to clients are compatible with the other types of substances they are using.

Mental health

The ACT team provides a full range of mental health services, and provide all aspects of treatment and psychosocial rehabilitation, including medication monitoring, assistance with lifeskills, job coaching, and support groups.

Substance use

The ACT team engages in substance use work with their clients almost daily. As the program manager said, "treatment – every minute is treatment". This work involves "motivation" and "lots of talking". For example, a team member will observe how things are going in a client's life and discuss how the substance use is helping the client achieve his goals or not. They might open a conversation by saying, "It seems like you are hung over today, do you want to talk?" Or they might say, "You are in a jail cell, is this what you want?"

The ACT team has found that clients don't think they are in treatment because they are used to thinking that treatment is something that happens in someone's office for an hour at a time. The treatment approach used in Walking to Wellness is so subtle, that clients don't realize they are getting it. On the other hand, if a client wants to enter a formal treatment program, Walking to Wellness will refer them to one. Some clients have been in addictions treatment through outpatient services or see an addictions counselor. Others participate in groups such as Alcoholics Anonymous, Narcotics Anonymous, and Dual Recovery Anonymous (for people with concurrent disorders).

[6] This form was developed by Dr. Kenneth Minkoff, a physician from the US who has experience working with individuals with concurrent disorders.

Social, recreation, life skills, vocational, and pre-employment programs

The ACT team includes a support worker who is responsible for assisting participants with social, recreation, life skills and employment activities. Several activities and outings are planned in a month, including movie nights, baseball, bowling, frisbee golf, a fishing trip, visit to Bouchard Gardens, and a trip to the library.

Arrangements have been made with the SPCA to give clients an opportunity to offer their services. Mental Health and Addictions also entered into an arrangement with Crescent House for participants to take on the landscaping responsibilities. They established a relationship with Malaspina College for clients to get some vocational testing done. Two participants attended Malaspina College and received Mental Health Support Worker certificates.

Walking to Wellness has also created vocational training opportunities by creating five positions for participants. Participants in these positions are able to earn monthly income through a Community Volunteer Program.

These positions include:

- Recreation Assistant(s) – assist in planning, organizing and running events; and
- Peer Support Worker(s) – assist others to the best of their abilities, using a caring, positive and non-judgmental holistic approach.

Clients who take on these positions are expected to refrain from using alcohol and drugs prior to and during activities, help staff at group outings, and model healthy behaviours that empower others and instill hope in their recovery. They are also expected to attend weekly check-in meetings to discuss issues that have arisen on the job and to receive feedback on their performance.

The goal of these initiatives is to build self-esteem so that participants can say, "I can do this". The initiatives provide a small stepping stone to get people working.

Housing

The ACT team has developed working relationships with several landlords in the community to help their clients access and maintain housing. In some cases, the team has agreed to provide specific services to help their clients keep their housing (e.g. frequent housekeeping support).

Nevertheless, the ACT team spends a significant amount of time every month helping clients with their housing. Housing stability continues to be one of the biggest challenges for the program. The main reason is that clients tend to get evicted as a result of their drug use and related outcomes, such as noisy parties, frequent comings and goings by the tenant and visitors, drug dealing, and damage to the unit. Other reasons for housing instability include significant rent increases (25 to 30 percent) which Walking to

Wellness participants could not afford to pay and a low vacancy rate which made it difficult for clients to access housing.

Changes in services

N/A

Most effective services

Walking to Wellness believes that all the services provided by the ACT team are essential to the program's success, as are:

- The rent subsidies provided through the SIL program; and
- Crescent House, which provides and emergency place to stay, respite care, and housing stabilization.

Connections with community programs/agencies

The original proposal for Walking to Wellness called for the creation of a community-based management committee that would include the agencies involved in creating the proposal. It was envisioned that this committee would take ownership of the program as partners, and ensure that the clients could access whatever services they needed. It was also envisioned that this committee would make decisions collectively about which clients would access the program. When the Ministry of Housing provided funding for the demonstration program, this committee assumed responsibility for its implementation. They drafted job descriptions, recruited staff, developed the terms of reference, and established the decision-making process.

This management committee has since dissolved. To take its place, the Community Clinical Team was created. This committee includes a front-line worker from each of the partner agencies. Each partner agency was asked to identify a key clinician who was most interested in the program. The committee members are responsible for *brokering* services for the program participants – to make sure they receive the services they need. For example, the Ministry of Human Resources assigned one worker to the team. That person serves as the contact for the ACT team and is responsible for ensuring that program participants receive the income assistance benefits that they are eligible for. The committee was also expanded to include the Mental Health Housing Coordinator.

The partner agencies agreed that the management committee will be resurrected if necessary.

The ACT team has developed working relationships with a variety of community agencies to facilitate recreational and vocational opportunities for their clients. As noted previously, Walking to Wellness clients volunteer at the SCPA and do the landscaping for the Island Crisis Care Society, which manages Crescent House. The ACT team has also forged links with the Canadian Mental Health Association (CMHA), and several participants have become active participants in a variety of activities offered by this

Association. In addition, the ACT team has worked hard to develop relationships with landlords.

2.7 Staffing and personnel issues

At the start of the program, the management committee originally hired three people to constitute the ACT team. However, for the majority of the project, one social worker and one nurse continued.

The social worker has a Masters degree in social work, a background in psychosocial rehabilitation, and a certificate in substance use management. The nurse is a registered psychiatric nurse who also has a background in psychosocial rehabilitation.

The goal had been to hire a third person to serve as the addictions specialist. However, it was very difficult to find an individual who was trained in addictions and who would work out on the street instead of in an office.

Eventually, Mental Health and Addictions decided to hire a second social worker (Bachelors of Social Work) who also had experience working with people who had substance use issues. A fourth position (assisted living worker) was created to provide social, recreation, life skills, vocational, and pre-employment support.

All staff have some training or experience in addictions and harm reduction. The staff work together as a *team*. They share equally in the kind of work that needs to be done with each client. The roles of each individual staff member are "blurred".

A general practitioner (GP) and psychiatrist are also part of the ACT team. They meet with clients as often as is necessary. The GP, who is also an addictions specialist, meets with the team every month. The psychiatrist is available to the team daily. Both of these individuals are paid on a per session basis.

Ideal staffing

In terms of ideal staffing, Mental Health and Addictions believes it would be useful if the team also included an Occupational Therapist.

Mental Health and Addictions believes it is essential for any ACT team to include a nurse because of the clients' medical and psychiatric issues that need to be addressed. The team also needs to include a social worker with training in psychosocial rehabilitation. All members of the team should have a solid understanding of addictions (the neurochemistry of addictions and recovery process) and harm reduction. Professional training is an asset because it gives team members credibility with other professionals that they need to interact with.

Mental Health and Addictions also believes it is essential that staff:

- *Like* working with people with a serious mental illness and are not afraid of psychosis;
- Are street smart, non judgmental, have common sense, and are able to think on their feet and deal with whatever new situation is being presented; and
- Are prepared to work in the clients' environment rather than in an office.

Staff burnout

The key informants did not identify burnout as an issue, but noted that starting with 20 new clients at once was too much. It was also noted that being part of the ACT team requires a huge commitment and tremendous dedication. It is very demanding work, and a person can do this work only if they are truly committed. "It is more than a job".

Policies for hiring formerly homeless individuals

The ACT Team itself includes professional staff. However, clients/participants can be hired as recreation assistants or peer support workers.

Professional development

One of the challenges of recruiting staff for the kind of work being done in the Walking to Wellness program is finding professional staff who have the additional skills necessary for working on the street. Mental Health and Addictions is not aware of programs that provide training for this kind of work.

To address this challenge, Mental Health and Addictions is considering adding an additional person to the team who could be mentored by existing staff and learn on the job. This approach would provide a learning opportunity for new staff to gain skills and experience as they transition into the program.

Mental Health and Addictions sent staff to Chicago for training in psychosocial rehabilitation. They also provide training in addictions and concurrent disorders, and are helping the assisted living worker obtain a Bachelor of Social Work.

2.8 Funding

Annual Revenue, 2004

Source of revenue	**Amount**
VIHA–Mental Health and Addictions, Acute Services	$338,072
Forensic Psychiatric services – for Crescent House	$15,000
Total	**$353,072**

Costs	**Amount**
Staff (4 FTE)	$250,000
Office expenses	$ 43,072
Client related expenses	$ 35,000
Staff travel	$ 15,000
Leasing of van	$ 10,000
Total	**$353,072**
Per diem	$32.24

In addition, funding for the rent subsidies is provided through the SIL program.

Since it costs about $1800 every time a person appears in the emergency department, Mental Health and Addictions believes the program is cost-effective. However, it is difficult to show cost savings for emergency and acute care services since the system continues to operate at capacity.

3. Outcomes, challenges and factors for success

Mental Health and Addictions defines success for the Walking to Wellness program as observable client recovery. Success is seen as any positive (and hopefully sustainable) change in the lives of the participants, including:

- Improved ability to function (e.g. ability to maintain housing, eat properly, attend to one's health and attend medical appointments);
- Improved quality of life;
- Reduced harms associated with substance use. This includes using more safely (e.g. clean needles/not sharing needles), using less harmful substances, being able to talk about their substance use, and reducing problems associated with drug use.[7]
- Reconnecting with family; and
- Less involvement with the police.

[7] Reducing problems associated with drug use could mean purchasing groceries before drugs, using with people who don't create problems, and avoiding having dealers on the premises.

The ACT team measures success one small achievement or step at a time.

Mental Health and Addictions also looks at success from the participant's point of view – based on what the client wants to achieve. Each participant develops his/her own goals. The ACT team has found that 100% of the community plans have been achieved to some extent.

Only two clients in the beginning didn't get engaged and left voluntarily after 2 years. None of the clients dropped out of the program in the first 2 years, although 2 died.

Mental Health and Addictions expected it would take about 5 years to work with its target population. The program is almost 5 years old, and 10 clients have graduated successfully – in terms of being able to transition to mainstream services.

In considering the above measures of success, Mental Health and Addictions believes the Walking to Wellness Program is very successful.

3.1 Impact of the program on residents

There is no quantitative data that measures program outcomes. However, Mental Health and Addictions believes the Walking to Wellness Program has improved the quality of life, physical health and mental health for the participants. The following observations have been made:

Measures of Success	**Outcomes**
Residential stability (e.g. length of time housed)	Some clients have been able to achieve housing stability, but this continues to be a challenge, for others. Of significance is that while some clients continue to be evicted from their housing: • Most clients are able to stay in their housing longer before getting evicted; • It is taking less time for clients to find another place to live after they are evicted; • The amount of time that any client is homeless has been reduced from months at a time to a few days at most, or not at all. In fact, the ACT team believes there is no need for any client to be homeless because the team can always find them a place to stay. It should be noted that the quality of housing for all participants has improved since they became involved in the program.
Reduced substance use and increased safety re use	Two people have achieved long-term abstinence (3 years). Among most other participants, there has been a noticeable decline in the level of harm that results from their substance use. They have longer periods of abstinence (i.e. use less often), use less harmful substances, and use more safely (e.g. less sharing of needles). Altogether, their substance use is having a less negative impact on their lives.

	In the first 2 years of the program about 1/3 of participants used IV drugs (cocaine and heroin). In year 5, five clients were on methadone.
Income	At the beginning of the program, most participants were not receiving income assistance or a disability pension. The staff got this set up for everyone. Now, everyone who needs income assistance is receiving it.
Less use of emergency/crisis services	Before they were involved in the program, the participants were frequent users of the emergency crisis system. Each had about 5 or more admissions to the psychiatric ward in the previous year. Since they became involved in the program, none of the participants have had any unplanned admissions. If an admission is necessary, e.g. there is a problem with medications or psychiatric decompensation, an admission would be planned.
Employment/vocational activities	Walking to Wellness provides a pre-employment readiness program. They look for opportunities in the community e.g. SPCA – where participants can work. Participants can be hired as a recreation assistant or peer support worker or to do landscaping for Crescent House and other related sites. During the fifth year of the program, 13 of the 30 participants were receiving some monthly income from employment.

3.2 Resident satisfaction

At the outset, there had been a plan to evaluate the results of the two-year demonstration project. Mental Health and Addictions entered into a contract with some individuals to conduct an evaluation, and these individuals prepared an evaluation plan. After an initial report, however, it became clear that the evaluation was not meeting the intended objectives and the contract was terminated.

3.3 Reasons for success

Mental Health and Addictions believes the main reasons for the success of Walking to Wellness are:

1. The ACT model itself, which provides a multi-disciplinary team of professionals providing intensive case management services to clients in their own environment.

2. The competence of the staff who are trained in nursing, psychosocial rehabilitation, addictions, and harm reduction, who are street smart, non judgmental, have common sense, are able to think on their feet and deal with whatever new situation is presented to them, and who are able to work with people with a serious mental illness.

3. The nature of the relationships between staff and the participants has been a key factor in the recovery process for the participants. Staff do whatever it takes to establish and maintain the relationship. Staff accept clients where they are at, while increasing expectations over time based on where the client wants to go. They seize opportunities where they can to help clients move ahead.

4. Crescent House, which provides clients with a safe place to stay, outside of the downtown area. This has been a critical element of the program by meeting the different needs of clients over time: an emergency place to stay if a client gets evicted, a temporary place to stay so a client won't lose his/her housing, and for others, a place to stabilize and learn how to live independently.

5. Ensuring that participants have access to needed services. In the first year of the program, the ACT team found that their clients had multiple issues related to their physical and mental health, substance use and ability to function – although they knew how to survive. The ACT team was able to access the necessary services for their clients. Being able to access psychiatric help outside of an emergency situation was very helpful in being able to do a proper assessment of a client's mental illness and to devise appropriate treatment options.

3.4 Challenges

From the beginning of the program, providing housing for their clients was the ACT team's biggest challenge. Acquiring Crescent House assisted the program. However, the ability to access decent housing for their clients continues to be a challenge. Being able to maintain their housing continues to be a challenge for some clients. While some clients have been able to maintain their housing in the community, others continue to get evicted on a regular basis. The most common reasons for eviction are behaviours arising from drug use (e.g. bringing dealers into the building) or engaging in the sex trade.

There are not enough "tolerant" landlords in the community, and some landlords of even the lowest quality housing in Nanaimo won't house some of their clients.

To address the housing needs of their clients, Mental Health and Addictions has identified a need for:

- Incentives for landlords to rent to their clients e.g. guarantee to repair damage; and
- A dedicated supportive housing building – "wet" housing where clients would not be required to be abstinent.

3.5 Lessons learned

1. Housing – As stated by the program manager, "Don't underestimate the therapeutic value of housing". Without stable housing, it is impossible to begin working with the participants. The ACT team found that their clients needed a safe place to live before they could begin to address any of their other issues. It was difficult for the team to stabilize clients who were in unsafe housing and difficult to keep track of those who were homeless. There is a need for a mixed approach - both dedicated and scattered site housing (e.g. SIL). Some clients want their own place to live right from the start. Others need a place to stabilize before they can move to their own apartment in the community. A dedicated building is needed for some clients who continue to get evicted from their rental housing but who could live successfully in the their own unit

if the building and management were tailored to meet their needs. Housing options should be in place before hiring the ACT team.

2. Devise a method to ensure that program participants will be able to access the services they need. This was the original intent of the management committee – to take ownership of the initiative and facilitate access to services. This includes forensic services, income assistance, housing, the police, and addictions services. Support from the services agencies must be clear at the management level from the start. Then, Management has to assign one staff person to be the contact person for the program and to take responsibility for brokering services. When this initiative first started, members of the ACT team spent about one month at the offices of the different partner agencies. The purpose was to get to know the agencies and their staff so they would be able to help their clients access the services they would need. This was very helpful.

3. Don't take on too many clients at once. Start slow. This program started with 20 clients. All of them were at the same stage of chaos. With two staff, this was too much.

4. If you are planning to evaluate your program, make sure the consulting team has the necessary qualifications and experience.

Contact: Bob Haubrich Manager, Access & Acute Services – Central/North Island Mental Health & Addictions Services (MHAS) Vancouver Island Health Authority 1200 Dufferin Crescent Nanaimo, B.C. V9S 2B7	Phone: 250-716-7746 Fax: 250-740-2670 E-mail: robert.haubrich@cvihr.bc.ca

5616 Fraser Street Supported Housing Program: Sponsored by Triage Emergency Services & Care Society	Vancouver, British Columbia

1. Background

This case study has been prepared based on an interview with staff from Triage Emergency Services & Care Society (Triage) and additional written information available on online.[1]

1.1 The sponsor

Triage was established in 1990 to provide quality housing and support services to marginalized populations. Triage's vision is "a home for every person". Its mission is to provide a continuum of housing and support opportunities for people with mental health, substance use and other challenges. Triage provides a range of services for these individuals, including:

Emergency shelter: 28 beds for homeless men and women.

Transitional housing: Princess Rooms, an old hotel with 45 rooms for individuals who have been chronically homeless, have high rates of repeat shelter use, complex health needs (most typically concurrent disorders), challenging behaviours, and histories of evictions; and The Vivian, a fully staffed 24-bed rooming house targeted to at-risk women in the downtown eastside of Vancouver who have mental health and substance abuse disorders.

Supportive housing: WindChimes, a building that provides 27 subsidized studio apartments for men and women with serious mental health concerns. Triage clients can also access 26 units in a building for mental health consumers that is owned and operated by the Neighbourhood Housing Society.

Triage Outreach Team: a 24 month project (April 2004 to March 2006) to work with chronically homeless individuals with concurrent mental health and substance use issues, and intervene in their cycles of homelessness, instability and poor health.

Project at a glance	
Sponsor name	Triage Emergency Services & Care Society
Goals	• Meet the needs of clients who want to become abstinent; • Help residents through the recovery process; and • Help residents create a substance-free lifestyle.
Target population	Individuals with concurrent disorders who are in recovery and have stopped using drugs and alcohol for at least 60 days.
Housing tenure	Transitional supported housing
Number of suites	30 units
Factors for success	Triage expects these will be the: • Relationships between residents and staff. • Extent to which treatment of mental health and substance use can be coordinated. • The peer environment. • Strong support networks.
Location	Vancouver, BC
Project start date	Construction is scheduled to start in the fall of 2005.

[1] See Background Information, 5616 Fraser Street Supported Housing Program, online at www.vch.ca/newslinks/media/ Oct_18th_QA_Final_version.pdf –

[2] While Triage considers these programs to provide transitional housing, there is no maximum length of stay.

1.2 Program goals and history

In 2003, Triage, together with Vancouver Coastal Health and the City of Vancouver, submitted a proposal to the provincial government through BC Housing and to the federal government through its Supporting Communities Partnership Initiative (SCPI) to develop an alcohol and drug free transitional supportive housing program for individuals with concurrent disorders. The proposal was accepted and both levels of government agreed to contribute capital dollars to the project. In addition, Vancouver Costal Health agreed to contribute to both the capital and operating costs, and to provide resources for mental health and addictions treatment. The City of Vancouver agreed to provide land for a 60-year lease. Triage will own the building, take care of the day-to-day operations, and provide on-site support to the residents. Construction is scheduled to start in the fall of 2005.

Triage sees the Fraser Street project as an important part of the continuum of housing and support services it wishes to provide for people with mental health, substance use and other challenges. Beginning in 2001, Triage identified a gap in services for clients who wished to become abstinent. Existing options were to refer clients to a detox facility and then to a recovery home. However, Triage found that the recovery homes were not designed for people with mental illness. Their clients were often asked to leave if they displayed symptoms (e.g. talking to themselves). Furthermore, Triage was finding that there were not enough resources in Vancouver to promote ongoing recovery from substance use. Triage identified a need for an alcohol and drug free housing option where clients would be able to access services to address both their mental health and substance use issues.

The goal of Fraser Street will be to help residents through the recovery process and help them create a substance-free lifestyle. Triage is aware that some of the people they work with, including some residents in the Princess Rooms, want additional support to stay alcohol and drug free. They also need a place where both the residents and staff are supportive of people with mental illness and where staff have the necessary skill to work with this population. Fraser Street will provide such a place.

Triage believes it is important to provide a continuum of housing and support options because this makes it possible to provide a range of options and choice to people with diverse needs. However, Triage points out that "choice" is the key word. While the continuum provides a range of options, clients are not required to move through the continuum. They may choose to access (or exit) any of Triage's services along the continuum at any time.

2. Program Description

2.1 The people

Fraser Street will be targeted to men and women with concurrent disorders. The residents are expected to be psychiatrically stable and receiving services from a mental health team in Vancouver. They must be in recovery (e.g. living alcohol and drug free) and have been free from alcohol and drugs for at least 60 days before applying to the program.

Triage and Vancouver Coastal Health want to ensure that the program is accessible to Aboriginal people and the diverse range of other ethnic communities that live in Vancouver. Triage will work to ensure that these individuals can access the Fraser Street program.

2.2 The housing

Fraser Street will be purpose built. It will contain 30 studio apartments, each with its own private kitchen and bathroom. Five of the units will be wheelchair accessible.

The building will contain significant amenity space, including computer rooms, multi-purpose rooms, laundry facilities, a kitchen (for group celebrations and to assist with lifeskills training), and a TV lounge, reading room, fireplace and barbecue. The building will be landscaped, and there will be a Japanese garden. The amenity space will be used to help the residents get involved in meaningful and enjoyable activities.

Fraser Street is a transitional supported housing program. It is expected that residents will stay 12 to 18 months. However, residents may be able to stay up to 2 years if this is what they need to maintain an alcohol and drug free lifestyle. At the end of their stay, Triage will help residents find a permanent place to live.

Residents will sign an agreement that sets out the program requirements and conditions under which a resident will be required to leave. At this time it is not clear whether the *Residential Tenancies Act* will apply.

2.3 Access to the program/housing

Applicants to Fraser Street will require a referral from an agency. There are no restrictions on the types of agencies that may refer clients. Application forms and procedures will be developed to gather sufficient information to ensure that an individual is eligible. Walk-in clients will be asked to refer through their support agencies. In this sense, Triage notes that the Fraser Street initiative is not "minimal barrier".

Triage plans to "screen out" applicants who have known histories of violence or sexual misconduct.

Eligibility criteria

To be eligible for Fraser Street, applicants must have a history of mental illness (e.g. depression, bi-polar or schizophrenia). At the same time, however, applicants will be admitted to the program only if they are psychiatrically stable and receiving services from a mental health team in Vancouver.

Applicants must also have a history of problematic substance use. However, they must be in recovery and have been free from alcohol and drugs for at least 60 days. They must also be working with an addictions specialist.

Part of the assessment process will be to determine a person's ability and commitment to

live an alcohol and drug free lifestyle and to take an active part in both their mental health and addictions treatment plans.

Degree of "housing readiness"

It is expected that most applicants to Fraser Street will have the skills to live independently. However, others will probably need some assistance and support to improve their level of functioning. For example, it is expected that some residents will need to develop skills to manage their medications and prepare meals.

Program expectations

Triage expects that all Fraser Street residents will be abstinent and will take their psychiatric medications as prescribed.[3] Triage anticipates that most residents will be able to self-administer their own medications. However, program staff will provide medication support, for residents that do not have this ability. This could include storing medications, handing them out, and issuing reminders. At the same time, Triage will help these individuals learn how to administer their own medications.

Residents will sign an agreement that outlines what kind of behavour is expected of them. This will include what is appropriate in the common areas. It is expected that some residents will have poor living skills and issues with anger management. Staff will work with these residents to help them address these issues.

Program demand

Triage knows that some of its clients want to participate in the Fraser Street program. Vancouver Coastal Health and the City of Vancouver have also identified a need. However, no formal assessment has been conducted to quantify the need.

2.4 Substance use issues and policies

Substance use

It is premature for Triage to speculate what are the most common substances that applicants will be in recovery from. The use of stimulants (e.g. cocaine, crack and crystal meth) is prevalent, but there may be equal or greater demand from individuals seeking to abstain from alcohol, marijuana, or opiates. Triage also points out that individuals who are in recovery from stimulants will likely display more challenging behaviours than others who have been addicted to opiates, if they relapse.

Triage also points out the more severe a person's mental illness is, and the more they are impaired, the more challenging it is to help them in their recovery.

[3] Triage notes that someone with a mental illness does not immediately become psychotic if they stop taking their medications. Mental health workers and Triage staff are trained to identify signals if a client's mental illness begins to show a worsening of symptoms, and they will watch for these signs.

Policies and approaches relevant to housing the target group

Use of substances

Residents at Fraser Street will not be permitted to use substances – on or off the premises.

Triage believes they will be able to know if a resident has started using again because someone who resumes the use of drugs or alcohol after a period of sobriety exhibits several changes in behaviour, attitude or thinking. These changes can include withdrawing from staff, staying in one's room, avoiding planned activities, changes in finances, different friends, changing sleep patterns, as well as the usual readily observed physical indicators. All these changes are noticeable in a facility with 24-hour staffing. They are also noticeable by other residents.

If Triage suspects substance use, staff will talk to the resident and give him/her a 48-hour eviction notice. Residents will have 48 hours to decide if they wish to recommit to their recovery plan. If a resident does not recommit to abstinence, Triage will bring him/her to their emergency shelter. Space will be dedicated in this facility for this purpose.

Triage has decided not to conduct urine or other tests to determine if residents have been using substances. There are several reasons for this. First, Triage believes staff should be sufficiently aware of their clients to be able to determine if a client is experiencing a relapse before a test is conducted. Testing catches people after the fact. Second, Triage believes it is better to promote an environment in the project that stipulates clearly that substance use will not be tolerated. Third, Triage notes that testing can produce false positives. This risk is exacerbated for people who are taking a range of psychiatric medications – or even common non-prescription medications such as Tylenol.

Strategies to address relapse

Triage understands that relapse is a normal part of the recovery process. Developing a strategy to address the potential for relapse will begin during the assessment process. A recovery plan, which will include relapse prevention and early intervention strategies, will be developed with each resident. Triage will work with each resident to identify the risk factors – triggers – feelings that generally come *before* a relapse.

Triage staff will monitor residents during their every day interactions for signs of relapse, or signs that a resident may be heading for a relapse. Triage expects that staff will get to know each resident, work with them, talk with them, and keep the lines of communication open. It is expected that staff will be proactive and deal with potential problems before they get out of hand.

If a resident does relapse, Triage will issue the 48 hour eviction notice, during which time the resident will need to decide if they wish to recommit to the program. Triage staff will have some discretion as to whether a resident should be evicted or not. Some residents may be permitted to return to Fraser Street after a short stay in the shelter.

In implementing a relapse strategy, a prime consideration for Triage will be to limit the impact on others in the building.

Safety and security

Fraser Street will be staffed 24 hours a day, seven days a week. Security measures will include cameras on all exits and in the parking area, alarms on all fire exits, and a ground floor that has been designed to provide excellent sight lines for staff. Because the building and its residents are expected to be alcohol and drug free, problems associated with drug use are expected to occur at reduced levels. Furthermore, Triage plans to "screen out" residents who have histories of violence. The police have indicated that they will treat Fraser Street the same as any other building in the community.

Guests

Triage wants the Fraser Street building to provide as normal a living environment as possible. Therefore, rules about guests will be kept to a minimum. However, all visitors will be required to enter the building through the front door and pass the main counter, which will be staffed 24/7. Unwelcome visitors will not be permitted. Visitors will be required to comply with the program requirements regarding substance use. They will not be permitted to enter the building if they are under the influence of drugs or alcohol and will not be permitted to bring drugs or alcohol into the building.

Role of staff in working with residents

Triage staff working at Fraser Street will be expected to get to know each resident and to build relationships with them. These relationships are to be based on open and honest dialogue. Staff will be expected to see each resident on an informal basis at least once a day. On a more formal basis, it is expected that staff will meet weekly with new residents and monthly after residents have settled in. Staff will be expected to be proactive in addressing potential problems before they get out of hand.

Legal issues

N/A because substance use is not permitted.

2.5 Exits from housing and/or programs

Voluntary move-outs

Triage expects that most residents will move out of Fraser Street within 12 to 18 months, although some residents may stay for up to two years. At the end of their stay, Triage will help residents find permanent housing. Triage will also provide ongoing support if a resident wants, to help him/her make the transition to living independently outside the project.

Triage expects that some of the residents may be able to live independently, without support. However, this will depend on the acuity of their mental illness. Others will require a rent subsidy, some support, or both.

Triage believes it is important that a variety of housing options be available. They hope

that some former residents will be able to access BC Housing units. Other options could include access to staffed apartments for people with mental illness. In addition, Triage has a commitment of funding from Vancouver Coastal Health for nine subsidized units through the Supported Independent Living (SIL) program. Triage will provide outreach support to the tenants in these units. SIL workers would be dually trained in both mental illness and addictions recovery.

Evictions

Residents will be evicted if they resume using substances or if their behaviour is disruptive to the community. However, Triage will take a proactive approach to try and prevent evictions – or prevent situations that could lead to a crisis and ensuing eviction.

If a resident is displaying problematic behaviour, staff will try to understand the underlying reasons for the behaviour. They will try to learn from it – to find out what the behavour is saying about the resident's issues. They will also try to help the resident work through his/her issues, and to develop strategies for dealing with the issues that are causing the behaviour. Once staff learn about what kinds of issues trigger certain behaviours, they will try to help the resident avert these situations in the future.

Residents who are evicted will be able to go to Triage's emergency shelter or Princess Rooms.

2.6 Services

Approach to service delivery

Fraser Street will be part of a multi-program, multi-disciplinary integrated model of concurrent disorders treatment. This will involve: a multi-disciplinary treatment team, including a dually trained psychiatrist and case manager hired specifically for this program (yet attached to a mental health team), with service coordinated with the resident's addiction counselor; a skill-based treatment approach focusing on client strengths; an assertive approach, especially for relapse prevention and early intervention; group treatment; motivational interviewing; Cognitive Behavioral Therapy; and an emphasis on community integration and meaningful activities.

Types of services

Mental health, substance use and rehabilitation services

Residents will be able to access to a range of rehabilitation programs provided through community agencies in Vancouver that provide training and assistance with life skills, employment and education.[5] Fraser Street residents will also be linked with a mental health team in Vancouver and will be able to access the professional rehabilitation programs available at the team (lifeskills assessment and training, social/recreation planning and assessment).

Fraser Street residents will be expected to see substance use counselors at the community health clinics or to participate in the Dual Diagnosis program operated by Vancouver Coastal Health. This is a specialist treatment resource for people with mental illness and problematic substance use. The program was established to help clients reintegrate back into the community, be positive role models of recovery from mental illness and substance abuse, and achieve an improved overall quality of life.

A range of alternative therapies, such as acupuncture will be considered. There is evidence that such therapies can be important additions to the treatment residents will receive from professional mental health staff.

On-site, Triage staff will be expected to provide core services including:

- Life skills support such as money management and food preparation;
- Social and recreational programs, both group and one-to-one;
- Programs to assist residents in maintaining a drug and alcohol free lifestyle (which may involve peer group meetings and treatment sessions with professionals); and
- Support groups that promote integration into the community.

The amount of time each resident participates in activities and services will depend on their individual need and could vary from a few hours per week to several hours per day.

Each resident's psychiatrist will be responsible for making sure his/her client's medications are appropriate.

It is expected that the case manager or each resident's addictions counselor will be responsible for providing ongoing counseling.

Leisure and recreation activities

When not engaged in a structured program, Triage expects the residents to use the amenities e.g. computers, reading room, garden, or one of the multi-purpose rooms. It is also expected that the residents will watch TV, clean their apartments, do their laundry, and participate in community activities.

[5] Some of the agencies providing these services include the Canadian Mental Health Association, Coast Foundation, Theo BC, and Gastown Vocational Services Education/Employment.

Triage's recreational therapists will organize daily activities in the building for the residents, including celebrations for special days such as Thanksgiving, Canada Day and birthdays.

Changes in services
N/A

Most effective services
N/A

Connections with community programs/agencies

The Fraser Street initiative involves a formal partnership with Vancouver Coastal Health, which will provide capital as well as operating funding. Vancouver Coastal Health staff will also provide regular and ongoing mental health treatment and rehabilitation services for each resident. The City of Vancouver is a partner in that they will provide the land for a 60 year lease. In addition, Triage will be working closely with the various mental health teams, health clinics, the Dual Diagnosis Program, the Semi-Independent Living (SIL) program, and a variety of other agencies in the community that provide relevant services.

2.7 Staffing and personnel issues

Fraser Street will be staffed 24 hours a day, seven days a week. Two shifts of health care workers will be on site at all times. After the first year, a review will be undertaken to determine if it is necessary for two staff to be on duty at night, or if one staff person will be sufficient. Staffing is expected to include the following positions:

Staffing (planned)	
1 Full-time project manager	Available Monday to Friday during the day.
1 Half-time administration support	Monday to Friday during the day.
2 Health care workers	Will take people to their appointments, help with the administration of their medications, assist with lifeskills, organize activities in the building, facilitate some group meetings, practice motivational interviewing and relapse prevention, provide one-on-one crisis prevention and intervention, and case management. Health care workers will be expected to have some training in mental health or addictions. Staff will be expected to work together and learn from each other.
Recreational therapists	Available seven days per week. They will work with residents to put together recreation and socialization plans, including 1-1 work and group activities.

Staff burnout

N/A

Policies for hiring formerly homeless individuals

Triage is considering how to promote peer support within the building. They are hoping that over time, some of the residents who have been there the longest will assume a leadership role. This could include helping newer residents settle in and offering advice and insight from their own experiences. Triage believes that residents who have been in the program the longest – and who have invested the most - may have a great interest in maintaining a safe and secure environment within the building.

Professional development

Triage plans to provide multi-week training sessions for its staff about mental health and addictions, how they work together, and about how to deliver integrated services to individuals with concurrent disorders. Triage may seek assistance from the Dual Diagnosis program and the Justice Institute to provide the training. Triage will also provide ongoing training on motivational interviewing.

2.8 Funding

The following is a draft first year operating budget for Fraser Street.

Annual Revenue:

Source of revenue	**Amount**
Vancouver Coastal Health	$844,806
Resident Rental Income	$117,000
Resident Food income	$16,425
Total	**$978,231**

Expenses	**Amount**
Direct service wages	$481,826
Relief staff (cost of replacing staff if they are not available e.g. on holidays or sick)	$89,898
Staff benefits	$154,487
Operating costs	252,020
Total expenses	**$978,231**
Per diem	$89

Residents will be asked to pay $325/month for rent. This is the amount of the shelter component provided under income assistance. It is expected that most residents will be receiving income assistance.

3. Outcomes, challenges and factors for success

Triage believes the Fraser Street project will be considered a success if residents:

- Are able to manage their mental illness;
- Gain a greater understanding about their addictions;
- Have fewer and shorter relapses and are able to learn from their relapses;
- Are able to remain abstinent;
- Learn skills for successful living; and
- Broaden their support networks (both formal and informal e.g. friends and family).

3.1 Impact of the program on residents

There are no outcomes to date. Triage plans to set up a process to measure specific outcomes (e.g. those related to the above factors) and evaluate the program.

3.2 Resident satisfaction

N/A

3.3 Reasons for success

Triage expects the reasons for success while residents are in Fraser Street will be the:

1. Relationships established between the residents and staff.

2. Extent to which the treatment of mental health and substance use can be coordinated in a functional way.

3. Peer environment. Triage hopes to create an environment in Fraser Street that will promote strong leadership among the residents who are motivated – to create a "healthy community".

After residents leave, Triage expects the main factor for success will be the strength of their support networks. Triage believes it will be critical for residents to create a broad network of support that will help them through the transition to a more independent living situation.

3.4 Challenges

Ensuring clients have access to the services they need

Once operational, Triage believes the main challenge will be getting all the programs coordinated, e.g. mental health, addictions, housing, rehabilitation services and perhaps the hospitals.

Community opposition

The Not In My Back Yard (NIMBY) issue was a significant challenge in moving this project ahead.

Triage held several public information meetings for neighbouring residents in April 2004, and applied for a Development Permit in May 2004. The City notified approximately 300 neighbouring property owners by letter in June. Public meetings were held in October 2004. A Special Meeting of Council to hear delegations took place two months later in December. Triage received its conditional Development Permit in March 2005.

Members of the community raised many questions about why the particular site had been selected and voiced strong opposition to the project. The main concern was that residents would relapse, commit crimes to raise money for drugs (e.g. break and enter into the neighbours homes), sell drugs in the community, and create problems in the neighbourhood. Some fears were due to the stigma of mental illness, and fears that people with mental illness and/or addictions are violent. Some people in the neighbourhood had also read research reports that commented on the difficulties in treating individuals with concurrent disorders.

In the end, City council unanimously supported the project and the project team did a good job in satisfying the requirements of the various city departments.

3.5 Lessons learned

1. Do as much research as possible from the start about the potential outcomes and benefits of the project you are proposing.

2. Do not hold community meetings in the summer because many people will be away on holidays. It is important to plan a process that can achieve as much community involvement as possible.

3. Take the initiative in working with the community to keep them fully informed on an ongoing basis. Do not underestimate the importance of communication.

Contact: Greg Richmond, Director of Housing Triage Emergency Services & Care Society 707 Powell Street Vancouver, BC V6A 1H5	Phone: 604-215-3046 Fax: 604-254-3747 E-mail : grichmond@triage.bc.ca

Westview Dual Diagnosis Program: Sponsored by Phoenix Residential Society | Regina, Saskatchewan

1. Background

This case study was prepared based on an interview with staff from the Phoenix Residential Society, and additional written information provided by them.[1]

1.1 The sponsor

The Phoenix Residential Society (Phoenix) was established in 1977 to help persons with a long-term mental illness or acquired brain injury live as independently as possible in the community with an enhanced quality of life and greater self-reliance. In addition to the **Westview Dual Diagnosis Program**, (created in 1993), Phoenix provides four other programs:

Phoenix House: a 24-hour staffed group home that provides psychosocial rehabilitation to 8 individuals, and 24-hour on-call service and crisis accommodation for clients in the Phoenix Apartment Living Services program (see below).

Phoenix Apartment Living Services (PALS): provides support services for up to 60 individuals living in a home of their choice in the community.

Phoenix Housing and Support Services (PHASS): provides basic help/residential crisis services for up to 8 individuals in the community who have particularly challenging behaviours.

Pearl Manor (Acquired Brain Injury Program): a 24-hour staffed supported apartment program that provides psycho-social and behavioural/cognitive rehabilitation to 6-8 persons.[2] An outreach worker provides support to 10 additional clients who live out in the community.

1.2 Program goals and history

The Westview Dual Diagnosis Program is a residential and addictions recovery program for adults in Regina who have a concurrent diagnosis of serious and persistent mental illness and substance abuse. The program is located in an apartment building referred to as "Westview", which provides supervised apartment living for 10 residents at a time.

Project at a glance	
Sponsor name	Phoenix Residential Society
Goals	Lead clients towards abstinence and psychiatric stability while they maintain a level of independence in the community.
Target population	Individuals in Regina who have a concurrent diagnosis of serious and persistent mental illness and substance abuse.
Housing tenure	Treatment facility where residents can remain 3-5 years.
Number of units	10
Factors for success	• The way staff work with residents and connect with them. • Setting abstinence as a goal. • 24 hour staffing. • Follow-up with former residents. • Providing a positive experience.
Location	Regina, Saskatchewan
Project start date	January, 1993

[1] See references at the end of this case study.
[2] One or two of the 8 beds are available for respite.

The long-term goal of the Westview Dual Diagnosis Program is to lead clients towards abstinence and psychiatric stability while they maintain a level of independence in the community. While abstinence is a goal, it is not mandated. The program incorporates a harm reduction philosophy in that participants are not automatically discharged for using drugs or alcohol.

This approach was taken from the beginning as a practical response to address the need for a treatment program in Regina that would help people with concurrent disorders learn how to maintain themselves in the community. Phoenix believed an approach that required clients to commit to abstinence as a goal would be more successful in attracting and maintaining clients compared to a program that would require strict adherence to abstinence.

2. Program Description

2.1 The people

The Westview Dual Diagnosis Program provides supervised apartment services to 10 residents at a time. The program is targeted to clients with concurrent disorders who also have reputations as being difficult to manage and entrenched in their substance use.

In April 2005, seven men and three women were living at Westview. Staff were working with another single man on an outreach basis. Most of the residents were between the ages of 23 and 50 years old. Six were Caucasian, two were East Indian and two were Aboriginal.

All the residents had a concurrent disorder of serious and persistent mental illness and substance abuse. One individual also had a brain injury. The kinds of mental health issues faced by the clients included: schizophrenia; bipolar, personality and adjustment disorders; and major depression.

Six of the residents received income assistance. The other residents received income from a variety of sources, including a disability pension, employment, support from family and savings. Westview staff have found that more residents are receiving income from the Canada Pension Plan (disability) compared to when the program first started.

2.2 The housing

Westview contains 10 apartment units: 9 one-bedroom apartments and one bachelor unit. All the units are self-contained and well maintained. Phoenix provides all the necessary furniture and household supplies.

The building also includes a common room, where all the group meetings are held, and one office.

Phoenix leases the entire building from a private landlord. Phoenix is responsible for the day-to-day property management and collects rent from the residents. The landlord takes care of "big ticket" items. The residents do some janitorial work. Cleaners come in every two weeks to clean the common areas of the building.

Westview is considered to be a treatment facility; not transitional housing. It is not just a place to live. All the residents are in different stages of addressing their substance use and mental health issues. Residents may stay at Westview for three to five years. As a treatment program, Westview is not subject to the Saskatchewan Residential Tenancies Act.

2.3 Access to the program/housing

Westview clients are referred from the Regina Mental Health Clinic. A case manager from the Clinic is responsible for facilitating the referral to Westview. Clients must be under the care of a psychiatrist from the Regina Qu'Appelle Health Region and priority is given to clients from this Region.

Westview requires a significant amount of information about each applicant, including assessments about their mental and physical health, and their addictions. Westview also conducts a criminal records check to determine if the applicant has committed any acts of violence, particularly sexual violence. Westview would look into this and conduct an assessment to determine if the individual would pose a risk to other residents, staff, or the community. They want to know as much as possible about each client so they can be prepared for any potential problems that might arise – or be "forwarned".

As part of the referral process, the Mental Health Clinic is expected to provide a community support/rehabilitation plan. This plan is prepared by the case manager at the clinic, and outlines what the case manager will do to further the client's rehabilitation. The client also provides input about their goals.

A committee that includes supervisory staff from the different programs provided by Phoenix, as well as staff from the Regina Qu'Appelle Mental Health Clinic, meets once a month to review all applications.

Eligibility criteria

To be eligible for Westview, applicants must:

- Be 18 years or older;
- Have a diagnosed mental illness in combination with substance abuse/dependence;
- Have a history of being unable to live independently in the community and require long-term rehabilitation services (but have **basic** independent living skills);
- Demonstrate adequate impulse control so as not to threaten the welfare of others, seriously disrupt the program or cause major problems in the community;
- Make a commitment to participate in the program toward the goal of abstinence; and
- Make appropriate financial arrangements to pay for the program prior to admission[3].

Degree of "housing readiness"

Applicants to Westview are expected to have some basic skills for being able to live independently.

[3] A financial worker who works out of the Regina Mental Health Clinic helps clients who are psychiatrically disabled to access the income assistance benefits they are eligible for.

Program expectations

The goal of the Westview Dual Diagnosis Program is to help residents become abstinent. Therefore, an underlying program expectation is that applicants are willing to set a goal of abstinence and to work towards this goal. It is also expected that residents will participate in the programs and be willing to talk about their issues and concerns.

Westview has an open door policy. If a resident decides that he/she is not ready to work towards abstinence, it is understood that they will always be welcomed back when they are ready. About half the individuals on the waiting list are people who want to come back.

It is also expected that residents will be well enough to participate in the program and activities. If residents do not want to take their medications, they will be asked to see their psychiatrist to discuss their concerns. Staff at Westview understand that it can take time for people to accept that taking medication may be a permanent part of their lives.

Residents are also expected to:

- Have regular contact with their case manager and psychiatrist as required;
- Be involved in developing, evaluating and following through with their individual program plans; and
- Inform staff of any legal charges immediately.

Program demand

About 6 or 7 people are on the waiting list for Westview at any one time. In determining priority, the admissions committee considers the need and demonstrated commitment of each applicant. They do not have a first come first served system. There is not a lot of client turnover, so applicants may need to wait a long time. However, applicants are encouraged to participate in some of the programs offered at Westview while on the waiting list for a unit.

2.4 Substance use issues and policies

Substance use

The most common substances that have been used by residents at Westview include, alcohol, marijuana, non-prescription drugs (e.g. antihistamines and gravol) and some prescription drugs (e.g. Ritalin and Atavan). Some residents have used cocaine, and at any one time, there may be one person with a history of intravenous (IV) drug use. Ts and Rs (Talwin and Ritalin), considered the "poor man's heroin" is the most common IV drug used by residents, although Westview has seen a decrease in the use of this drug lately. Poly-substance abuse is common among Westview residents.

When the program first started, none of the clients used cocaine or IV drugs, but over time, increasing numbers of clients have been using these substances. Westview has not yet received applications from individuals using crystal meth. However, use of this drug is becoming more prevalent among young people in Regina, and some of them have entered the mental health system through the hospital's psychiatric ward.

Westview staff believe it is important to know the kinds of substances residents are using

because different substances may require different approaches to detox. Staff also note that it is difficult to detect use of over-the counter drugs when conducting urine tests. Poly-drug use can cloud the clinical assessments, making it difficult to determine if a resident's behaviour is due to drug use or a psychiatric breakdown.

Westview supports the best practices approach to treat mental health issues and substance use concurrently.[4] Substance use can create a barrier to recovery from mental illness. Westview notes that working with individuals with a concurrent disorder is more challenging than working with people with a mental illness or substance use. For example, the amount and types of substances being used will affect the mental illness and types of medications that can be prescribed.

Policies and approaches relevant to housing the target group

Use of substances

Substance use is not permitted in Westview. The house is "dry" - providing an alcohol and drug free environment. However, the program is "damp". While residents are not supposed to use alcohol or drugs (on or off site), it is also understood that relapse is part of the recovery process. If a resident shows overt signs of relapse, they must agree to follow through with a detox plan.

If residents bring alcohol or drugs in the building, they may be suspended from Westview for 3 to 7 days. (They could stay in the hostel at the Salvation Army). Residents will be expected to use this time to consider what they want. If they want to return to Westview, they must demonstrate how they plan to change their attitude and behaviour.

Bringing alcohol and drugs into the building repeatedly is grounds for eviction.

Apartment checks are conducted on a random basis and if staff have reason to suspect that someone is using substances. Urine tests are conducted randomly. Residents agree to these measures upon admission to the program.[5]

Security measures

Staff have a panic button that they can wear. This button is hooked up to an alarm-monitoring company, and if pressed, a loud siren will sound. The police would come very quickly.

Staff monitor who goes in and out of the building, and their office has a pony door.[6] Staff appreciate this when they are alone, since they can have the top part of the door open while also maintaining a partial barrier. In addition, there is always someone to call – on a 24 hour basis.

[4] This refers to Best Practices articulated by Health Canada and Psychosocial Rehabilitation Canada.
[5] These provisions are included in the Dual Diagnosis Program Expectations and Behaviour Guidelines.
[6] This is a door that is cut in half so the top part can be open while the bottom is closed.

Guests

The following rules apply:

- All visitors to the building are to be let in only by the resident they are going to visit.
- All visitors must leave the building by11:00 p.m. on weekdays, and 1:00 a.m. on weekends.
- Overnight visits may be arranged on weekends in consultation with office staff.
- Residents with less than one year sobriety or who have brought alcohol and/or drugs into Westview in the past must visit with their doors open or in the common room and expect staff to check in occasionally.

Conflicts among residents

If a resident is experiencing conflict with another resident or staff, they are expected to approach the person directly and ask for a meeting to discuss their concern. If the conflict is not resolved, the resident is expected to ask staff or the program supervisor to arrange for a 3-way meeting.

Temporary absence

If residents are temporarily absent from their unit (e.g. hospitalized), Westview will keep the unit available for up to three months. During the absence, the rent must be paid and there must be an expectation that the resident will participate in the program upon his/her return.

Strategies to address relapses

There are two residential workers on staff (called key workers). Each has a caseload of 5 residents. If a resident relapses, the worker will talk to them about the situation. Staff use the relapse as a learning experience. For example, they may discuss with the resident what they might do differently next time. Staff will ask if abstinence is still a goal. If the resident has more frequent relapses, staff will again discuss with the resident what they might do differently the next time. A resident who has experienced a relapse may be asked to participate in the in-house detox program. The resident continues to live in their unit, but cannot leave the building for 7 days, and must participate in all the on-site programs. Depending on the types of substances that have been used, Westview may refer the resident to an outside detox (e.g. if there is concern about the potential for seizures or other complications).[7] If residents go to an off-site detox, they can come back to their apartment afterwards. The process is seen as a learning experience.

If a resident does not wish to go through detox or otherwise address the relapse, he/she may be discharged from the program. This step would be the last resort. By the time this step is taken, the behaviour of this resident could be affecting the other residents, and the person may be becoming a danger to him/herself and others.

[7] Use of certain substances can lead to a higher risk of seizures during withdrawal than others e.g. heavy use of alcohol, Valium or Atavan. Detox from these substances may require medical supervision, which is not available on-site at Westview. Westview may also refer residents to an outside detox if they have serious health problems that could lead to complications during withdrawal or if the on-site detox process has not been successful with the resident in the past.

Role of staff in working with residents

The role of staff is to focus on connecting with the residents, building trust, and developing relationships. Relationships are seen as the key to engaging with the residents.

Staff have frequent contact with each resident. If residents don't come downstairs to circle check[8], staff will knock on their door 3 times and enter. Staff also dispense medications to residents on a daily basis. They are pro-active and work to engage residents throughout the day.

Staff need to have a certain approach and philosophy of life. They need to:

- Embrace psychosocial principles of rehabilitation
- Be skilled
- Know how to take care of themselves
- Be accepting and tolerant
- Have problem solving skills
- Be able to work in a team
- Have emotional intelligence

When interviewing staff to work at Westview, Phoenix asks behaviourally-based interview questions. Individuals who are task or goal oriented may not be best suited for the work.

Westview staff focus on psychosocial rehabilitation. They aim to serve as a role model and help residents get their needs met. Their approach is to be supportive – not judgmental or critical. For example, residents are not "punished" for not following rules. Westview staff also look at what motivates people. They help residents with self-evaluation. For example, staff might ask "how do you think you can you get what you want" and "how does your behaviour affect your ability to get what you want?"

Westview recently introduced an incentives program as an experiment to encourage residents to engage more actively in Westview programs. So far, the approach appears to be working. Residents who participate in programs at least 50% of the time or more are eligible to go out for "pizza night" or brunch, or can be eligible to be hired to do janitorial work. Residents may be eligible to go on a special outing if their participation in programs is "exemplary". Westview has also identified 17 tasks that residents are expected to work on.[9] For each task where competency is achieved, the resident may choose a celebration: small gift for everyone ($2.50 per person), pizza party, or ice cream party, up to a $25 limit.

[8] A meeting at 9:30 every morning. Residents receive a positive thought and discuss their plans/goals for the day.

[9] Areas of competency include: acceptance of substance use disorder, acceptance of psychiatric disorder, periods of sobriety, periods of psychiatric stability/symptom management, completed stepwork, self regulated recovery plan, medication management, budgeting, apartment care, self care, health care, healthy lifestyle, daily structure, interpersonal skills, sense of purpose/meaning. Taken from a document prepared by Phoenix Residential Society, *2005 Clinical Conferences, Hosted by Mental Health and Addiction Services Regina Qu'Appelle Health Region, What we have learned so far: Implementing Better Practices in the Westview Dual Diagnosis Program,* March 10, 2005.

Legal issues

Not applicable because use is not permitted on the premises.

2.5 Exits from housing and/or programs

Voluntary move-outs

The maximum length of stay at Westview is 3-5 years. Most clients stay an average of 2-3 years. Once residents have completed the program they must move out of their housing unit. If they wish, they may receive outreach assistance from staff at Westview or may be referred to the Phoenix Apartment Living Services (PALS) or Phoenix Housing and Support Services (PHASS) programs (described on page 1). Former residents may also continue to attend Alcoholics Anonymous, Narcotics Anonymous and other group meetings on site. If they are part of one of the other Phoenix programs, they may participate in some of the leisure and recreational activities as well.

A discharge plan is developed for all residents who leave the program. This plan is developed by the case manager, key worker, and staff from PALS, together with the resident. They discuss where the resident wants to go, what activities they want to do, and what services they want to receive. Most clients want to participate in the PALS program, and they are given priority among all applicants to the program.

Some residents who have left Westview moved to another city, others moved back home with their families, while others moved out with someone else from Westview and shared a house.

Regardless of the reasons for leaving Westview, Westview keeps the door open. They maintain good relationships with those who move out so they can always come back if they would like to.

Evictions

Reasons for an eviction would include:

- Bringing alcohol and drugs into the building repeatedly;
- Violence; and
- Not participating in the program/activities.

There are very few occasions when Westview has required someone to move out. It is more likely that a resident will decide to leave – that the program is not for them.

2.6 Services

Approach to service delivery

Phoenix follows an approach to service delivery based on best practices (according to Health Canada and Psychosocial Rehabilitation Canada) and an integrated approach in the delivery of both mental health and addictions services. This means that the services delivered by Westview staff are intended to address both mental health and substance use issues concurrently.[10]

Types of services

Mental health and addictions services

Westview staff provide the following mental health and addictions services on site: psychosocial rehabilitation (to help residents achieve their goals), medications management, group work and individual counseling, crisis intervention and relapse prevention. This is hands-on direct service, provided on-site 24 hours/day. In addition, each resident is assigned to a key worker. The caseload ratio is one worker to 5 residents.

Each resident has his/her own individual program plan. Residents are expected to meet with their key worker once a week to review their plans. A team that includes the program supervisor, key worker, resident, and perhaps case manager, generally meets once a month to review the plans.

Services also include:

- In house, non-medical detox
- Support recovery groups, including in-house Alcoholics Anonymous and Narcotics Anonymous meetings, relapse prevention, problem solving and holistic personal growth groups
- Formal addiction assessments
- Training to help develop social and independent living skills
- Outpatient counseling
- Recreational and social activities (to provide an alternative lifestyle to substance use)
- Support to family members

Some of the goals at Westview are to help residents:

- Learn to identify the effects of substance on their mental health symptoms
- Identify the underlying reasons for their substance use, consequences of substance use, and alternatives to substance use
- Develop relapse prevention plans

Westview also conducts referrals to other programs and services off-site. For example, Aboriginal residents may be referred to culturally-based programs.

[10] For example, when providing counseling services, staff would address both mental health and substance use issues.

All clients must be under the care of a psychiatrist from the Regina Qu'Appelle Health Region. This could be either a private psychiatrist or one who works at the Mental Health Clinic. The Mental Health Clinic provides case management services, and residents see their case manager at the clinic about once/month. Residents also receive injections of their psychiatric medications at the clinic.

Westview residents can also access a number of outside addiction-related treatment services, including outpatient day programs at Alcohol and Drug Services and withdrawal management at local detox centers.

Money management

Westview helps residents budget their money and tries to help them become more financially responsible. Most residents negotiate a daily or weekly allocation of their funds, while a few receive their income on a monthly basis.

Changes in services

Phoenix introduced the PHASS program about four years ago to provide support to eight individuals in the community who have particularly challenging behaviours. Westview residents who leave prematurely are now able to receive ongoing support through this program.

Over time, the harm reduction approach has become a bit more front and centre. For example, while all clients are expected to have abstinence as their goal upon admission, Westview will continue to work with a resident who has resumed their substance use longer than they might have in the past. Westview staff may continue to work with the resident as long as he/she is not interfering with the progress of the other residents. Rather than abstinence, the goal might be to help the resident use less. The system of incentives is also a new initiative, introduced in June 2004.

Most effective services

Phoenix believes the most effective service they provide at Westview is the 24 hour on-site staff. They believe the target population really needs the staff to be there.

Connections with community programs/agencies

Phoenix has an arrangement with the Salvation Army that the Salvation Army will accommodate a resident who is suspended from the Westview Program in their hostel. This arrangement provides an alternative to discharging the person. It gives the resident some time to think about what they want and to come up with a plan.

Phoenix also has close working relationships with the Regina Mental Health Clinic, Addiction Services, local detox services, and the mental health unit of the Regina Hospital.[11]

[11] It is interesting to note that the Mental Health Clinic has a financial worker on site. Most of the Westview residents in receipt of income assistance were able to access their benefits through a financial worker at the Clinic.

2.7 Staffing and personnel issues

The Westview program has the equivalent of 7.6 full time staff, including administrative support. Current staff positions include:

Current staffing	Ideal staffing
1 Executive Director (part-time, shared among all the programs).	N/a
1 Program Supervisor	N/a
2 Key Workers	N/a
10 Casual staff	N/a

During the day, one to three staff are on duty at any one time. This includes one casual staff person (available 10 a.m. to 1:00 p.m.) and one key worker. The program supervisor may also be on-site.

There is always one staff person on duty at Westview on weeknights and on weekends

There is 24 hour on call support via the Program Supervisor and crisis response services from the Mental Health Clinic.

Phoenix believes this level of staffing is adequate.

Staff burnout

Staff burnout has not been identified as an issue at Westview.

Policies for hiring formerly homeless individuals

The majority of staff at Westview have a history of substance use and are in recovery. Phoenix believes these individuals benefit the program. The organization believes it is important to hire staff who are able to see life through the eyes of the people they are providing services to.

Westview also plans to expand their peer support services. They would like another person to help plan more recreational activities, spend more one-on-one time with a resident if they have a particular issue, facilitate more group work, and encourage greater resident participation in Westview programs. Westview would also like the peer support worker to facilitate greater resident participation in the decision-making process at Westview, e.g. through a resident advisory board.

Professional development

Phoenix makes professional development and staff training a priority. They send staff to external training programs and conferences and provide in-house training sessions once a month. All full-time staff are expected to come to the monthly training sessions.

Phoenix staff may participate in training sessions provided by the Health Region, and may invite Health Region staff to their own training sessions.

Staff who are sent to external training sessions are expected to share what they learned with others upon their return (e.g. during an in-house training session).

A few examples of training topics include:

- Psychosocial rehabilitation
- Best practices in concurrent disorders interventions
- Non-violent crisis intervention
- Reality therapy and choice theory
- Suicide intervention training
- Addictions
- Medication management
- Personality disorders
- Eating disorders

2.8 Funding

Reporting period for Westview 2003-2004

Source of revenue	**Amount**
Health District Grant	$292,613
Client User Payments*	$67,082
Trustee Fees**	$7,958
Other (Interest etc.)	$389
Total	**$368,042**

Costs	**Amount**
Staff salaries and benefits	$220,524
Building expenses	$76,832
o Rent ($55,860)	
o Utilities ($5,093)	
o Care of building/grounds ($13,322)	
o Insurance ($1,502)	
o Equipment and furniture etc. (1,055)	
Office expenses (office rent, maintenance, telephone etc.)	$14,041
Transportation	$12,133
Food/supplies	$10,569
Training and education	$9,289
Recreation/education	$8,083
Purchased services	$4,475
Housekeeping	$2,642
Promotion/publicity	$168
Medical supplies	$143
Miscellaneous	(59)
Total costs	**$358,840**
Per diem	$93

*The Provincial Government, through Social Services, pays Phoenix $585/month for each resident in receipt of income assistance, to cover the rent and all expenses related to the building including the furniture, supplies, laundry, utilities, common room, and a damage deposit. Residents who are not receiving income assistance must pay the $585 out of their own funds.

** Phoenix serves as a financial trustee for most of the residents. In addition to sending Phoenix an amount for the rent, Social Services sends Phoenix a monthly cheque for each resident in receipt of income assistance for their basic living allowance, and other amounts that they may be entitled to (e.g. special diets). Phoenix deducts the amount for the rent (i.e. $585), pays any other bills the resident may have, and provides the rest to the resident or the key worker to manage on behalf of the resident. Phoenix receives a trustee fee for managing these funds.

Funding for Westview has been stable. The organization has grown and expanded over the years.

3. Outcomes, challenges and factors for success

Phoenix defines success for the Westview Dual Diagnosis Program as:

- Improved quality of life for the residents;
- Reduced use of acute care resources;
- Collaboration and cooperation with the Regina Qu'Appelle Health Region and other agencies in the community, such as the Canadian Mental Health Association, Partners in Employment, Salvation Army, and Addiction Services; and
- Providing an integrated service delivery approach to mental health and addictions, and showing that this can be done.

Phoenix believes its program has been successful and has served to improve the quality of life for the residents and their families. In addition, health care professionals report that the health of their clients has improved as a result of being involved in Westview.

In 1997, the Westview program was identified as a Best Practice in Mental Health Reform by Health Canada.[12] Their program has a great reputation in the community and is being recognized nationally. They are seen as having expertise – practical information about how to serve the target population. People come to them for mentorship – to develop programs for their clients.

Some organizations have questioned Phoenix about the length of time for the Westview program. They say, "3 to 5 years – isn't that a long time"? Phoenix responds that it has taken people 30 to 40 years to get to where they were when they entered the program, and it takes a long time to change. Moreover, Phoenix believes there is a need for long-term follow-up services to continue even after a resident leaves Westview. While Phoenix does not have any specific numbers, they believe that most of the people who graduated from their program and are living successfully in the community continue to receive ongoing support (e.g. through the PALS program, approved homes and other follow-up from the Mental Health Clinic).

[12] *Best Practices in Mental Health Reform, Discussion Paper prepared for the Federal, Provincial, Territorial Advisory Network on Mental Health.* 1977. See Chapter 5.

3.1 Impact of the program on residents

Phoenix reports that they have no ability to measure program outcomes, although work in this regard is on the horizon. Nevertheless, they believe their program has had the following outcomes:

Outcomes	**Examples of Changes**
Residential stability (e.g. length of time housed)	Unstable living before. More stable once involved with the program.
Use of emergency services	Fewer inpatient hospitalizations and use of emergency services.
Substance use (e.g. decreased use/participation in treatment programs?)	Much less use. Decreased involvement in detox and other treatment programs.
Mental health	Increased medications compliance.
Physical health	Better health. Better access to health care and medications.
Employment and education	Only one current resident is employed. Two are in pre-employment, and one is working towards a BA.
Income	Better financial picture. Incapable of working before. Opportunity for training and education. Can get training allowances.
Improved self care	Better self care
Personal networks (e.g. more contact with family, new friends)	Better contact with family – including parents, siblings and children.

3.2 Resident satisfaction

Resident satisfaction surveys have not been undertaken recently.

3.3 Reasons for success

Phoenix believes the top 2-3 reasons for the success of Westview are:

1. The way in which staff work with the residents and are able to connect with them. Staff are flexible, creative, look at the needs of each client, and provide support as needed. Staff treat the residents with honesty and respect. This gives residents a positive experience. Even after they leave Westview, former residents feel a connection to the place. They often phone and stay in touch with the staff. Some continue to attend some of the group meetings and participate in activities. Westview staff believe that the ongoing connection helps former residents continue with their recovery. If they need help, they know they can always come back.

2. Setting abstinence as a goal.

3. 24 hour staffing.

4. Follow-up with former residents – if they wish, through outreach provided by Westview or the PALS program. Even clients who leave Westview prematurely and who still

struggle with their mental health and substance use issues are able to receive assistance through the PHASS program.

5. The positive experience while at Westview. This positive experience changes the way most residents view substance use and their mental health issues. While at Westview, they have fun, see another way of living, develop better relationships with their families, and develop new friendships with the other residents and people they meet in the support groups. Staff are positive role models. Residents see staff don't have much money either, and are in recovery, yet they are leading happy and productive lives. Westview can instill hope that change is possible, and gives the residents more skills than they had before. This makes it easier for them to find their place in society.

3.4 Challenges

Underlying issue of poverty makes it difficult to make fundamental life changes

While Phoenix believes the Westview program has achieved the goals originally intended, they state that social issues, such as poverty and a lack of good quality affordable housing, lead to apathy and a lack of hope. These are barriers to recovery. Phoenix believes there is a need for:

- Greater political will, leadership and direction to address the needs of people with concurrent disorders;
- More programs that use a psychosocial rehabilitation approach (look at people's strengths and focus on recovery); and
- More community-based programs.

Phoenix notes that for some residents who never had a job or healthy relationship, long-term success is more difficult to achieve. Even when they recover, it is hard for them to find their place in society. It can be difficult for them to imagine a better life and this can lead to despair.

Stigma associated with concurrent disorders

Westview believes that one of the biggest barriers to recovery for individuals with concurrent disorders is the stigma they face from society as well as from mental health professionals. A significant number of mental health professionals have a negative attitude toward people with concurrent disorders and have low expectations about their ability to function in the community and their prospects for recovery.

On the other hand, Westview has experienced tremendous support from the Mental Health System in Regina and the Mental Health Clinic. They generally work together well and have good communication. Westview believes that the more mental health and addictions professions work together the better.

Insufficient funding

Phoenix notes that while their funding has been stable, they need more resources to maintain programs and staff. The salaries they can afford to pay their staff are low compared to what other employers can offer. This makes it difficult to attract and maintain trained professional

staff. Phoenix tries to balance their low wages with good working conditions such as flexible hours.

Community support

Although providing housing to individuals with a concurrent disorder can lead to complaints from the neighbours, this did not happen with Westview. Phoenix took over an existing rental building and did minor renovations. They went about their business as quietly as possible, and did not seek permission from the neighbours. There was no need for a rezoning. The building is supported by the neighbourhood and is viewed as a bright spot. Westview staff speculate that this may be because the population living in Westview is no different from the people who lived there before, and the neighbours may appreciate the 24-hour staffing. There have been no conflicts with any of the neighbours. The nature of the neighbourhood may also play a role – it is not exactly "prime" real estate.

3.5 Lessons learned

The agency key informants had the following advice for other organizations that might be interested in creating a program to address the needs of people with concurrent disorders in their own communities:

1. Be as professional as possible. This includes doing your homework and being organized. Review the literature and Best Practices. Check other programs. Document and articulate your program ideas. Be perceived as experts in the field. Be committed to excellence.

2. Consult/communicate with anyone who has anything to offer. People want to feel consulted and considered. This helps them take ownership.

3. Don't reinvent the wheel. See what is working already.

4. Make sure you have sufficient resources to do staff training.

5. Have an evaluation plan to measure outcomes from the start, and track outcomes from the start.

6. Involve people who are going to be hired from the beginning. Give them an opportunity to take ownership before the residents move in.

References

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Contact: **Carole Eaton**, Executive Director, Phoenix Residential Society, or **Ann Marie Piniach**, Supervisor, Westview Dual Diagnosis Program Phoenix Residential Society 1770 Halifax Street Regina, Saskatchewan S4P 1T1	Phone: 306-569-1977 Fax: 306-569-1986 E-mail: phoenixsociety@accesscomm.ca

Mainstay Residence: Sponsored by Main Street Project Inc.	Winnipeg, Manitoba

1. Background

This case study features the Mainstay Residence, a transitional housing program provided by Main Street Project Inc. in Winnipeg. It also includes a description of the Co-occurring Mental Health and Substance Use Disorders Initiative (CODI) underway in Winnipeg and some discussion of how this initiative affects the ability of Mainstay residents to access services. The case study was prepared based on interviews with staff from Main Street Project Inc., the Winnipeg Regional Health Authority, and additional written information provided by the key informants.

1.1 The sponsor

Main Street Project Inc. has been operating since 1972. Its mission is to provide a safe, respectful and accessible place for individuals at risk in the community, advocate for a more inclusive society, and assist marginalized individuals to make real choices. The Main Street Project works with individuals in the City of Winnipeg who are in need and unable to function due to substance use, mental health issues, injuries, abuse and/or homelessness. Their role is to assist these individuals through their periods of crisis and support them to make the best possible choices.

The Main Street Project provides a variety of services, including:[1]

24 Hour crisis intervention: Includes a drop-in centre, transportation to medical appointments, direct crisis work, and a night-time van patrol.

Emergency shelter: Can accommodate 58 people who need a safe place to sleep at night.

Detoxification centre: 25 beds for individuals requiring supervision and assistance during substance use withdrawal (non-medical).

Intoxicated Persons Detention Area: A locked facility with 20 cells for individuals apprehended by the Winnipeg Police under *The Intoxicated Persons Detention Act*.

Transition Services Team: A multidisciplinary team that specializes in counseling, advocacy, relapse prevention, housing, money management, assessment, case planning, life skill development and community outreach.

Project at a glance	
Sponsor name	Main Street Project Inc.
Goals	Provide a safe place where residents can receive support, stabilize, and develop plans to re-establish themselves in independent housing in the community.
Target population	Men and women with a history of substance use, mental health issues or co-occurring disorders (substance use and mental illness) and/or are at risk of homelessness.
Housing tenure	Transitional housing
Number of suites	34 beds in 28 rooms
Factors for success	• Relationship between staff and the residents. • Ability of staff to engage the residents. • Longevity of the Main Street Project and trust in the organization.
Location	Winnipeg, Manitoba
Project start date	1993

[1] Materials provided by Main Street Project Inc. re proposal for additional staffing, December 6, 2004.

Mainstay Residence: Provides 34 beds of transitional housing (featured in this profile).

Individuals may pass through all the different services provided by Main Street Project, starting with the Intoxicated Persons Detention Area, moving to the Detox, perhaps staying in the Mainstay Residence, and then moving to independent housing in the community. Some people move through some or all of these services on a recurring basis.

1.2 Program goals and history

The Mainstay Residence was built in 1993 with funding from Canada Mortgage and Housing Corporation and the Manitoba Housing Authority. It provides supervised transitional housing for men and women who are unable to function in the community or who wish to stabilize their lifestyles to achieve greater independence in the community. Most of the residents have a history of substance use, mental health issues or a co-occurring disorder (substance use and mental illness) and/or are at risk of homelessness. The goal of the Mainstay Residence is to provide a safe place where residents can receive support, stabilize, and develop plans to re-establish themselves in independent housing in the community.

2. Program Description

2.1 The people

Mainstay Residence had 174 admissions in 2004. In April 2005, 20 people were living there. This included 16 men (80%) and four women (20%). All the residents were 23 to 50 years old.

About 60% of the residents were Aboriginal, 36% were Caucasian, and 4% were a visible minority. About 40% of the residents had concurrent disorders, 30% had a substance use issue, and 20% had a mental health issue. The remaining 10% of residents were dealing with other issues.

Most of the residents (84%) were receiving income assistance, 10% received a combination of income assistance and employment income, 2% received most of their income from employment, and 4% received their income from other sources such as a pension or family.

Main Street Project reports that this profile is fairly typical of the people Mainstay has served over the last three years. However, Mainstay, also serves transgendered individuals, and is starting to receive more applications from younger people (18 to 30 years old).

Most of the residents with mental health issues have schizophrenia and a borderline personality disorder. They often display a continuum of behaviours. The rest of the residents with mental health issues often have a bipolar or general anxiety disorder. Many residents have complications from long histories of substance use. Some have histories of suicide attempts and a few have brain injuries and Fetal Alcohol Syndrome (FAS).

2.2 The housing

The Mainstay Residence has 34 beds in 28 rooms. There are 22 private bedrooms and 6 rooms that are shared. The bathrooms are shared. Women are housed on a separate floor. Meals are provided in a community dining room. The building also includes laundry facilities. Mainstay Residence is a dedicated building adjacent to the Main Street Project facility that accommodates all the Main Street programs and administration offices.

The length of stay varies for each resident depending on their goals. The average length of stay is 3-5 months. If an applicant is waiting to get into a treatment program, it is expected that they would be a shorter-term resident (e.g. less than 5 months). It is expected that residents with concurrent disorders will require more time to achieve their goals, and that they would stay for about 6-12 months.

Mainstay is not a place for people whose only need is housing. All new residents moving into Mainstay are required to develop a plan.

At the same time, it should be noted that a few residents have been at Mainstay for several years. Main Street Project has found that housing options for these individuals are particularly limited, and they have nowhere else to go. Mainstay has become their community.

2.3 Access to the program/housing

Most of the Mainstay residents are referred from Main Street Project's detoxification facility, while others are referred from the drop-in centre or emergency shelter.

Mainstay also receives referrals from other agencies in the community, such as hospitals, transition houses for women fleeing abuse, and addictions treatment programs. Walk-ins/self referrals are also accepted.

Sometimes a treatment facility will refer a client to Mainstay who is in the treatment program but is unable to comply with the requirement to remain abstinent. Other times, an applicant wants to enter a treatment program. However, because a person can stay in Detox for 10 days, and most programs require 30 days sobriety, some people apply to Mainstay so they can receive support and accumulate more "clean" time. Some people apply to live at Mainstay following treatment but before they are ready to live independently in the community.

It can take 2-3 days to process an application. Each application is reviewed by Mainstay staff, a Transition Services Team member, the Manager of Transition Services and Crisis staff, where necessary and feasible. This allows for consideration of a wide range of issues and an informed decision.[2]

[2] Main Street Project Inc., Annual Report 2003-2004.

Mainstay staff meet with each applicant to review the Mainstay house rules and discuss what will be expected of applicants once they are housed. For example, some residents may be required to take specific medications.

In selecting residents, staff aim to create a balanced community. They look at the dynamics and vulnerabilities of each resident and applicant. Some of them have long histories with each other, and it important to take this into account when considering an application. For example staff would not want to house an applicant if he had sexually assaulted one of the existing residents in the past.

Because of the limited staffing at Mainstay, if an application indicates aggressive behaviour, additional information may be requested. This could include a review of medical history, case notes from other service providers, discharge notes from other facilities and criminal records.

Eligibility criteria

To be eligible to stay at Mainstay, applicants must be willing to pay $17.29 for room and board. Most applicants receive income through the welfare system or the Canada Pension Plan (disability), and can afford this amount.

Most of the residents at Mainstay need to be able to use the stairs. There are only a few rooms on the ground floor to accommodate individuals with mobility issues (e.g. who may require a walker or wheelchair).

Degree of "housing readiness"

Residents are expected to be able to bathe, feed and dress themselves, and use the washroom without assistance.

Program expectations

All residents are expected to be working on a plan to achieve positive change in their lives. It is expected that residents will be working on goals that could include:

- Stabilizing their lives;
- Connecting or reconnecting to mental health programs, addictions counseling, or other support programs/services in the community;
- Successfully completing an alcohol or drug treatment program;
- Changing drinking habits;
- Having less involvement with the law;
- Maintaining good psychiatric or medical care;
- Reconnecting with family; and
- Being able to live successfully in the community.

All residents are expected to follow the house rules. These rules focus on treating other residents, staff, volunteers, visitors and the facility with respect. Residents are expected to refrain from loud and disruptive behaviour or abusive language. Violence is not tolerated under any circumstances. Residents are also expected to clean up after themselves, participate in chores as requested by staff, keep their rooms clean and in good order, take responsibility for personal hygiene (e.g. bathe or shower, and wash clothes on a regular basis) and respect rules about visitors and curfew (11:00 p.m. on weekdays and 1:00 a.m. on weekends).

Residents that have a medical prescription for their mental illness are required to take their medications as prescribed.

Program demand

Mainstay does not maintain a waiting list for its program.

2.4 Substance use issues and policies

Substance use

Applicants to Mainstay have a history of using a wide variety of substances including alcohol, marijuana, crack cocaine, and prescription drugs. A history of sniffing solvents (e.g. paint and paint thinner) is also common as is drinking products such as hairspray and mouthwash. Some clients have died from drinking hairspray.

Main Street Project is finding an increase in the use of cocaine and crystal meth, and Mainstay is receiving an increasing number of applications from a younger group of people who are addicted to crack. These individuals are more affluent than Mainstay's traditional client group. The parents are desperate for assistance.

People with a history of solvent use can be among the most difficult to work with. The use of solvents damages the central nervous system. People who sniff solvents become unsteady on their feet. Sniffing also causes cognitive brain damage. It is particularly difficult for this group to access resources because very few are targeted to serve them. Also, most programs involve group work, and it is particularly difficult for individuals with a history of solvent abuse to participate in these groups because of their cognitive limitations. Even if individuals with a history of solvent abuse are able to access specialized treatment programs, there are no resources in the community to help them continue with their recovery. Main Street Project's strategy is to get these individuals into Detox as often as possible and to try and keep them safe.

Main Street Project has found that for people with concurrent disorders, complications can arise when the psychiatric medications are not compatible with the substances they are using. Substance use often interferes with the prescribed medications. Staff also note that persons with concurrent disorders often have a history of involvement with the criminal justice system; lack life skills and social skills; have poor hygiene; and have

difficulties with anger management, which complicates their lives and makes it difficult for them to live in the community.

Policies and approaches relevant to housing the target group

Use of substances

Drugs, alcohol or inhalants of any kind are not permitted in the rooms or common areas of Mainstay.

Residents are expected to be abstinent or working towards abstinence.

Any resident who causes a disturbance as a result of substance use is required to sleep in the shelter or the Intoxicated Persons Detention Area for a night. If a resident uses substances repeatedly, staff will discuss the possibility of the resident being discharged.

Residents will be discharged if they sell drugs on the premises.

Security measures

Staff monitor everyone who comes and goes in the building.

Guests

Visiting hours are from 2:00 p.m. to 4:00 p.m. and 7:00 p.m. to 9:00 p.m. Visitors are not permitted in the lounge area or client rooms, but are expected to visit in the dining area. Sometimes, residents ask staff to prevent certain people, including family members, from visiting.

Conflicts among residents

Any resident experiencing conflict with another resident is expected to address this directly with the fellow resident in a respectful and non-threatening manner. If the resident is uncomfortable with this or is unsuccessful, the resident is expected to inform Mainstay staff or Transition Services Team staff.

Strategies to address relapses

If a resident has used substances, is intoxicated, and is causing a disturbance, he/she will be required to sleep in the shelter or the Intoxicated Persons' Detention Area for a night.

After the effects of the substance have worn off, the resident will be required to meet with Mainstay staff or their Transition worker before being allowed to return to their room.

Repeated use of substances may result in a discharge.

Residents who are abstinent

Residents looking for a totally alcohol and drug free environment can find it a source of conflict if other residents are using drugs, alcohol or other substances.

Role of staff in working with residents

Mainstay has one staff person on duty at all times – 24 hours a day. Their role is to:

- Provide supervision;
- Ensure that Mainstay rules and regulation are followed, especially in regard to alcohol and drug use;
- Deal with "on the spot" issues that may arise with the residents;
- Observe any changes in behaviour among the residents (e.g. check to see if they are acting differently from what is normal for them);
- Log the comings and goings of all residents;
- Store medications and remind residents to take their medications as prescribed; and
- Assist with daily living skills as necessary.

Legal issues

There have been some isolated incidents of police "bothering" clients who use solvents or drugs. Main Street Project staff report that their clients are afraid of some police, but feel save with others.

2.5 Exits from housing and/or programs

Voluntary move-outs

Mainstay is considered a stepping stone, and expects most residents to move out within a few months or a year – according to their plans. Some residents may decide on their own that they want to leave before accomplishing their goals. Others may require hospitalization or the services of a crisis stabilization unit.

Residents can continue to receive services from Transition Services Team staff after they move out.

Most of the shorter-term residents leave Mainstay to enter a treatment program. Elderly residents often go to a personal care home or residential care facility. Others return to where they lived before, go to a rooming house, a shared living situation or a hotel. Some of the individuals with concurrent disorders go to a residential care facility, a room and board situation, or may leave the province. Some may move to an independent living situation, but they will usually get evicted within 6 months.

Evictions

Residents could be asked to leave the program prematurely for violating the house rules and for disregarding their plans.

Staff would try to prevent the premature termination of services by speaking with the resident and trying to find ways to address the problems. A discharge is never taken lightly.

Incidents of violence and repeated violations of the drug/alcohol rules and any other conduct that places other people at risk will be taken very seriously and may result in an immediate discharge.

2.6 Services

Approach to service delivery

The model of service delivery for Mainstay residents includes the following:

- 24 hour on-site staffing;

- Individual assessment and counseling provided by Main Street Project's Transition Services Team. This is a multidisciplinary team that specializes in counseling, advocacy, relapse prevention, housing, money management, assessment, case planning, referrals, life skill development and community outreach. Residents have the opportunity to work with a primary transition worker to examine their lives, identify areas of change and develop a workable plan for change.

- Mainstay is also a designated site for implementation of the Winnipeg Regional Health Authority's Co-occurring Mental Health and Substance Use Disorders Initiative (CODI). Residents with mental health issues and concurrent disorders have access to a Community Mental Health Worker employed by the Winnipeg Regional Health Authority. This person has received specialized training to work with individuals with concurrent disorders. A description of CODI is attached to this case study.

Types of services

The following services are provided to Mainstay residents.

Housing services – provided by Mainstay staff

Mainstay provides room and board; laundry facilities; access to a free phone; and basic toiletries.

One staff person is on duty 24 hours a day, 7 days a week to provide supervision,

stability, and security for the residents. They are available to deal with issues as they arise and also provide personal assistance in the following areas as required:

- Serving meals;
- Storing and monitoring residents' medications;
- Arranging transportation to important appointments; and
- Arranging the public trustee to handle residents' affairs where appropriate.

Counselling and case management – provided by Main Street Project

Transition Services Team. Everyone in Mainstay is attached to a member of the Transition Services Team and has a primary transition worker assigned to them. They provide case management services to help the residents achieve their goals. Transition Services Team staff often link their clients to services outside the program to get them ready to move out of Mainstay. Specific types of services include:[3]

- Advocacy on behalf of clients to help them access services and appropriate levels of service;
- Assessments to determine service needs of clients;
- Counselling for clients to address personal issues and those relating to abuse, addiction grief etc.;
- Cultural services, for example, clients of First Nations ancestry have access to sweats, Elders and other culturally appropriate resources;
- Goal setting to help clients develop their own specific action plans;
- Housing referral to help clients access appropriate and safe housing;
- Life skills development to help clients develop the sills needed to live independently;
- Money management to help clients develop skills to effectively manage their funds – upon request; and
- Support to help residents engage in activities of personal interest (e.g. computer skills training, fishing, reading, movies, gardening, and other recreational activities); and

Transition Services staff also provide outreach to maintain contact with their clients after they leave Mainstay and are living in the community. It is estimated that they maintain contact with 60-80% of clients in the first month after they move out of Mainstay. The length of time they will continue to provide support varies from client to client. They may continue to provide support for a few years. The frequency of contact varies depending on need.

Other services at Main Street Project. Residents at Mainstay may also use the other services provided at the Main Street Project, including the drop-in centre, Detox and even the emergency shelter if necessary.

[3] Transition Services brochure, Main Street Project Inc. Annual Report 2003-2004, and proposal for additional staffing, December 6, 2004.

Mental health and concurrent disorders – provided by the Winnipeg Regional Health Authority

A Community Mental Health Worker employed by the Winnipeg Regional Authority provides services on-site at Mainstay 2 half days a week (7 hours/week). This person is responsible for working with all the residents who have a mental illness and concurrent disorder. Her responsibilities include consulting with the staff and working with the residents as needed.

The exact nature of her work with the residents depends on the needs of each individual, their cognitive abilities, level of functioning, and interests. The Community Mental Health Worker helps clients access services they need, including consultation with a psychiatrist, addictions counseling and treatment.

Other services in the community

Mainstay residents are also able to access other services in the community.

Changes in services

One full time Occupational Therapist and one part time Therapeutic Activity Worker were hired in the summer, 2005 to help residents gain the skills they need to be able to sustain themselves in the community (see staffing).

Most effective services

All are essential.

Connections with community programs/agencies

Main Street Project has a formal working relationship with the Winnipeg Regional Health Authority – Mental Health Services. They also have informal connections with a wide variety of agencies who serve clients who would benefit from Mainstay, including the Addiction Foundation of Manitoba. While Alcoholics Anonymous and Cocaine Anonymous run groups at the Detox, Mainstay residents do not attend these meetings, but rather attend meetings held off the premises as a way to get used to living in the community. In addition, Mainstay clients can be at a very different stage in their addiction or recovery compared to clients at the Detox.

2.7 Staffing and personnel issues

Current staffing at Mainstay includes having one Attendant Staff person on duty 24 hours a day, seven days a week.

As noted previously, residents also have access to Main Street Project's Transition

Services Team and the part time community mental health worker employed by the Winnipeg Regional Health Authority.

During the summer of 2005, Main Street Project received funding to hire additional staff to work with the Transition Services Team. These included:

- One full time Occupational Therapist – to provide assessments and specialized supports to Mainstay residents; and
- One part time Therapeutic Activity Worker to assist clients in the utilization and development of daily living skills.

Main Street Project staff had identified a need for this additional staffing because they were finding that a significant number of individuals who left Mainstay were unable to maintain independence in the community. They reported that out of 142 clients who stayed at Mainstay in a 12 month period (2003-2004), 56 had resided at Mainstay more than once. The majority of these 56 had been admitted twice, but one individual was admitted 7 times.[4]

Anecdotal evidence and a review of case files indicated that the main reasons clients returned to Mainstay were:

- Lack of life skills leading to eventual loss of accommodation and subsequent homelessness;
- Underdeveloped coping skills that limited the individual's ability to address life stressors and resulted in a decreased sense of safety and competency; and
- Low self-esteem and subsequent lack of assertiveness leading to an increased need for advocacy and assistance to access community services.

The specific goals for the additional staff are to:

- Increase the residents living skills, independence, and quality of life while reducing their vulnerability to homelessness;
- Provide clients with positive, successful experiences thereby increasing self-esteem, interpersonal skills and sense of personal power;
- Provide clients with skill based opportunities to decrease boredom, promote social interaction, movement and positive change; and
- Develop micro-economic development opportunities for clients.

In addition, Main Street Project staff would like to be able to have a nurse practitioner or doctor on site to help ensure that their clients receive proper medical care.

Staff burnout

N/A

[4] Proposal for additional staffing, December 6, 2004.

Policies for hiring formerly homeless individuals

Main Street Project has hired people with histories of homelessness and/or substance use. They report that there were more successes than failures. They also point out that agencies should require these individuals to have achieved some stability in their sobriety. For casual employment and volunteer work, Main Street Project requires at least one year sobriety.

Professional development

All staff receive basic training in first aid, Cardio Pulmonary Resuscitation (CPR), suicide prevention, and non-violent crisis intervention. Some staff attend workshops to improve communication skills and learn more about conflict resolution. Transition Services Team staff attend training session in addictions, stages of change, motivational interviewing, and case management.

Main Street Project is also a designated training site for CODI, and staff have received training on concurrent disorders.

Staff have identified a need for more training about street drugs such as cocaine and crystal meth, and in how to respond to medical emergencies.

If staff identify a training program that they are interested, they can put in a request to attend. Main Street Project has a professional development budget for such activities. Staff may also attend training sessions provided by the Winnipeg Regional Health Authority. Main Street Project notes that one of the biggest barriers to attending training sessions is not the cost of these sessions but the cost of replacing staff who attend them.

2.8 Funding

Reporting period 2003-2004

Source of revenue	**Amount**
City of Winnipeg – grant (client services)[5]	$112,259
United Way of Winnipeg – grant (client services)	$101,950
Province of Manitoba – per diem (residential component)[6]	$71,530
Province of Manitoba – per diem (client services)	$56,798
Other – per diem (residential component)	$14,187
Other – per diem (client services)	$7,891
Manitoba Housing Subsidy (residential component)	$68,150
Transfer from MHA (client services)	$12,000
Total	**$444,765**

[5] Refers to staffing for Mainstay residents.
[6] Refers to all the costs associated with operating the facility.

Costs	**Amount**
Wages and benefits – (client services)	$263,733
Wages and benefits – (residential component)	$12,000
Purchased materials and services (client services)	$77,212
Purchased materials and services (residential component)	$111,905
Amortization of capital assets (residential component)	$10,270
Mortgage interest (residential component)	$57,817
Total	**$532,937**
Excess (deficiency) of revenues over expenses	($88,172)
Per diem costs	$43

Residents pay $17.29 per day for room and board.

Main Street Project identified several funding concerns: The City of Winnipeg reduced their budget by 10% in 2004; and per diems are attached to the client and don't cover the actual costs of running the facility. Main Street Project had identified a need for additional staff to make Mainstay successful, and was able to access this additional funding in 2005.

3. Outcomes, challenges and factors for success

The Main Street Project defines success for Mainstay as being able to provide a place where the residents feel safe, supported, and able to make progress in achieving their goals. Staff say that Mainstay has been very successful in this, and it is no small accomplishment.

In the past, most of Mainstay's residents lived there on a long-term basis. Most of them had been deinstitutionalized, ended up on the street, and had very limited options for living in the community. Mainstay has shifted its focus to provide more of a transitional housing program. Their goal is to help residents stabilize, achieve goals, and move on. In this regard, Mainstay notes that they have not been as successful as they would like. While residents often achieve the goals set out in their plans, most are unable to maintain these positive changes when they move out. Main Street Project believes their new staff (Occupational Therapist and Therapeutic Activity Worker) will help Mainstay residents acquire the necessary skills to be able to live independently in the community. Main Street Project staff also hope that the additional staff will also make it possible other members of the Transition Services Team to spend more time in the community with residents who have moved out.

Outcomes related to (Co-occuring Mental Health and Substance Use Disorders Initiative (CODI)

Main Street Project staff have identified the following outcomes from being involved in CODI.

1. Increased understanding. Staff at Main Street Project have a long history of working with people with concurrent disorders.[7] Staff believe the training they received as a result of CODI has given them a better understanding of the types of issues their clients deal with and a better understanding of the reasons for certain behaviours. As a result, they are able to be more patient and supportive. For example, prior to receiving the training, staff may have assumed that a certain behaviour was due to substance use. Now, they are aware that the client could be having a problem with his/her psychiatric medications, or another health issue.

2. Better access to resources. The community mental health worker reported having greater success in accessing resources for clients with concurrent disorders. CODI has helped to "open doors". It is easier for clients to access mental health counseling, psychiatric services, and psycho-geriatric assessments than in the past. However, Main Street Project staff still find it difficult to help clients access resources - including treatment programs, and believe more services are needed in the community to serve individuals with concurrent disorders and a history of solvent abuse.

3. Less "ping ponging". Clients are still falling through the cracks - but less often. Before, staff would refer clients to services, but the services would say that the client was not appropriate, and refer them somewhere else. Now, the Community Mental Health Worker is able to call an addictions service agency and make the connection. The staff at different agencies have a better understanding of what services each agency can provide and what each agency requires before they can provide service. For example, it is more clear that "Mental Health does this, Addictions does that, and in order to provide service, they need….."

4. More knowledge and better service. As a result of their training, staff know more about the impact of different drugs. This makes it easier for them to discuss the medication needs of their clients with their doctors. For example, staff can tell the doctor about the various substances the client is using so this can be considered when determining the appropriate prescription for psychiatric medications. Staff can ask about alternatives. They now know that some medications are OK if a mental health client is using substances while others aren't.

5. Better networking and communication. One of the CODI initiatives involved organizing roundtable/networking meetings among those working in the field. This began a process where Mental Health and Addictions staff could get to know

[7] They used to refer to these individuals as having a dual diagnosis, but with CODI, they now use the term "co-occurring disorders".

each other and talk more. The result is a more concerted effort to brainstorm to find solutions for people with concurrent disorders. Another spinoff is that Main Street Project is more connected to a wider range of resources provided by the Winnipeg Regional Housing Authority, including their housing portfolio.

6. New strategies. Staff are learning new ways to work with people with concurrent disorders. Some of their strategies now include working with their clients to look at the negative outcomes of their substance use. For example, if a person is going to court often, staff can point out some of the reasons for this. They can also work with clients to help them shift to substances that may be less harmful.

3.1 Impact of the program on residents

Main Street Project has not had sufficient resources to track and evaluate program outcomes. However, now that they have been able to hire additional staff, they plan to do this. This will include documenting program outcomes for residents while they are at Mainstay and after they leave.

Main Street Project has observed that most of their residents do very well while they are living at Mainstay. They "thrive". Some achieve a level of stability and success that they never had anywhere else. There are some success stories. For example, one person used to sniff paint and wouldn't talk to anyone. He now talks. Another client had used cocaine for 10 years, went to the Main Street Project detox, lived at Mainstay, participated in recovery meetings, and got a job one year later. This person continues to be very involved in Cocaine Anonymous and sits on the Main Street Project's Board of Directors.

The following anecdotal information is available about how Mainstay affects the lives of its residents. Information is not available about what happens to residents after they leave Mainstay.

Measures of Success	**Outcomes**
Residential stability (e.g. length of time housed)	Most residents who come to Mainstay are able to stabilize during their stay. However, while one of the program's goals is to give clients the skills and support they need to achieve residential stability in the community after they leave, a significant number of people who leave Mainstay are not able to maintain themselves in the community for very long. Being able to live somewhere for 6 months is a major accomplishment. It is hoped that the new/additional staffing will help address this situation.
Reduced substance use and increased safety re use	Many residents in Mainstay decrease their substance use or decrease the harms associated with their substance use. Some become abstinent while at Mainstay or enter treatment after they leave.
Mental health	While at Mainstay, residents are compliant with their medications. They experience reduced hospitalizations, improved self-care and hygiene.

Physical health	While at Mainstay, the health of residents improves. Residents are encouraged to take care of their medical and dental needs. Meals are provided, so residents eat better and more nutritious meals, which also helps their health. Residents can also get home care if they need it.
Employment	Getting a job is one of the main goals for some residents. A few are employed. Main Street Project helps people connect to work opportunities. Some residents are definitely employable, but they can lose their jobs if they go through a crisis.
Income	Staff at the Main Street Project (detox and shelter) help clients access income assistance. Other residents are able to increase their incomes through employment.
Personal networks (e.g. more contact with family, new friends)	Staff help residents strengthen existing relationships and build new ones. This can take a while. Some have no family. Some are disconnected as a result of residential schools. Many residents with concurrent disorders are disconnected from their families.

3.2 Resident satisfaction

N/A

3.3 Reasons for success

Main Street Project staff believe the main reasons why residents are able to stabilize while at Mainstay are the:

1. Relationship between staff and the residents.

2. The ability of staff to engage the residents (particularly the community mental health worker, crisis staff and transition services team staff).

3. The longevity of the Main Street Project. Some clients have a long history with Main Street. They trust the organization and it gives them hope.

3.4 Challenges

Insufficient resources for Mainstay clients

One of the main challenges for helping Mainstay residents achieve long term success in the community has been a lack of resources. To address this issue, Main Street Project sought additional funding. They were successful and have just hired a full-time occupational therapist and part-time therapeutic activity worker.

High need clients

Mainstay has been challenged by an increasing number of younger (18 to 30 years old) crack users who can create significant problems in the building. They are generally more affluent than Mainstay's traditional clients and are usually disrespectful. Some have drug induced psychoses and can make the more mature residents crazy with their behaviours. However, there are no other places for them to go. Some come through the detox and are waiting for treatment. Others come because they have lost their housing.

Lack of resources for clients after treatment

Main Street Project reports that they can help their clients access treatment, but are unable to provide a sufficient level of support after they return. They come back to Mainstay – to the same friends and neighbourhood - and lose everything they gained in treatment. Many want to change their lives, but are not able to. Main Street Project believes there is a need for alcohol and drug free transitional housing in a different neighbourhood, where people can live after they complete treatment.

NIMBY

Main Street Project reports that they never had a problem with NIMBY because they located their programs where the clients already were.

3.5 Lessons learned

1. Residents should have access to a multi-disciplinary team, based on the Assertive Community Treatment (ACT) model, situated within the Main Street Project that can provide a high level/intensive services to residents to help them develop the skills for independent living while at Mainstay and to provide ongoing support after they leave.

2. In order to implement the systems changes required to make CODI a success, agencies need to make a long term commitment to the process. There is also a need for ongoing coordination, training and sufficient resources to address the needs of people with concurrent disorders.

Contact: Lainie Neal, Executive Director Main Street Project Inc. 75 Martha Street Winnipeg, Manitoba R3B 1A4	Phone: 204-982-8244 Fax: 204-943-9474 E-mail: lneal@mainstreetproject.ca

Co-occurring Mental Health and Substance Use Disorders Initiative (CODI) Winnipeg Region

Background

In the spring of 2001, the Winnipeg Regional Health Authority, Addictions Foundation of Manitoba, and Manitoba Health initiated the Co-occurring Mental Health and Substance Use Disorders Initiative (CODI).

These agencies recognized that individuals with co-occurring mental health and substance use were often poorly served in both mental health and substance abuse settings. The result was over-utilization of resources in criminal justice, primary health care, child protection, and women's and homeless shelter systems.[8]

Some of the barriers to services that were identified include:[9]

- Difficulty diagnosing a dual disorder;
- Most programs are not designed to accommodate dual disorder clients;
- Lack of specialized services and cross-trained clinicians;
- Differences between Mental Health and Substance Abuse treatment philosophy and methods;
- Lack of common assessment language between the Mental Health and Substance Abuse systems; and
- Organizational and funding barriers to service collaboration.

Goals

The vision of CODI is to improve outcomes for persons with co-occurring mental health and substance use disorders in Winnipeg. The mission is to provide welcoming, accessible, integrated, continuous and comprehensive services to this same target population.[10]

In practice, this would mean that regardless of where someone goes for assistance, their issues would be dealt with. That door should be the door to a full range of mental health and addictions services. Ideally, staff would conduct an assessment to identify the person's needs, and then move them to the right door. The motto of CODI is that there is "No Wrong Door".

Developing an Integrated System

The CODI planning group decided to develop a system of Integrated Services. They considered two different approaches:

[8] Co-occurring Mental Health and Substance Use Disorders Initiative, Winnipeg Region, October 2004
[9] Presentation prepared by Barry Fogg.
[10] Winnipeg Region CODI Framework January 2005.

Program Integration: where treatment is carried out by an integrated, multi-disciplinary team working within the same program setting; and

Systems Integration: where service providers are linked across programs and systems to facilitate welcoming, comprehensive and continuous services.

The planning group decided to proceed with the Systems Integration approach. As a next step, the planning group hired international consultants Drs. Kenneth Minkoff and Christie Cline. They adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model developed by Dr. Minkoff.

The basic assumptions of this CCISC model are that:

- Mental health and addiction programs do not have to change dramatically to serve people with co-occurring disorders;
- Programs do not need to be fully integrated or fall under unified administrative authority to be effective in delivering integrated services; and
- Clinicians trained in either mental health or substance use treatment do not have to become experts in both specialties, but they do require a basic level of competency in the field that is not their specialty.

Key Principles

The following key principles were adopted for CODI:

1. Co-occurring disorders are an expectation, not an exception. This means that whenever a client with a co-occurring mental health and substance us issue appears in the system of care, they should be able to access the services they need. There is No Wrong Door.

2. Clients should be able to establish empathic, hopeful, integrated and continuous relationships. The course of treatment should include continuous, integrated and unconditional relationships that last over multiple treatment episodes.

3. Individuals with co-occurring disorders can be organized into four sub-groups with a combination of needs that range from high to low severity of psychiatric symptoms and high to low severity of substance use.

4. Supportive case management needs to be balanced with empathic detachment. Supportive case management includes an assertive intervention that ensures clients receive essential components of care. Empathic detachment is a technique that focuses on helping clients accept responsibility for their own recovery.

5. When mental health and substance use disorders co-exist, both conditions need to be addressed as primary disorders.

6. Mental health and substance use disorders are both persistent bio-psycho-social problems that have parallel phases of recovery and stages of change. It is important to recognize that an individual may be in one phase of addressing the mental illness, but in a different phase of addressing the substance use disorder.

7. There is no one correct program of intervention. Service responses need to be individualized to match client needs – based on diagnoses, stage of change, level of functioning, strengths and level of care required.

8. In treatment planning, outcomes for clients need to individualized and flexible. Substance use outcomes need to include incremental harm reduction as well as abstinence options. With harm reduction, interventions are geared to movement from more to less harm, with an emphasis on immediate and realizable goals. The eventual goal may be abstinence, but the user does not have to begin this way.

Achievements to date:

- Agreement to participate by all Winnipeg Regional Health Authority Mental Health Programs, Addiction Foundation of Manitoba, and ten other independent mental health and addiction programs.

- Training completed for a group of 40 designated trainers who are responsible for assisting in the knowledge transfer process within their own and in other mental health and addictions programs in Winnipeg

- Creation of the CODI Interagency Network. Mental health and addictions clinicians meet regularly to discuss challenges, identify solutions, and explore ways to improve the coordination of services.

- Manitoba Health has introduced this initiative to other regional health areas across Manitoba.

- Training modules have been prepared. They address nine areas of clinical competency topics related to serving individuals with co-occurring disorders.

- Manitoba Health identified deliverables as to what is expected from agencies serving individuals with concurrent disorders. These deliverables address issues such as: the percentage of staff who have completed training and evidence that the agency has adopted policies and procedures consistent with the CODI principles.

Contact: Barry Fogg, Mental Health Addiction Services Development Specialist Winnipeg Regional Health Authority 401-189 Evanson Street Winnipeg, Manitoba R3G 0N0	Phone: 204-940-1695 Fax: 204-940-2644 E-mail: bfogg@wrha.mb.ca

Project Name: Housing and Supports Peel (HASP) Sponsored by Supportive Housing in Peel (SHIP)	Peel Region, Ontario

1. Background

This case study has been prepared based on an interview with senior staff from Supportive Housing in Peel (SHIP) and Peel Addiction Assessment and Referral Centre (PAARC), with additional written information provided by SHIP.

1.1 The sponsor

Supportive Housing in Peel Inc. (SHIP) has been in operation since 1984, and in 1992 formally divested from the Canadian Mental Health Association. The original mandate was to serve people with severe mental illness.

SHIP's mission is to optimize the quality of life for individuals with mental illnesses in Peel and West Toronto by providing housing and community based services. SHIP is the sponsor organization for Housing and Supports Peel (HASP), a program delivered through a partnership with PAARC and five other agencies.

Besides HASP, SHIP runs five other programs:

- Supportive Housing Etobicoke York (SHEY), an initiative in West Toronto focusing on individuals living with serious mental illness who are homeless or at risk of homelessness;
- Core Program which consists of two group homes and various Independent Living units throughout the community.
- Rent supplement program;
- Volunteer program; and
- Centralized intake program.

Project at a glance	
Sponsor name	Supportive Housing in Peel
Goals	Eliminate homelessness for people with serious mental illness and provide them with suitable accommodations and the necessary counselling supports.
Target population	Clients with severe mental illness who are homeless or at risk of homelessness.
Housing tenure	Long term, permanent housing
Number of units	218
Factors for success	▪ Spirit of cooperation among partners ▪ Generosity among partnering agencies ▪ Flexibility in the program ▪ Communications protocol ▪ Adequate program funding
Location	Peel Region
Project start date	2000

The Homeless Initiative in Peel, also known as Housing and Support Peel (HASP) is the focus of this case study.

1.2 Program goals and history

The goal of HASP is to eliminate homelessness for people with serious mental illness and provide them with suitable accommodations with the necessary counselling supports. The housing component is managed by SHIP and agency partners provide services to individuals housed through SHIP. The partners are: PAARC, Peace Ranch, Trillium Health Centre, India Rainbow Community Services, Centre for Addiction and Mental Health, Canadian Mental Health Association/Peel.

When money became available through the Mental Health Homelessness Initiative (Phase 2) funded by the Ontario Ministry of Health and Long Term Care, Peel agencies collaborated to submit one proposal rather than each agency preparing a submission. The waiting list for social housing in Peel numbered 12,000, and two to three percent of applicants on this list were identified as living with serious mental illness. Agencies assumed that many individuals with mental illness were hidden and not reflected by the waiting list data. Individuals living in shelters could not be moved due to their mental illness and substance use: they had become perpetual residents, unable to work or maintain housing. Many other individuals with serious mental illness were seen to be at risk due to substandard housing or insecure housing arrangements.

A primary concern among agencies was the lack of housing and services for individuals with concurrent disorders. Other concerns included providing services for people from the South Asian community and those with a dual diagnosis who required mental health and housing supports. SHIP took a lead role in talking to agencies to determine who they could partner with for this funding opportunity. This collaborative process served to further enhance communications with mental health agencies, addiction programs, hospitals and organizations serving the dual diagnosed. SHIP found that PAARC's holistic approach to addictions with a harm reduction philosophy and acceptance of all models of change towards wellbeing complemented their own philosophy to optimize health and wellbeing. SHIP's partnership with PAARC would allow for individuals with concurrent disorders to be housed and supported with individualized services. PAARC provides case managers, direct service and consultation for clients with concurrent disorders.

2. Program Description

2.1 The people

All service recipients housed and supported through HASP live with mental illness, and about 40 percent have a concurrent disorder. Twenty five individuals have dedicated services for their concurrent disorder.

Five percent of service recipients have a dual diagnosis. The proportion of clients with dual diagnoses and concurrent disorders has remained constant over the past three years. The mental health challenges most commonly seen among HASP clients are:

schizophrenia, manic depression (bi-polar), personality disorder, depression, obsessive compulsive disorder, and anxiety disorders.

While most service recipients are single and a majority are male, 17 families and couples have been housed since the program began. Ninety five percent of households receive income assistance through the Ontario Disability Support Plan (ODSP) with five percent receiving social assistance.

The age range for HASP clients is 23 to 50, with more clients at the older end of this range. Less than 50 percent of individuals in the program are from a visible minority group. While SHIP does not currently have data on the ethnic and cultural background of clients, they do note ten or more individuals being from the East Asian community.

2.2 The housing

HASP provides 218 units of permanent housing with supports available specifically for their clients through SHIP. Each tenant signs a housing agreement that specifies that they are both client and tenant with associated supports to assist them in recovery. If the relationship between HASP and the client breaks down, SHIP would make every effort find appropriate services including providing support through its own program.

The units are self contained and vary in size to accommodate individuals and families. The housing is of a quality that encourages tenants to stay over the long term.

Thirty units are in three low rise buildings owned by SHIP, and 188 units are available through rent supplement agreements, for a total of 218 units. SHIP has lease agreements with various private and non-profit housing providers in Peel Region.

Individuals housed in the rent supplement units pay rent based on their income or the maximum shelter allowance permitted by ODSP. For the building owned by SHIP, the rents are set at a level to cover the operational costs of the building, while remaining affordable to tenants on fixed incomes.

2.3 Access to the program/ housing

Individuals may be referred to HASP by an agency or they may refer themselves. There are no restrictions on who can fill out the application. Typically a support worker with an agency fills out the application for their client. Referrals come from community mental health clinics, general hospitals, psychiatrists, and community agencies.

Upon receipt, the referral package is reviewed by the central intake coordinator who follows up with the applicant if additional information is required. The application is then reviewed by a mental health worker, addictions worker or concurrent disorders committee. In some cases joint assessments involving both the mental health and addictions workers are undertaken if support needs of the individual are unclear. After an assessment of lifeskills, level of service required, and risk, a recommendation goes back to central intake. Once approved, the application goes to SHIP to find housing, and at this

point the individual would be on a waitlist. At the time housing is offered, support services are in place.

Eligibility criteria

To be eligible for housing and supports with HASP, applicants must:

- Have a primary diagnosis of a serious psychiatric illness and be assessed as needing and able to use a supported housing program;
- Be homeless or at imminent risk of homelessness;
- Be an adult, resident of Peel region or have an established support system in Peel Region or the west end of Toronto;
- Have a source of income to meet financial requirements;
- Be willing to learn the skills necessary to maintain a home;
- Consent to the sharing of information between partner agencies; and
- Have completed the application form and arranged for a psychiatric report.

Reasons an applicant may be denied access to the program:

- the individual's needs are too high and cannot be addressed through the services; and
- being in the program would put the individual at further risk.

Degree of "housing readiness"

At time of housing, individuals must have enough of a skill base to manage initially on their own as their workers assist them to develop additional skills needed for living on their own.

Program expectations

The expectation is that service recipients participate in developing a better lifestyle for themselves. In this sense, the requirements of the program are highly individualized. Clients establish goals related to their own needs.

Service recipients are not required to become or remain abstinent, nor are they required to take their medications although it is recommended. Addressing non-compliance around medications is a goal for HASP in working with a client. Part of the uniqueness of HASP is its flexibility to work with a client over a long period without the pressure to discharge the individual for non-compliance. As long as the individual is willing to accept support services, he or she can remain in the program.

Program demand

As of September 2005, approximately 200 people on the waiting list for housing through SHIP have been flagged for the HASP program. Of those, staff estimate that 20 percent or more have a concurrent disorder or a substance use issue that is serious enough that the individual needs to have a dedicated substance abuse worker.

2.4 Substance use issues and policies

Substance use

The most common substances used by people entering HASP are alcohol, marijuana, crack cocaine, prescription drugs, with some individuals also using heroin. Some use of hallucinogens and amphetamines, including ecstasy, are also evident. Staff do not report changes in the types of substances used by their client group over the past three years.

In discussing substance use among individuals with concurrent disorders, staff identified a number of challenges and responses that emerge in working with clients.

The side effects of prescription drugs for mental illness are intense. Many people will seek relief from the side effects through alcohol and marijuana, and may find it difficult to strike a balance between alleviating side effects and not abusing a substance to the point that the effectiveness of the medication is compromised.

For HASP, there is concern about the health risks to clients who use opiates and injection drugs. Other challenges surface when clients are selling drugs (eg. crack cocaine) as a way to make money.

Clients who use crack cocaine can spiral down quickly as compared to those with addictions to alcohol and prescription drugs who can go for a longer period without noticeable changes. The highly addictive nature of crack cocaine, and the inability among many users to sustain the drug can mean they go into withdrawal (for example during the last two weeks of the month before the income support payment comes). Or clients may experience a lot of angst about not having the drug available as a tool for coping. When this situation emerges, PAARC increases the number of visits with the client, helps the individual find solutions to his or her situation such as planning more at the beginning of the month, spreading substance use and money out over the whole month, or visiting a detox centre. PAARC works with the medical profession to look at how drug therapy can ease withdrawal and can arrange for a client to be hospitalized if the situation is serious.

PAARC's focus in providing service as part of the HASP partnership is to help people deal with their substance use and mediate the harmful effects. Clients, however, can end up with mixed messages: supports such as family and abstinence based programs often take a different view. An individual's use of substances can bar him or her from some services and programs. PAARC steps up the support to individuals banned from other programs.

Another problem identified by PAARC among HASP clients is the mixing of too many different types of drugs. The result can look like the individual is going through psychotic episodes.

Individuals with concurrent disorders require more care and support than clients with mental illness only. When working with individuals living with mental illness, there are many models to work from in providing support and fostering self awareness. With

concurrent disorders, often the individual does not have the ability to develop insight into his or her own behaviours and responses, hence insight-based therapy can have little or no impact. In addition, the referral destinations for this population are limited.

Mental illness can sometimes mimic a substance abuse problem and the reverse is also true. As a result in looking at symptoms, it can be difficult to determine what is really happening for the individual.

Individuals with personality disorders present different kinds of challenges. In approaching a client to provide support, consideration needs to be given to personality traits, type of mental illness and nature of substance use. The high level of support provided by PAARC can often seem like a poor fit with individuals with personality disorders who benefit from clear boundaries, and clear and precise messages. People with substance abuse issues, on the other hand, often do not function well with precise boundaries (including abstinence-based frameworks.) Consideration also needs to be given to the interplay of the medication for mental illness and the substance use of the individual.

Support to clients with concurrent disorders is provided by housing support workers on a one on one basis. HASP clients also have access to a lifeskills group.

Policies and approaches relevant to housing the target group

Use of substances
Service recipients are not monitored: they are treated like anyone living in a private residence. There are no policies at SHIP specifically related to substance use.

As with other landlords, SHIP does not tolerate substance use in common areas or drug dealing on the property.

Security measures
SHIP has mobile security staff and cameras installed at building entrances. Security measures can be increased as needed.

Guests
Long term guests are monitored, to ensure there are no contraventions of the lease or Ontario's Tenant Protection Act.

Conflicts among residents
Tenant support assistance and help being a good neighbour are part of the housing support services. Conflict resolution and mediation services are also available. SHIP holds landlord and tenant workshops to help inform tenants of expectations and the provisions under the Tenant Protection Act and provides a move-in package to all new tenants.

Temporary absence
SHIP has an absence from unit policy addressing the needs of clients who are absent for

medical reasons. Unique situations are addressed on an individual basis.

Strategies to address relapses
Not applicable, as there is no expectation of abstinence.

Role of staff in working with residents
HASP clients link with SHIP's housing staff largely within the framework of a landlord and tenant relationship with points of contact relating to tenant relations and responsibilities under the Ontario Tenant Protection Act. Housing staff consists of a housing coordinator who is onsite once a week at a scheduled time, tenant support worker who knocks on doors and interacts with tenants on an informal basis and is responsible for the settlement program. Housing staff have a protocol for understanding and dealing with issues that emerge with the tenants.

HASP clients link with PAARC and other agency staff for their support needs. This may be on a weekly or monthly basis, and more often if the individual's wellbeing is compromised.

Legal issues

In instances where there is contact between the police and HASP clients, the police generally work to de-escalate the situation without having to lay charges or take other actions. Through dialogue, the officers try to reach an agreement with the individual, for example related to concerns about drinking and driving or possession of a weapon.

The clients' perspective on the police is that the police are not supportive and 'hate them.' Some feel that the police tend to overreact. It appears that officers may feel more comfortable when a social service worker is also present. In this case the police are used as a backup, or as a safety support for staff or a vulnerable individual.

Senior staff explained that individuals who are vulnerable due to illness, homelessness, or who are in some way disengaged from supports can be targeted by drug dealers and coerced into carrying drugs into Canada from other countries. HASP has had clients involved in this type of illegal activity.

From the agency perspective, there are challenges inherent in maintaining client confidentiality and going to the police when community safety is at risk. The agency has a protocol about how much information can be shared. Staff and general community safety are other considerations for the agency partners with HASP.

2.5 Exits from housing and/or programs

HASP offers long term permanent housing, and therefore anticipates tenants will stay for a long period. In 2004, HASP had one discharge from its program. As of September 2004, the vacancy rate for the HASP program was 3.5 percent.

Voluntary move-outs

If an individual decides to move out, he or she can still continue to receive support services for mental health and addictions issues. In this case the person would be transferred to the core program offered by PAARC instead of receiving service under the HASP umbrella.

A service recipient who becomes abstinent may choose to move out. Housing support workers are available to provide support if the individual feels the current environment is unsafe, threatening or not in keeping with their plan towards harm reduction. The individual makes his or her own choices.

Evictions

Evictions occur as a result of violation of the Tenant Protection Act, for example when building safety is jeopardized or illegal activities are taking place on the premises. As the housing provider managing the unit within the HASP program, SHIP does have an eviction prevention program, and sees eviction as a last resort. Tenants who leave prematurely tend to end up in a shelter.

In the five years HASP has been operating, staff have seen a decrease in the percentage of voluntary exits over the past three to four years. In the past year, move outs occurred in less than five percent of units.

2.6 Services

Approach to service delivery

HASP takes a holistic approach to providing mental health and substance abuse services with a focus on reducing harm and improving the wellbeing of service recipients, informed by the principles of psychosocial rehabilitation.

Types of services

Mental Health

The core services are case management and housing support, including lifeskills teaching, home maintenance, crisis prevention and response, community orientation and liaison with the client's other supports or service providers. Case management services are provided on the basis of 1 case manager for 10 clients. These services are provided by the following agency partners: PAARC, Peace Ranch, Canadian Mental Health Association (Peel), and India Rainbow Community Services.

Substance Use

Services related to substance use include assessment, referral, case management, counselling and crisis intervention. These services are provided by PAARC.

A variety of strategies are used to encourage participants to focus on reducing harm to

themselves and improving their well being. Staff look at individual needs and tailor services to meet those needs, while drawing from various models of care and 'best practices' approaches.

Clients access support services on an as-needed basis, with some services available onsite and others offsite. Evening and weekend services are not provided through HASP, however, clients can obtain assistance through Mobile Crisis of Peel.

The mental health and substance use services available through HASP are funded by the Ontario Ministry of Health and Long-term Care.

Individuals with concurrent disorders do have access to programs that focus on developing lifeskills and social skills. These are available through PAARC.

Changes in services

When HASP began, the concurrent disorder part of the program was supported by one housing support worker and one outreach worker, who were supplied by PAARC. As the program evolved, the outreach worker position evolved into a community support worker position and then became housing support. Clients with concurrent disorders within HASP are now supported by two housing support workers.

Most effective services

Senior staff noted the following as key features of HASP that make it possible for clients to keep their housing:

1. Housing is carefully tailored to the needs of the individual;
2. Housing is linked to support services with a harm reduction approach; and
3. An eviction prevention program is in effect to help the HASP clients stay housed.

Connections with community programs/agencies

HASP is a result of formal agreements between the following agencies:

- SHIP is the lead agency and provides the housing. SHIP coordinates access to the housing and supports, meetings of the agency partners, and program evaluation requirements and is responsible for day to day administration of the program. SHIP also provides support to clients with a dual diagnosis.
- PAARC provides case managers, direct service and consultation for clients with concurrent disorders.
- Peach Ranch, Trillium Health Centre, India Rainbow Community Services, SHIP, and Canadian Mental Health Association/Peel provide support for maintaining housing, community orientation, setting up units, lifeskills teaching, crisis prevention and response, and liaison with the client's other supports or service providers. India Rainbow Community Services also offers diversity training and consultation for housing support workers as required.

- Centre for Addiction and Mental Health provides specialty expertise for individuals with a dual diagnosis. Services include partnering with housing support workers, multi-disciplinary consultation, education, training, bridging support, and network development for resources and supports.

The program has access to psychiatry and linkages with the mobile crisis team in Peel, hospital Emergency Department, food banks, local detox centre, and justice of the peace. A joint management committee, operations committee and policy and procedure committee bring together the partners as needed.

2.7 Staffing and personnel issues

The table below shows the current staffing in 2005 compared to the ideal level of staffing they would like to have.

Current staffing for HASP	**Ideal staffing**
Housing Services (SHIP) ▪ Housing Coordinator: 1 FTE ▪ Director: .5 FTE ▪ Administrative Assistant: .5 FTE ▪ Tenant Relations: .75 FTE ▪ Central Intake Coordinator: .75 FTE Support Services: ▪ Trillium Health Centre (South): 5 FTE (with one acting as team leader with small caseload) ▪ Trillium Health Centre (North): 5 FTE (with one acting as team leader) ▪ PAARC: 2 FTE ▪ CMHA (Peel Branch): 1 FTE ▪ India Rainbow: 1 FTE ▪ Peace Ranch: 1 FTE ▪ SHIP: 2 FTE **Total: 21.5 FTE**	▪ More administrative staff ▪ Capacity to add to staff dedicated to concurrent disorders

Staff Retention

A key staffing challenge is to retain staff. Support workers and case mangers working at other agencies often have higher wages.

Staff Burnout

Burnout in this field is always an issue. With the development of the program, implementation of protocols and clearer admission parameters, staff turnover is decreasing, and currently little staff turnover is experienced.

Policies for hiring formerly homeless individuals

While HASP does not have policies about hiring formerly homeless individuals or individuals with a history of substance use, PAARC has a policy that those with a history of addictions must demonstrate they have been stable for a period of two years.

Professional Development

One half day per month is dedicated to staff training. Topics include: Tenant Protection Act, CPR, risk assessment, working with offenders with developmental disabilities, working with offenders with a concurrent disorder, and lifeskills. In addition, sessions are provided on particular mental illnesses.

2.8 Funding

The following summarizes annual revenue and expenses for HASP as of March 31, 2005.

Source of revenue	**Amount ($)**
Rental Income	922,320
MOHLTC	1,405,408
Rent Supplement	634,000
Total	**2,961,728**

Costs	**Amount**
Labour	1,149,474
Operating	255,934
Payments to Landlords	1,556,320
Total	**2,961,728**

3. Outcomes, challenges and factors for success

Senior staff feel the program has been entirely successful and has achieved its goals.

3.1 Impact of the program on residents

Senior staff at SHIP and PAARC outlined a number of outcomes of the program to date.

Measures of Success	Outcomes
Residential stability (e.g. length of time housed)	Long term housed achieved. Low unit turnover.
Increased safety in substance use	The harm reduction approach teaches clients to use more safely (e.g. use clean needles and properly use a crack pipe). It also highlights the effects of using at different times of the day.
Mental health (eg. maintaining medication, reduced hospitalizations)	Staff report an overall reduction in hospitalizations for service recipients over time and improved mental health.
Income	The program assists many clients to go from having no income source to obtaining some form of social assistance or disability support.
Improved self care and reduced high-risk behaviour	Staff report improvements in clients' ability to care for themselves and choose less risky behaviour.
Personal networks (e.g. more contact with family, new friends)	Staff report clients do strengthen their personal networks, including more contact with family and friends.

It is difficult for staff to assess whether substance use decreases with the program as they have no baseline information for tracking over time. For some clients, the program and supports reduce the stigma about substance use and make it easier for the individuals to admit to using. While some clients make significant progress towards reduced substance use and improved well being, others struggle constantly.

3.2 Resident satisfaction

Results from a survey of 18 tenants who attended a workshop in January 2004 indicated the majority of respondents are satisfied, very satisfied or extremely satisfied with:

- How well maintained their building is;
- How safe they feel coming and going from their building;
- How safe they feel within their units;
- The sense of cooperation among their neighbours; and
- How cooperative and accessible staff are.

3.3 Reasons for success

Spirit of Cooperation: Partners work together in problem solving which results in creative solutions. Further there is recognition and appreciation of various agency mandates, and the working style is one of inclusion not exclusion.

Generosity among the partnering agencies: An example of this is demonstrated by agencies with unexpected year-end surplus dedicating that money to clear up rent arrears among HASP tenants.

Flexibility: All partners keep flexibility in mind when working with clients and each other. Flexibility in the program and supports has allowed some clients with complex needs to stay in existing units.

Communication: An established communications protocol has insured partners have a clear understanding of common issues.

Funding: HASP has access to adequate program funding.

3.4 Challenges

SHIP and its partners identified a number of challenges to implementing this initiative, as well as strategies for addressing these challenges.

1. *Pressure outside the partnership to acquire and fill units quickly in the beginning.*

This resulted in HASP accepting and moving in service recipients before the individuals were truly ready for long term housing. The HASP agencies then realized that some individuals who had been accepted were not appropriate for the program. To address this, a number of changes to the program were made:

- An intake and assessment process was fully developed and implemented;
- Sufficient time was allowed for the service recipient to become housing ready;
- Housing readiness was defined and the eligibility criteria tightened; and
- Acquisition of new units is delayed until service recipients are assessed and ready to move-in.

2. *Rent arrears developed quickly.*

The result was large amounts of debt accumulated and a reduction in the number of units in the total portfolio. As the housing provider, SHIP realized that service participants did not have an understanding of the need to pay rent nor the consequences of rent arrears. HASP did not have a protocol in place to quickly resolve rent arrears. Strategies to address this included:

- Developing a tight protocol between SHIP and partner agencies to deal with rent arrears;
- Establishing rent re-payment schedules with service recipients;
- Establishing a protocol with the province's social assistance and disability support programs to allow for direct payment of rent; and
- Requiring previous rent arrears to be paid before being housed (though there is some flexibility with this policy).

3. *Vacancy rates were higher than desired.*

Some units were left vacant because service recipients did not want them, and others were vacant because incoming service recipients needed to give two months notice before moving. In other cases, units were acquired before clients were ready to move in. Strategies to address this include:

- Acquiring units as service recipients are ready;
- Avoiding assumptions about the type of unit service recipients want or need; and
- Moving quickly to prepare and fill a unit when a vacancy is anticipated.

4. The link between permanent housing and support services can be difficult to maintain.

This challenge is illustrated by service recipients refusing support once they were housed or individuals no longer needing support after a period of time. Strategies to address this include:

- Thorough assessments to determine service recipients who really want and need support;
- Development of policy outlining expectations for admission to the support program and housing;
- Development of policy to discharge clients no longer wanting or needing support; and
- Embracing the recovery philosophy and recognizing that support is not always needed.

While NIMBY has not been an issue in buildings owned and managed by SHIP within the HASP partnership, the housing provider reports that there have been complaints about clients in the scattered units. These complaints typically relate to loud behaviour, music, knocking on doors, yelling, throwing things off balconies, sleeping or being intoxicated in hallways, allowing too many people into the unit, damage to unit or building, and volatile behaviour. Staff work with tenants to resolve issues as they emerge.

In some cases, neighbours in buildings with scattered units will target a HASP tenant through a series of complaints. A protocol and procedures are in place to follow up with both the tenant and the neighbours to resolve difficulties.

3.5 Lessons learned

1. Choose your partners carefully at the outset. Give consideration to how stable the management is and what the effects of changes in staffing could be down the road.

2. Have a memorandum of agreement between the partners, and make it a priority to review the agreement annually. Identify what the partners like and do not like. Find out how good the partners feel about the project.

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Contact: Laurie Ridler Executive Director SHIP (Supportive Housing in Peel) 969 Derry Road E. Unit 107 Mississauga, ON L5T 2J7	Phone: 905-795-8742 Fax: 905-795-1129 E-mail : laurie@shipshey.ca

Project Name: Housing with Outreach, Mobile and Engagement Services (H.O.M.E.S.) Sponsored by Good Shepherd Non-Profit Homes Inc.	Hamilton, Ontario

1. Background

This case study has been prepared based on an interview with staff from the HOMES program of Good Shepherd Non-Profit Homes, with additional written information provided by senior staff.[1]

1.1 The sponsor

Good Shepherd Non Profit Homes Inc. opened its first housing project in 1993. This social housing provider has its origins with Good Shepherd Centres, a faith-based organization operating in Hamilton for over 40 years and offering emergency assistance (food, clothing, and shelter) to individuals in need on a year round basis. Good Shepherd Centres also offer assistance with social and life skills, referral services, pastoral services and counselling.

Project at a glance	
Sponsor name	Good Shepherd Non-Profit Homes
Goal	Provide safe, secure, affordable and supportive housing for those with a history of homelessness and mental illness
Target population	Individuals living with mental health illness and who are homeless or at risk of homelessness
Housing tenure	Long term/permanent housing
Number of units	191 units
Factors for success	▪ Offering choice ▪ Flexibility and forgiveness ▪ Open and honest communication
Location	Hamilton, Ontario
Project start date	2000

In addition to sponsoring HOMES, Good Shepherd Non-Profit Homes owns and operates supportive housing serving individuals with special needs. Their portfolio includes:

- Emmaus Place, a 66 unit apartment complex for hard-to-house adults; (some HOMES units are in this building);
- Emmanuel House, a 10-bed palliative care residence;
- Taylor Apartments, housing families and individuals in 15 units;
- McGinty House, a 10 bed residence for men (all HOMES units);
- Mathias Place housing 28 single adults living with mental illness (all HOMES units).

[1] See references at end of this case study.

1.2 Program goals and history

HOMES has been in existence since 2000. The purpose is to provide safe, secure, affordable and supportive housing for those with a history of homelessness and mental illness. The program is funded by the Ministry of Health and Long Term Care under the Homelessness Initiative. The program was developed in response to changes in services provided by hospitals and a lack of new initiatives for people living with mental illness in the community.

In developing HOMES, Good Shepherd Non-Profit Homes knew that the challenge would be to house and support the 'hardest to house,' including individuals with concurrent disorders. Specific program objectives are to:

- Provide supports to tenants to maintain their housing and well-being and improve access to treatment and community services;
- Provide life skills and psychosocial support;
- Increase the 'wellness' of tenants;
- Provide contracted professional services as required;
- Provide peer support to tenants as appropriate;
- Provide coaching and support to tenants on volunteer, educational, and employment opportunities; and
- Provide crisis support and intervention to tenants.

The HOMES program is integrated with other services of Good Shepherd Centres in the following ways:

- Referrals to HOMES are received from shelters through the Street Outreach workers (who work through Public Health with some of their funding coming through the HOMES Program), and from hospitals, other mental health programs, community agencies, families, and self-referrals.
- HOMES tenants can be linked into the trusteeship program operating through the Good Shepherd Centres or the trusteeship programs run by 2 other Hamilton agencies.
- HOMES tenants can obtain clothing, personal and household supplies, linens and hot meals if they run out of money or need help setting up their household
- HOMES tenants can participate in the Christmas dinner organized through the Good Shepherd Centres which feeds 3000, and can receive gifts and Christmas food baskets through their holiday program.

2. Program Description

2.1 The people

Fifty five percent of HOMES tenants are single men, 34 percent are single women, and less than one percent are transgendered. Seven percent of tenants are couples and three percent are families with children. Forty eight percent of tenants are between the ages of 25 and 44; 34 percent are 45 to 54, and 13 percent are 55 to 64. Only 6 percent are 18 to 24. Almost 50 percent of HOMES tenants have a concurrent disorder.

Of 191 individuals who have received housing and supports through HOMES since September 2004:

- 4 (2 percent) identified as Aboriginal;
- 177 (92.7 percent) identified as English speakers;
- 3 (1.6 percent) identified as French speakers; and
- 11 (5.8 percent) had neither English nor French as their native language and would prefer to have service in a language other than English or French.

Staff report that in recent years HOMES has done more translation to meet the needs of clients from various ethnic groups (e.g. Vietnamese).

Nine percent of those served had criminal legal problems in September 2004; 5 individuals had been granted a conditional discharge (from a forensic order) and 12 were on probation.

For income, 79 percent receive assistance from the Ontario Disability Support Program, 15 percent receive social assistance, and 23 percent have a pension.

The following challenges are typical of the individuals served over the past three years.

Types of issues	**Number of clients**	**Percent of clients**
Mental health diagnosis	191	100 %
Concurrent disorder (mental health and substance use)	95	49.7 %
Dual diagnosis (developmental disability and mental illness)	17	8.9 %
Total clients served as of Sep. 04	**191**	

The most common mental illnesses reported among the tenants served through HOMES are categorized as:

- Schizophrenia and other psychotic disorders;
- Mood disorder;
- Personality disorder; and
- Anxiety disorder.

In addition, approximately 74 percent of HOMES tenants report having at least one significant physical illness. Most commonly reported are: arthritis/mobility, respiratory problems, back problems, gastrointestinal disorders, diabetes, and high blood pressure.

2.2 The housing

The HOMES program has 181 units of permanent housing with individualized supports. Some units are owned by the housing provider, and others are managed through a head lease:

- 55 units are within buildings owned by Good Shepherd Non-Profit Homes;
- 50 units are in social housing buildings owned by the Hamilton Housing Corporation; and
- 76 units are in private rental buildings scattered throughout the city. Good Shepherd has a head lease with the landlords and rent supplements make the units affordable to HOMES tenants.

The units within buildings owned by Good Shepherd range from bed-sitting rooms with own bathroom and fridge and common facilities such as lounges, dining room and kitchen to bachelor or one bedroom apartments with a community room shared with other tenants. The scattered units are bachelor, one, two, and three bedroom apartments. Of the 26 buildings with HOMES units, all have onsite laundry, many have an elevator, onsite superintendents and maintenance staff, and over one third have onsite office staff. All of the units are suitable for people to stay on a permanent basis and are conducive to individuals wanting to make a home for themselves.

2.3 Access to housing

The six top referral sources for HOMES are: hostels and shelters (18 percent); specialty psychiatric unit (15 percent); outreach team coordinated by Public Health (14 percent); family or friend (12 percent); self (12 percent); social services agency (10 percent).

HOMES does take individuals referred by the forensic unit of St. Joseph's Hospital: people charged with a criminal offence but found to be not criminally responsible. While housed through the HOMES program, these individuals continue to be seen by nurses and/or social workers and a psychiatrist from the out-patient forensics team. These tenants are still under an order from the Ontario Review Board but are allowed to live in the community at the discretion of the Review Board and the hospital administrator.

Once a referral is received, a screening phone call takes place to determine basic eligibility. Neither the applicant nor the referring agency is required to fill in forms.

At time of intake, the applicant is interviewed in person by the two Directors of the HOMES Program. The interview takes place at a location that is convenient for the applicant. The purpose of the interview is to discuss with the individual what is needed to meet his or her particular needs. The housing provider assesses what type of unit and

building and level of support are best suited to the individual as well as the person's level of wellness. The referring agency may also provide input into the assessment of needs and how best to respond. No formal screening tool is used during intake, and there is no committee process to review applications. Applicants receive immediate feedback about when they can expect to be housed.

Eligibility criteria

To be eligible for HOMES, individuals must have a mental health illness and be homeless or at risk of homelessness. The program embraces a broad definition of homeless and at risk, and accepts individuals with varying levels of need for support.

Individuals may be deemed ineligible if they do not need the supports that are offered with the housing or they will not benefit from the supports offered.

Degree of "housing readiness"

HOMES does not require a particular degree of housing readiness. Instead each applicant is assessed and the program works from whatever his or her skill level is.

At intake, applicants are asked about their interest in and ability to cook and clean for themselves. If an applicant says he just eats peanut butter sandwiches and pizza this is not held against him, nor is an offer of a unit withheld. Individuals who say they want to learn cooking, shopping, and cleaning skills are housed within one project where there are opportunities for teaching, group cooking and prompt and teach cleaning. Individuals who do not want to cook or clean, or who are unable, are housed in a higher support building where a hot meal each day is provided, breakfast club takes place on site and a personal support worker is available to assist tenants with hygiene and cleaning.

Collective kitchens are available so that all tenants have the chance to learn cooking skills. Recovery support workers and housing support workers all assist tenants at times to tidy, clean, and organize their apartments.

Program expectations

Abstinence is not a requirement or expectation of individuals accepted into HOMES. Instead the focus is on harm reduction: working with tenants to minimize harm to their physical health; minimizing risks to the individual's safety; educating about the supports that are available; and helping individuals make their own decisions.

Participants are not required to take their medication, although staff do encourage and help to facilitate responsible use of medications. The thrust is towards self awareness and education. Staff seek to develop a rapport with each individual and recognize the signs warning that the tenant is in trouble. The rapport between staff and HOMES tenants allows staff to talk frankly with individuals when their substance use increases and to point out how they respond when on or off medication. Staff put the responsibility back

on the tenant to take ownership in staying well.

Upon acceptance into HOMES, tenants sign a lease with Good Shepherd Non-Profit Homes as well as an agreement to use the HOMES support services. The supports are geared to the individual's needs and can include 1 to 4 onsite visits per month from the housing support worker. If at some point problems emerge with a tenant and he or she refuses to see the support worker, the agreement can be used as a tool to continue service during the difficult period.

Program demand

HOMES staff do maintain a waiting list. In December 2003, HOMES stopped accepting referrals, as the waiting list numbered 100. Since then, staff worked through this list, while taking the occasional urgent case (e.g. someone living in a car). Referrals were also accepted for specific types of units that could not be filled by those on the waiting list. A wait of over a year is not unusual. For HOMES the ideal is to do the intake within one month of the referral and to house the individual in the second month.

As of June 2005, 17 individuals were on the waiting list for an intake interview. (HOMES now does not permit the number to go above 20 at any one time). Six applicants have had an intake and are waiting to be matched with an apartment. Three have been matched with an apartment and are awaiting a move-in date. Five are housed within HOMES and are waiting to transfer to a preferred location.

2.4 Harm reduction and substance use

Substance use

Among the HOMES tenants, the most common substances used are crack and alcohol. Some tenants do smoke marijuana, however staff note that this does not appear to be debilitating for them. A small number of tenants are on methadone for an addiction to heroine and some use prescription drugs. Staff do not feel that there have been significant changes in the types of substances used over recent years.

One of the problems that results from substance use is financial hardship. With increased substance use, the individual may not attend to personal physical needs such as food and there can be increased reliance on food banks. Some food banks have limits on how often an individual can use them. Access to trusteeship programs and "pay direct" agreements from social assistance and the Ontario Disability Support Program have been critical to ensuring that rents are paid. These arrangements also serve as a "harm reduction" tool that limits substance use.

Another problem related to substance use is that some tenants will 'disappear' around cheque time. They will then re-emerge one or two weeks later and may need detox or access to a food bank. Addictions can mean that tenants part with personal possessions that they were proud of and may have a history of destructive relationships.

Staff are concerned for the physical health of individuals who are entrenched in their addictions. While there may be many things that can be done to improve physical health, the individuals need to be willing to keep medical appointments and reach out. Staff do offer to attend appointments with tenants.

HOMES staff have access to two psychiatrists who will consult with tenants over a short period, with a focus on looking at the impact of substance use on mental health. Attention is paid to the effect that alcohol and other drugs have on medications, and the realities of the person's life and substance use. Some problems can be resolved by changing medications or changing the time of day that medications are taken.

Individuals with concurrent disorders, as well as those with either mental health or substance use issues all need a non-judgemental, friendly listener: someone who will not be angry at them and will return to offer support even if they relapse.

A significant challenge for many individuals with mental illness is recognizing that medication may be helpful. A lack of trust, unhealthy coping strategies, and past difficulties with health care professionals can present barriers to accepting medication that may be helpful. If addiction is the coping strategy, then hard times can be particularly scary for the individual. Significant challenges face those who are working through dependency issues. From the support worker perspective, it is crucial to build rapport and a trusting relationship with the individual, to demonstrate patience and a willingness to 'be there' over the long term.

HOMES employs Recovery Support Workers who have personal and professional experience with addictions. Their insight, skills, and personal awareness can help others have a 'breakthrough.'. A Dual Recovery Anonymous group is offered to both tenants and the community at large that provides a 12-step model for discussion about both substance use issues and mental health symptoms. Housing Support Workers also help to link tenants to community support programs and interventions.

For many tenants, the Housing Support Workers are like a surrogate family that they don't want to let down. A time of relapse into old behaviours can bring a deep sense of shame to the tenants. In addition, a history of poor relationships can mean that mental health and addictions issues are intertwined. The solution then is not just medication or moving to a new location: tenants need to be supported in looking at how everything is interconnected and in developing new ways to cope.

Policies and approaches relevant to housing the target group

Use of substances

Use of drugs and/or alcohol in private living spaces is not a problem within HOMES nor does it contravene tenancy rules for the housing provider. The housing falls under Ontario's Tenant Protection Act, and use of substances is not a concern unless it interferes with the ability of others to enjoy or feel safe in their housing.

Dealing drugs in large quantities or drug related activities that resulted in a lot of traffic in and out of a unit would be concerns for the housing provider if complaints were received.

A tenant using alcohol or drugs in common areas inside or outside the building would be asked to take it to their own unit. A tenant selling drugs on the property would receive one or more warnings that this activity is grounds for eviction. If drug dealing did not cease then the housing provider would begin eviction proceedings.

Security measures
Two buildings which include units for HOMES tenants have staff onsite 24 hours a day. Other buildings have security staff on site. Video cameras are located in building lobbies and entrances.

Guests
If guests are quiet and the traffic generated from guests is during the day, then there are no problems with having visitors. Problems emerge when guests are involved in loud parties, yelling, and throwing things off of balconies.

The general rule is that tenants are not permitted to have long term guests (defined as more than 5 nights per month), although consideration is given to individual circumstances, such as a relative visiting from a distant place. Tenants who have partial custody of their children are permitted to have them stay for longer periods as well.

Conflicts among residents
When a tenant behaves in a way that disturbs others in the building, frontline staff speak directly to him or her. If further action is required the Director of Housing visits the tenant to discuss the complaints. Depending on the situation, the housing provider may begin eviction proceedings.

When tenants experience conflict among themselves, staff work with to resolve the conflict. This is not typically a big problem. Staff offer personal coaching to the individuals involved, and if all parties are HOMES tenants, staff might opt to sit down with them and talk it through.

Temporary absence
Tenants who vacate their unit on a temporary basis can retain their tenancy if the housing provider knows the reason for the absence and where the tenant is (e.g. seeking addictions treatment or visiting an ill parent in another city). The unit will be held as long as the tenant still has an income. Tenants who are going to be absent for long periods (incarceration, hospitalization, and long-term addictions treatment) that may result in a loss of income are asked to agree to vacate and are offered housing when they return.

Residents who are abstinent
Residents who want to abstain from alcohol or drug use sometimes choose to move out of

Good Shepherd housing or housing supported through HOMES. Other times, they do not move and instead obtain help from staff in saying 'no.' Those who do want to move most often are transferred to another unit within the portfolio of Good Shepherd Non-Profit Homes: to a building where they do not know anyone or where staff thinks there is less substance use.

Role of staff in working with residents

The support provided is tailored to the individual needs of the tenants. HOMES staff remain in close contact with program participants, and can even be reached multiple times a day by phone. Mobile staff visit tenants in their homes, provide accompaniment to medical appointments and transportation to the food bank if needed. The amount of contact between tenants and staff can also depend on whether the tenant attends any of the organized social and recreational activities.

For sites where there is either 12 hour or 24 hour onsite support, staff have offices in the buildings (owned by Good Shepherd Non-Profit Homes or one building is owned by Hamilton Housing). Tenants can access staff as needed. These buildings also offer social and recreational programs, with some facilities also operating with volunteers to help with tasks such as crafts or driving.

Where there is not 24 hour on-site support, HOMES provides 24 hour on call for all tenants in the program.

Strategies for engaging tenants in activities include knocking on unit doors to prompt them when an activity is being organized, speaking to them in the hallways to encourage them, and having a central place to post notices about activities. A newsletter goes to all tenants in scattered units supported by the mobile team to let them know about upcoming activities and to help keep them connected.

A good relationship between staff and tenants prompts tenants to participate in activities. Introducing tenants to each other and arranging for a tenant to have someone to go with are further strategies to engage tenants in community activities. The mobile team offers rides to encourage participation and at times an activity can be linked to a regular visit with a tenant or a trip to the food bank.

Legal issues

HOMES staff cannot recall instances where the police laid charges related to dealing on the premises of their housing, although some tenants have been charged with drug offences that occurred outside the building. In general police have had little involvement on drug issues in Good Shepherd buildings.

While tenants would say that the police treat them disrespectfully, HOMES staff report good relations with the Hamilton police. Through the COAST program (which teams up mental health professionals with police), police officers have been well educated. When dealing the HOMES tenants, there is usually acknowledgement that the individuals have

mental health issues and usually are treated better than someone who is just perceived as being an addict.

2.5 Exits from housing and/or programs

Voluntary move-outs

The HOMES program provides long term housing, and as such tenants are expected to stay for years. If someone does move out voluntarily and is not linked to another service, they can continue to receive support through HOMES. This support, however, is short term and ends when the tenant is reconnected with the outreach team managed through the City of Hamilton's Public Health Department, or is connected with another support agency.

Of the individuals who move out, some are moving to an 'improved' housing situation, which includes moving in with their boyfriend/girlfriend, getting married, moving to their parents' house, or moving in to private sector housing. Others give up occupancy of their unit due to long hospital stays or a long jail term.

Evictions

Individuals can be evicted for non-payment of rent and violations of the Tenant Protection Act. The housing provider is not quick to evict tenants when problems occur. Consideration is given to where the individual is in dealing with his or her mental health and addictions issues, and there is recognition of the significant barriers that many individuals face. For example, many individuals who are housed have not had responsibility for many years for paying rent.

With eviction as a last resort when a tenant falls into rent arrears, the housing provider will agree to a repayment plan in order to keep someone housed. A trusteeship program is available to tenants. Direct deposit for the rent portion of social assistance and disability payments can also be arranged.

Evictions do sometimes happen as a result of behavioural problems. If a unit has become a 'safe house' for drug users, or it is being used to sell drugs and complaints about the amount of traffic to and from a unit are received, then the tenant receives informal and formal warnings about possible eviction. While the housing provider can be more lenient if the problems occur in a building it owns, this is not true for units in the community covered by a head lease where superintendents and security staff are voicing concerns. Tenants who are headed for eviction are asked if they want to agree to vacate the unit, be evicted, or move to another unit that the housing provider has and get a fresh start. If they agree to vacate the unit, the housing provider may offer some rent rebate to use as a deposit on a new unit.

If needed, the housing provider proceeds with eviction, following the process required by

the Ontario Rental Housing Tribunal. If a tenant is taken to the Tribunal, HOMES will often ask for mediation or will do mediation before going to the Tribunal and give the tenant a chance to agree to a set of conditions. Tenants are typically given many chances to resolve their issues or behaviour.

When tenants go to jail or to a hospital for a long term stay, they are given the opportunity to voluntarily vacate their unit, with the agreement that they will be re-housed upon discharge.

Individuals who are evicted typically end up back in lodging homes or shelters, while some find housing in the private sector.

2.6 Services

Model of service delivery

HOMES embraces psycho-social rehabilitation and a recovery based model in housing and supporting individuals with concurrent disorders. The focus is on the strengths of the individual and what challenges he or she wants to work on. The nature of the support provided by HOMES staff is intensive case management.

Types of services

Tenants can access different levels of service depending on their individual needs. Those who need 24 hour a day onsite support are housed in buildings owned by Good Shepherd Non-Profit Homes. Those requiring a lower level of support are housed in scattered units and are supported by a mobile team.

Through HOMES, tenants have access to the following services and resources delivered by HOMES staff:

- Intensive case management provided by housing support workers available onsite and offsite seven days a week through staff support and on call. The average ratio for case management across the program is one staff to ten tenants.
- Recovery support workers and other support workers with specialized training in substance use/recovery who work onsite with tenants
- Personal Support Workers who assist with life skills, food, transportation, clothing, cleaning and hygiene
- Intensive individual counselling, support groups, referrals, accompaniment to medical appointments and 12 Step programs, life skills and social skills training, nutritional counselling and support, and foot care
- Medication lock-up and prompting
- Meal program (in 24 hour support buildings and also through Good Shepherd Centre)
- Social and recreational activities
- Vocational Support Worker for assistance finding paid and unpaid work opportunities, including access to a casual labour pool

- Dual Recovery Anonymous group, an offsite support program delivered by HOMES for tenants but also open to members of the public.

In addition, tenants have access to a mental health nurse and psychiatrists who work both on and off site. The Psychiatrists linked to the program have particular training in concurrent disorders and talk openly about what substances have fewer negative consequences for specific psychiatric conditions. Pastoral support and a trusteeship program are available through linkages with the Good Shepherd Centre.

Tenants can also access the City of Hamilton's street outreach van and be linked to the injection drug user worker and HIV network.

Changes in services

In the past three years, three enhancements to the program where implemented.

- A new residence for men (McGuinty House) opened and more units were added to the HOMES program.

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- The Dual Recovery Anonymous was launched, meeting monthly. It is open to tenants and to the public.

- The position of Vocational Support Worker was added to the HOMES program.

Most effective services

The following features of HOMES are key to keeping people housed and assisting them in achieving the stability in housing that they have.

- Choice: having a choice of housing types and levels of support that can be offered

- Flexibility and Forgiveness: having an ability to give second chances. Staff know not to blame tenants and are challenged to find different ways to respond to problems. Staff also have the flexibility to transfer tenants between sites in HOMES as needs change. Intake procedures ensure easy access to the program: staff will do intake wherever the applicant is. Neither the referring agency nor the individual are required to fill in any forms. Applicants receive immediate feedback on when to expect housing.

- Open Honest Communication: this is an expectation between staff and tenants.

Connections with community programs/agencies

Formal partnerships with local agencies are in place to provide housing support workers for HOMES. Staff are seconded from Wesley Urban Ministries (which operates a drop in and shelter) and the Salvation Army Lawson Ministries (providing housing and support services for people with developmental delays). In addition, Good Shepherd Non-Profit

Homes pays for the outreach staff that are linked to the City of Hamilton's street outreach initiative. This link with the City's broader street outreach initiative is the 'Engagement' part of the HOMES program and is a strategy for linking people living on the streets and in shelters with housing and supports.

2.7 Staffing and personnel issues

The table below shows the current staffing for HOMES, noting that the ideal staffing for this program would include an additional four program workers.

Current staffing	**Ideal staffing**
Program Manager/Director 2.5 FTE Program Supervisors/Team Leader 2.0 FTE Program Workers 35.3 FTE (includes Housing Support Workers, Recovery Support Workers, Recreational Support Workers, Vocational Support Worker) Nursing staff 1.0 FTE Housing Coordinator 1.0 FTE Admin, Information Services and clerical staff 5.0 FTE Maintenance/Janitor 2.0 FTE Total staff: 48.8 FTE	As indicated with the addition of 4 more program workers.

Policies for hiring formerly homeless individuals

HOMES has a formal policy to hire individuals with personal experience dealing with mental health and substance use issues for the Recovery Support Worker position. Further, HOMES values related personal as well as professional experience in the other support worker positions. An individual with a history of mental health or substance use issues would not be excluded from any position, including a manager or director position.

Training

During nine months of the year, all possible staff attend a half day training session as part of an in-service education program. Staff are surveyed to identify training needs. The following are examples of topics addressed during staff training: HIV/AIDS; tuberculosis; communicable diseases and precautions; schizophrenia and other specific

illnesses; crisis intervention, self care, substance use, mental illness, rehabilitation planning and goal setting and CPR. In addition, staff have access to other courses outside of the in-service training, including: harm reduction, sex trade 101, mental health recovery, mental health ACT, and case management.

2.8 Funding

All of the units through HOMES are subsidized. In some cases, the tenants' rent is set according to their income, and in other cases, tenants pay a fixed amount according to the maximum shelter allowance provided by social assistance or the Ontario Disability Support Program. In some buildings tenants also pay a fixed amount for food that is prepared and shared communally.

The funding for the HOMES program is stable over the foreseeable future. Over the past few years, the program received a 2 percent increase in funding.

Summary of Revenue and Expenses for 2004-2005
For Program/Support Component of HOMES

Source of revenue	**Amount**
Ministry of Health and Long Term Care	2,839,743
Total	2,839,743

Costs	**Amount**
Direct staff (41.8 FTE)	1,763,643
Other staff (clerical, bookkeeping) (7 FTE)	272,500
Benefits for Direct and other staff	350,000
Operating	$ 501,600
Total	**$ 2,839,743**[2]
Per diem on total	$43.22 per client per day

Other Revenue:

Revenue from tenants	$349,700
Rent Supplements from MOHLTC	$265,300
Enhanced Maintenance Funding from MOHLTC	$ 45,000
This revenue supports: 65 units at Emmaus (only 15 of these units are part of HOMES) 15 units at Taylor Apts. (only 1 unit is with HOMES)	

[2] Prior to the launch of HOMES, MOHLTC provided funding to Good Sheppard Non-Profit Homes for support services to 65 tenants in one building and 15 tenants in another. While only about 15 of these 80 units are used for the HOMES program, the organization still supports these individuals/units, and that support is included within this budget, as well as support for six additional families in rent supplement units.

10 units at Emmanuel which is a palliative housing program All scattered units with private landlord

3. Outcomes, challenges and factors for success

With respect to substance use among tenants, it can appear the use of drugs or alcohol increases when housed with supports under a harm reduction model. Staff note that applicants tend to underreport their substance use at intake. Further, when living on the street or in shelters, the individual has little privacy to drink or use substances, and gaining access to permanent housing can be a huge improvement in their life. When housed with a stable source of income, an individual can have more money available, which can have an impact on the amount or type of substances used.

From the vantage point of staff and anecdotal evidence from other community agencies, a noticeable change in the lives of HOMES tenants is reduced hospitalization. In addition, HOMES sees a big increase in the number of individuals obtaining financial assistance through the Ontario Disability Support Program once housed.

Success is defined through the combination of housing stability and quality of life factors

3.1 Impact of the program on residents

HOMES identifies nine specific consumer objectives related to supports to housing. Following is a summary of these objectives, measurable targets and actual outcomes for tenants.

Consumer Objective	**Measures of Success**	**Outcomes (for tenants 2003/2004 year)**
Improved ability of tenants to carry out activities of daily living	# of groups held # attendees	RN seeing 35 tenants for health teaching (187 visits) Personal support worker supporting 35 tenants (cleaning, hygiene, lifeskills) Nutritionist seeing 26 clients (150 visits) 48 collective kitchens 10 tenants in garden project 9 received ODSP special diet money
Increased capacity of tenants to manage finances and pay rent	Less than 5 % evictions Less than 3 % in rent arrears # of tenants enrolled in trusteeship program	Only 7 (3.2 %) evictions Less than 2 % in rent arrears 80 tenants enrolled in trustee program
Increased opportunities for social/recreational	# of social / recreational activities	48 activities per week 343 attendances per week

programs, fitness and nutrition	# of clients participating	Walking groups, breakfast clubs, exercise groups implemented
Access to psychiatric help	# of tenants seen # of consults to staff	69 tenants seen 186 visits by psychiatrists, 6 staff consults
Access to foot care		65 foot care sessions
Access to housing for non-English speaking groups	# of tenants with English as a Second Language	Translation obtained for 7 tenants of other language groups
Increase social skills/self esteem	# of tenants served by peer support workers	28 tenants served by peer support workers Dual Recovery Anonymous group started, with 12 to 15 tenants attending each session.
Improved access to meaningful activities and employment	# of tenants seen for individual help # of tenants registered for Casual Labour Pool (CLP) # of tenants hired for cleaning tenants program	61 tenants served by vocational support worker 22 tenants worked for CLP 43 CLP jobs provided – 95 placements provided 903.75 hours of work done 3 tenants hired for program, 15 security tenants, 4 tenants hired one-time for café survey
Diffuse crisis/avoid hospital intervention	Data collected on baseline and current hospitalizations	27 tenants had 40 hospital admissions (1098 days) vs. baseline of 52 people had 66 admissions (4947 days)

3.2 Resident satisfaction

A tenant satisfaction survey completed February 2005 indicates a very high level of tenant satisfaction with the housing and supports available through HOMES. Below are some findings from this survey:

- 70 percent of respondents reported that what they like most about the HOMES program is the staff and/or having staff support; 26 percent said they like the housing most (safe, private and independent)
- 83 percent indicated they agreed or strongly agreed with the statement 'I am content with the amount of social activities offered by the HOMES program
- 86 percent agreed or strongly agreed with the statement 'I feel the HOMES staff are compassionate towards my mental health issues'
- 89 percent agreed or strongly agreed with the statement 'I feel that HOMES staff do attempt to understand me'
- 89 percent indicated overall satisfaction with the HOMES program.

The survey was distributed to 173 tenants and the analysis is based on 65 surveys that were completed and returned.

3.3 Reasons for success

Staff feel HOMES is a very successful program, as demonstrated by significant community partnerships, positive tenant satisfaction survey, reduced hospitalization among this client group, and the absence of complaints. The reasons for success are:

1. Ensuring tenants have choices about their housing and supports, and all aspects of their life.
2. Flexibility in the housing and supports offered, including having a broad range of housing and supports available to tailor to specific and changing needs of tenants
3. Having a broad range of staff, including individuals with personal and professional knowledge of mental health and addictions issues.
4. Personalized and non-bureaucratic procedures for intake and other housing functions.

3.4 Challenges

HOMES staff identified a number of challenges to implementing this initiative, as well as their strategies for addressing these challenges.

Not In My Backyard or NIMBY is an issue at the outset of a new housing initiative. To deal with this, Good Sheppard Non-Profit Homes relies on its good reputation and has been successful in gaining acceptance once they become established in a community.

It is a challenge to keep very ill individuals stable enough to live in the community. The HOMES strategy is to support tenants and not give up on them. Staff look for what motivates each individual and the ‘good’ in each person.

Receiving complaints about HOMES tenants can be a challenge. In buildings dedicated to individuals with mental health and/or substance use issues Good Shepherd Non-Profit Homes has had incidents where neighbours have complained about tenants or complained about the police coming by. While these complaints are not ongoing, staff work hard to deal with issues as they arise.

When problems emerge in the scattered units in the HOMES program, a written complaint is received from the property manager. The complaint is reviewed by the Assistant Director or Director of Housing, and a strategy for resolving the issue is developed with the help of front line staff.

3.5 Lessons learned

1. To implement a program like HOMES, the sponsoring organization should already have a good infrastructure in place, including an existing housing program, human

resources support, and accounting services.

2. It is important to have a trusteeship program available to the tenants, to ensure rent is paid and assist tenants in money management.

References:

Housing Demographics, Power Point presentation, May 10, 2005. Good Shepherd Non-Profit Homes Inc.

HOMES Program Annual Service Summary for April 1, 2003 to March 31, 2004, Power Point presentation. Good Shepherd Non-Profit Homes Inc.

Tenant Satisfaction Survey – HOMES Program, February 2005. Good Shepherd Non-Profit Homes Inc.

2004/2005 Operating Plan and Annual Report, Submitted to Ministry of Health and Long-Term Care, June 25, 2004. Good Shepherd Non-Profit Homes Inc.

Contact: Lorraine Chapman Director of Mobile Housing Supports, HOMES Program Good Shepherd Non-Profit Homes Inc 35 Aikman Avenue Hamilton, ON L8M 3M8	Phone: 905 528-3655 Fax: 905 528-2732 E-mail : lorrainechapman@goodshepherdcentres.ca

Concurrent disorders programme Canadian Mental Health Association - Ottawa Branch	Ottawa, Ontario

1. Background

This case study has been prepared based on an interview with staff from Canadian Mental Health Association (CMHA)-Ottawa Branch and from documents provided by CMHA.

1.2 The sponsor

In 1953 the CMHA-Ottawa Branch began to plan and develop services for persons with mental health. Over fifty years, the work has expanded to encompass public education, support services, and social action. In the mid-1990s CMHA-Ottawa Branch shifted its focus to provide services to individuals with serious mental illness[1] who were homeless: it is important to note that most people living in poverty with a serious mental illness are almost continually at risk for homelessness due to the limited affordable decent housing stock.

The mission of CMHA-Ottawa Branch is to:

- Advocate and provide client-directed services and programs with and for people with mental health problems; and
- Enhance, promote, and maintain the mental health of individuals and communities through education and awareness.

1.2 Program goals and history

When the focus of CMHA-Ottawa Branch changed in the mid –1990s to serve clients with a serious mental illness who were homeless or at risk of homelessness, it became apparent that a significant proportion of these persons had co-occurring substance use disorders. It became clear that in Ottawa, as elsewhere, two separate systems – one for mental health and one for addictions – operated independently. Consequently, clients were not well-served, frequently not accessing the range of services that they needed to address the range of complex issues.

Project at a glance	
Sponsor name	Concurrent disorders programme
Goals	▪ Increase the capacity of CMHA Ottawa to provide integrated treatment for concurrent disorders ▪ Develop and deliver a group treatment program in partnership with 5 community addiction treatment agencies. ▪ Provide regular comprehensive training to the Ottawa community in working with individuals with concurrent disorders. ▪ Develop the capacity to provide the CMHA Concurrent Disorders Training.
Target population	Persons with co-occurring substance use & mental health disorders who are homeless or at risk
Housing tenure	N/A
Number of units	N/A
Factors for success	▪ While not directly linked to the Programme: the availability of affordable decent housing. ▪ Adopting the components of integrated treatment: integration of services; comprehensive; assertive; reduction of negative consequences; long term perspective; motivational based treatment; and multiple psychotherapeutic modalities. ▪ A harm reduction focus. ▪ Being a strength-based, client - directed service. ▪ Having a case manager assigned to each client.
Location	Ottawa, Ontario
Project start date	2001

[1] See note at the end of this profile.

By 1998 CMHA-Ottawa Branch had identified two priority areas: individuals with a concurrent disorder and developing the capacity to respond to their needs. However, at that time there was no specific funding support for this work, so the capacity to develop a comprehensive response was limited.

In 2001 funds from the federal Supporting Communities Partnership Initiative (SCPI) of the National Homelessness Initiative helped initiate a pilot project for a concurrent disorders programme. The funding provided for:

- Initial development of Concurrent Disorders training materials for frontline staff;
- Two 'train the trainer' education projects where 36 frontline staff from 14 mental health and addiction agencies were trained to deliver the workshop materials; and
- The development and implementation of CMHA Ottawa's concurrent disorders treatment groups for clients of the agency.

2. Program Description

2.1 The people

The target group for CMHA-Ottawa Branch – persons who are homeless or at risk with serious mental illness - have by definition been found to have general lifetime prevalence rates of concurrent disorders ranging from 20% to 80% (depending on a variety of client clinical characteristics and demographics). At CMHA-Ottawa Branch in particular, the client rate of current concurrent disorder consistently averages 40-50%.

The situation of CMHA clients is similar to that described in the literature. Negative outcomes associated with serious mental illness and substance use include:

- Increased re-hospitalization;
- Increased psychotic symptomology;
- Increase in depression and suicidality;
- Tendencies toward violent behaviour;
- High rate of incarceration;
- Inability to manage finances and meet daily needs;
- Housing instability and homelessness;
- Non-compliance with medication maintenance and treatment;
- Increase in HIV infection and other communicable diseases;
- Higher service utilization and systemic cost; and
- Difficulty sustaining mutually beneficial family/social contacts.

All clients served in the concurrent disorders treatment groups are clients of CMHA-Ottawa Branch, that is, they have a primary case management service attached to them. Clients may attend their weekly concurrent disorder group, but the primary case manger develops the overall treatment plan with the client and ideally meets with the group facilitators and the client every 3-4 months to monitor treatment goals that are specifically related to substance use.

The program has incorporated the components of Integrated Treatment (as defined by Mueser[2]).

- Integration of services An integrated approach has a range of supports available (e.g. case managers, psychiatrists, psychologists, nursing support, occupational and recreational therapists) to deal with substance use and mental disorders simultaneously.
- Comprehensive treatment This can include residential care, case management, supported employment, family psycho-education, social skills training, training in illness management and pharmacological treatment.
- Assertive outreach It includes intensive case management and individual meetings in the client's environment.
- Reduction of negative consequences
- Long-term perspective Programs are time unlimited and people move through treatment at their own pace.
- Motivational based treatment Individuals are supported in identifying their own goals and to take responsibility their recovery process.
- Multiple psychotherapeutic modalities These can include individual counselling, integrated group treatment and are often these used simultaneously.

Last year the Concurrent Disorders Programme worked with 89 persons (56 men; 33 women) of whom 41 had mood disorders, 28 had a diagnosis of schizophrenia and the rest had a diagnosis of anxiety/personality disorders. Most (54) were between 35 and 54 years; 12 were over 55; 14 between 25 and 34 and 9 between 16 and 24 years. Most were receiving social benefits and were not working, although 3 had sporadic, casual employment and 2 worked in regular, competitive jobs. The majority (75) were Caucasian while 7 were Aboriginal and 7 others were from visible minorities.

2.2 The housing

Clients of the program gain access to housing the same as "regular" clients of CMHA-Ottawa Branch - there are no advantages or no disadvantages[3]. However, landlords may be more interested in clients who are addressing previously know substance use problems. Clients can use CMHA-Ottawa Branch as a reference for landlords.

2.3 Access to the program/housing

Concurrent disorders groups

All clients of CMHA-Ottawa Branch become clients through the intake and assessment services. As part of the initial and ongoing assessment of all clients, the following assessments are

[2] See for example, Mueser et al. (2003) *Integrated Treatment for Dual Disorders: A Guide to Effective Practice* New York: Guilford Press

[3] CMHA-Ottawa Branch does have a Housing Outreach Program, documented in Kraus, Serge, and Goldberg (2005) *Homelessness, Housing, and Harm Reduction: Stable Housing for Homeless People with Substance Use Issues* Ottawa: CMHC

undertaken:

- Functional Assessment (adapted from Mueser text, basic social work/life domain assessment and many alcohol and drug use questions)
- Drug Abuse Screening Test (DAST-10); Alcohol Use Disorders Identification Test (AUDIT); the Dartmouth Assessment of Lifestyle Instrument (DALI)
- Clinician Alcohol Use Scale (AUS) and Clinician Drug Use Scale (DUS)
- 6 month drug/alcohol follow-back calendar
- 24 month residential follow back calendar
- Substance Abuse Treatment Scale (SATS)
- Multnomah Community Ability Scale (MCAS)

If an outreach client has been assessed as requiring longer-term (more than a year on average) support, they are referred to the intensive case management services (called Community Support Work) where workers have a limited caseload of 12 clients with whom they work for long periods of time on specific rehabilitation goals.

Any CMHA-Ottawa Branch worker can refer a client on their caseload to the concurrent disorder groups. The process to join a group includes:

- Be a client of CMHA-Ottawa Branch (either an Outreach or Community Support Worker client).
- CMHA-Ottawa Branch worker completes a brief referral form to the Concurrent Disorders groups.
- The client and worker (if requested by the client), attend a monthly information session where the client meets the group facilitators, hears about the groups, etc. If someone is uncomfortable going to an initial group meeting, the concurrent disorders group facilitator can meet them individually – this is seen as part of the assertive engagement process. The client is assigned to the appropriate group (i.e. level of treatment, gender, age, etc.) depending upon availability or they are invited to continue attending the monthly drop-ins until a vacancy occurs. The monthly drop-in are held at CMHA-Ottawa Branch and facilitated by CMHA-Ottawa Branch group facilitators. These provide interim support to clients awaiting assignment to a group and are an intake information session to clients not sure if they are interested in going to groups.

There are currently ten groups operating in the Concurrent Disorders Programme and five more are to be added in the fall of 2005. There are different persuasion and active treatment groups[4] and some of the new groups to be added will be relapse prevention for people who have not had any problematic use for 6-12 months.

The goals of the persuasion and active treatment groups:

- Persuasion Groups - Help clients develop an understanding of how substance use has affected their lives, to become motivated to work on reducing their use of substances, and, if desired, to achieve abstinence. There needs to be an accepting group

[4] This follows the Stages of Treatment: engagement, persuasion, active treatment, relapse prevention.

environment where clients are free to discuss their experiences with alcohol and drugs without fear of judgment, confrontation, or social censure. By providing a safe environment to discuss positive aspects of substance use, this can set the stage to discuss negative consequences of use. Ultimately the goal is to develop and nurture the interest in working on substance abuse.

- Active treatment groups - Clients have already developed an awareness of the negative effects of substance use on their lives and the focus shifts to further reduction of substance abuse or on how to successfully maintain abstinence. This is achieved by developing group support for shared goals, developing new skills for dealing with high risk using situations and improving other aspects of clients day to day lives.

Training
In addition to the "direct service" concurrent disorder groups, CMHA-Ottawa Branch provides intensive training to community mental health and addiction workers on working with people with concurrent disorders. The Concurrent Disorders Training Programme includes the following sessions:

Day 1:	Mental Health Issues
Day 2:	Problematic Substance Use
Day 3:	Concurrent Disorders: Assessment and Treatment Planning
Days 4 & 5:	Intervention Strategies: Motivational Interviewing

These training strategies are reflective of best practices that have been developed in the field of concurrent disorders and utilize current resources. In 2004-2005 the 5.5 days training was offered to 105 participants from 25 agencies. In the fall of 2005, CMHA-Ottawa Branch undertook training outside of the Ottawa area in Peel region with 200 community mental health workers.

Eligibility criteria

A client of CMHA-Ottawa Branch with an active substance use disorder.

There are rules in terms of functioning within groups:

- Persons could be denied access to a group in for a particular week if they were exhibiting behaviour that was threatening to other participants in the group. They may be welcomed back the following week, or if other group members no longer feel safe with them, they can be accommodated in another group.

- People not required to be sober in persuasion groups if their behaviour is not dangerous.

Certain adjustments are needed to make groups effective, including serving food, allowing for breaks to allow people to smoke, if some participants are psychotic make sure that there are at least two staff persons on hand, etc. There may also be the need for specific support; for example if people are trauma survivors or have Post-Traumatic Stress Disorder (PTSD),

sensitivity around these issues is essential. A men's group has been in operation since early February 2004 and has two male facilitators. There are women's groups with a feminist focus of empowerment, facilitated by women.

Degree of "housing readiness"

Not applicable. NB: Housing is not related to treatment.

Program expectations

This is a harm reduction program: Clients set treatment goals in relation to where they are at in their stage of change. Relapse is expected. However, since 2001, when the focus was almost exclusively Persuasion groups in the Concurrent Disorders Programme, there are now significant numbers of clients who make up active treatment groups – these are people who have moved along and chosen remarkable reductions/eliminations of substances.

For the first time, in the fall of 2005, CMHA-Ottawa Branch will need Relapse Prevention groups for clients who have been sober or maintained their level of use for a significant period of time. Generally this period is a year or more and "sobriety" includes adherence to planned reduction of use to the point that the substance use is no longer interfering with the person's life. CMHA-Ottawa Branch has found that as people experience more and more wellness there is a diminished commitment to substance use.

Many clients chose to not take medication or to not properly take medication. CMHA's role is to help them understand the consequences of their choices, to support their decisions, and build an alliance that will assist in influencing clients to make better decisions in the future.

Program demand

A waiting list is not maintained for the program but a monthly drop-in is an opportunity for people to come if they have not yet been placed in a group.

2.4 Substance use issues and policies

Substance use

Most common substances are alcohol and marijuana although there is also a significant amount of crack being used. There has not been a great change in this over the last few years, although youth (there is a youth group) tend to take whatever is the latest club drug. "They will basically do anything." Seniors, on the other hand, mostly use alcohol although, like other clients, there is a significant abuse of prescription drugs.

All ten concurrent groups have different issues around substance use. Many had substance use problems before their mental illness was diagnosed. The combination of different drugs and mental health problems can vary as well. For example, people with schizophrenia can become very impaired with marijuana, while small amounts of alcohol can have a huge impact on seniors who may have cognitive problems due to ageing.

Furthermore, unlike alcohol, which is standardized, substances like marijuana are not controlled. In one instance, a client who suffered from acute psychosis seemed to be getting progressively worse for no apparent reason, until his team realized that he had changed drug dealers and the bad "weed" had triggered psychosis. He was urged to return to his regular drug dealer, and his symptoms eventually abated.

Policies and approaches relevant to housing the target group

N/A.

Strategies to address relapses

With the evolution of the groups and the stages of the clients, some of the groups are now moving their focus to prevention of relapse.

Role of staff in working with residents

At the heart of the approach used by the CMHA-Ottawa Branch is the relationship with the clients. Staff members are expected to undertake specific tasks (e.g. assessments) but also:

- Assist clients in accessing and obtaining other community resources where needed and advocate with and for clients to access available resources.
- Where resources do not exist or are inadequate, advocate within the system to develop or improved essential services and resources for individuals with serious mental illness.
- Deliver services in a way that maintains the staff member's personal safety and the client's physical, social, cultural, and emotional well being.

Staff also are expected to avail themselves of opportunities for professional development, to bring forward training needs and take responsibility for seeking out relevant training opportunities.

The qualities that are expected of staff include:

- Comprehensive knowledge of mental illness, substance use disorders and treatments.
- Comprehensive knowledge in the functions and principles of case management and the rehabilitations principles of psycho-social rehabilitation.
- Up to date knowledge of relevant mental health policy and legislation including the Mental Health Act.
- Knowledge of community based and hospital in-patient/out patient resources.
- Demonstrated specific knowledge of health issues and of social problems associated with psychiatric disabilities, poverty, and the impact of mental illness on functional capacity.
- The ability to establish positive and supportive relationships with clients
- The ability to work independently in a non-structured environment, including ability to work flexible hours
- A demonstrated strong belief in a client-directed practice
- A demonstrated non judgmental attitude toward individuals who choose alternative lifestyles
- The ability to respond appropriately to crisis situations, including suicide

interventions,

- The ability to maintain a mature problem-solving attitude while dealing with interpersonal conflict, potentially hazardous conditions, personal rejection, hostility or time demands.
- The ability to work with other professionals particularly from other disciplines to problem solve and achieve common goals in a participative manner using a cooperative approach
- The ability to communicate with others in a warm and helpful manner while simultaneously building credibility and rapport
- The ability take action is solving problems while exhibiting judgment and a realistic understanding of issues, able to use reason, even when dealing with emotional topics/situations.
- The ability to use a systematic approach in solving problems through analysis of problem and evaluation of alternative solutions.
- The ability to create positive energy (motivation) in both individuals and group.

Staff also understand that part of their working conditions include possible exposure to unpleasant conditions, second hand smoke, verbal abuse, threat of physical abuse, and communicable diseases.

Legal issues

Clients who are referred by the courts and for whom part of the release conditions, bail or probation, is participation in a program, may find that the harm reduction approach is at odds with a more traditional/conventional program, such as AA, that expects sobriety. This is a challenge for a program that is based on voluntary participation and that takes a harm reduction approach.

This issue has generally been resolved fairly easily – probation officers will accept the programme but CMHA will be increasing its court outreach in the coming months and clients from the criminal justice system will be targeted.

2.5 Exits from housing and/or programs

Voluntary move-outs

People are free to move through the groups when they feel ready to do so – for example from a persuasion group to active treatment. Relapse prevention groups will be formed in the next few months because of this need. There also have been situations where people in active treatment groups have been asked to move back to a persuasion group because other group members felt that they were not ready for this stage or the person had fallen back.

Evictions

N/A

2.6 Services

Approach to service delivery

CMHA uses intensive case management for its clients and the primary case manager develops an overall treatment plan with the client. If a person needs long periods of support, they may be supported over several years by CMHA's intensive case management service, or if they meet programme criteria, they may be referred to one of the ACT (Assertive Community Treatment Teams) operating in Ottawa. However, like all community mental health reasources, availability is always an issue.

Outreach work is important to the process of reaching and engaging people into the system of care and support. The intake points for CMHA Ottawa are in-patient psychiatric units and hospital emergency departments, the criminal justice system (provincial court), emergency shelters/drop-in programmes, and community/family/self referrals. The outreach team works on a regular basis with various points of access: six workers with housing outreach (e.g. shelters), nine workers with hospital outreach and four court outreach workers. Their work consists of meeting people and convincing them that they have something to offer that could interest potential clients. Their basic role is assist the client in such a way that ends homelessness, keeps them out of the criminal justice system, and/or reduces/eliminates the likelihood of returning to hospital (or at least staying for a reduced amount of time in any of these costly and/or inappropriate systems). Intake and assessment fucntions are undertaken by three assessment and intake workers.

Any CMHA-Ottawa Branch worker can refer a client on their caseload to the concurrent disorder groups.

The approach used by the concurrent program was developed in conjunction with Kim Mueser and uses an approach that integrates the stages of change: pre-persuasion (i.e. not recognizing the need for treatment); persuasion (i.e. developing the awareness of substance use problems and increasing the motivation to change); active treatment; and prevention of relapse[5].

Types of services

Mental health and addictions services
There are currently ten groups operating in the Concurrent Disorders Programme, with three full-time facilitators, two work at CMHA, the other full-time position is spread acrossthe agencies dealing with addictions. CMHA purchases the counselling services from the community addiction resources and the groups are held at the various community sites, such as the Amethyst Women's Addiction Centre, the Maison Fraternité, Sandy Hill Community Health Centre's Addictions and Problem Gambling Services of Ottawa, Centretown Community Health Centre's LESA (Lifestye Enrichment for Senior Adults) program, and the Rideauwood Addiction and Family Services.

[5] See the literature review for more detail about this approach.

On a general level, all clients of CMHA-Ottawa Branch have access to whatever services are provided, including the concurrent disorders groups, individual counselling, fully time psychiatric nurses, occupational and recreational therapists. The multidisciplinary support available to clients includes nursing support, psychiatrists, psychologists, recreational therapy, occupational therapy, and housing support. Clients also are encouraged to make use of "normal" services as well to encourage clients to get familiar with these and to further integrate them into the community

CMHA-Ottawa Branch regular services (e.g. case management and outreach) are available Monday-Friday from 9 to 5 pm. Extended hours services (e.g. follow-up/after hours for regular clients) are available to 8 pm on weekdays and 9 am to 5 pm on weekends/all statutory holidays. All clients have a crisis plan that identifies what to do in emergency situations.

Changes in services

In 2001, when the concurrent disorders groups were first started, all were at the persuasion stage (see above), now this represents about half of the groups. The others are now either at the treatment stage and moving towards the prevention of relapse. Recent budget increases will permit creation of five new concurrent disorders groups.

In terms of the overall work of CMHA-Ottawa Branch, recent changes include hospital outreach (begun in February 2004), and more recently, expanded funding for outreach services in the court division. There have been changes in the process of outreach and assessment: to increase efficiency and consistency in assessments, this work is undertaken by three persons working with the three referral points (i.e. housing, hospital, and court outreach).

Initially services were offered 24/7 but few calls were received. This was modified to be available until 10 pm, but again, few calls were received after 8 pm, which led to modification of the schedule to that currently offered (weekdays: 12 - 8 pm; weekends: 9 am - 5 pm).

Most effective services

The components of an integrated approach:

- Integration of services
- Comprehensive treatment
- Assertive outreach
- Reduction of negative consequences
- Long-term perspective
- Motivational based treatment
- Multiple psychotherapeutic modalities

Connections with community programs/agencies

CMHA-Ottawa Branch has service agreements with community partners, such as hospitals

and shelters, which define what CMHA will provide as services. There is an agreement with addiction services (including staffing for one facilitator position for the concurrent disorders groups) to buy the services of the organisation. Of the 1.5 new positions that are to be created for the Concurrent Disorders Programme, the .5 will be from the community.

2.7 Staffing and personnel issues

Current staffing	**Ideal staffing**
Co-ordination: 0.2 FTE	More staffing would permit more services.
Staff training/education: 0.5 FTE	More staffing would permit more services.
Group facilitator: 4 FTE	More staffing would permit more services.

Staff burnout

This is high stress work and some of the means to reduce the stress include:

- An employee assistance program that includes confidential referrals to counselling.
- A relaxation room that staff can book into which includes a SAD light, a comfortable chair, a Zen fountain, and music.
- A joint labour management committee that looks at improvements and ideas that could ameliorate working conditions (e.g. massages, Reiki).
- Periodic planned staff wellness days.

Policies for hiring formerly homeless individuals

The CMHA-Ottawa Branch hiring policy is to not exclude anyone, although there are educational and experiential requirements. There are staff members with serious mental illness who are in recovery. One individual who is in one of the concurrent groups has also taken the concurrent training course and could be a volunteer in one of the other groups.

Professional development

Training of staff is a priority and staff is encouraged, if not expected to take advantage of opportunities for training. There is an annual minimum of ten staff training days on a variety of topics.

There are ongoing training sessions or “boosters” for staff as well as computer training. There also are informal sessions such as lunchtime meetings organised by nurses to discuss issues such as medication side effects or Foetal Alcohol Syndrome (FAS). Other sessions may be held on an ad hoc basis depending on what is required; for example a session on men in trauma/victims of childhood sexual abuse was recently held.

2.8 Funding

Annual Revenue*:

Source of revenue	Amount
Public (Province of Ontario, City of Ottawa)	$6,636,008 240,695
Charitable (United Way)	$364,236
Other programs	$477,360
Total	**$7,718,299**

Expenses	Amount
Salaries and benefits	$4,697,901
Building and Grounds Supplies and other	616,161 $2,435,921
Total	**$7,749,983**

*Year ending March 31,2005 for all of CMHA-Ottawa Branch

Provincial changes to the way that budgets are allocated, will mean that agencies will have to apply annually (and rationalize requests) for mental health budgets.

3. Outcomes, challenges and factors for success

The program is viewed as being successful, although the definition of "success" has to be seen as a moving target. Funding from SCPI was a significant opportunity to develop and demonstrate this work around concurrent disorders without having to take away budgets from other activities. The work has allowed integration of issues around substance use into regular business: it is now expected that assessment of substance use is regularly done. This translates into better service for clients and, ultimately, this is how "success" should be measured – meeting clients' needs.

A fidelity scale, developed by Kim Mueser[6], which identifies elements that should be in place to have an integrated approach to concurrent disorders. has been adopted . This allows CMHA-Ottawa Branch to assess how it measures up in a concrete way, while recognising which components it may not be interested in providing.

3.1 Impact of the program on residents/participants

An evaluation of the Concurrent Disorders Program in the first 18 months of operation, undertaken by Aubry et al. (2003) from the Centre for Research on Community Services examined three questions:

[6] See the Health Canada website: http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/bp_disorder-mp_concomitants/appen-annexe-i_e.html.

- Are there changes in functioning (i.e., housing status, mental health, alcohol use, drug use) for clients over the course of participation in the group program? How do the changes in functioning over time for clients participating in the group program compare to similar clients not participating in the group program?
- Are there changes in the quality of life of clients over the course of participation in the group program? How do the changes in quality of life over time for clients participating in the group program compare to similar clients not participating in the group program?
- Does the frequency of participation in the group predict changes in functioning and quality of life of clients?

The study matched 28 clients in the Concurrent Disorders Programme who had participated in at least seven sessions with a comparison group. Multiple methods were used to assess the two groups including functioning and substance abuse, demographic and clinical information, interviews and self-report measures assessing level of symptomatology, substance abuse, and quality of life.

The results revealed that the program held "some promise as an adjunct to support services for clients presenting with mental health problems and substance abuse" (Aubry et al. 2003). Participation in the in the concurrent disorders group appears to be value-added:

- Concurrent disorders group program clients report significant reductions in alcohol consumption and significant improvements in their level of satisfaction in the areas of daily activities and finances

- A greater number of sessions was predictive of a decrease in clients' level of satisfaction (subjective quality of life) with their health. A possible interpretation is that greater participation in the concurrent disorder treatment group is sensitizing participants to the adverse consequences substance abuse is having on their health.

The authors did point out limitations of the study, including that it is in the early stages of program development of the program, clients were followed for a short period and the sample size was small.

An evaluation of the CMHA-Ottawa Branch "Train the trainers" program (Josephson et al. 2003) which included a concurrent disorders component, examined satisfaction and transferability of training by participants. Results revealed a generally positive view of the training and materials, although less so for the concurrent disorders module. Furthermore, there was satisfaction among participants in helping them structure their pre-existing knowledge (which was generally high).

Outcomes	**Examples of Changes**
Residential stability (e.g. length of time housed)	NA
Use of emergency services	There appears to be a remarkable decrease in use.

Substance use (e.g. decreased use/participation in treatment programs?)	No decrease has been noted, although there is a need for relapse prevention groups, indicating stabilisation in use.

3.2 Resident satisfaction

N/A

3.3 Reasons for success

- The use of the integrated treatment model, in particular the pairing of the group treatment programme within a case management program.
- While not directly linked to the Concurrent Disorders Programme, the availability of affordable decent housing is critical.
- Those who have done well engage in the treatment process: they come to concurrent groups, engage with the case manager. There is a wide range of support that can be offered ranging from sending out a doctor or nurse to the client to giving taxi chits. No one can say, "You can't help me with that".
- Being persistent.
- Being a strength-based, client-directed service.

3.4 Challenges

There remains a need for systemic changes, including the inaccessibility of resources by clients. For example most of the addictions programs from the Ministry of Health are abstinence-based. In spite of recognition of harm reduction as a "best practice", there is a disconnect between what is recognised as "best" and what is funded.

Professionals working in mental health need to be trained in substance use – there is a very strong likelihood that their clients will have substance use problems. An analogy would be if case managers were working with a client group in which half had cardiac problems and there was a high probability that they would have a heart attack. It would be foolish not to train case managers in CPR.

On an agency level, one of the challenges is to see the role of the mental health worker differently as someone who can deal with substance use as well. The clientele itself is challenging – this is an ongoing challenge. There is a need to be sensitive to the clientele, starting from the moment that they are assessed, "We need to make their lives easier, not a paper hell."

3.5 Lessons learned

- Get everyone on board.
- The wheel doesn't have to be reinvented – there is much information out there including evidence-based best practices (e.g. from Health Canada)

- Organisational support is very important. This support needs to be at the top and throughout management to be effective.
- While working in partnerships with agencies dealing with addictions is more complex and challenging than developing or hiring such skills within the organisation, there will not be systemic changes until mental health and addictions agencies work together and bring about the necessary changes in unison.
- The program has demonstrated that people with serious mental illness can participate in groups but this requires adaptation, including providing food (this is foreseen in the budget), smoking breaks, sufficient staff, and specific support when needed (e.g. PTSD).

References

Josephson, Gordon, Tim Aubry, and Brad Cousins (2003) *Evaluation of Concurrent Disorders "Train the Trainers" Program* Ottawa: CMHA-Ottawa Branch http://www.socialsciences.uottawa.ca/crcs/pdf/training.pdf

Aubry, Tim and Heather Smith Fowler (nd) Community Mental Health Evaluation Initiative (CMHEI): *Evaluating intensive case management for people with severe mental illness who are homeless* Centre for Research on Community Services (CRCS), University of Ottawa http://www.cmhaottawa.ca/research.htm

Aubry, Tim et al. (2003) *Evaluation of Concurrent Disorders Group Treatment Program: Outcome Evaluation Report* Ottawa: Centre for Research on Community Services (CRCS), University of Ottawa

Definitions:
The Ontario Ministry of Health uses three dimensions to identify individuals with **serious mental illness**: disability, anticipated duration and/or current duration, and diagnoses. The critical dimension is the extent of disability and serious risk of harm to themselves or others, related to a diagnosable disorder.

Disability refers to the fact that difficulties interfere with or severely limit an individual's capacity to function in one or more major life activities.

Anticipated Duration/Current Duration refers to the acute and ongoing nature of the problems identified which can be determined by empirical evidence and objective experience or through the subjective experience of the individual.

Diagnoses of predominant concern are schizophrenia, mood disorders, organic brain syndrome, and paranoid and other psychoses. Other diagnosable disorders such as severe personality disorder, concurrent disorder and dual diagnosis are also included.

Source: *Making It Happen: Implementation Plan for Mental Health Reform.*

An individual with **multiple and complex needs** is defined as a person who meets the

criteria for serious mental illness, has had past episodes of aggressive or violent behaviour, and has one or more of the following characteristics, including: psychotic symptoms that include feeling threatened, under control of outside forces and increased hostility; three or more psychiatric hospital admissions within the last 2 years or has been detained in an inpatient facility for 60 or more days with this period; subject of two or more police complaints / interventions within the last12 months or has been incarcerated in a correctional facility for 30 or more days within this period; recently evicted from housing or is homeless or living in shelters; current problems with drugs and/or alcohol; and/or problems following-up with recommended treatment plans.

Contact: Donna Pettey Program Manager The Canadian Mental Health Association - Ottawa Branch 1355 Bank Street, Suite 301 Ottawa, Ontario K1H 8K7	Tel: (613) 737-7791 Fax: (613) 737-7644 General e-mail: cmhaoc@magma.ca Website: http://www.cmhaottawa.ca./index_e.html

HIV Program Fédération des OSBL d'habitation de Montréal (FOHM)	Montreal, Quebec

1. Background

This case study has been prepared based on an interview with staff from the HIV Program and documents provided by them.

1.2 The sponsor

The Fédération des OSBL d'habitation de Montréal (FOHM) was constituted in 1987 by non-profit housing organisations from the central neighbourhoods in Montreal. Having observed that rooming house residents often lived in precarious, if not dangerous situations, it became obvious to these organisations that there was a need to mobilize and promote a solution: non-profit housing that was safe, decent, and affordable. The growing number of non-profit housing organisations also saw the need to speak with one voice when needed.

The FOHM now represents about 80 housing organisations with about 4,000 units. It also manages six buildings, with 195 units, for the City of Montreal public housing agency, the Office municipal d'habitation de Montréal, (OMHM).

The goals of the FOHM include: bring together organisations that offer affordable housing to single, low income persons; support the creation of new non-profit organisations with similar goals; develop services for management of non-profit housing organisations; offer affordable housing to low income persons in Montreal; offer community support and training to increase the autonomy of tenants.

Project at a glance	
Sponsor name	Fédération des OSBL d'habitation de Montréal (FOHM) HIV program
Goals	▪ Offer clients affordable, decent and safe apartments. ▪ Help clients stay in their homes. ▪ Use a harm reduction approach to substance abuse. ▪ Ensure that clients' have the highest quality of life possible. ▪ Co-ordinate various services, including health and support clients in maintaining regular contacts with key agencies/services.
Target population	Persons with who are homeless or at risk, with substance use disorders who are HIV positive. Most have psycho-social problems.
Housing tenure	Permanent housing
Number of units	10
Factors for success	The major reasons for the success of the program are: ▪ Collaboration between agencies ▪ Multidisciplinary nature of the teams that are involved ▪ Tolerance ▪ Consistency ▪ Flexibility ▪ Supervision and support.
Location	Montreal, Quebec
Project start date	1996

One of the major issues that has preoccupied the FOHM in the last few years has been the recognition and need for housing with community supports.[1]

1.2 Program goals and history

In 1996 the Centre Dollard-Cormier[2] approached the FOHM to provide units for their clients who were homeless or at risk, had substance abuse problems, and who were HIV positive. Many had socio-psychological problems. Funding was offered to FOHM to hire a worker to co-ordinate community resources and support so that clients would not find themselves alone and/or homeless.

The project now includes ten persons, living in ten apartments.

The goals of the project are to:

- Offer clients affordable decent and safe apartments.
- Help clients stay in their homes.
- Use a harm reduction approach to substance abuse.
- Ensure that clients have the highest quality of life possible.
- Co-ordinate various services, including health.
- Support clients in maintaining regular contacts with key agencies/services.

2. Program Description

2.1 The people

Clients are people who have substance use problems and are HIV positive. Most have a range of socio-psychological problems; many have experienced depression for many years – self-medication with drugs or alcohol is one of the common consequences. Other problems include borderline personality. Because of consumption of alcohol, some participants have cognitive losses. Participants also can have problems of managing anger or difficult relationship with others.

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[1] More information about FOHM can be found in Best practices agencies and Luba Serge (1999) *Documentation of Best Practices Addressing Homelessness*, Ottawa: Canada Mortgage and Housing Corporation. A 2002 document, *Le logement avec support communautaire: Document d'orientation* prepared by the FOHM, defines the position on social housing with community support (http://www.rqoh.com/PDF-fohm/definitionsupportcomm.pdf).

[2] The Centre Dollard-Cormier was formed when three centres (Alternatives, Dorémy-Montréal and Préfontaine) dealing with alcoholism and drug abuse were merged. The three had specific mandates that continue to shape the services offered: Alternatives dealt with youth; Préfontaine with the homeless population; and Dorémy-Montréal had a medical approach to substance abuse. One of the programs at the Centre Dollard-Cormier, the Services à la Communauté, is profiled in Kraus, Serge, and Goldberg (2005).

It is important to note that the diagnosis of the core problems is undertaken by partner and referral agencies such as Dollard-Cormier (substance use and mental health), local hospitals or the Centres de Santé et de Services sociaux (CSSS). [3]

In 2004, the project worked with 16 people: 15 men and one woman.

2.2 The housing

The housing consists of studio/one-bedroom apartments scattered in six different buildings owned by the City of Montreal and administered by the FOHM. Some of the units are bigger than others and in general, they are in good condition. Three non-profit member housing organisations also have made units available to clients of the program. Three participants currently live in such units.

The housing is permanent and all the participants have leases. There are two reasons for this. The first is that people may reduce/cease their consumption if they are "anchored" by the housing. The second reason is that people can continue to live in the units even if they no longer need or desire the support services.

Rent is 25 percent of income. An additional amount paid by participants covers the cost of electricity, cable, telephone (in part), and social activities such as community meals, visits to the beach, sugaring-off and Christmas parties.

2.3 Access to the program/housing

Eligibility criteria

Participants are homeless or at risk, have problems with substance use and are HIV positive. Most have psychological or social problems (e.g. aggressive behaviour, inability to deal with agencies, institutions, etc.) stemming from psychological problems. Often mental health problems that have not been diagnosed - many clients refuse to have anything to do with the mental health system.

Participants are referred to the program through one of the workers at Dollard-Cormier. In turn, referrals to Dollard-Cormier can come from nurses, social workers or doctors, as well as local hospitals.

People can be refused access to the program if they refuse support services offered by FOHM or if they have previously been tenants of the FOHM and were evicted for non-payment of rent or for violence.

Furthermore, if mental health problems are too great to be dealt with by either the program

[3] These are the result of a fusion of the CLSC (community health and social services centres) and long-term care facilities.

worker or a worker/professional from another agency, the person cannot be accepted into the program.

Degree of "housing readiness"

Housing readiness is not one of the criteria of the program.

Program expectations

The approach used is one of harm reduction and there are no expectations in terms of cessation of use. However, participants are expected to respect others as a minimum (e.g. not making too much noise, have too many visitors, etc.). People are expected to take their medication, although this is not a condition, instead persuasion is used. The role of housing is especially important and one of the influential arguments is the ability to continue to live in the apartment and have an autonomous life is related to taking medication. (NB for this group the medication can be for mental health problems and/or for the HIV.)

Individuals choose to be in the program and are expected to participate in elaboration of a service plan with the program worker. The plan includes goals that are set by the participant such as reduction of consumption (e.g. only using substances three times a week), better nutrition, better money management, taking care of the apartment, and seeing to health needs. The goals are reviewed and revised periodically with the program worker. The objective is to help the participant move to greater autonomy and self-sufficiency.

Program demand

A waiting list of 5-10 persons is kept by Dollard-Cormier. The waiting period ranges from 6 months to a year.

2.4 Substance use issues and policies

Substance use

Participants use a range of substances: cocaine, alcohol, marijuana, and prescription drugs. Heroin is currently too expensive for people, although one participant is on methadone. The type of drug used has not changed greatly over the last few years.

Problems arising from different types of drugs have been observed. For example people using cocaine or alcohol have a greater tendency to violence.

Other issues can arise from consumption – for example, the social networks based on consumption can lead to "the street installing itself in the apartment", while for some women, consumption can lead to prostitution as a means to support their habit.

Policies and approaches relevant to housing the target group

Use of substances
A harm reduction approach is used – what happens in participants' apartments is up to them - as long as they do not disturb other residents. If people use syringes, they are encouraged to use them safely.

Consumption is not permitted in common areas, nor is drug dealing.

Security measures
Security measures vary by building but there is a 24/7 emergency number for problems with the building that all participants can use. Clients are asked to use 911 for all other emergencies.

Guests
The residents are responsible for their guests – including behaviour that could disturb neighbours. Apartments are too small for more than one person and, because the rent is subsidized, they cannot be shared permanently.

Conflicts among residents
The primary method to deal with conflict among residents is to give them the tools to manage differences and problems. Residents are encouraged to speak to each other and solutions, for example, having the person experiencing difficulties send a letter to the other resident, are suggested. There have been instances when workers have intervened and, in very rare cases, the police have been called.

Temporary absence
There is some flexibility for temporary absences but because they have leases, the terms of the lease, including payment of rent, must be respected.

Residents who are abstinent
Because the housing is permanent, participants continue to live in their units and follow-up services are available to them.

Strategies to address relapses
Relapses are understood as part of the process of reducing/ceasing use of substances. There have been participants who have stopped consumption for up to two years and then relapsed. Because this is not an unexpected occurrence, support services continue to be offered to participants, to a lesser or greater degree according to the need and desire of the individual.

Role of staff in working with residents
One of the major elements to working with participants is establishing trust and a positive relationship – something that is not always easy. Issues such as substance use, conflict with other residents or calling the police are all carefully weighed and considered in the light of the long-term relationship that is being set up and the goal of creating confidence. This is especially important in the way that workers speak to participants. For example judgemental

statements such as “you consume too much”, are not allowed.

It is important to point out that while there is one worker directly assigned to this project, a larger team from the FOHM and other agencies is part of the support network. One of the pivotal relationships is that with janitors who work in the buildings and are a daily contact point. They play a role in making sure that participants, as well as the other residents, are doing well and not experiencing any particular difficulty. Janitors are often the first in line when a problem occurs or seems to be developing. They do not intervene, except in an emergency, but will take note and speak to the worker if they see signs of problems.

The role of the staff was summarized as, “In a small way, the FOHM is acting as a substitute social network, which, for many participants, is not just not available.”

Legal issues

Generally the police are aware of the nature of the buildings and of the harm reduction approach. A critical aspect of the work with participants is developing a trusting relationship, and avoiding police coming down is an important aspect of building this trust (compared to the relationship participants may have had while living on the street). Nonetheless, there have been times when the relationship with the police has been difficult.

2.5 Exits from housing and/or programs

Voluntary move-outs

Support services and housing units are separate – persons can decide that they no longer want or need the services but can continue on living in their apartment as long as they respect the rules in the building.

People who have left both the program and the housing have found themselves in projects that deal with HIV/AIDS as well as in shelters or on the street. Other participants have gone to prison or into long-term programs for substance use.

In 2004 there was a turnover rate of 70% in the program: 3 deaths, 2 voluntary departures, and 2 evictions.

Evictions

Great effort is made to avoid evicting residents and various means are taken to resolve the issues. However there are a number of factors that can lead to evictions, all linked to non-respect of the lease conditions. These include non-payment of rent, violence or problems such as too much noise, clients with dogs that cannot control barking, etc. In these instances, eviction proceedings must be undertaken at the Quebec Rental Board.

People also have had to leave the program and their unit because their health has deteriorated to such a point that they cannot stay at home in spite of the services available. In a number of

cases participants have died.

2.6 Services

Approach to service delivery

The model for service delivery is centred on co-ordination and partnership with a range of services and agencies. The program, through the FOHM, revolves around the housing. Much of the emphasis is put on health, autonomy, and the progress that individuals have made (e.g. maintaining their housing, meeting goals, etc.).

The program acts as a bridge between daily life and the various institutions and agencies. For example, there is co-ordination with the team that work at a community-based HIV/AIDS organisation. Participants may be linked to the Clinique Cormier-Lafontaine for persons with concurrent disorders. Medical staff can be called in if needed and participants usually have given permission to divulge personal information if deemed necessary.

The services that participants are given or encouraged to use are determined on a case-by-case basis. Often certain problems, such as those related to health, must take precedence and other issues follow. The complexity of the situations – the HIV status, mental health problems and substance use – make the diagnosis complicated and often, only when persons become stabilized, are other problems revealed.

Participants take part in job creation and training program – especially with those that have been created for homeless or formally homeless persons, such as the local street journal, l'Itinéraire. They also may participate in workshops that may be given by other agencies, while the program worker may help them with daily tasks, such as accompanying them to do their shopping.

The worker assigned to this project is available during normal working hours, as are the janitors in the projects. Furthermore, there is a 24/7 emergency number. Finally, at times it has been the neighbours who have called the emergency number or 911 when a participant has not been able to do so themselves.

Types of services

Mental health and addictions services
Depending on the needs, participants are referred to services available in the community, including detox centres in hospitals. It is important to note that to have access to the program, participants are clients of Dollard-Cormier and already benefit from the range of services offered by Dollard-Cormier or partner agencies such as the Clinique Cormier-Lafontaine, a concurrent disorders clinic jointly administered by Dollard-Cormier and the Hôpital Louis-H. Lafontaine,

Changes in services

There is evolution in the types of services offered depending on the needs. Many participants need help in day-to-day living. Recently a community garden was added to the activities offered.

Most effective services

The most effective services are:

- The availability of the worker, including their availability to accompany clients to appointments with agencies and services.
- Access to community resources.
- Knowledge of the services and the network.
- Stable housing.

Connections with community programs/agencies

The partnership and co-ordination with other programs and agencies is at the heart of the approach used.

2.7 Staffing and personnel issues

Current staffing	**Ideal staffing**
1 FTE This is the one person attributed to this program, but other staff at FOHM, such as janitors, play an important support role. This would not be sufficient if the other services such as Dollard-Cormier were not available. Therefore, while there is one full-time employee for this program, the worker sees herself as part of a much larger team that includes the various agencies that work in close collaboration.	The current staffing is adequate.

Staff burnout

Burnout is an important issue for workers and this is especially difficult in situations when a participant dies. While, infrequent, the death of a participant from a drug overdose is especially difficult and raises many questions around intervention

Support is given to the worker. For example there are meetings with a psychologist twice a month and the work conditions allow for longer annual vacations, “mental health days”, and extra health days.

Policies for hiring formerly homeless individuals

N/A

Professional development

The ongoing professional development is encouraged. Sessions offered at Dollard-Cormier, such as those on cognitive difficulties and substance use, personality problems, etc. are available. Furthermore, a budget has been set for participation at conferences (e.g. current research on HIV/AIDS) and for professional development.

2.8 Funding

Annual Revenue:

Source of revenue	**Amount**
Dollard-Cormier	$114,960
Total	$114,960

Expenses	**Amount**
Staff, support and activities*.	$114,960
Total	$114,960

*NB some of the costs of activities are covered by a "surcharge" on the rent. This surcharge also covers other services (e.g. cable, part of the telephone). Rental costs and expenses are part of the overall FOHM budget.

3. Outcomes, challenges and factors for success

The primary definition of success is maintaining residential stability.

3.1 Impact of the program on residents/participants

Outcomes	**Examples of Changes**
Residential stability (e.g. length of time housed)	Residential stability is seen as the starting point for many other changes that occur in participants' lives. Sometimes as people find some stability in their housing situation, they begin to recognise other needs and seek support for these.
Use of emergency services	Use of emergency services is seen as a sign of success. Clients who are living on the street have more difficulty taking care of their health and using health services. Most have been HIV

	positive for a long time and are very sick. They are often confronted by serious problems that require emergency services (e.g. infections) so the use of emergency services is seen as a sign that they are beginning to take care of their health.
Substance use (e.g. decreased use/participation in treatment programs?)	People change their consumption habits: they may decide to consume less or switch to different substances, such as beer with lower levels of alcohol.
Mental health	Housing stability helps people stabilize use of medication – one of the challenges is finding the right kind and dosage of medication, but this is easier to do when the person is stability housed.
Physical health	Again, housing stability has been found to help stabilize physical health – problems are more easily identified and following treatment requires much less effort on the part of the participant (compared, for example with life on the street or in a shelter/temporary situation).
Employment and education	All the participants are on social assistance although they may participate in work programs, such as those at l'Itinéraire, the local street journal. Some speak of pursuing educational goals, but none have followed through at this point.
Income	Participants depend on social assistance. One of the major constraints is the cost of medication, which can go up to $2,000/month for some. While they are on social assistance, this cost is covered.
Improved self care	This is one of the visible changes for participants. They wash their clothing, have their hair cut, and overall hygiene is better.
Personal networks (e.g. more contact with family, new friends)	Once people are stabilized, many express a desire to re-establish contact with family and social networks that they had before they began to consume. Having stabile housing and a phone help greatly in this respect.
Other	In many instances, when participants become aware of the difference in their circumstances before and after the program, there is a strong desire to not return to their previous lives. This is often a strong motivator to take charge of different aspects of their lives.

3.2 Resident satisfaction

N/A

3.3 Reasons for success

A major factor in the success of the program is the collaboration between agencies.

The multidisciplinary nature of the teams that are involved is critical, as is the shared belief in the program. In looking back over almost a decade of operation of the program, there has

never been any moment when its ability to meet its goals was in question or when any control over the process was lost.

Other critical factors are:

- Tolerance
- Consistency
- Flexibility
- Supervision and support.

3.4 Challenges

In the early days, the management of HIV was different and less successful – many died at that time. Medical advances in the last 10 years have made a big difference.

An ongoing challenge is expanding the apartments that are available to participants. The FOHM is trying to include other non-profit member organisations, and at this moment, three such units have been made available to participants.

3.5 Lessons learned

It is critical to understand the milieu that people come from – the street, substance use, HIV/AIDS.

It is very important to have a good understanding of housing and housing management.

References

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Contact: Aline Bestavros Intervenante Fédération des organismes sans but lucratif d'habitation de Montréal (FOHM) 1650, rue St-Timothée, suite 105 Montréal (Québec) H2L 3P1	Tel: (514) 527-6668 Fax: (514) 527-7388 General e-mail: fohm@videotron.ca Website: http://www.fohm.org/index2.php?section=fohm&item=accueil

APPENDIX B

Interviews with Residents/Individuals using the Programs Provided by the Case Study Agencies

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1. Participants' backgrounds

The researchers conducted face-to-face interviews with 25 individuals who were receiving services from six of the case study agencies where on-site interviews took place.[1] Interviews varied in length from 30 minutes to almost 1.5 hours, although most interviews lasted 45 minutes to one hour.

Thirteen participants lived in housing that was owned or operated by the case study agency, and also received services provided by them. The other participants lived in housing owned or operated by private landlords or other non-profit societies. The case study agencies had helped the participants secure their housing and provided ongoing support to help them maintain it.

1.1 Prior housing/homelessness

About two thirds of the participants (16) reported having been homeless for a period of time in their lives - some for a few years. Most had stayed in shelters or couch surfed with friends and family, while some had been "on the street" or in the "bush".

Five participants reported unstable housing histories, which included living in hotels, shared living arrangements, rooming houses and run down buildings. Another individual had been living in a large apartment that was declared "illegal". Eight participants reported that they had spent some time in a psychiatric hospital/ward as a result of their mental illness. Five participants reported that they had spent some time in jail.[2]

1.2 Characteristics

About three-quarters of the participants (19) were men and six were women. They ranged in age from 29 to 55 years old, but most were in their forties.

All the participants had issues with substance use – although some had stopped using substances at the time of the interview, and almost all the participants had a mental illness or mental health issue. Participants were also living with a variety of health issues including being HIV positive (one program was targeted to this population), Hepatitis C and diabetes. Participants were asked about their ethnic or cultural backgrounds. They identified themselves as shown in Table 1.

[1] These were the Walking to Wellness Program, Westview Dual Diagnosis Program, Mainstay Residence, Housing with Outreach, Mobile and Engagement Services (HOMES), Housing and Supports in Peel, and Concurrent Disorders/HIV Project. The researchers had planned to interview four individuals from each of the case study agencies. However, five interviews were completed at one location where the agency had arranged for an additional person to come in case one of the clients decided not to participate.

[2] Numbers don't add up to 25 because some individuals had been homeless and spent time in a psychiatric hospital and/or jail. Some had been in a psychiatric hospital or jail prior to becoming involved with the case study agency.

Table 1. Ethnic/cultural backgrounds

Self-identified ethnic/cultural background	Number
Canadian - including Canadians with European ancestry	4
Aboriginal	5
Quebecois/Acadian	4
The United Kingdom (Britain, Scotland, Wales and England)	3
English and French	2
Other (Caucasian, Dutch, Russian, Ukrainian, Irish/Norwegian, Central Asian and "a bit of everything")	7
Total	25

1.3 Where from

Most participants (17) were from the same province where the interview took place, and 7 were from another province within Canada. One participant was from another country. Only five participants were born in the city where the interview took place. The remaining participants were from another city. They had come to the city where the case study agency was located for several reasons: to be with friends or family, health reasons and an affordable place to buy a house.

1.4 How they became involved with the program

Most participants had been referred to the case study agency by a service provider in the community, including a shelter, health or mental health agency. One was referred by a psychiatric hospital, and another was referred by the police. Some shelters helped their clients apply to the program. A few participants were approached by outreach workers attached to the case study agency. A few participants had been involved in another program delivered by the agency, and staff referred them to the housing/support program described in the case study. A few participants had been involved in the program on a previous occasion and had decided to come back. One of them had been given a choice of entering the program or being prosecuted for assault the first time, but the second time, she decided on her own that she wanted to return.

2. Current housing

2.1 Length of time in current housing

As shown in Table 2 below, most participants (17) were living in permanent housing. Eight were living in housing that is considered transitional because residents are expected to move out after a period of time. One of these buildings is actually considered to be a treatment facility where residents may remain for 3-5 years.

Table 2. Length of time in current housing

Length of time in current housing	Transitional	Permanent	Total participants
Less than 1 year	4*	4**	8
1		2	2
2	1	2	3
3	3	4	7
4 or more		5	5
	8	17	25

* One participant had lived there a few years on a previous occasion.
** One participant had been on waiting list for non-profit housing for several years and at the time of the interview had only just moved in. He had lived in his previous apartment for several years.

Table 2 shows that most participants (15) had been living in their housing for two years or more while 8 had been in their housing for less than one year. Of the 17 individuals in permanent housing, nearly two-thirds (11) had been in their housing for two years or more and 4 had been in their housing for less than one year. It should be noted, however, that one of these individuals had been living in another apartment for several years while on the waiting list for his current unit.

2.2 Type of housing

Six participants were in buildings operated by a private landlord. The rest were living in non-profit housing that was owned or operated by the case study agency or another non-profit agency. About half the participants (13) were living in units that are integrated within non-profit or private rental buildings that serve a mix of tenants. The rest (12) were living in buildings dedicated to the target group or a similar clientele (e.g. people with concurrent disorders or mental illness and in need of support). Seventeen participants had their own self-contained unit – either a bachelor, studio or one bedroom apartment. The remaining eight had a private bedroom in a building with shared living space (e.g. bathrooms and/or cooking facilities).

Table 3. Type of housing

Ownership/Management	Dedicated/scattered housing	Type of unit
19 non-profit 6 private landlord	13 scattered sites or integrated in buildings with a mix of tenants 12 dedicated buildings	17 self-contained units 8 shared living space

2.3 Satisfaction

Participants were asked to rate how satisfied they were with their housing on a scale of one to five (with 5 being most satisfied). As shown in Table 4, most participants were satisfied with their housing (eleven were satisfied and five were very satisfied). Four were not satisfied.

Table 4. Satisfaction with housing

		Number of participants
1	Very unsatisfied	2
2	Not satisfied	2
3	Neutral	5
4	Satisfied	11
5	Very satisfied	5

There did not seem to be any correlation between the type of housing participants were living in and their level of satisfaction in terms of ownership, being in a dedicated building or scattered unit, or the type of unit, except for a concern from one participant in a private rental building who thought the rent was too high.

What participants like most

When asked what they liked **most** about the place where they were living, participants provided the following comments:

Housing. Seventeen participants mentioned something they liked about their housing. Some simply appreciated having a roof over their head – "a place to stay". As one participant said, "I can work out, eat, watch TV, relax and sleep. I can do anything!" Another said, "It's home – it's mine. I'm happy when I come home." One participant said it was the best place she had lived in 12 years. Another said it was the first time in his own place, and it contributed to feelings of self worth and confidence.

Some participants said they liked the size of their unit, privacy, having their own bedroom, having their own bathroom, having a balcony, the size of their fridge and their view. Others mentioned the grounds – a quiet and peaceful garden and a stream that ran by. One participant appreciated being on the ground floor – with no stairs.

Six participants said they liked the location of their housing – it was close to services, places for coffee, the lake and a nice park.

Five participants commented on the communities within their buildings. They discussed how they had friends in the building and that the tenants were getting to know each other. They also commented on the importance of common areas for providing a place to meet and socialize. One participant said he "likes it that he can be by himself in his room or with others in the common areas". One participant likes it that all the tenants in the building are in the same program. She feels she can talk with her neighbours about what is going on with her and can walk around the building in her pyjamas. She said there was a feeling of closeness in the building. Another appreciated that the building is small and everyone has the same income. One participant said he "feels accepted for who he is".[3]

[3] Three of these participants lived in dedicated buildings, one lived in mixed non-profit building, and the other lived in a private rental building.

Four participants in non-profit managed buildings dedicated to the target population mentioned feelings of safety and security. One participant said she felt safe in the hallways and another appreciated that there was no harassing landlord. Having a superintendent that was good at fixing things was valued by one participant.

Two participants in non-profit buildings said they liked the affordable rent. One of them appreciated that the cost of heat and hydro was included in his rent, which helped with budgeting.

Staff. Four participants said what they liked most about the place where they were living was the staff. They valued their relationships with the staff and being able to talk with them.

The program. Participants also mentioned some specific aspects of the program that they appreciated. These included having staff available 24 hours a day "so you can always talk to them", the money management program, "so you aren't hungry mid-month", and assistance with managing their medications. Participants also appreciated that the program is not too regimented, the food is good, and nobody comes in drunk. One participant appreciated that the tenants were able to get donations of clothing, furniture, pots and pans and other items from the community to help them set up their apartments. Another participant said, "now that I've had some clean time, the program is starting to work for me".

What participants like least

When asked what they liked **least** about the place where they were living, participants raised the following concerns:

Housing. Seventeen participants mentioned something that they didn't like about their housing.[4] Six participants expressed concerns about the building: that the security system in the building is broken, there are no decent locks, there is a lack of privacy, poor sound insulation between units, there are problems with the plumbing, and the common areas are run down and dirty. Four had complaints about their unit: that it was too small, didn't have a balcony, didn't have air conditioning, and didn't have a stove or cooking facilities.

Four participants raised concerns about other tenants in their building, including a drug problem, noise, not enough other women in the building, gossiping and other conflicts. One of these participants said he feels that the landlord takes advantage of the tenants. He said he had painted some units in the building and cleaned the common areas in the building for little or no pay. He wants to please the landlord because he doesn't want to lose his apartment. Another participant complained that the management can be harsh and judgmental. These comments applied to dedicated and scattered site housing in both non-profit and private rental buildings.

Three participants in non-profit managed buildings dedicated to the target population expressed concerns about the location of their housing. They said that it is a problem

[4] Totals are greater than 17 as some participants mentioned more than one concern about their housing.

being right downtown. There is too much temptation close by – bars or restaurants with liquor licenses, and it is too easy to get drugs. One participant said that there are too many "crack heads" in the area.

One participant living in a private rental apartment said he thought it was too expensive. Another (in a non-profit building) complained about the grounds – that there is no grass around the building.

2.4 Housing rules

Participants were asked if there were any rules for living in their housing and what they thought of these rules. Most participants agreed that the rules were necessary for the comfort, safety and security of the tenants and that they were reasonable and understandable. One person acknowledged that the rules "are fair but hard to follow". However, another felt that the landlord was imposing too many rules.

The participants identified the following rules and/or program requirements:

Guests. Several participants pointed out that guests are required to leave by a certain time (e.g. 10:30 p.m. or 11:00 p.m.) Some participants commented that they agreed with this rule because otherwise the guests would wake people up. On the other hand, one participant was not happy that his friends have to leave by 11 p.m.

Drugs and alcohol. Different programs had different requirements. Some participants stated that drugs and alcohol were not permitted on the premises. Others stated that drugs and alcohol were not permitted in common areas (including outside on the building premises) but participants could do what they wanted in their own apartment. Another participant noted that they were not permitted to sell drugs. In one program, residents who are under the influence of a substance are not permitted to return to their unit - there is a separate place in the facility where they may go to "sleep it off". One participant who lived in housing where drugs and alcohol are not permitted noted that if she was using, the rules wouldn't be good. However, if you are trying to change, the rules "fit the bill".

Long term guests. Participants noted that there was a limit to the length of time that guests can stay. One participant noted that you get a lot of "clingons" - too many people have others crashing at their place. This included the participant himself whose roommate was paying him $100/week and bought him a TV. The participant no longer wanted the roommate living with him. [This appears to be a problem with lack of enforcement of the rule rather than with the rule itself.]

Money management. Most participants reported that they appreciated having their income managed. One participant said that at first she didn't like this arrangement and she wanted control of her money, but now she said that she likes it better this way. One participant whose money was being managed by the public trustee said she wanted more control over her finances.

Requirement to participate in the programs. Some participants thought this was good. Another commented that some residents have low motivation and "this can wear on you."

Medication management. Several programs assisted participants with managing their medications (e.g. signing for pills).

Hygiene/cleanliness/proper dress. Some programs require residents to shower regularly, do their laundry, keep their room clean, and dress properly (e.g. with shirt on).

Treat others with respect. Some programs try to ensure that the residents/tenants treat each other with respect, and make it clear that violence is grounds for termination of the housing or program.

Other. Some of the other rules include letting staff know if you will be away for the weekend, not playing loud music, turning off the TV at a certain time, not too many parties, not bringing women into some of the common areas, and no dogs. One participant complained about not being permitted to watch TV or movies late at night.

3. Activities

3.1 Daily activities

Participants were asked about a typical day and the programs and activities they are involved with. They mentioned a variety of activities, including preparing their own meals, cleaning their apartments, and attending to their health issues by going to medical appointments and taking their medications. One participant picks up his methadone almost daily and travels to a nearby city once a week to pick up his prescription.

The participants also discussed visiting with friends - both inside and outside the building. Some like to play cards, pool or chess with the other residents. Others go to drop-in centres and various programs. Some visit their families. One participant takes his son to school and picks him up most days.

Participants also mentioned going to the movies, for bike rides, walks, the park, coffee, listening to music, watching TV, feeding the ducks and geese, and reading the bible.

Some participants are also involved in community activities, such as swimming at the "Y" and going to the library.

Eight participants said they had some form of part-time work, and one participant was attending a job training program.

Two participants had attended a local community college while in the program and had received certificates to be community mental health workers.

3.2 Mental health programs

When asked if they were participating in any mental health programs or activities, 20 respondents said they were. Some attended drop-in programs in the community, including those operated by the local Canadian Mental Health Association. Others attended group meetings and programs in the building where the case study agency operates. Several participants said they receive visits from their support worker – usually once a week. Some participants also reported that they would see a psychiatrist or nurse.

The following table is a summary of what participants said they like or dislike about the mental health programs they are involved with.

What they *like* about the mental health programs	**What they *don't like* about the mental health programs**
• Provides structure and focus. • 24 hour staffing - if having a problem, can talk to someone any time. • Ability to discuss both mental illness and substance use, and how drugs affect their symptoms. • The programs are very supportive. • The staff. One person commented on how staff "look out for your best interests". Another who participates in a group program likes it because "the girl who runs it is very nice and does a good job with the group. She is in control and also jokes around." • When you run into problems you can talk them out. • Good conversations and "talking about stuff I never had time to tell anyone." • Talking to the psychiatrist.	• Some group members/participants are not motivated. • Didn't like the programs at first. Was in denial – didn't think she had an illness. Thought she was punished for doing drugs. But likes them now. • Sometimes you'd rather be doing something else. • One person who attends a drop in groups says that what he doesn't like are "some of the idiots who also stop by" and who the participant describes as "paranoid schizophrenics telling you that they are the King of England."

One participant said she would like more group sessions, videos and testimonials from people who have stabilized.

3.3 Substance use programs

When asked if they were participating in any programs to address their substance use, 14 participants said they were. Some of the programs were provided on-site. Often, the participants reported attending Alcoholics Anonymous, Narcotics Anonymous, 12-step or other group meetings. Others reported seeing a counsellor. Some support workers visited their clients in their homes. One person reported being on a methadone program. Three participants reported that they participated in dual recovery or concurrent disorders programs rather than a program just for substance use. Three participants said they no longer go to substance use programs because they no longer use drugs or alcohol.

Another person who was involved in a program that provides both mental health and substance use services concurrently said that after being involved for 3-4 years, he decided to pull away and become more independent.

What they *like* about the substance use programs	**What they *don't like* about the substance use programs**
• The education. • Everyone is willing to help – staff and residents. • Staff understand. • Staff "light a fire under your ass". If you're not doing OK, they tell it to you straight. • You can talk about your problems with others. • You can relate to some things people say. • Counsellor who gives him "tips". • Prefers program targeted to people with concurrent disorders. Based loosely on 12-step, but with less rhetoric. • The facilitator understands both mental health and addictions. • AA meetings help keep him sober, so he keeps going back.	• Can't stand the rhetoric and slogans at AA and NA meetings. • Sometimes may need more one-on-one counselling than is available in groups. • They don't listen to us very much. • Being required to pray to the higher power at the end of each meeting.

3.4 Activities offered by the case study agency

Eight participants reported that they participate in group activities organized by the case study agency. Some of the activities included going to an amusement park in the summer, cooking classes, a camping trip, walking trips, bowling, swimming, going to the library, going for coffee, frisbee golf, karaoke, euchre, and going to hockey or baseball games.

One person liked that the programs are geared to where the residents are at. She brings her son and thinks it's great that family members are able to participate. Another person said he enjoyed working in the community garden because "you get to do something different". Another found the activities fairly enjoyable – they "get you out and active". On the other hand, one person stated that transportation can be a problem as he doesn't like overcrowded vans.

4. Previous situation and how changed

4.1 Health

Physical health

Participants were asked what their health was like before they became involved with the case study agency. One participant said he was pretty healthy, although noted that he was really skinny. Three said they were OK, although one of them noted that he had lost 35 lb, dropping from 190 to 155 lb. Altogether, 6 participants reported that they had been losing weight prior to their involvement with the program. One participant went down to 70 lbs. On the other hand, one participant reported that he was obese. Another 7 participants reported that they were not eating enough food or getting the proper nutrition. One of these participants said he was always hungry.

Four respondents reported that they were HIV positive. Prior to getting involved with the program one person reported that he had been very ill, was down to 100 lb and had an infection in his mouth. The other two reported low energy and weight loss. Four respondents had Hepatitis C, although one of them said he didn't appreciate the implications until after becoming involved in the program. Three participants reported back problems, and two reported difficulties sleeping.

Other health concerns that participants reported having before becoming involved in the program included being run down and not taking care of themselves, high cholesterol, a life-long thyroid condition, high blood pressure, osteoarthritis, hip problems (one person had an artificial hip), liver trouble, fibromyalgia, memory loss, and bladder problems.

One participant had been attacked a few years prior to the interview. He had been hit on the back of the head and spent 2 weeks in a coma. He had been told that he would not walk again. At the time of the interview he was able to walk with a cane but had problems with his balance and partial paralysis on his left side, memory loss, difficulties with concentration, and epileptic seizures. Another participant reported that he was unable to remember anything after two minutes.

When asked how becoming in involved with the case study agency had affected their physical health, five participants reported that they were feeling better (stronger, healthier, or in good shape) since becoming involved with the program. Ten participants reported that they were eating better. One participant stated that he had a full fridge. Another reported that since being diagnosed with diabetes she is on a special diet and the worker is paying more attention to her health. Three participants reported that they were sleeping better.

Six participants reported that since becoming involved with the program, they have been able to address some of their health problems. One of the participants who was also diagnosed with heart problems stated that "without the program, I would probably be in prison or dead". One participant was having problems with his stomach and was going to

go for some tests. Another was being evaluated by a specialist once a year. Another is able to rest when she needs to, now that she has a place to live.

On the other hand, one person reported that he was developing arthritis. He said that he feels himself getting older and the effects of aging. Another feels that her health is worse now due to past damage, and a third participant complained that she was gaining weight and was *not* happy about it. Three participants reported that they had no change in their health since becoming involved with the case study agency.

Mental health

When asked about their mental health before becoming involved with the case study agency, almost all the participants reported that they were having difficulties. Six participants were struggling with depression and two were suicidal. Four participants said they had been hearing voices. Four reported feelings of paranoia. Two participants reported that they had schizophrenia. Participants reported that they were also struggling with other issues including stress, talking to themselves, their minds "playing tricks on them", anger, post traumatic stress, and heading for a nervous breakdown.

When asked how becoming in involved with the case study agency had affected their mental health, almost all the participants (21) reported that they were feeling better since becoming involved in the program. For example, one person said he felt better, more confident and had a more positive attitude. He said, "I will not give up on life no matter how low I get". Another said he feels more secure and enlightened. He feels he is part of something and has more to do – he values his life more.

Seven participants indicated that they felt better (including happier, more stable, less stressed, more self-esteem and more self-respect) *because* of the program. Some of the specific reasons given included the staff/support worker. One participant said that without her support worker, she believes she would have committed suicide. Other reasons included being able to speak with the staff, peer support, counselling, group activities, and being able to access a psychologist/psychiatrist.

Two participants reported that they were better able to handle their mental illness as a result of what they had learned while being in the program. One of them said that now, if she is going through a psychosis or hallucination, she will write down what she is experiencing and can talk to staff. The other person reported that he understands his symptoms and is able to manage them better without making them worse. Another person said that the voices went away as soon as he stopped using drugs and alcohol and was able to sleep.

Four participants attributed their improved mental health to "being on the right meds". One participant said he appreciated the medication support provided by the case study agency.

Two participants noted that their housing contributed to their sense of stability. As one participant said, she no longer has the stress of not knowing where she will live the next day or what she will eat. With housing, she feels secure. She likes being able to have

control over her space, her life and what she eats. She has less stress and more security. This person also said she looked forward to her weekly visits from the support worker.

One participant attributed his better outlook to the work he was doing with a homelessness street journal.

Substance use

When asked about their use of drugs or alcohol before becoming involved with the case study agency, all the participants, except one, indicated that they had substance use issues. This included using alcohol, prescription drugs, marijuana, cocaine, crack, morphine, heroin, opiates, solvents, LSD, and hashish. Some participants used a combination of drugs and or alcohol.

When asked if there had been any changes in their use of drugs since becoming involved with the case study agency, close to half the participants (12) indicated that their substance use had decreased. Two said that they have "slowed down" on their drug and alcohol use and were no longer injecting drugs. One participant said his "slips are fewer and farther between", and another that he has had more clean time in the last 5 years since being involved with the program than the 7-8 years before that. One participant said that he used to drink ¾ of a bottle of whiskey before becoming involved in the program but has switched to drinking a few beers every day. One participant said he is using less now because of the work he is doing with his counsellor. He is learning more about what triggers his use and feels closer to "conquering the problem". He also feels that a change in location would help him. Another participant says that working has made the difference to his substance use.

Six participants said that they had stopped using substances since becoming involved with the case study agency. One participant had been sober for one month since entering the program. Another said she quit drinking as soon as she became involved with the program because she was so grateful to be there. There were some relapses along the way, but at the time of the interview she had been sober for about a year. Another decided to quit after he was beat up. He also noted that it was helpful to have someone else look after his money so he wouldn't spend it on drugs or alcohol. Another participant quit using substances because he got tired of being sick. He too noted that the staff had encouraged him.

Five participants indicated that their substance use had increased since becoming involved with the case study agency – although the amount may not be significant. One person had been referred from a psychiatric hospital where he had remained abstinent, but had begun using substances while in the program. One participant said she is using more crack because there is a crack dealer close by. Another reported being a binge drinker who was drinking more than before, but was drinking less harmful substances - she was drinking vodka and rum rather than mouthwash or perfume.

One participant had stopped drinking since he became involved with the case study agency. However, he had started using cocaine a few times a month. It was continually offered by his friends, and when he tried it "it bit him".

Table 5. Changes in substance use

Substance use	Number of participants
Using less	12
Stopped	6
Increasing	5
Less quantity but started using a new substance	1
Don't know	1
Total	25

Prior experience with a treatment program

Less than half the participants (11) had been to a treatment program before becoming involved with the case study agency. Another three participants reported that they had been involved in Alcoholics Anonymous and/or Narcotics Anonymous. Eleven participants had not attended a treatment program – although a few had been in detox. Some of the reasons for not trying a treatment program were that they didn't think they needed it and nothing was available.

Among the 11 participants who attended a treatment program, five individuals had found the programs helpful or somewhat helpful for varying periods of time. One person had spent 60 days in a hospital for cocaine use and hasn't used it since. However, this same person was drinking a significant amount of alcohol when he became involved with the case study agency. One person pointed out that although the program was pretty good, going to treatment can "bring a lot of pain out".

Five participants who went to a treatment program said that they didn't like it, and had some specific complaints. For example:

- One person quit because the therapist insisted he could become heterosexual. As he said, "I had struggled with my homosexuality for 10 years, and this was not helping".

- Another felt there was too much emphasis on guilt and shame, and not enough attention paid to nutrition.

- Another participant felt there was both too much and too little going on. He couldn't keep up with the requirement to attend meetings every day at 9:00 a.m. and again from 1 p.m. to 2 p.m. He felt there was too much information. At the same time, there was nothing to do after the meetings.

- A fourth person was "turned off" by the counsellor who he felt was too closed minded. He also didn't like the requirement for regular attendance at Alcoholics Anonymous, Cocaine Anonymous, and Narcotics Anonymous meetings.

- Another person felt that the treatment program put too much stress on her. They made her look at things. She became a "depressed drunk". Although the programs showed her there were options, her addiction was too strong. She didn't think she could change and didn't think she needed to change.

One participant pointed out how the lack of decent affordable housing in an alcohol and drug free environment made it difficult to remain abstinent upon leaving a treatment program. He had tried a treatment program about 5 times in the last 10 years. Each time, he would leave treatment and go back to where he could afford housing - where everyone was using - and he would start using again.

4.2 Income

Eleven participants reported that their incomes had increased or they had more disposable income since becoming involved with the case study agency. Some of the reasons included:

- Being able to access income assistance;
- Being able to increase the amount they received from income assistance due to disability or special nutrition requirements;
- Having part-time employment; and
- Having more disposable income because of reduced housing costs.

Ten participants stated that their income was the same since they had become involved with the case study agency. The main reason was that most of them were already in receipt of income assistance before becoming involved with the case study agency. Some of the shelters had helped their clients access income assistance.

Regardless of whether their income had increased or remained the same, nine participants reported that their income was stable. Eight participants reported that the program was managing their funds to help them with budgeting or their funds were being managed by a trustee. Seven of them appreciated this service and the fact that their rent is paid and they had money throughout the month for groceries, coffee and cigarettes. As one person said, "before, I was broke 2 hours after cashing my cheque". Another said, "If it wasn't for the trustee program, I'd be on the street. They make sure the rent and cable are paid". Another person said that if his money wasn't budgeted he would spend it all on drugs. Now, he can pay rent, buy food and get enough spending money for coffee and cigarettes. On the other hand, one person wanted to get off the public trustee program and get control over her income. Participants who were not involved in a money management did not indicate if they were having difficulties budgeting their incomes.

Almost all the participants received income assistance as their main source of income, but eight participants also reported that they do some part time work. This included janitorial services for the case study agency for a few hours in any given month, working at a homelessness street journal, being part of a casual job pool, landscaping, yard work, painting and construction. One person reported that he sometimes makes money telling jokes. One participant provided peer counselling and another was a recreation assistant

for the programs they were involved with. Participants reported earnings from $120 month, up to $400 a month, and $8/hour for 40 hours a week ($320), but not every week.

4.3 Family

About two thirds of the participants (16) said they were in touch with members of their families. Eleven of them said that their relationships with their families had improved since becoming involved with the case study agencies. One participant said her relationship with her son had improved dramatically. Another reported that he had been out of touch with his father a long time, but that now he and his father has gotten closer. He reported that his father sees the change in him and for the first time in 10 years has said he is proud of him. Another participant recounted how the previous weekend he had attended horse races with his parents and had money to pay for his own bets and food. He said that he felt good about this and so did his parents. He also said that his parents understand more now about his problems and are supportive. Another participant reported that he has become friends with his ex-wife and has spent the last 5 years (since he has been involved with the program) trying to make up to his son for the time he was not there for him.

One participant said that his housing support worker made him talk to his sister and his relationship with his son is 100% better. The support worker talked to his ex-wife to reassure her that he would never hurt his son.

Two participants said their families are very pleased that they are involved in the program, and one said that his family has noticed a great deal of improvement. He speaks with his family on a weekly basis and notes that it is easier to keep in touch because he is more stable. He used to be a great worry to his mom, but "she is much happier now".

A few participants were able to express some of the challenges of staying in touch with members of their family who use substances. For example, one father said he sees his children less because their mother is still using alcohol and he doesn't want to relapse. Another participant is also struggling with how to maintain contact with members of her family who continue to use substances. She identified a need to learn how to say no and set boundaries when she sees them. At the same time, she is interested in establishing contact with other members of the family who don't use substances and whom she used to ignore – or hide from.

Five participants said they have no contact with their families. One participant said that his parents are dead, and the siblings don't talk to each other. Another doesn't want to know anything about his family – although he has some contact with his mother. Another indicated that there were some problems with the family. One said that relations have become more distant since becoming involved with the case study agency and another said she disowned her family some time before becoming involved with the program.

4.4 Friends

Eight participants reported that they had made new friends since becoming involved with the case study agency. One participant said she has made many new friends since moving into the building. She feels she can speak freely with her friends in the building since they are all in the same situation. Another participant reported that she is not embarrassed to have people over now. Four participants discussed how they were spending less time with former friends who were still using substances. As one of them said, "they just want beer and money". Two participants said that they had a few good friends who have stayed friends over the years. One person said, "I don't have many friends, but the ones I have see the difference in me".

4.5 Use of emergency services

Sixteen participants reported that they haven't used emergency services since becoming involved with the case study agency. Some of the reasons were that they have others to look after them, including a doctor, nurse or their support worker. One participant reported that she used to use the emergency department when she overdosed, but doesn't need this service anymore. Another said that he had better control over his anger and has someone to call any time. "I can call his machine and sound off if I get really mad at someone". One participant used to call the crisis lines but not any more. She just sees her support worker.

Four participants reported that they are making much less use of the emergency departments. Three participants reported going to the hospital for physical problems e.g. broken leg, falling off his bicycle, and after a fall in his apartment.

5. Factors responsible for changes

When asked about the factors most responsible for the changes in their lives, the most frequent response was the staff, the program, housing, and the participant's own motivation to change.

5.1 The staff

Sixteen participants reported that the staff who were working with them were responsible for the changes in their lives. This included participants from each of the case study programs. The participants commented specifically on the quality of the relationships they had with the staff. As one participant said, "people need trust and positive healthy relationships to make positive changes in their lives". Other participants reported that the staff genuinely care and are really nice. They make sure you get to appointments. They try to help you help yourself. One person said, "they listen/hear me, including the nurses and workers. I feel as if there is a network that has been formed around me. I'm really lucky to be so well surrounded".

Other participants focused on the availability of staff, and appreciated the 24 hour staffing – the fact that staff are onsite for support in case help is needed. Others said they appreciated being able to call the support worker any time.

Participants also appreciated the care and attention they received. A few participants said they looked forward to the visits from the support workers. This was essential for one participant who stated that she wouldn't be able to go out to the appointments.

Participants valued some of the specific ways in which staff supported them, by helping them to identify options, checking on them to see how they were doing, taking them for coffee, and taking care of whatever needed to be taken care of. Participants appreciated that staff would talk to them. One participant said the worker would ask why he drank and he would answer – and this helped. Another participant said that staff would help him figure out what to say to someone who wanted him to go for a drink. He pointed out that it is hard to say no to a friend since they would get mad. Another participant said "staff make sure everything is good. They are there when you want to talk, provide tobacco, and the meals are good and on time".

One participant said that the staff are involved in all facets of his life. They are always there to help, regardless of the type of problem.

Another participant said how becoming involved in the program had been difficult in the first year. Staff helped him get a strong support system. They spent a lot of time with each client and talked with each one about what was going on in their lives. They provided a sense of security. Staff helped him look at his mistakes from the past and encouraged him to share his experiences with other clients. Staff also provided a great deal of information regarding substance use and mental health. They accepted him for who he was without blame. He started to trust the people at the program and saw it was time to "grab hold and make changes".

One participant appreciated hearing personal stories from the counsellors who had similar experiences. They were able to say, "I've been through that and know what you're talking about." Hearing them say how they escaped and got past their addictions gives her hope that she can make the changes she wants in her life.

5.2 The program

Nine participants said that the program itself was responsible for the changes in their lives. This included the safety and structure provided by the program and the fact that the program provided a home. As one participant said, "the program has given him hope". Some of the specific aspects of the program they appreciated were:

- Home visits – since with her physical problems and depression she would not be able to go out to the appointments;
- Peer support and counselling of group members;
- Managing the money;
- Group outings – opportunities for good clean fun helps keep your mind off using and contributes to a sense of well-being;

- Learning a lot e.g. budgeting;
- The rules about no drugs and alcohol;
- The fact that the program started small with only a few clients at a time made it possible for staff to spend enough time with each new client; and
- Helping participants access the kind of specific services they need e.g. psychiatrist, medical doctor.

One person noted that being sober had helped his mental health. Another person explained how after 6 months in the program, he was doing well. He had one relapse after a year and worked through it with the help of the group. He became more active in the groups, and eventually gained a sense of accomplishment. His self-esteem grew, and this affected his whole life.

5.3 Housing

Eight participants identified housing as a factor responsible for the changes in their lives. They noted that the housing provided safety and stability. One person said, "if I hadn't moved in here, I'd have ended up in an apartment surrounded by assholes, hooked on acid, with my family having nothing to do with me. I like the way it is now." Another participant appreciated that the program he is involved with has a home that can provide the clients with a temporary place to stay if needed. Another commented on the sense of community within the housing. She stated that the tenants in the building get together and talk. She doesn't feel she could make it in a 1 bedroom apartment on her own without supports and neighbours in the same situation.

5.4 Motivation

Four participants identified their own motivation - desire to have a better life and do better – as the main factor responsible for the changes in their lives.

5.5 Employment

Two participants said that working had made a significant change in their lives and was very important to them. One of them said that he had gone 48 days without gambling since he started working. He was working too hard for his money to risk losing it.

6. Goals

When asked about the kind of changes they would like to see for themselves over the next year, if any, participants identified the following goals.

Employment and education. Eleven participants said that they wanted to be employed. For some, this meant part-time or even volunteer work such as walking dogs for the SPCA or working in one of the programs provided by the case study agency. One person was looking forward to writing for the homelessness street journal. Others said they wanted to be working full time. One person expressed interest in being able to provide drug addiction and chemical counselling, another (who received a mental health worker certificate) expressed interested in the mental health field, and another was interested in

starting up a business. One participant was involved in an employment program at the time of the interview.

Education, lifeskills, self improvement and seeking happiness. Ten participants discussed wanting to make improvements in their lives and increasing their happiness. They expressed interest in going back to school/college and taking general interest courses in life skills, budgeting, learning to drive and cooking. One participant wanted to take up painting again. Participants also said they wanted to become more assertive, learn to set boundaries and say no, and develop a stronger sense of themselves. One participant said he wanted to stop gambling.

Improve physical health. Eight participants said they would like to improve their physical health and take better care of themselves. This included exercising more, stopping smoking, seeing doctors, and getting dentures.

Move to better housing. Six participants said they would like to move somewhere else – to get their own place – a regular apartment or just a bigger place. One person specified that he wanted to live in a different location e.g. outside the downtown core - "A place to call home".

Getting off drugs. Five participants said they would like to stop using drugs or alcohol. One of them had been abstinent for a month and was hoping to be able to continue. Another participant was using methadone and wanted to be able to stop using that as well.

Family ties. Three participants said they would like to improve their relationships with their families. Two would like more contact with their children and one would like to have more of a relationship with his brothers and sisters.

Financial. Two participants wanted to make changes in their financial situation. One wants to get a pension he thinks he's entitled to from his past work. The other wants to be able to control her own money.

7. Participants' suggestions

Participants were asked if they had any words of wisdom or advice for other organizations that might be interested in doing a similar project to one like their case study agency. They were also asked to provide comments about what features of the program they thought should be different and what should definitely stay the same. The following themes emerged from their comments.

7.1 Staff

It is clear that staff, and the way they relate to clients will be critical to the success of any program. Eleven participants discussed what was important to them in terms of staff. They believe programs need to hire staff who are empathic, honest, and who are able to listen, provide positive encouragement, be understanding, and non-judgmental. They also believe it is important for staff to get to know each resident and to establish relationships based on trust. As one participant said, the program needs to have "good support workers who do not pressure you and who you can trust and be truthful with". The personal touch is essential. They want "hands-on staff" and note that small projects make this possible.

The participants also value staff who will:

- Treat them with respect;
- Be able to get along with everybody;
- Be available when needed;
- Be vigilant about how each client is doing – particularly if a client is unwell;
- Help them with practical day-to-day issues, such as making sure they get to appointments, helping with transportation, as well as sorting out issues with government bodies and welfare cheques; and
- Understand both mental health and addictions.

On participant said, "people are on guard when they enter the program. They've suffered so much. They have been badly damaged. They have trust issues. They are fragmented. It is important to be gentle with these people. Staff need patience and commitment. And they need to really want to do it."

7.2 The program

Sufficient staffing. In addition to the qualities of staff, participants identified a need for programs to have *enough* staff. It is important to them that staff are available when needed and keep in touch with them (at least weekly) to make sure they are OK and have enough food to eat etc. Participants in buildings with 24 hour staffing appreciated that there was always someone available on-site that they could talk to. They also stated that they appreciate the counselling and support provided by staff and look forward to their visits. A few participants thought their program could use more workers. They noted that sometimes clients need more one-on-one time than is currently available.

Support groups. Participants said they like support groups because they help people get to know each other, learn more about themselves and their issues, and can bring people closer together. On the other hand, one participant expressed concern that "when a group of addicts gets together that some people could take the others down".

Program size. Participants expressed support for small projects where staff can know everyone by name. They expressed concern that a large project would feel like an

institution. Another participant also suggested starting small to make it easy to iron out any start-up issues.

Program structure and activities. Participants indicated that the structure provided by programs is very important. Several participants commented on the need for structure in their day and the need to keep busy - to alleviate boredom and give the tenants more to do. One participant said that structure is particularly important for people coming off the street – to prevent self-defeating patterns. They thought it was important to provide on-site programs and activities as well as fun group outings such as bowling and go-karting. They thought it was important to encourage people to get involved in activities but also cautioned on the need to provide adequate supervision, particularly if some of the participants are unwell.

Help with budgeting. Most participants who had their finances managed for them thought this was very helpful. They recognized that if they have money, they will probably spend it on drugs, and will not have enough for rent or food throughout the month.

Links to services in the community. Participants also identified a need to ensure that clients have access to services they need in the community, including doctors, nurses and counsellors.

Privacy. Two participants expressed concern about staff sharing the details of their caseloads with each other. They want to be able to talk with staff sometimes "off the record", but expressed concern that staff would always write down everything they said and share it with other staff.

Flexibility. One participant said to make sure the program meets the needs of each individual who is there. Another also suggested that program sponsors be prepared to evolve and change over time.

House rules. Some participants expressed support for existing rules, while others wanted more freedom and flexibility. It was suggested that regular resident meetings be held and that staff be available to deal with issues of concern to the tenants and with any conflicts that may arise among the tenants.

Spirituality. Programs should recognize the need for some clients to be in touch with their spirituality, religion and cultural backgrounds.

7.3 Housing

Several participants discussed the importance of affordable housing. One stated that he had spent time in psychiatric hospitals and believes it is better to put money into programs such as the one he was in and into low cost housing. He said that he hasn't been to a psych ward since becoming involved with the program. He also said "housing - if it's a safe place to live, that's the foundation of everything. If you are not relaxed where you are living, it puts stress on everything. You don't eat or sleep properly."

Another participant said, “This is the only opportunity I see for people like me to get an apartment instead of living in just a room. Please tell others that this is a serious matter. Focus on helping us with the stress level in our lives. Safe homes is a first step. Then focus on why people are doing drugs and alcohol. People need safety and support, but you can’t baby them. You need to get the person’s trust in order to help them.”

Participants identified a need for more affordable housing – “there shouldn’t be such a long waiting list” and for good quality housing, in a nice/safe area. They stated that housing (units and common areas) need to be well maintained. Participants appreciated housing where if there is a problem the superintendent will fix it. They also identified a need for housing to be safe, and stated that landlords should deal with safety issues e.g. proper locks and a security system at the front door.

Participants also identified a need to consider the types of units available to clients (e.g. self-contained – with a private bathroom and kitchen). They identified a need to ensure privacy. Some participants expressed a desire for larger units. Some participants like to live in a building with on-site staffing and common space for socializing with other tenants. One participant who had been in transitional housing said she would like to have stayed longer. She thinks that residents should be able to stay as long as they want to.

Other suggestions included:

- Ensuring that procedures are in place to address conflicts among tenants.
- Ensuring that participants receive help to acquire furniture and household supplies.
- Providing a public phone in all buildings.
- Ensuring that buildings are designed so that services are accessible services (e.g. laundry room closer to the units and less expensive).
- Ensuring that landlords and superintendents are able to deal with the clients. Program sponsors need to ensure that landlords understand what it means to provide housing to people with a mental illness.
- Ensuring that eviction prevention strategies are in place so that instead of evicting someone and making them homeless, there is a place for them where they can go and store their stuff. “Don’t leave them high and dry on the street”. Participants identified a need for short-term options for people who are evicted, and suggested realistic rent repayment schedules when a tenant falls into arrears.

7.4 Substance use

It was clear from participants that some are working hard to be abstinent. These participants appreciated rules that required abstinence in their housing. Some participants expressed concerns about living with others who are using substances. A few expressed concerns about overt drug use and the prevalence of drug activity in their building or area where they are living even in buildings/programs where there is no requirement or

expectation for participants to become abstinent. One participant suggested that there should be separate places for people who use drugs and people who don't. Another suggested that "while staff are not pro-addiction, they could be more against addictions to put more onus on the individual to be accountable".

Participants also suggested that people who use substances receive more education on the harms that come from drugs. They further suggested more public education about why people use drugs and alcohol so the public would recognize that not everyone is "bad" just because they do drugs.

7.5 Food and health

Participants commented on the need to provide good and nutritious food. One participant pointed out that nutrition and education about nutrition are particularly important in a person's first year of recovery as they have done so much damage to themselves from drugs and alcohol. Where meals are provided, participants suggested that the program sponsors hire a good cook, offer healthy food choices, and serve meals at times that recognize different sleep patterns - not everyone is ready for breakfast at 6 am. At the same time, it is clear that it is difficult to please everyone. One participant called for more perogies, hot dogs, hamburgers, fish and chips, pizza, less chicken, no spinach, and no asparagus.

Participants also suggested that programs place greater emphasis on helping their clients get exercise. They suggested that outings encourage people to be active e.g. baseball, skating, swimming, and picnics.

7.6 Employment

Participants noted the importance of employment. They suggested that programs help their clients find a job. This includes giving them the tools they need, such as access to computers, access to programs that will help clients prepare for employment, learning how to look for a job, and opportunities for work experience.

7.7 Marketing

Participants thought it was important that programs such as the ones they were involved with be available to help more people get off the streets. They thought there should be information and pamphlets about each program and more counsellors on the streets to tell more people about the programs. One participant thought it would be a good idea to get someone who is living on the street, is well known, and has a serious addiction problem, to "straighten out his life" and become a champion for the program. He thought this would get others interested in the program. Others also suggested letting more people know that these types of program exists – "go to them".

7.8 Advice to potential clients

Participants were asked what advice they would have for someone who wanted to become involved in a program similar to the one provided by the case study agency they were involved with. Most participants suggested that if a person is interested in

addressing their drug or alcohol use, they should give the program a serious try. They should come to the program with an open mind and trust that the program is safe and has their best interests at heart. A few participants said they wouldn't know what to say and didn't think it wise to give advice. Two participants expressed words of caution. One of them said, "Get used to the cameras and staff writing down everything you say." Another said, "Don't get involved, you'll have some nasty surprises."

Appendix C

Innovative Approaches for Providing Services to Homeless People with Concurrent Disorders (Substance Use and Mental Illness)

A Review of the Literature

Prepared for the
National Research Program
National Secretariat on Homelessness
Health and Homelessness Issues in Canada

Submitted by:

Luba Serge
Deborah Kraus
Michael Goldberg
The Social Planning and Research Council of BC

February 2005

1. Introduction

The purpose of this literature review is to:

- Provide a review and synthesis of literature from Canada, the US, UK, Europe and Australia on treatment (including residential and non-residential programs), housing and services for people who are homeless and have concurrent disorders;
- Summarize the state of research regarding differing approaches to working with people with concurrent disorders; and
- Identify areas of consensus, differences of opinion, and areas where further investigation is required.

An additional goal was for the literature to serve as the basis for identifying case studies for subsequent phases of the study on *Innovative Approaches for Providing Services to Homeless People with Concurrent Disorders (Substance Use and Mental Illness)*.

It is important to note that the literature review is not comprehensive as several related issues would have gone beyond the scope of this study. Therefore, discussion of issues such as drug effectiveness, interaction of drugs, types of mental illness, links between types of substance being abused and type of mental illness have not been included in the literature review.

A major challenge in the review of the literature is that of language and definition. This is discussed in greater depth in section 2.1. The naming of the condition of mental illness and substance abuse varies considerably in time and location. Thus, *dual diagnosis* appears to have been the term favoured in North America until recently and it has been replaced by *concurrent disorders*. (However it should be noted that "dual diagnosis" is currently used to describe mental illness and developmental delay in parts of Canada.) In other countries, notably Australia and the UK, the term that seems to be more favoured is *comorbidity*, while some studies use terms such as "*multiple problems*". Furthermore, there is variation in descriptions of conditions. Some of the literature may use *mental disorder* while others speak of *severe mental illness* or *substance abuse* and *substance use disorder*. Some of these differences may relate to degree of severity but this is not clear from the literature. For this reason, most of the language used in this overview of the literature is taken from the terminology used in the particular studies being referred. The result is that different terms are used throughout this review, and these terms may or may not mean the same thing. To come to a common set of definitions and terms is beyond the scope of this study.

The literature review presented several additional challenges:

- The researchers identified an overwhelming amount of literature for this study from the US, and it was not possible to review everything. At the same time, there was not a great deal of relevant research from the other countries (e.g. Canada, the UK, Europe and Australia);

- While there was a great deal of material on concurrent disorders, there was very little that focused on the homeless population;
- Much of what has been written regarding approaches to treatment have produced findings that are inconsistent, making it difficult to draw conclusions;
- Much of the research comes from the US, and as noted in the European and Australian literature, the US findings may not be applicable to other countries; and
- Finally, the data on homeless persons with concurrent disorders is plagued with the same difficulties as all other research into homelessness; incomplete or non-existent prevalence counts with the added obstacle of the complexity of assessing the subpopulation of persons with concurrent disorders.

In carrying out this literature review, the researchers focused on materials published in English or French from Canada, the United States, the UK, Australia, and Europe, since 1990. The researchers searched major medical, health and social science indexes and databases through various library systems and electronic data bases such as Academic Search Premier (EBSCO) and ProQuest using combinations of words relating to homelessness, concurrent disorders, mental illness and substance use/abuse. Canadian, US and European web sites were reviewed. For Canada, some of the sites included Canada Mortgage and Housing Corporation, Health Canada, Canadian Centre on Substance Abuse, and National Homeless Initiative website. US sites include the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Department of Housing and Urban Development (HUD), and National Alliance to End Homelessness.

In the UK, sources of information included DrugScope, the London Drug & Alcohol Network, and the National Treatment Agency for Substance Misuse as well as sites such as Homeless Link, Crisis, and government websites such as the Office of the Deputy Prime Minister. The search for materials from Europe included reports available from the European Federation of National Organizations Working with the Homeless (FEANTSA), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), and the The Interdisciplinary Centre for Comparative Research in the Social Sciences (ICCR).

2. Concurrent Disorders - An Overview

2.1 Definition of Concurrent Disorder

According to Health Canada, concurrent disorders refer to the "*combination* of mental/emotional/psychiatric problems with the abuse of alcohol and/or other psychoactive drugs" (Health Canada 2002). This would include any combination of mental health and substance use disorders, as defined for example on either Axis I or Axis II of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV[1]. Axis I

[1] The DSM IV, published by the American Psychiatric Association, provides definitions, symptoms and characteristics for mental disorders. Individuals are evaluated on five axes within DVM IV: Axis I deals with mental disorders (e.g. anxiety disorders; cognitive disorders; psychotic disorders; substance-related

includes major psychiatric disorders (e.g. anxiety disorders, mood disorders, cognitive disorders, psychotic disorders, and substance-related disorders). Axis II identifies personality disorders and mental retardation (Health Canada 2002).

Another recent and similar Canadian definition is used in the Interim Report of the Standing Senate Committee On Social Affairs, Science and Technology, *Mental Health, Mental Illness and Addiction.* This report states that "the term *concurrent disorders* most commonly refers to individuals who suffer from a mental illness and a substance use disorder at the same point in time". The report describes mental disorders or illnesses as "clinically significant patterns of behavioural or emotional function that are associated with some level of distress, suffering (even to the point of pain and death), or impairment" (Kirby and Keon 2004).

The term *substance use disorder* "refers to a habitual pattern of alcohol or drug use that results in significant problems in work, relationship, physical health, financial well-being, and other aspects of a person's life. Substance use disorders encompass two sub-categories: substance abuse and substance dependence. *Substance abuse* refers to a maladaptive pattern of use despite the affected person's knowledge of the negative consequences associated with such use. *Substance dependence* is characterized by a loss of control, preoccupation with and continued use of substances despite its negative consequences (Kirby and Keon 2004).

The present literature review shows that information about concurrent disorders is far from being uniform and consistently defined. Definitions vary from study to study. Often, it is not clear what type of mental illness and substance use disorder is included in discussion of a concurrent disorder. Much of the literature about concurrent disorders uses the DSM-IV categories of mental disorders. However, other studies that discuss concurrent disorders refer to the combination of a severe mental illness (such as schizophrenia or bipolar disorder) and substance use disorder.

The Australian review of the literature finds that studies do not differentiate between psychotic and non-psychotic spectrum disorders, and that few differentiate between types of abuse or level of abuse or dependence (National Comorbidity Project 2003). In Quebec, a permanent committee dealing with addictions formed by the provincial government has suggested that there is a need to expand the definition of concurrent disorder to one that goes beyond severe mental health problems and includes issues such as major depression, anxiety, and severe panic attacks (Comité permanent de lutte à la toxicomanie 1997). In the UK, the Department of Transport, Local Government and the Regions (DTLR) has adopted a definition of "multiple needs" that encompasses homeless people with three or more of the following: mental health problems; misuse of various substances; personality disorder; offending behaviour; borderline learning difficulties;

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disorders); Axis II identifies personality disorders and mental retardation; Axis III deals with relevant physical diseases and conditions: Axis IV identifies psychosocial and environmental issues (e.g. negative life events); and Axis V is an assessment tool for overall functioning based on a 100-point scale.

physical disabilities; physical health problems; challenging behaviours; vulnerability because of age (Croft-White and Parry-Crooke 2004).

Thus some of the results presented below deal with individuals considered "difficult to house" or persons with "multiple problems" while other research has focussed on persons with "severe mental illness". The difficulty in assessment, the overlap in substance abuse and mental disorders, and the complexity of understanding the causal links is an issue that resurfaces in the literature (Farrell et al. 2003). As discussed below, this complexity is a major difficulty for agencies dealing with homeless people with concurrent disorders.

Not all substances are included in this literature review. For example, because it is not widely included in most studies, nicotine addiction is not covered. However, it should be noted that there has been interest in the connection between its use and psychiatric disorders. For example, one study that examined the link between co-morbidity and smoking found that early onset of smoking (i.e. before the age of 13) was linked to a significantly higher likelihood of family alcoholism; to alcohol use disorders; significantly more depressive disorders; and significantly more likely to be diagnosed with drug dependence and abuse (Crawford et al. 2003).

Since the 1980s, various terms have been used to describe the combination of mental health and a substance use disorders. These have included dual diagnosis, dual disorders, comorbidity and co-occurring addictive and mental disorders. The terms chemically abusing-mentally ill (CAMI), mentally ill – chemically abusing (MICA) and substance abusing-mentally ill (SAMI), have also been used to describe this population.

The more recent literature is moving away from the term dual diagnosis because this term:

- Can apply to individuals with other types of challenges such as co-existing psychiatric disorders and developmental disabilities (Health Canada 2002, and Drake et al. 2004); and
- Does not adequately reflect the reality that individuals with a co-occurring severe mental illness and substance use disorder typically have multiple challenges. For example, physical illness, behavioural and forensic problems, personality difficulties and homelessness are often layered upon severe mental illness and substance misuse (Marshall 1998, McHugo et al. 2001, and Drake et al. 2004).

Health Canada has expressed preference for the term concurrent disorders because it provides a distinction from other work in the field of developmental disabilities and mental health. In addition, "thinking of mental health and substance use problems as a plurality rather than duality is more consistent with the typical clinical presentation of abuse of multiple drugs, including alcohol, and often more than one psychiatric diagnosis" (Health Canada 2002).

2.2 Prevalence of concurrent disorders

As mentioned above, the most comprehensive work done on concurrent disorders is in the US. The concept of concurrent disorders is relatively recent – only gaining prominence in the last two decades. This may be explained by the closure of large psychiatric hospitals, a process of deinstitutionalisation that occurred not only in North America but in Europe and Australia along with the increased availability of drugs in the community. This increased interest has been spurred by economics – health costs are significantly higher for this population, as well as recognition that "there may not just be a gap in service provision, but a chasm…." (Crawford et al. 2003). However, the dominance of US literature may introduce biases that are country-specific. As studies in other countries demonstrate, while the data is not as developed as that in the US, there may be characteristics and even treatment approaches that are not necessarily transferable from the US. It is important to note that most researchers strongly advocate the need for more research – both to understand prevalence and characteristics and to assess the effectiveness of treatment options.

2.2.1 Canada

In Canada, there are no national studies that estimate the prevalence of concurrent disorders. The Health Canada report on Concurrent Mental Health and Substance Use Disorders quotes literature summarized by US authors which estimates that between 40 – 60% of individuals with severe mental illness will develop a substance use disorder at some point during their lives (Health Canada 2002).

The Standing Senate Committee On Social Affairs, Science and Technology, provides data from the 2002 Canadian Community Health Survey (CCHS) conducted by Statistics Canada. While there is no information about the number of individuals with a concurrent disorder per se, the survey found that one out of every 10 Canadians aged 15 and over (about 2.6 million individuals) reported symptoms consistent with mental illnesses and/or substance use disorders during the past year. The CCHS also found that among youth between 15 and 24 years old, 18% reported having experienced mental illness and/or substance use disorders (Kirby and Keon 2004). Another study of adolescents with substance use disorders found that over three quarters (76%) had concurrent anxiety, mood or behaviour disorders (Kirby and Keon 2004).
In British Columbia, it has been estimated that between 40 and 45% of individuals with substance use disorders have concurrent mental disorders. In some populations, such as women with a history of cocaine or opioid dependence, the rate may be as high as 90%. It has also been estimated that in BC, 70% of people who access community addictions services also access community mental health services (BC Ministry of Health Services 2004).

An Ontario study of one-year prevalence of psychiatric disorders among individuals 15-64 years of age found that 18.6% of respondents from the Mental Health Supplement of the 1990 Ontario Health Survey presented with one or more current alcohol, drug or mental health problems (Offord et al. 1996). Close to 10,000 individuals living in household dwellings in Ontario participated in this survey. Another study of the Ontario sample found that 55% of individuals with a lifetime alcohol diagnosis also qualified for a mental health diagnosis (Health Canada 2002).

In Quebec, estimates, considered conservative, are that one third to half of the clientele in the psychiatric sector has concurrent disorder and that this proportion rises to half to two-thirds for the clientele of addiction resources that have mental health problems. It is noted, however, that the rates vary according to studies, instruments of measurement used and the centres studied. One study that examined eleven public drug and alcohol addiction centres found that 88% of the clients registered on personality disorder scales (Comité permanent de lutte à la toxicomanie 1997).

2.2.2 USA

The general conclusion from several US studies is that between 40-60% of individuals with severe mental illness will develop a substance use disorder at some point during their lives (Health Canada 2002, p. 53). However, most surveys suggest that the rate of *recent* (in the past 6 months) substance abuse in people with a severe mental illness is lower, ranging from 25-35% (Mueser et al. 2003 p. 6).

The most extensive study to examine the prevalence of concurrent disorders was the 1990 Epidemiologic Catchment Area study in the U.S. This study involved a comprehensive assessment of both psychiatric and substance use disorders using structured interviews with over 20,000 randomly selected people in the U.S. The data show that approximately half (47%) of persons with schizophrenia and 56% of persons with bipolar disorder had a lifetime history of a substance use disorder, compared to 17% for the general population (see the table below). Alcohol was usually the most commonly abused substance, followed by cannabis and cocaine (Mueser et al. 2003). Drug use appears to be more prevalent among patients in the US with concurrent disorders compared to Germany and United Kingdom where problems with alcohol are more common (Marshall 1998).

Persons with schizophrenia or bipolar disorder were found to be 4.6 and 6.6 times as likely, respectively, to have had a substance use disorder in their lifetimes compared with the general population (McHugo et al. 2001 and Mueser et al. 2003).

Lifetime prevalence of substance use disorders for various psychiatric disorders (USA)

Group	Any substance abuse or dependence	Any alcohol diagnosis	Any drug diagnosis
General population	16.7%	13.5%	6.1%
Bipolar disorder	56.1%	43.6%	33.6%
Schizophrenia	47%	33.7%	27.5%
Obsessive-compulsive disorder	32.8%	24%	18.4%
Major depression	27.2%	16.5%	18%
Any anxiety disorder	23.7%	17.9%	11.9%
Source Mueser et al. 2003 p. 5			

In terms of people with substance use disorders, according to data from the National Co-morbidity Survey, between 41% and 66% of individuals with an addictive disorder also

have at least one mental disorder (Beaulieu and Flanders 2000). That is to say, more than half of people with substance use disorders are also diagnosed with a mental disorder at some point in their lives (Little 2001*).*

2.2.3 U.K.

There is an acknowledged lack of detailed information in the UK about comorbidity. The Office for Population Census and Survey (OPCS) carried out three comorbidity studies: a private household study; and institutional survey of hospitals, hostels, and residential homes; and a survey of 1,061 homeless persons in leased accommodation, hostels, night shelters and sleeping rough but using day centres (Crawford et al. 2003). Drug use "ever" was lowest among the household sample (5%), followed by the institutional sample (10% but increasing to 22% for those with neurotic disorders), and highest for the homeless sample (28% but up to 46% for night shelter users). The most problematic use was among shelter and day centre users in terms of drug dependency (29% and 24% respectively compared to 11% of hostel users and 2% of the household sample) as well as use of injection drugs (14% of night shelter users compared to 8% of the overall homeless population and 0.2% of the household sample). Substance abuse was found to be especially high among persons with a phobic disorder, panic disorder and depression and a high prevalence of mental illness was found among the homeless population (Crawford et al. 2003).

While this is the largest national sample undertaken in the UK, there is a suggestion that caution should be used in the representativeness of the sample for the homeless population (Farrell et al. 2003). However the survey does demonstrate "the striking impact of extreme deprivation on alcohol, tobacco and drug use and dependence, particularly among the homeless population." Furthermore, while the survey demonstrates the need for greater integration of primary care, substance misuse services and general psychiatric services, "the needs of the homeless population for an integrated service are striking" (Farrell et al. 2003).

Other British studies have found higher levels of psychiatric distress among females than males in a group of 1,075 adults who were opiate dependent (Marsden et al. 2000 cited in Crawford et al. 2003); whereas a study in Camberwell, South London found that patients with dual diagnosis were significantly younger than a control group (McCrone et al. 2000 cited in Crawford et al. 2003). A study of inner London found that 36% of patients with psychosis misused drugs and/or alcohol and that "inpatient admission rates amongst those patients were almost double those of patients with psychosis alone" suggesting that co-morbidity was a significant health problem in the UK, as in the US (Weaver 1999).

A study of a wet hostel in East London found that residents often had not only alcohol dependency but also mental ill health. "The range of mental health problems encountered in a wet hostel can include cognitive impairment related to long-term alcohol dependency, alcohol induced psychosis, manic depression, clinical and reactive depression. Some residents may also have a learning disability" (Providence Row Charity 2003). A study of four wet shelters in the UK found that 84% of residents interviewed reported being depressed and "low in mood" and half described other mental health

problems including psychotic illness (10%) and anxiety/panic attacks (22%). Only one quarter said that they were being treated for this – primarily through their GPs (81% were registered with a GP), while 8% were being treated by a specialist (Crane and Warnes 2003).

2.2.4 Europe

A few studies that deal with comorbidity were identified and they are briefly summarized below.

Greece: A study of 176 opiod-dependent men recruited from prison and treatment services in Athens found that lifetime and current prevalence of any mental disorder reached 90% and 66% respectively (Crawford et al. 2003).

Finland: A study of 6 hospitals found psychoactive substance use disorder in 28% of 1,222 psychiatry referrals (focussing on the 35 to 50 year old age group). Variables which were found to predict substance use included attempted suicide as the reason for the referral, divorce, living alone, unemployment, unskilled worker, mental health treatment or hospital admission in the last 5 years, and current mental health treatment. The prevalence of substance use varied according to the source of referrals – ranging from 14% of neurological patients to 35% of medical referrals to 50% of emergency department attenders (Crawford et al. 2003).

2.2.5 Australia

Data from the People Living with Psychotic Illness component of the National Survey of Mental Health and Wellbeing revealed that of those with psychotic illness, 30% reported alcohol abuse-dependence, 25% of cannabis abuse and 13% of other illicit substance abuse (National Comorbidity Project 2003). A study of 194 outpatients with schizophrenia with current or lifetime abuse/dependence disorders found that they were "predominantly single, young males with unstable accommodation, high rates of criminal behaviour, and high levels of symptomatology" (Crawford et al. 2003). After nicotine, alcohol, marijuana and amphetamines are the most commonly abused substances by persons with psychotic disorders (National Comorbidity Project 2003).

Research would indicate that the most common dual diagnosis is substance abuse disorders (especially alcohol and nicotine) and anxiety and affective disorders, but this is related to the high prevalence of these disorders in the general population. Thus, 37% of those with alcohol dependence in the previous 12 months were found to meet the criteria for anxiety disorders, and 46% of those with drug dependence (National Comorbidity Project 2003). The Australian Survey of Mental Health and Wellbeing found that 1.2% of the adult population had an affective and/or anxiety disorder and concurrent substance use disorder. Further analysis of this data revealed that 16.5% of those reporting cannabis dependence met criteria for anxiety disorder and 14% for affective disorder (National Comorbidity Project 2003).

Australian research reveals different patterns of concurrent disorders in mental health services compared to drug and alcohol services. It is suggested that mental health services commonly see clients with schizophrenia and substance use disorders while drug and alcohol services deal with persons with affective, anxiety and personality disorders (National Comorbidity Project 2003).

The Australian review of the literature (National Comorbidity Project 2003) points out that an impetus in dealing with dual diagnosis has been the understanding that this group has worse psychiatric symptoms, treatment compliance and prognosis, they use more treatment and service resources, have greater propensity for suicide, and exhibit the higher rates of HIV and hepatitis. However, this understanding was based on US studies and research into the Australian association between substance use and schizophrenia, found "no increase in hospitalisation or suicide attempts among this specific group of people with dual diagnosis". It is suggested that structural differences may explain this and that the "free hospital and community care, subsidized medications, public housing and pensions for the chronically ill" available in Australia may be responsible (National Comorbidity Project 2003).

Research into homelessness and mental illness has found that while affective and non-psychotic disorders are seen as less severe than major psychotic disorders; they are far more prevalent among homeless persons. Furthermore these illnesses are found to have specific symptoms that have a great impact on everyday life and medication is often ineffective or inappropriate for this group (Robinson 2003).

2.3 Relationship between Mental Illness and Substance Use

Several different theories or suggestions have been proposed to explain the strong connection between mental illness and substance use disorder. These include:

- Mental illness lowers the threshold for experiencing negative consequences from relatively small amounts of substances (Mueser et al. 2003);
- Antisocial personality disorders increase risk factors for both mental illness and substance use disorders (Mueser et al. 2003);
- Substance use may play a role in the development of a severe psychiatric disorder or precipitate a mental illness in some individuals (Marshall 1998); and
- Some individuals in the early stages of a psychotic disorder "self-medicate" unpleasant symptoms with alcohol or drugs (Marshall 1998). People find out early on that drugs and alcohol help with symptom management. They don't know what's wrong, they know something's wrong, and they feel more normal when using. Patients may feel that illicit drugs have fewer side effects than medication, work better than their psychiatric medications, are more available, and less stigmatizing (Carey et al. 2000).

It is often difficult to distinguish between primary (substance independent) and secondary (substance induced) depression in alcohol dependence but alcohol dependent persons have been found to have greater rates for bipolar disorders, schizophrenia and antisocial

personality disorder than the general population and while self-medication has been proposed as the cause of heavy drinking, it rarely improves the pre-existing psychiatric symptoms and often intensifies them (Crawford et al. 2003).

There is evidence that substance use often precedes the onset of psychosis (Marshall 1998). According to one study of 310 individuals participating in a self-help group in New York, half the participants (50%) used drugs or alcohol before they started experiencing mental health symptoms. About one third of study participants (38%) showed the reverse pattern and started experiencing mental health symptoms before they ever used drugs or alcohol. Twelve percent started experiencing symptoms and using drugs or alcohol at the same age. Two thirds (69%) reported that their mental health symptoms get worse when they are using drugs and alcohol, and 44% felt like using drugs or alcohol "very much" when they experience symptoms (Laudet et al. 2000).

The literature discusses how substance use and mental disorders may reinforce each other. Treatment of one condition is often hampered by the symptoms of the other if the latter is not addressed or treated. For example, the treatment of a substance use disorder is complicated by a severe mental illness. High levels of psychiatric severity are associated with little or no improvement in formal substance abuse treatment (Laudet et al. 2000 and Carey et al. 2000). Cognitive impairment and social anxiety can interfere with a broad range of therapeutic activities, including participation in commonly used group treatment programs. At the same time, treatment of the mental illness is more complex due to the substance use.

2.4 Characteristics of individuals with a concurrent disorder

2.4.1 Comparison with mental health clients without a substance use disorder

Individuals with concurrent disorders have higher rates of adverse outcomes compared to individuals with mental illness alone, as set out below. (It should be noted that some of these would appear to stem from substance abuse per se, for example involvement in the criminal justice system because of drug offences or financial difficulties due to expenditures on drugs or alcohol.)

Greater symptoms of mental illness. The impact of substance use on individuals with a mental illness can lead to greater rates of psychotic symptoms, and different substances can have different symptomatic effects. Alcohol has been associated with memory loss, hallucinations, and has been found to worsen depression. Marijuana can result in paranoia and more side effects from medication. Cocaine abuse can cause paranoia during use and suicidal behaviour during withdrawal (Laudet et al. 2000). Substance use can also increase non-compliance with medication and other treatment, and lead to higher rates of relapse and psychiatric hospitalizations (re-hospitalizations) among individuals with mental illness (Leal et al. 1999).

Childhood trauma. A study that examined different types of maltreatment (e.g. emotional, physical, sexual abuse, emotional and physical neglect) found a high prevalence of childhood trauma in persons seeking treatment for alcohol and drug

addiction – nearly 80%. The study concludes that "childhood victimization may be a common antecedent of both substance abuse and personality disorders, contributing to their high rate of comorbidity" (Crawford et al. 2003).

A study of 156 dually diagnosed homeless persons in rehabilitation programs found that 89.6% had been subjected to at least one childhood risk factor (Blankertz et al. 1993). The most frequent type was living with parents who abused drugs, alcohol or both, out-of-home placements, mentally ill parents, and sexual abuse. Furthermore, the rates of sexual and physical abuse were felt to be much higher on the part of staff than what the clients reported. One quarter of the clients had parents with a dual diagnosis profile (Blankertz et al. 1993). One of the issues examined by the study was the impact of these factors on rehabilitation and on behaviours. Previous research has demonstrated that abused patients had more difficulty in forming therapeutic alliances. Out-of-home placements was found to be the factor that had significant association with progress in the rehabilitation program – linked to the possibility that placement is often a response to abuse or that persons who have been placed see rehabilitation as another placement.

Violence, disruptive behaviour and criminal activity. Individuals with concurrent disorders tend to have more violent and disruptive behaviour compared to individuals with solely a mental illness. This has been attributed to the use of substances as well as cravings for substances. Substance use can also result in conflict with the law due to possession of illegal drugs, disorderly conduct, theft or assault resulting from efforts to obtain drugs (Hartwell 2004). Individuals with a concurrent disorder who are involved with the criminal justice system are more likely to have committed public order (25%), property (13%), and drug offences (11%) than their non-substance-abusing counterparts who are more likely to be incarcerated for arson (3%), assault and battery (34%) and murder (3%). Those with a concurrent disorder are more likely to be homeless upon release, and are more likely to be re-arrested compared to individuals with a mental illness who do not have a substance use disorder.

Increased risk of suicide. Risk of suicide is significantly increased in persons with a substance use disorder as well as in individuals with schizophrenia, bipolar disorder, and major depression. This risk is compounded in persons with a concurrent disorder.

Inability to manage finances. Individuals with concurrent disorders have more difficulty managing their finances and have more financial problems than other mental health clients, as they tend to spend their money on drugs and alcohol rather than food, clothing, and rent.

Poor physical health and HIV infection. Severe health issues are common among individuals with concurrent disorders. Studies have demonstrated increased vulnerability to HIV and hepatitis infection as a result of unprotected sex and sharing needles. Antisocial personality disorders have been found to increase HIV risk among injecting drug users (Laudet et al. 2000). Alcohol and drug use may also have direct effects on the liver, heart, and lungs and can increase vulnerability to accidents. The net result for

clients with concurrent disorders is that they are vulnerable to early mortality and considerable morbidity as long as they continue to use substances.

Problems with interpersonal relationships/social isolation. Concurrent disorders are associated with more difficult family relationships, marital problems, and interpersonal conflicts with relatives and friends, leading to a lack of social supports (Marshall 1998, Laudet et al. 2000, Alverson et al. 2000 and Carey et al. 2000.)

Victimization. Clients with concurrent disorders are more prone to victimization compared to persons with severe mental illness who do not use substances as their judgment may be impaired by substances or cravings for them, and they are more likely to be exposed to others who may take advantage of them sexually and financially.

Homelessness. Persons with concurrent disorders are strongly predisposed to homelessness. They have more difficulty accessing housing and are more likely to lose their housing than other individuals with mental illness alone. Frequent and long periods of hospitalization may also result in a loss of housing, particularly in areas where there is a shortage of affordable housing and waiting lists are common. A loss of family/social support, and financial problems also lead to an inability to maintain stable housing (McHugo et al. 2001, Drake et al. 2004, Tsemberis and Eisenberg 2000, Carey et al. 2000, Mueser et al. 2003 and Bebout et al. 1997).

Gender differences between women and men who have concurrent disorders

Several studies have identified the following differences between men and women with concurrent disorders.

- Women with concurrent disorders have been exposed to more sexual, physical and emotional abuse as children and adults compared to men. Women had more trouble with victimization. (Crawford et al. 2003 and Watkins et al. 1999). One author has concluded that victimization and violence are “normative experiences” for many women with concurrent disorders, while they are not normative experiences for men with concurrent disorders (Watkins et al. 1999). It is estimated that the lifetime rate of violence for women with serious mental illness is double that of the general population (the rate in the general population is between 21% and 34% - Crawford et al. 2003).

- Women with concurrent disorders have been found to be more fearful of seeking treatment than men. Women fear being harmed, abused or victimized in the process of asking for help. One author has recommended that concurrent disorder programs be specifically targeted to women, with women-only case managers (Watkins et al. 1999).

- Women are more likely to use mental health and primary care services than men, who are more likely to use alcohol specific services. It is proposed that this may

explain the later and more severe situation of women when they gain access to alcohol and drug specific services (Crawford et al. 2003).

- A lack of motivation has been identified as a barrier facing more men than women. For men, continuing in treatment was often motivated by a fear of becoming violent. Watkins recommends strategies that increase motivation, such as motivational interviewing may be particularly effective for men with concurrent disorders. Men tended to see themselves as coerced into treatment by external forces, or as needing treatment as a means of obtaining external control of either violent or criminal behaviour (Watkins et al. 1999).

- Women with concurrent disorders have been found to have better social functioning than men with concurrent disorders. One study reported that more women had been married, had more children, more contact with their children, and more total social contacts than men (Brunette and Drake 1998).

- Women have been found to have a later stage of onset of schizophrenia than men and higher pre-morbid functioning but the effect of substance use in women is greater than men. "It may be that the women with the worst schizophrenic symptomatology are the ones who are most likely to use substances." (Crawford et al. 2003).

- Fewer women reported a history of incarceration than men, and women reported fewer criminal charges and convictions.

- Women had more problems with depression and anxiety than men.

It has been suggested that the differences between men and women may require different approaches to treatment. Not only have women been found to have higher rates of comorbidity and more likely to have a history of physical and sexual abuse, it also may be more difficult to retain them in treatment. Those with a higher level of burden (i.e. a combination of psychological/psychiatric problems, health problems, substance use and residential stability) are more likely to drop out of treatment early (Crawford et al. 2003). Because women are more active in relationships and family life than men, they may need more education and training related to sexuality, family planning, parenting, and risk behaviours for sexually transmitted diseases. In addition, a need was identified to develop new and specific interventions that address victimization issues.

In B.C., the new planning framework to address problematic substance use and addictions calls for the development of more gender and culturally sensitive interventions for substance use disorders and mental disorders (BC Ministry of Health Services 2004).

2.5 Concurrent disorders and homelessness

2.5.1 Prevalence

Individuals with a concurrent disorder are believed to be among the most visible and vulnerable of the homeless population (National Health Care for the Homeless 1998).

In the US, it has been estimated that about one third of people who are homeless have serious mental illnesses, and that between 50 and 70 percent of homeless adults with serious mental illness have a co-occurring alcohol or other drug use disorder (Rickards et al. 1999, Conrad 1993, Tsemberis et al. 2003, and Gulcur 2003). It has also been estimated that about 10-20 percent of homeless people in the US have a concurrent disorder (Buckner et al. 1993 and National Health Care for the Homeless 1998).

A few limited studies in Canada are consistent with the US. For example, in British Columbia, it was estimated that about 10% of shelter users had both substance use and mental health issues (Eberle et al. 2001).

A 1998 study of Pathways to Homelessness in Toronto, estimated that approximately 66% of homeless persons had a lifetime diagnosis of mental illness. Depression was the mental illness most reported, while about 11% were found to have a lifetime prevalence of severe mental illness. About 66% had a lifetime diagnosis of substance abuse, and 86% had either a lifetime diagnosis of mental illness or substance abuse (Mental Health Policy Research Group 1997 and Kirby and Keon 2004). The City of Toronto has estimated that up to 20% of its homeless population suffers from severe mental illness and addictions (City of Toronto Mayor's Homelessness Action Task Force 1999).

The Toronto study found that most mental health facilities are unable or unwilling to work with people who have an addiction. At the same time, addiction treatment facilities are not equipped to deal with people with a serious mental illness (City of Toronto Mayor's Homelessness Action Task Force 1999).

A Montreal study of the clients of twelve facilities dealing with persons with multiple problems found that 85% had mental health problems, 75% were homelessness, 65% had problems with alcohol, and 53% had problems with drugs (Comité aviseur itinérance multiproblématique de la Régie régionale de la Santé et des Services sociaux de Montréal-Centre 1994). This study also found that the problem of access to care for homeless persons with multiple problems was especially difficult for those between 18 and 25 (Comité aviseur itinérance multiproblématique de la Régie régionale de la Santé et des Services sociaux de Montréal-Centre 1994).

Homeless Link in the UK carried out a study of homelessness agencies to find out if they were dealing with clients with multiple needs. The vast majority, 88%, of the 155 agencies that replied said that they worked with such clients and these represented almost half of the total of their clients. This proportion was higher when dealing with rough sleepers (Homeless Link 2002). The study found that of those sleeping rough nearly 58% of those over 50 and 53% of young people had multiple needs (Croft-White and Parry-Crooke 2004). A study of 200 drug users in Scotland (of whom 68% had been homeless at some point in their lives and 32% were homeless at the time of the interview) found that 27% had experienced mental health problems (Neale 2001).

The Homeless Link study found that the main sources of referrals to agencies came from community Social Services (63%). It is suggested that this route is due to the fact that homeless persons with multiple needs do not fit the criteria for mental health services and the only option is then the voluntary sector. Just over a tenth of accommodation for homeless persons was targeted to persons with multiple needs (Homeless Link 2002).

Individual studies of different target groups among the homeless have identified a range of rates of concurrent disorders. For example, studies of homeless women have found the following:

- 46% of homeless women in a Baltimore Homeless study identified as having a major mental illness had abused alcohol at some time in their lives and 20% had abused drugs (Buckner et al. 1993);
- A study of homeless women in the St. Louis area found lifetime rates of comorbidity for mental illness and alcohol use disorder to be 28.4% compared to 12.6% in the general population sample (Reardon et al. 2003); and
- Among women in another study, 6% were found to have both a mental disorder and problems with alcohol, and 2% had both a mental health and drug disorder (Buckner et al. 1993).

In a New York study of 677 mothers in families requesting shelter and 495 housed mothers, it was found that only 4% of families requesting shelter had ever experienced mental hospitalization. Eight percent had been patients in a detox centre for either drug or alcohol abuse compared with 2% of the respondents from housed families. The author suggested that this finding reflected the relative health of families who are entering shelters for the first time (Weitzman et al. 1992).

Another study has noted that patterns of substance abuse and mental illness vary across demographic subgroups. It reports that:

- "Homeless single women are more likely to have mental illness alone, without any substance use disorder;
- The prevalence of substance use disorders in men is about twice that in single women; and
- Compared with all other subgroups of homeless people, female heads of homeless families have far lower rates of both substance abuse and mental illness" (Hwang 2001).

This literature review did not find much information regarding the prevalence of concurrent disorders among street youth. However, studies do show high rates of substance use and mental health issues. A 1991 study of street youth in Toronto found that alcohol and drug problems were prevalent and serious (47% drank weekly and 6% reported daily drinking). One-third showed high levels of depression and almost half reported attempting suicide at least once.

A study of the mortality rate among 1,013 street youth in Montreal found that from 1995 to 2000, 13 died from suicide and 8 from an overdose (Roy et al. 2004).

A study of 523 street youth in several centres in BC found that 47% in Vancouver, 44% in Victoria, and 32% in suburban/coastal communities reported that they had been diagnosed by a health professional as having an alcohol or drug addiction. More than a quarter of participants in the street youth survey (27%) had attempted suicide in the previous year. A significant proportion of youth had been told that they had a health issue, such as major depression or bipolar disorder (18%), chronic anxiety disorder or panic attacks (11%), and schizophrenia (6%) (McCreary Centre Society 2001).

A US study of homeless youths who are gay-lesbian found that they had high rates of depression and injection drug use (Noell and Ochs 2001).

The most complete portrait of youth with concurrent disorders comes from an Australian study of 674 homeless youth between 12 and 20 in Melbourne (Mallett et al. 2003) revealed that:

- Newly homeless youth were less likely to use drugs than those who were experienced homeless, although 20% of the latter group had not used drugs in the last 3 months.
- Almost half of those who used alcohol and drugs used two to four different drugs.
- Living arrangements have an impact on drug use – 92% of those living on the street or in squats had used drugs in the last 3 months, and they had used more types of drugs than those living in other arrangements.
- 67% had experienced at least one sign of drug dependency.
- 23% had symptoms indicative of mental illness and drug dependency.
- Those with mental illness and drug dependency had reported more health compromising practices and outcomes.
- Newly homeless youth with mental illness and drug-dependence reported more suicide attempts in the last 3 months.
- Some youth were found to use drugs to cope with and suppress personal pain – often associated with a traumatic life event, typically sexual assault or the death of a significant person.
- Those who left home as a consequence of personal drug and alcohol use seem to be more likely to become long-term homeless.
- For young people with a mental illness and who take drugs, the mental illness was not the reason for leaving home.

The study also interviewed 34 service providers.

- Drug use was seen to be a pathway into homelessness, a consequence of homelessness and a factor in prolonging homelessness by service providers.
- Clients with multiple needs slip through the gaps because they do not meet the criteria for any one service. Relatively high numbers are found to have both mental health and substance abuse problems but they were not found to be well-served by the system which sees these as separate client groups (Mallett et al. 2003).

Some studies report that alcohol use disorders usually begin after the onset of mental illness although it has also been suggested that alcohol abuse often precedes schizophrenia (Drake and Mueser 2002). Studies have also found that both alcohol use disorders and mental illness usually precede homelessness (Sullivan et al. 2000 cited in Reardon et al. 2003). A study conducted by Sullivan et al. (2000) found that two-thirds of the homeless mentally ill developed their mental disorder before becoming homeless.

2.5.2 Issues and challenges for homeless persons with concurrent disorders

The literature reports that individuals with a concurrent disorder who are homeless have more issues that need to be addressed than others with a concurrent disorder. Once homeless, they are likely to remain homeless longer than other homeless people. Most clients are unable to navigate the separate system of mental health and substance abuse treatment. Often they are excluded from services in one system because of the other disorder and are told to return when the other problem is under control (Dixon and Osher 1995, Drake et al. 2001, Drake et al. 1997, and Rickards et al. 1999 and Bebout et al. 1997).

Some of the specific issues facing individuals with concurrent disorders who are homeless include the following:

Risk of suicide. Homeless mentally ill persons face a high risk of suicide and concurrent disorders significantly influences the risk of suicide among this highly vulnerable group. (Prigerson et al. 2003).

High prevalence of injection drug use. A study of homeless individuals with severe mental illness in Baltimore and Boston found a high lifetime prevalence of injection drug use. The proportion of homeless men with a mental illness who injected drugs was 26% in Baltimore and 16% in Boston. The proportion of homeless women with a mental illness who injected drugs was 8% in Baltimore and 6% in Boston. A previous study conducted in a New York City men's shelter found a 23% lifetime prevalence of injection drug use (Susser et al. 1997).

High prevalence rates for HIV, hepatitis B and hepatitis C. Studies have found high prevalence rates for HIV, hepatitis B and hepatitis C among homeless persons with concurrent disorders (Klinkenberg et al. 2003).

Other. Studies have also found that homeless individuals with concurrent disorders:

- Have high rates of contact with the criminal justice system and are more likely to be homeless at release than their non-substance-abusing counterparts (Hartwell 2004);
- Are more isolated and disconnected from social support networks, more mistrustful of people and institutions, and more resistant to accepting help than their domiciled counterparts source (Drake et al. 1991); and
- Come from very dysfunctional family backgrounds (Blankertz and Cnaan 1994).

Episodic homelessness. A study of homelessness among adult men and women admitted to three shelter-based therapeutic community drug treatment programs in New York found that only a minority described themselves as homeless for most of the year prior to treatment, and only two thirds indicated that they had been homeless for a week or more in their adult life. The majority of the sample had a psychiatric diagnosis as well as a substance use disorder. Individuals reported multiple episodes of being homeless, but the total amount of time homeless was less than one year. This study concluded that the homelessness that describes this sample appears episodic rather than continuous (Jainchill et al. 2000).

Formerly homeless. A survey of close to 5,000 formerly homeless and never homeless individuals in Colorado found that the formerly homeless still experience substantially elevated rates of current psychiatric disorders and alcohol use disorders. In fact the prevalence rates were quite similar to those for the currently homeless. The author concluded that this underscored the need for intervention programs to assertively follow these individuals, even after stable housing is obtained. She further asserted that this group should be considered extremely vulnerable to relapse into homelessness and should be a high priority target for intervention (Reardon et al. 2003).

Reliance on emergency services. A study of 2,578 homeless and marginally housed individuals in San Francisco found that mental illness and substance use were factors associated with repeat use of hospital emergency departments (Kushel et al. 2002 and Reardon et al. 2003).

2.5.3 Issues and challenges facing homelessness agencies

Concern has been expressed that public mental health service systems are not versatile enough to meet the multiple needs of homeless individuals with concurrent disorders and have failed to engage most of this population in treatment (Reardon et al. 2003). However, it is also recognized that it is often difficult to engage this population, and they often enter the system only while in crisis. Because of non-compliance with medication and treatment plans, they tend to move in and out of services. Even when homeless individuals do enter specialized psychiatric and substance user treatment programs, dropout rates are high.

While there are barriers that stem from the situation of the homeless individuals with concurrent disorders, there also are considerable barriers for agencies dealing with this population. The issue of substance abuse disorders and psychiatric/psychological problems is far from clear for the experts. For example, in Western Australia while assessment practices in mental health services were more comprehensive that those in drug and alcohol services, “assessment in general was considered neither sufficiently consistent nor sufficiently standardised to guide needed treatment for this population” (National Comorbidity Project 2003).

Assessment is no less complex for agencies dealing with homelessness. In the UK Homeless Link found great divergence in the way that agencies assessed clients and a

"commonly agreed robust model of assessment" was an urgent need (Homeless Link 2002). This study found that the homeless sector was being "used to hold people with multiple needs, without the necessary resources and expertise to work effectively with them". When 18 organisations that had participated in the study were asked why they did not deal with this group, five stated that they did not have the expertise to deal effectively with this group. (The others stated that this was not an issue for their group or that they had no such clients.)

A study dealing with multiple needs in four areas of the UK (Aberdeen in Scotland, Wrexham in Wales, Birmingham and London in England) surveyed service providers and found that there was a lack of information about this population, attributed to the complexity of interpreting definitions and variation in assessment of multiple needs in the client group. It was found that agencies had a wide range of assessment processes but that none "appeared to use them as a way to pull together the different elements in order to identify 'multiple health needs'" (Croft-White and Parry-Crooke 2004).

Other issues that have emerged along with availability of services included the lack of flexibility, and the provision of appropriate care - a problem with prejudicial care or biases on the part of services (Crisis 2002). One review of psychiatric practice finds that persons with concurrent disorders are found to be "dangerous", "bad" (i.e. malingerers) and that the "myth of the 'typical' dual diagnosis client as difficult to treat, unresponsive, and chaotic abounds in services" leading to rejection of persons on the grounds that the "other order is primary" (Phillips 1998). Another study of 389 rough sleepers in London, found that 39% had been excluded from one or more services for homeless persons in the last year, mainly for physical violence or drug use, and that those dependent on alcohol or drugs were more likely to have been excluded (Fountain and Howes 2001). In Scotland a review of good practices towards homeless drug users found that one of the key gaps was the shortage of agencies willing to work with and house persons who were not yet ready to address their drug use (Scottish Homes 2001).

In Australia, some homelessness agencies have noted an increase of persons with concurrent disorders, but that common agreement between mental health and drug and alcohol sectors on measures needed to work effectively to address both issues was not yet attained (Australian Federation of Homelessness Organisations 2003).

3. Recommended treatment approaches for people with concurrent disorders

While there is ample literature from the United States about treatment approaches for concurrent disorders, literature from outside the US approaches this evidence in a more guarded fashion. For example, the Australian review of studies concludes that,

> " approaches to the management and care of clients with comorbid mental health and substance use disorders have not been studied systematically nor evaluated rigorously to a satisfactory degree, in part because treatment approaches vary in their conceptual underpinnings, settings, range of service components and

intensity of treatment, making it difficult to draw conclusions. …Furthermore service delivery models are dependent on a range of factors such as the availability of a workforce, structural relationships between mental health and alcohol and drug services and the feasibility of establishing specialist services in regional, rural and remote settings." (National Comorbidity Project 2003).

3.1 Treatment and support

One of the major barriers to dealing with concurrent disorders is that of two separate systems that have developed to deal with mental health and with addictions. The integration of these two systems is a major issue in the treatment of concurrent disorders, and becomes especially problematic with a homeless population that not only faces the barriers described above but also is confronted with navigating two, often incompatible, systems.

Historically, substance use treatment services for homeless people have been offered either sequentially or in parallel. In sequential treatment clients might be told they must receive treatment for their substance use disorder before they can be treated for their mental illness, or vice versa. This approach was found to be ineffective because it was difficult to stabilize one disorder without addressing the other (Hendrickson et al. 2004). In the UK it has been found that many hostels exclude drug users altogether, "thereby making successful engagement with treatment very difficult for homeless people" (Randall and DrugScope 2002). Other research in the UK has found that when homeless persons with multiple needs sought services, "professional boundaries frequently intervened, as a 'dispute' appeared to arise between healthcare specialist as to which need should be addressed first" (Croft-White and Parry-Crooke 2004).

In a parallel approach, clients receive services from two or more systems simultaneously (Kraybil et al. 2003). One of the drawbacks identified to this approach is that while in theory the providers of separate services should attempt to coordinate care by making regular contacts and reaching consensus on essential elements of the treatment plan, in practice, this rarely happens. In addition, it is difficult for an individual to participate in two different treatment programs, in different locations, and that may follow different and perhaps conflicting philosophies and approaches to treatment (Mueser et al. 2003; Hendrickson et al. 2004 and Drake et al. 2001).

According to Health Canada, having two separate systems of care has usually meant parallel or sequential services being delivered across the two systems with little or no coordination and less than optimal outcomes. Poorer outcomes are thought to result from various systematic factors, including:

- Compounded feelings of stigma;
- Competing perspectives on the primary problem and;
- The additional burden on the consumer to retell their story, deal with additional transportation issues and in general, follow through on two separate treatments which may offer conflicting therapeutic advice plans" (Health Canada 2002).

A number of models have been developed to deal with concurrent disorders. One of the major issues that many address is the need to integrate the two systems of care.

3.1.1 Integrated models of treatment and support

There appears to be considerable diversity in defining integration and the extent varies across different studies and settings. An Australian review identifies four services delivery models: case management (including intensive case management that limits the caseload or assertive case management that involves a case manager who is a clinician); community residences (as an alternative to psychiatric hospitals) and day programs; assertive community treatment (discussed below) and therapeutic communities (National Comorbidity Project 2003).

According to most of the US literature, integrated treatment means that both mental health and substance use services are provided by the same clinicians or team of clinicians, working in one setting to provide appropriate mental health and substance use interventions in a coordinated fashion. The caregivers take responsibility for combining the interventions into one coherent package (Drake et al. 2001, Meisler et al. 1997 and Mueser et al. 2003). This approach minimizes any potential conflict over different philosophical perspectives that may exist between the mental health and substance abuse treatment systems.

Some of the differences between an integrated approach and traditional substance abuse treatment includes: a focus on preventing increased anxiety; emphasis on trust and understanding; harm reduction rather than immediate abstinence; slow pace and long-term perspective instead of rapid withdrawal and short-term treatment; stage-wise and motivational treatment (see below) rather than confrontation and front-loaded treatment; support in familiar settings and readily available; 12-step groups for those who choose and could benefit from this rather than mandated to all; and pharmacotherapies according to psychiatric and medical needs instead of contraindicated for all in substance abuse treatment (Crawford et al. 2003).

In the US, "the more comprehensive integrated program models include common mental health interventions, such as medication management and support services, as well as assertive outreach, intensive case management, individual, group and family counselling and, on occasion, intensive day or residential components. Some of these features such as assertive outreach and intensive case management are critical features of Assertive Community Treatment (ACT) teams which can include substance abuse counsellors. As the models for integrated treatment evolved, they incorporated interventions tailored to the person's stage of recovery, motivational interviewing and a range of other service activities" (Health Canada 2002). Elements of an integrated treatment model proposed by Drake and Mueser are described in more detail below.

However, the US literature also notes that integration can occur in several ways: from the top down (e.g. through the integration of service systems) and from the "bottom up". One study suggests that ACT teams (discussed below) "can create "virtually" integrated

services for clients regardless of the operation of the service system" (Rosenheck et al. 2002).

The Canadian literature expresses support for an integrated approach to treatment for individuals with concurrent disorders.

For example, in the Best Practices report on Substance Abuse Treatment and Rehabilitation (Roberts et al. 1999), Guideline 17 provides that:

> While evidence is limited, it appears that providing integrated services for people with co-occurring substance use and mental health problems holds more promise than offering services in sequence or parallel. Close liaison and coordination to enhance referral and case management need to occur among the respective specialized services and informal street-level agencies in a community. Training appears crucial, not only for staff of respective specialized services, but also for social services and correctional staff where these clients often present themselves. Excluding people with mental health problems from addictions treatment and excluding those with alcohol or drug problems from mental health treatment should be discouraged (Roberts et al. 1999).

The Health Canada report (2002) also recommends integrated treatment as a best practice, but suggests new ways of thinking about integration. The report proposes that there are many ways to better integrate an individual's treatment and support across units within the same facility or across community agencies, and that increasing collaboration blurs the distinction between the old terms of integrated treatment and sequential and parallel treatment. There is support for the concept of system integration, which means:

> The development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of services to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/support workers working for different treatment units or service providers. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan (Health Canada 2002).

The Health Canada report recommends that within this integrated approach:

- Interventions for substance abuse and severe mental illness be planned and implemented concurrently; and
- That a range of services be provided, including a staged approach to engagement and service delivery; outpatient setting, motivational interviewing and cognitive behavioural treatment; and harm reduction and comprehensive psychosocial rehabilitation supports.

The Interim Report of the Standing Senate Committee On Social Affairs, Science and Technology, has also identified a need to integrate mental health services with addiction

treatment services. The Committee recognizes that individuals with concurrent disorders require help and services from several sectors, including mental health, addictions, health care, education and social services. In terms of the specific needs of people who are homeless, the Committee has expressed a desire to hear more about what role the federal government can play in the context of the National Homelessness Initiative (Kirby and Keon 2004).

An initiative is currently underway in Manitoba to create a more integrated system of service delivery. The Co-occurring Mental Health and Substance Use Disorders Initiative (CODI) began in Winnipeg in 2001 as a project of the Winnipeg Regional Health Authority, the Addictions Foundation of Manitoba and Manitoba Health. Drs. Kenneth Minkoff and Christie Cline were hired as consultants to provide training and consultation during a 12 month period from April 2002 to March 2003 in the Winnipeg Regional Health Authority area. In the Spring of 2003, planning began to expand the initiative to other regional health areas across Manitoba. CODI has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model developed by Dr. Minkoff. The goal is to create a coordinated mental health and addiction service delivery system that is able to provide universally accessible, welcoming, and integrated services for persons with co-occurring mental health and substance use disorders (Winnipeg Regional Health Authority and Manitoba Health 2004). [2]

In BC, the provincial government's new framework for addressing problematic substance use and addiction states that treatment and support for concurrent disorders must be planned and implemented together, unless there are compelling clinical reasons for focusing on one of the disorders first (e.g. life-threatening factors).

In assessing the combination of services in the UK using the US experience, it is emphasised that "simply combining treatment modalities is not enough" and that other issues should be considered in developing combined services (Weaver 1999). The first issue is whether collaboration between substance misuse specialists and mental health professionals is possible, given the difficulties encountered in the US. It is suggested that part of the difficulty in the US may stem from abstinence-oriented services, which is not as strong a focus in the UK. Other issues include the possibility that focussing on psychosis within dual diagnosis services in the UK is premature since there is a lack of prevalence data and that the problem of patient motivation needs to be addressed given the different approaches in the psychiatric services (i.e. low motivation and poor engagement in substance misuse programs) and substance misuse treatment (i.e. action-oriented, stressing abstinence). Weaver (1999) concludes that low patient motivation is a major issue in dealing with co-morbidity and that the different attitudes towards patient motivation on the part of psychiatric and substance misuse services need to be overcome to develop a team approach.

The Australian review of the literature on service delivery for people with concurrent disorders finds that there are several limitations to the studies, including "overall the

[2] In 2003, the Vancouver Island Health Authority also began a project to develop a comprehensive, integrated system of care according to the model developed by Dr. Minkoff.

quality of the studies is poor in that there were small sample sizes (primarily the result of high attrition rates and refusal to participate), poor randomization, limited follow-up periods, and narrowly defined outcomes." Moreover, because no Australian studies are found, it is not clear how applicable these are to their context – further complicated by the US study samples that have a high proportion of African Americans. The studies also were found to predominantly involve males, making it unclear whether findings were applicable to females and many excluded violent and unmanageable persons. As well, outcomes were found to be limited to psychiatric and substance abuse symtomatology, neglecting " the importance and value of considering broader social and quality of life issues" (National Comorbidity Project 2003).

According to literature from the US, integrated programs that incorporate the following components have been found to achieve positive outcomes for individuals with concurrent disorders.

3.1.2 Comprehensiveness

Because the issue of homelessness and concurrent disorders is so complex, research demonstrates that addressing a wide range of issues is necessary. Homeless persons with concurrent disorders typically have a wide range of needs, such as finding work or other meaningful activity, improving the quality of family and social relationships, developing capacity for independent living, leisure, recreation, and developing skills for managing anxiety, depression and other negative moods. Integrated treatment programs need to be comprehensive because the recovery process occurs in the context of making many life changes. The literature identifies the following seven types of services that should be part of a comprehensive treatment program (Drake et al. 2001, Mueser et al. 2003):

a. **Residential services/housing** – Clients who are homeless or living in environments with a great deal of substance use face special challenges in achieving sobriety. These individuals require residential services or housing that will accept where they are at in terms of their substance use (See section on residential treatment and housing).

b. **An appropriate model of case management** – Case management is the core service delivery intervention for clients with concurrent disorders (Mueser et al. 2003). It has been found to be most effective when provided in the context of a multidisciplinary team that includes a case manager, a psychiatrist, and a variety of other professionals such as a nurse, substance abuse counsellor, clinician, and vocational specialist. Mueser recommends that whenever possible, the team should also include a nurse and employment specialist. He also suggests that early in the formation of such a team it may be practical to include one or more case managers experienced in treating severe mental illness and one or more experienced in treating substance use, with the expectation that they will learn more about how to treat concurrent disorders as a function of shared training and treatment experiences.

c. **Supported employment** – Helping clients with concurrent disorders develop meaningful lives is an important goal of treatment. One common goal of clients is to obtain competitive work. Supported employment programs emphasize helping clients obtain competitive jobs in the community by minimizing pre-vocational assessment and training, emphasizing rapid job search based on client preferences, and providing follow-along supports to help clients maintain jobs or move on to other jobs. Studies have shown that clients with concurrent disorders want to work and are capable of getting and keeping jobs in supported employment programs (Mueser et al. 2003). Supported employment can help clients obtain and keep competitive jobs thereby improving their self-esteem, financial standing, and investment in psychiatric stability, and decreasing free time for using substances.

d. **Family psychoeducation** – Studies have shown that families can play a crucial role in providing support to clients with concurrent disorders and such support is associated with improvements in substance use outcomes. Family psychoeducation is aimed at teaching families, including clients, basic information about concurrent disorders and the principles of their treatment, as well as reducing stress and improving coping.

e. **Social skills training** – Research has shown that social skills training for clients with severe mental illness is effective for improving social functioning. Skills training may be especially important for clients with concurrent disorders because of the important role social relationships play in maintaining ongoing substance use and because these clients need to develop new relationships with persons who do not abuse substances if they are to be successful in achieving sobriety.

f. **Training in illness management** – This includes teaching clients strategies for managing their disorders, helping them to recognize early warning signs of relapse and develop a relapse prevention plan, coaching in methods for taking medication as prescribed, and teaching strategies for coping with persistent symptoms and pursuing personal goals.

g. **Pharmacological treatment** – Antipsychotic, antidepressant and mood stabilizing medications continue to be mainstays in the treatment of severe mental illness, with more effective and more benign new medications becoming available every year. Research shows that psychotropic medications can reduce symptom severity and relapses, and clients with concurrent disorders should have access to these medications.

3.1.3 Stage-Wise Treatments/Staged interventions

Effective programs tailor interventions to the person's stage of treatment or recovery. Stages of treatment are closely related to "stages of change" - based on the observation that people who change behaviours progress through a series of distinct stages, including precontemplation, contemplation, preparation, action and maintenance, each

characterized by different motivational states (Mueser et al. 2003, Drake et al. 2001 and Drake et al. 2004).

Commonly recognized stages of treatment include the following:

- Engagement (precontemplation) - Establishing a working alliance between the clinician and client. Outreach is often necessary to accomplish this goal. The process of engagement typically begins with practical assistance related to securing food, clothing, shelter, crisis intervention or support – forming a trusting relationship;

- Persuasion (contemplation and preparation) – Developing the client's awareness that substance use is a problem, and increase motivation to change. Individual counselling in the persuasion stage can be based on *motivational interviewing* which enables clients to identify their personal goals and to discover how their use of substances interferes with attaining these goals. One of the goals is to empower the client to have insight, courage, hope and desire to change his or her substance use disorder.

- Active treatment (action) – Helping clients acquire skills and supports for controlling their illnesses and pursuing goals, including reducing substance use and if possible, attaining abstinence. Active treatment interventions can include working to increase skills and improve supports, individual cognitive-behaviour and counselling, and supported employment Active treatment groups and social skills training groups can help clients reduce their substance use by developing skills for dealing with high risk situations, for example coping with boredom. Relapses are common during the active treatment stage, and are viewed as part of the course of a chronic illness. They are used as opportunities to learn more about what the individual will need to achieve sustained reductions of substance use.

- Relapse Prevention (maintenance) – Helping clients develop and use strategies for maintaining recovery. This can include helping clients to address other goals in their lives, e.g. social relationships and work. Some clients attend self-help groups, some continue in concurrent disorder groups, some review their substance use status regularly with their clinicians, and others use a variety of community-integrated networks to maintain sobriety and improve functioning in other areas (McHugo et al. 2001 and Mueser et al 2003).

3.1.4 Engagement interventions…Assertive outreach

Many clients with concurrent disorders have difficulty linking with services and participating in treatment. Homeless persons with concurrent disorders have been found to benefit from outreach, help with housing, and time to develop a trusting relationship before participating in any formal treatment. It is believed that if clients can gain access to services and maintain needed relationships with a consistent program over months and years, this will help to support treatment initiatives (Drake et al. 2001).

3.1.5 Motivational Counselling Interventions

Effective programs incorporate motivational interventions which involve helping individuals to identify their own goals and to recognize that not managing one's illness interferes with attaining those goals (Drake et al. 2001).

3.1.6 Reduction of negative consequences

Given the damaging impact of concurrent disorders on the lives of clients, Mueser (2003) states that the first and foremost goal of clinicians should be to reduce the harmful effects. This goal is based on the fact that many people with addictions lack the motivation to endorse abstinence early in treatment, or even to decrease their use of alcohol or drugs; yet significant gains can be made initially by focusing treatment on reducing the negative consequences of alcohol and drug use. Harm reduction can protect clients from the most dire consequences of their substance use and also help develop a good working alliance. Examples of strategies to reduce the negative effects of substances include supplying clean needles, securing stable housing, limiting access to money for purchasing substances, accessing food or vitamins, teaching safe-sex methods for persons who exchange sex for money or drugs, and obtaining needed medical treatment.

A series of focus groups with clinicians who were all experienced with concurrent disorder treatment found strong support for the harm reduction approach and for meeting clients where they are at (Carey et al. 2000). One author stated that "abstinence as a condition for entering or continuing in treatment may be too high a threshold for people who perceive that they receive real benefits from drug and alcohol use" (Little 2001).

An examination of practices in the UK found that while abstinence may be appropriate for some dually diagnosed persons, other options were needed. It is proposed that the emphasis on abstinence models in the US has lead to a split in the treatment for those with dual diagnosis, with an emphasis on the mental illness aspect. This leads to a culture of non-disclosure of drug use, which impedes treatment. Furthermore, this approach does not consider drug use as self-medication (i.e. effective adaptation and symptom management) or the "socialising" phenomenon that drug using may represent (i.e. socially marginalized and isolated persons are provided with an alternate identity and membership of a social group where they are less stigmatized). Finally, drug use may be "the only area of the dually diagnosed clients' life in which they feel they have any degree of independent personal control." Work in East London with a population of dually diagnosed homeless persons is based on understanding drug use and establishing a relationship. This approach has been found to result in higher retention rates and more continuity (Phillips 1998).

3.1.7 Active Treatment Interventions

Effective treatment programs help people acquire the skills and supports they need to manage their own illnesses. It is recommended that a wide range of interventions and combinations of interventions be available to clients, including:

- Counselling to help clients develop skills and supports to control their symptoms and pursue an abstinent lifestyle. Counselling can include group, individual, or family therapy or a combination of these (Drake et al. 2001);
- Cognitive and behavioural skills training;
- Family and social network interventions;
- Self-help; and
- Medications.

3.1.8 Social support interventions

Effective programs focus on strengthening the immediate social environment, and recognize the role that social networks and family interventions can play in recovery from dual disorders (Drake et al. 2001).

3.1.9 Long term perspective

Effective programs recognize that recovery tends to occur over months or years in the community. People with severe mental illness and substance abuse do not usually develop stability and functional improvements quickly, even in intensive treatment programs. Instead, they tend to improve over months and years in conjunction with a consistent dual diagnosis program. Effective programs therefore take a long-term (time unlimited), community-based perspective that includes rehabilitation activities to prevent relapse and to enhance gains (Crawford et al. 2003, Drake et al. 2001 and Mueser et al 2003).

3.1.10 Representative payee programs

Representative payee programs (where an individual or agency assumes responsibility for the client's finances) have been seen as particularly effective for people with dual disorders. They can stop the cycle of homelessness and drug use by ensuring the rent is paid (Dixon and Osher 1995).

3.2 The ACT model

One of the models that would appear to integrate many of the elements described above is the ACT model, which has become increasingly popular not only in the US but elsewhere. Developed in Madison, Wisconsin in the 1970s as a response to "revolving door" consequences of the deinstitutionalisation of the 1960s, it is based on an acceptance that clients with severe mental illness have a right to live in as normal an environment as possible but with intensive support (Tibbo et al. 1999). Over 400 ACT teams exist in the US, and Australia and there is a growing number in Canada. In the UK the Department of Health had a target of 220 teams in place by 2003, serving an estimated population of 20,000 (Minghella et al. 2002) although these are not considered ACT teams but rather

include elements of Intensive Case Management and Assertive Outreach (Marshall and Creed 2000).

ACT differs from clinical case management in several ways (McHugo et al. 2001):

- Instead of waiting for clients to come to the clinic for treatment, most services are delivered to them in the community in their natural living settings (e.g. assertive outreach);
- The ACT team is responsible for providing most treatment and services to clients;
- Cases are formally shared across members of the treatment team;
- Smaller caseloads are used – typically 1 clinician for 10 clients, rather than 1 clinician for 30 or more clients; and
- There is continuous 24 hour, seven day a week coverage.

Case management activities can include:

- Psychotherapeutic work (e.g. developing a working relationship with the client, individual counselling, psychoeducation about concurrent disorders, and family work);
- Advocacy and coordination to ensure that clients are able to meet basic needs such as food, clothing, financial support, access to health care, and housing;
- Coordinating medication treatment and responding to crises; and
- Promoting rehabilitation and recovery to help or inspire clients to achieve their own personal recovery goals. Assistance could include increasing structured activity and helping clients to develop social, leisure skills and lifestyle changes.

There appear to be a number of advantages of the ACT approach when compared to intensive case management (ICM), which does not have a shared caseload. A review of the literature includes: “greater continuity of care, improved ability to respond to crises, reduced staff burnout, and improved job satisfaction” (Latimer 1999). The approach recommended by Mueser (2003) also incorporates the Strengths Model of case management which focuses on clients’ assets and building on natural supports to help clients achieve personal goals.

3.2.1 Evaluations and fidelity to the ACT model

Various studies of the effectiveness of the ACT model for clients with concurrent disorders have found that:

- Clients showed more progress toward substance use recovery and decreased substance use severity (Health Canada 2002);
- Fewer hospital admissions (McHugo 1999 and Meisler 1997);
- More likely to remain in contact with psychiatric services (Marshall and Creed 2000);
- Greater medication compliance (Crawford et al. 2003);
- A study in Edmonton (Tibbo et al. 1999) found that enrolment in an ACT program resulted in an average drop in length of hospital stays from 72 days to 32 days;

- Increased housing stability and reduced homelessness (Meisler 1997, Tsemberis et al. 2000 and Tsemberis et al. 2003);
- ACT can be more cost-effective than standard case management over the long term (e.g. 3 years) (Clark et al. 1998).

However, one of the critical factors in assessing ACT outcomes appears to be the fidelity to the model. Fidelity scales have been developed in the US and include: assertive outreach; case sharing; smaller case loads; team leader who is an active team member; dedicated time from a psychiatrist; 24 hour coverage; and services provided mainly in the community (Marshall and Creed 2000). In the UK some disappointing outcomes were reported in use of the ACT model, but part of the problem may be due to some departure from the model (Minghella et al. 2002). A Canadian review of the economic impact of ACT identified high fidelity as not only a shared caseload model and provision of the majority of the services in the community, but also four of the following five criteria:

- Staff: client ratio of 1:12 or better;
- A psychiatrist on staff;
- At least 1 nurse on staff;
- At least some coverage outside of normal working hours;
- At least 2 team meetings a week (Latimer 1999).

A program developed in England included a minimum team size of eight persons in its definition of high fidelity (McAuley et al. 2003). However, a number of impediments were identified in trying to implement ACT in a rural setting including access to services over 24 hours by the team (the solution was to link to other services to cover the full period) and length of time for team members to travel to reach clients (the conclusion was there needed to be increasing emphasis on making the appointments count).

The Canadian review of the literature focussing on the economic impacts of ACT (i.e. hospitalization, use of emergency services, outpatient visits, and housing) included program fidelity as a criterion (Latimer 1999). The review found that the "most consistent effect of ACT is the reduction of time spent in the hospital". Other effects include housing stabilization (although because this includes supervised housing, the author suggests that the economic impact is unclear), and a trend towards reduced use of emergency rooms.

3.2.2 ACT and other models of intensive case management

One of the issues for non-US researchers is the applicability of the ACT model to their country. For example, a review of ACT implementation in Canada identifies only four evaluations including one in Waterloo, Ontario although "intensive case management (ICM) was the community model employed". According to the author, the difference between the two models is caseload sharing, but finds that "…favourable outcome measures have been consistently found in different adaptations of ACT in different environments with different hospital policies over some 15 years, suggesting the likelihood of a very strong program effect" (Tibbo et al. 1999).

In the UK in the 1990s the move was towards case management and intensive case management (i.e. smaller case loads and teams consisting of social workers and nurses) for the less stable, "revolving door" clients. Because there was no distinction made between case management and the ACT approach, controlled trials revealed that while there were improvements in the numbers of patients remaining in contact with services, there were substantial increases in persons admitted to hospital and there were no consistent improvement in clinical or social outcomes, and where available, there appeared to be increases in health costs (Marshall and Creed 2000). Some debate followed these findings and the question of whether models developed in the US were applicable to the UK, especially given the unique features of the National Health Service (e.g. standard care includes access to community psychiatric nurses and general practitioners).

A British review of the literature finds that intensive treatment (i.e. multiple interventions for several hours daily over a period of weeks or months) "….showed minimal evidence for sustained improvement once treatment stopped and the overall costs are prohibitively expensive" (Crawford et al. 2003). This would appear to echo findings from one of the earliest assessments of ACT in the US that found that while the approach resulted in reduced time in the hospital, improvements in clinical outcomes and substantially reduced costs, "when ACT was withdrawn, these substantial benefits were lost" (Marshall and Creed 2000). The study finds that even in integrated treatment, the patient/key worker ratio can be very low and therefore expensive, "although the better outcomes may later offset the initial investment." Adding housing to an integrated service is found to be effective in terms of housing stability and reduction in use when compared to a parallel approach (Crawford et al. 2003).

The Australian review of the literature is also somewhat restrained in the reaction to the research. It concludes that case management is effective in treating persons with dual diagnosis but there is "little evidence for difference between the various models of case management", attributed to the lack of randomised controlled/clinical trial that compare the models. The review does find that intensive case management is superior to a 12-step recovery approach that integrates mental health services but that this is in relation to improved mental health outcomes but not in relation to drug and alcohol outcomes. Finally the study by Darke and colleagues is found to provide "limited evidence" of the efficacy of ACT for persons with dual diagnosis (National Comorbidity Project 2003).

Mueser suggests that the ACT model of case management may not be required for all clients with concurrent disorders but merits inclusion as a component of integrated treatment for clients prone to frequent crises, relapses and rehospitalizations, and legal problems. Presumably, this could apply to people who are homeless – particularly those who are episodically or chronically homeless.

Furthermore, while ACT teams have smaller case loads than standard case management (SCM) and provide more individualized and intensive treatment, over a three-year period it was found that SCM was more efficient than ACT, while the relationship reversed in the third year (Clark et al. 1998).

3.3 Residential programs

Both the mental health and addictions systems have used residential treatment programs for their clients. However, the approaches that have been used by each have traditionally been different. In mental health residential treatment, the focus is generally on developing individual interpersonal skills and competencies to prepare for integration into society. In the past, substance abuse residential treatment (e.g. therapeutic communities), has focused on personality change, and abstinence. Urine tests are conducted regularly, and these residences usually have a style of confrontation (Blankertz and Cnaan 1994).

During the 1990s, more integrated approaches were developed with some success. One author conducted a review of 10 studies that examined residential treatment programs for people with concurrent disorders and concluded that an integrated approach, which combines mental health and substance abuse interventions leads to more successful result. This approach recognizes the needs of individuals with severe mental illness and is slower, less confrontational, more repetitive, more focused on motivation, and more behavioural than what is provided in many traditional substance abuse treatment settings (Drake et al. 2004 and Kasprow et al. 1999).

Most of the studies examining short-term residential treatment programs (3-6 months) have been found to suffer high drop-out rates, and success rates are considered low. [However, this literature review did not find criteria or guidelines as to what constitutes a normal drop-out rate or criteria for success.] For example, one study compared two residential programs for individuals with concurrent disorders. The experimental program was a residential model based on a psychosocial rehabilitation approach. The comparison program used a modified therapeutic community (based on substance abuse treatment). While the experimental project was more successful, both were considered to have had high drop-out rates: 47% in the comparison group and 19% in the experimental group. In the experimental group, 29% in residence for more than 60 days exited "successfully", and two thirds of these individuals moved to apartments or supported living. In the comparison group, 8% of individuals in residence for more than 60 days exited successfully, and all of these individuals moved to a group residence or halfway house (Blankertz and Cnaan 1994).

The literature appears to indicate that homeless individuals with concurrent disorders do not accept an environment that is too restrictive or rigid, and heavily controlled residential treatment models in which housing and treatment are tightly bundled are associated with recruitment and retention problems. It is recommended that programs be flexible and encourage people with concurrent disorders to enter gradually without requiring abstinence (Bebout et al. 1997 and Blankertz and Cnaan 1994).

It has been suggested that successful strategies in residential programs include weekly psychoeducational groups in which clients can learn about and discuss issues related to their co-existing disorders. Certain elements of successful group meetings include active listening, ceremony and ritual, and flexibility (e.g. throw dogma to the wind – do whatever is necessary to promote therapeutic or growth experiences). Goals can also

include uncovering hidden resources and motivations, harnessing the power of the group, focusing on the positive, and reserving judgement, exploring spirituality, emphasizing psychoeduation, and incorporating relapse prevention in everyday activities (Beaulier et al. 2000).

The literature states that programs segregated from the community result in rapid relapse rates when clients are discharged and suddenly reintroduced in to the community. Vulnerability to relapse is not significantly reduced even if individuals spend long periods of time in separate, controlled living environments, whether these are residential programs, hospitals, or jails/prisons. Residential programs are most likely to be successful when they are located within clients' natural communities, and when they provide opportunities for community reintegration (Meuser et al. 2003). One of the longer term residential programs that was reported to show successful outcomes was Gemini House, a residential and rehabilitation program in New Hampshire for individuals with concurrent disorders and histories of either long-term or repeated institutionalization in hospitals or jails.

The Gemini House program includes both a residential program with capacity for 15 clients and a day program which serves both clients in the residential program as well as other clients, including some who are making the transition in or out of Gemini House, and graduates who are living in the community. In addition to clients who are residents at Gemini House, 5-10 more clients participate in the day program. Twenty-four hour staffing is provided at the residence, with 11 staff members covering the residence, day program and community outreach.

Active programming is a central feature, and clients are not permitted to stay in their rooms during the day. They are expected to work or attend school. Programming is provided to address psychiatric stabilization, abstinence, independent living skills, community re-integration and vocational rehabilitation. There is moderate tolerance for substance use relapses, which are viewed as natural parts of the recovery process from concurrent disorders. On the other hand, clients are also expected to demonstrate some commitment to working on their substance use problems as a condition for living at the residence.

Programmed community reintegration is an important goal for all clients at Gemini House. The integration of clients in their larger community outside the program starts at the beginning of their residence. From the time of their admission, clients participate in some activities in the community, such as work or school. Excursions in the community are planned regularly. The process of moving out of Gemini House is quite gradual, taking place over many months. Even after clients have moved out of the House and into apartments in the community, they may continue to be involved in the outpatient program and may even spend some nights back in Gemini House. Clients continue to have contact and receive support from the program staff as they resume living in the community. Thus the goal of reintegrating clients into their local community is accomplished by never completely severing their connection to the community.

The literature also describes Foley House, a short-term harm minimization residential service in Sydney Australia that serves clients who use a myriad of substances, who generally live on the streets, and are at risk of transmitting or acquiring HIV and/or hepatitis.[3] As of July 1998, it was estimated that about 80% of their clients had either received a mental illness diagnosis or were displaying symptoms of mental illness. At Foley House, staff acknowledge that the majority of addicted people are not at the stage where they are attempting to modify their lifestyle or situation. Some people want to learn how to moderate their usage or develop controlled using. Others do not want to change their drug usage but want to deal with some of their emotional or physical problems. Some just want a break from living on the streets. The goal is to encourage clients to improve their knowledge, hygiene, basic health and future prospects within their chosen lifestyle. Foley House provides board and lodgings, education regarding safer sex and safer using procedures, and information regarding transmission of blood borne infections and STDs. They encourage clients to link up with other services, organize future accommodation, and have dental and general health checkups. Clients need to list some goals they want to achieve during their stay. A progress report is completed every 2 weeks to see if the client is accessing sufficient services. During these reports, injecting demonstrations and condom demonstrations are done and each client practices steps to being "safer" in these practices.

One of the problems identified with Foley House is that when clients complete their stay, there is often nowhere else to send them. Waiting lists for subsidized housing are very long and these clients cannot get into supported accommodation services because they are still using. If they do manage to get a subsidized housing unit, they often find living by themselves too difficult and "self-sabotage". Whatever gains they make while at Foley House are lost because they have to go back on the streets. When back in the "war zone" they continue to be refused services by other agencies and many end up in jail or dead from drug overdose or suicide. The authors identify a need for longer term housing to help clients transition from fully supported accommodation to living on their own, and more integrated services where clients could receive both mental health and addictions services from one agency or for mental health and drug and alcohol agencies to work close together so that clients are not longer "ping ponged".

3.4 Barriers to Treatment

The literature has identified several factors that are particularly difficult for individuals who were working on their recovery. These include:

- Dealing with difficult feelings, inner conflicts, anger, sadness and loneliness that may have been masked by active addiction, and feelings associated with entering recovery such as shame, regret and guilt. It has been reported that dealing with feelings is particularly important and difficult for individuals with a history of childhood trauma, an issue that affects a significant portion of individuals with concurrent disorders. Many individuals with a history of emotional, sexual or physical abuse or trauma develop dependence on a variety of drugs, especially

[3] The maximum length of stay is 12 weeks.

opiates, alcohol and marijuana, to relieve traumatic memories and other symptoms of post traumatic stress disorder (Little 2001).

- Socio-economic issues, particularly employment and financial problems. In one study, vocational and employment issues were the most cited goals for the next year – mentioned by 46% of subjects. Education, including earning a high school equivalency and going to college was a close second, cited by one third of respondents (30%). However, study participants also recognized that they faced many obstacles, as some had never worked or had not worked in many years, and did not possess job skills. Another concern was that symptoms and medication side effects would make it difficult to find or maintain employment. Some subjects cite difficulties coping with people and poor impulse control as major obstacles to entering or re-entering the workforce. Subjects may also need training in skills other than job-related ones, such as personal habits, time management and social and workplace relations. Study participants also believed that the stigma of having a concurrent disorder would be an obstacle to finding a job.

- The maintenance of sobriety. Most subjects in the sample started using drugs and alcohol in adolescence and have used almost continuously ever since. Many have used drugs and alcohol to help deal with painful feelings (low self-esteem, past traumas, perceived social inadequacy) and have known no other life until they entered the treatment system. Recovery is very demanding on the individual who must deal with old thought patterns, triggers, demands, and requirements of a new lifestyle. Socio-economic and emotional issues, and sometimes physical health issues (many emerge from years of addiction with serious, chronic health problems) can make matters worse. Furthermore, it can be demoralizing to see how slow progress is at first.

A study among homeless and recently homeless clients involved in a residential and non-residential treatment program in Los Angeles identified several impediments to successful treatment outcomes (Weinberg and Koegel 1995).

Street competence versus program competence. The researchers found that one "very pervasive impediment to recovery" was the difficulty in reconciling the attitudes, skills and behaviours that served people while they were homeless, compared to what was expected from them in treatment. The study noted that living as a homeless person calls for a certain set of attitudes and behaviours, while functioning as a competent member of a social model recovery program calls for another. For individuals entering the programs from a homeless living situation, the result was a tension that repeatedly surfaced.

Street competence strategies that were identified included learning not to trust anyone, presenting oneself as aggressive or unpredictable, exploiting others, assuming that others intended to take advantage of you, and recognizing that courtesy and fair play were niceties that could cost you dearly in the end. The goal while on the street is to avoid physical harm, reduce vulnerability to victimization and exploitation, determine whom or

whether to trust, and managing the vast negative emotions that living homeless provokes. It was noted that living homeless had trained people to studiously avoid reflecting on their feelings about themselves and their lives.

On the other hand, program competence required active participation in program activities, willingness to candidly express one's thoughts and emotions, and cooperation and friendliness with counsellors and other clients. The program expected that participants would behave with openness and trust.

Thus, clients entering from a homeless situation were in a position where expected behaviour was often at odds with patterns of conduct that had proved effective for managing life on the streets.

Recovery versus subsistence needs. The authors of the study reported that individuals faced tension between pursuing a program of recovery and meeting basic survival needs for shelter, food, clothing, and income. For homeless clients in the non-residential program, it was difficult to focus on the demands of the program while being pre-occupied with concerns about their day-to-day survival. This was a significant difference between the residential and non-residential program.

Employment. The desire for employment was another issue that affected recovery. The researchers found that employment was a significant priority for many participants – not only because of the income it could provide but also because employment provided confirmation that they were "well" and fully functioning members of society. Getting and having a job was very important, and sometimes conflicted with treatment. If a job opportunity came up, people felt compelled to leave treatment to take it.

Recovery and reality. Another significant impediment to successful treatment of many of the homeless clients with concurrent disorders revolved around the tension between the high expectations they initially brought into treatment and their ultimate recognition that treatment would not necessarily eradicate all the longstanding problems that affected their lives. Many had to confront the disappointing realization that much of what they most disliked about their lives would remain even if they achieved their goal to remain sober. Often, their problems had deep roots that predated their substance use. Sometimes sobriety and stability made their problems more blatant and harder to face. This recognition, plus the challenge of creating a life that was as eventful and stimulating as their former lives had been, made the release provided by drugs very enticing.

For many, recognition that recovery would not necessarily result in a "fairy tale ending" often produced a pervasive sense of homelessness and despair.

As one person said "See Darin, it's hard for me to stay clean, because my life when I'm clean is so horrible. They say it gets better, but for me it never got better. I knew when I relapsed that it wasn't the answer, that I was gonna be even worse off, but I didn't care. I just wanted relief from that misery, even if it was only going to be a temporary fix and was going to make things worse in the end. I just said, "Give me the temporary fix".

Some of the particular issues identified by study participants included the rarity of intimate companionship, lack of meaningful activities in their lives, chronic loneliness, and boredom of their lives. It was noted that straight life was often excruciatingly dull, tedious, and frighteningly predictable compared to a life dominated by substance use.

The authors of this study identified a need to:

- Recognize that the coping skills of homeless individuals entering treatment may be in conflict with successful participation in treatment.
- Recognize how difficult the transition to treatment might be for homeless individuals and that they need sufficient time for the transition to occur.
- Recognize that it may be difficult and maybe impossible for homeless individuals to attend to treatment without having reached some degree of stability first. There is a need to ensure that basic needs for housing and income are met.
- Recognize the psychological importance of employment, which suggests a need to explore closer links between work and recovery opportunities.
- Help people anticipate the challenges they will face after treatment. Strategies could include helping participants build meaningful relationships and find new ways of entertaining themselves (Weinberg and Koegel 1995).

The authors observed that those in residential treatment enjoyed many advantages relative to those in non-residential treatment. They did not have to struggle to find shelter, food and clean clothing, and they were less vulnerable to the demands of being immersed in program life and street life. However, the intensity and isolation of such program may not be for everyone. In addition, they had the trauma of re-entering the real world at the end of their tenure in the program.

In BC, the framework recognizes that residential treatment is warranted and effective for a small number of clients and along certain points of the treatment continuum. Residential programs that include childcare and parenting support are increasingly effective as a strategy to engage women in treatment and improve treatment retention. All treatment must be balanced with the woman's choice of outpatient or residential treatment.

3.5 The role of housing

There is consensus in the literature that housing is the cornerstone of care, particularly for people who are homeless and have concurrent disorders (Drake et al.1991). In the UK, one report summarises the situation, "People without accommodation are unlikely to be offered treatment, and those leaving treatment without suitable accommodation and support are very likely to relapse" (Randall and DrugScope 2002). Numerous studies have reported that stable housing is nearly always central to attaining treatment goals and that housing must be part of any comprehensive treatment program.

The need for housing is repeated by persons who are homeless. For example, a study in Scotland revealed that "having 'a home of one's own' was associated with a sense of purpose, self-respect and responsibility" and that for some "feeling settled in their own accommodation was an important first step in being able to address their addiction" (Neale 2001). A study in Montreal of the trajectories of homeless persons who were substance users and in the process of stabilisation found also that housing was the cornerstone for stabilisation and that the ability to maintain the housing was the result of a more global process of rehabilitation (Mercier et al. 1999).

However, there appear to be differences of opinion and new ideas regarding what type of housing should be available and regarding the relationship between housing and treatment. For example, while studies have shown that most mental health consumers want to live in their own residence, several studies in which housing was provided for homeless mentally ill people in the mid-1990s demonstrated that substance abuse posed serious problems for their ability to maintain stable community housing (Schutt and Golfinger 1996, Hurlburt et al. and Bebout et al. 1997). Those studies found that progress toward substance abuse recovery seemed to be the most important factor associated with achievement of stable housing over time, perhaps especially for those using crack cocaine.

On the other hand, there are others who believe housing, and the stability that come with having a stable living environment needs to come before treatment. For example, Alverson et al. (2000) found that positive quality of life factors (e.g. engagement in a regular, interesting and enjoyable activity, **decent stable housing**, a loving relationship with someone sober who accepts the person's mental illness, and a positive, valued relationship with a mental health professional) **precedes** rather than follows sobriety. The absence of two or more of these factors is predictive of and is associated with continued substance abuse. This finding suggests that an abstinent lifestyle requires meeting basic needs, developing close relationships, and achieving meaningful activities. The authors conclude that the oft-heard mental-health line that "one must first get sober and get a life" is mistaken. For these clients, at least, attaining a more satisfying life precedes rather than follows attainment of sobriety.

In the UK, a survey undertaken by Homeless Link included a sample of over 2,300 homeless persons with multiple needs who had been resettled. The tendency in London was found to be tenancy sustainment or floating support while outside of London this was more likely to be 24-hour supported accommodation. Overall nearly a quarter (22%) of all tenancies by clients with multiple needs failed but there was a wide disparity between London where only 5.4% of the tenancies failed, and outside of London where 35% failed. The largest failure rate was 24-hour supported accommodation (41%) both in and out of London, although the study was not able to discern why this kind of accommodation was less successful. Furthermore, time-limited services were twice as likely to fail (Homeless Link 2002).

In Germany evaluations of projects that housed persons who had been homeless, some with a long career of homelessness and life in institutions found that with few exceptions

they were able to cope permanently in "normal" housing if they received the necessary supports (Busch-Geertsema 2002).

A follow-up study of homeless persons who had been re-housed in Dublin, Hanover, and Milan targeted single persons "with problems" (Busch-Geertsema 2002). The typical problems were addiction (alcohol and drugs), mental illness, and prison experience. Most of the persons who had been re-housed had been homeless for years (nearly half in Hanover and Dublin had been homeless for five years and more), with a majority having slept rough. Most of the rehoused persons had been staying in permanent independent housing for one to two years, although some had been in their units for more than five years and some more than ten years. (It should be noted that the projects had been monitored for a number of years and some tenants had left – but the tenancies that failed did so in the first 12-16 months after rehousing.) The study found that all tenants had reached a certain level of autonomy but only a small number had reached full autonomy, and the majority still had problems. Comparison of experiences in different cities, revealed that the histories of the persons "do not pre-determine their rehousing careers, but there are increased risks and a need for more intensive social support for people with a long history of homelessness and for those who cannot cope with mental health and addiction problems". One of the issues that stems from this observation is the "unpredictability" when the rehousing process starts as to who will be able to keep problems such as addiction and mental health under control. "This uncertainty calls for a flexible approach concerning the provision of personal support and crisis intervention."

The study finds that across all three projects "integration into normal housing has a very fundamental impact on the overall integration of homeless people into society" but that it is not the solution to all the problems of the persons who have been rehoused and that support is needed. For many with serious health problems, including addiction and mental illness, rehousing helped them cope with health problems (e.g. visit doctors, get used to regular medication) and for some, to control their consumption of alcohol and other substances. (In the projects in Hanover and Ireland only a few persons were abstinent, while the project in Italy required total abstinence before housing was acquired.) Interviews with the residents revealed that self-contained units were a source of "autonomy, security, privacy and 'normality'" and that good-quality housing was important. However, the study did find that rehousing "put an end to homelessness, but many did not escape poverty". For many this was due to their inability to take up employment because of age, ill health, low levels of education, training and job-experience, coupled in some instances with high rates of unemployment – especially for those with low qualifications.

The importance of flexible and individually tailored support was underscored in the study – before and after rehousing. The results support the criticism made against "rigid staircase systems" that have fixed and relatively long periods of stay at various stages and other standardised models for reintegration[4]. "There is no 'one size fits all' solution." The

[4] Similar to the US continuum of care, some European countries have a "staircase" approach to reintegration of homeless persons. See for example, Sahlin, Ingrid 1998 *The staircase of Transition*

need for multidimensional support is emphasised. However, the kind of support and control on those with the most complex problems remains unclear. The Italian example required that a rigorous process be followed before rehousing. Interviews with residents revealed that "the persons with extreme marginalisation histories are the most ready to recognise the value of restrictions and of the severity of the rules in the first phase of the process", although it should be noted that Individual Rehabilitation Plans were drawn up for each person. Nonetheless, there was some "severe" criticism by some interviewees of the degree of control in the early phases. The study concludes that complete abstinence should not be a condition but that excessive consumption, extreme anti-social behaviour and severe mental health problems and refusal to co-operate with support services could soon lead to renewed homelessness. Nonetheless it is stated that successful outcomes of second and third efforts at rehousing illustrate the need for "fluid" resettlement plans that allow persons to "fail" and return (Busch-Geertsema 2002).

A study of "wet" hostels in the UK (Crane and Warnes 2003) adds a cautionary note to the ideal of abstinence. In a review of studies of street drinkers and the impact of participation in numerous detoxification programs, the authors state, "There is now evidence to suggest, however, that multiple episodes of alcohol withdrawal may increase the incidence and severity of seizures during detoxification, render a person more vulnerable to brain damage, and contribute to alcohol-related neuropathology and increased cognitive dysfunction..."

The predominant and more traditional approach to housing homeless individuals with severe and persistent mental illness in the US has been an approach that follows a Continuum of Care. Individuals are expected to become more engaged in abstinence as they move along the continuum. The stages of engagement include outreach, intended to encourage clients who are homeless and mentally ill to accept a referral for the next step along the continuum, followed by a wide range of programs such as drop-in centres, shelters and safe havens. An objective of this second stage is for clients to become "housing ready" – i.e. able to meet the criteria of housing providers to comply with psychiatric treatment and to maintain sobriety. The third point in the continuum is housing. The expectation is that clients will "advance' to more independent, less supervised and less restrictive settings as they master the appropriate skills required at their current placement.

The Continuum of Care approach has had limited success and has been criticized for several reasons (Tsemberis 2003, Dixon and Osher 1995 and Gulcur 2003):

1. Service providers have pointed to difficulties in engaging individuals with dual diagnoses for services.

National Report 1997: Sweden FEANTSA, Brussels or De Gouy, Anne. 1997 *Les Services Destinés aux Sans-Abri, Vous avez dit innover?* National Report 1997: France FEANTSA, Brussels

2. The requirement that individuals change housing as they "progress" through the continuum may be counterproductive, even causing symptomatic relapse. It is stressful and taxing for consumers to repeatedly develop working relationships with new service providers along each step of the continuum. Stress can also result from congregate living.

3. Many consumers prefer to live in independent housing and have complained about the institutional qualities of many treatment-oriented housing settings and the fact that consumer choice or preference may be ignored (Dixon and Osher 1995). Some researchers have suggested that choice in housing and treatment, which has been associated with greater housing satisfaction and improved housing stability, may be critical to engagement and retention (Gulcur 2003).

4. Skills learned for successful functioning at one type of residential setting are not necessarily transferable to other living situations. More recent research suggests that the most effective way to teach a person the skills required for a particular environment is in that environment.

5. It takes a substantial amount of time for clients to reach the final step on the continuum.

6. Individuals who are homeless are denied housing because placement is contingent on accepting treatment first (Tsemberis and Eisenberg 2000).

7. There is no data on how rapidly a given individual should progress through the phases, so time limits may seem arbitrary and a step-wise progression may not mirror the client's clinical course.

The "housing first" model is an alternative to the continuum of care. In this model, housing is viewed primarily as a place to live, not to receive treatment. Central to this idea is that consumers will receive whatever individual services and assistance they need to maintain their housing choice. Proponents of this model emphasize that it facilitates normal community roles, social integration, and increased independence and control for the client (Dixon and Osher 1995, Tsemberis and Asmussen 1999 and Tsemberis et al. 2003).

Pathways to Housing in New York is one of the better known "housing first" programs. It provides housing to individuals rejected by other housing programs due to the refusal to participate in psychiatric treatment, active substance use, histories of violence or incarceration, and other behavioural or personality disorders. All clients are offered immediate access to permanent independent apartments of their own. Housing is not connected to treatment. Consumers who are active substance users are not excluded from housing and consumers who relapse while housed are considered in need of treatment, not eviction to a more supervised setting. Housing can be maintained as long as consumers meet the terms and conditions of their leases (Tsemberis et al. 2003).

Support services are provided through a multi-disciplinary ACT team. These services address housing issues, money management, vocational rehabilitation, mental health and substance abuse treatment, and other issues. The goals are to meet basic needs, enhance quality of life, and increase social skills and employment opportunities. The majority of services are provided to tenants in their homes and communities. Staff are available 24 hours a day, 7 days a week. Unlike traditional ACT models, clients are able to determine the type and intensity of services they receive.

Several studies have been done to evaluate the effectiveness of the Pathways program. In one study, the housing retention rate of the Pathways supported housing program was compared with rates of other New York City agencies operating residential treatment programs according to the continuum mode. The study found that 88% of the Pathways tenants remained housed, whereas only 47% of the residents in the City's residential treatment system remained housed. The study also found that after clients are housed, they are much more likely to seek treatment for mental health problems and substance use voluntarily (Tsemberis and Eisenberg 2000).

Another more recent study compared the Pathways program with a control group that used the continuum of care model. A total of 225 participants recruited from the streets and hospitals were randomized into two groups. A total of 126 participants were assigned to the control group that used the continuum of care model and 99 participants were assigned to the experimental group who then entered the Pathways Housing First model. The results showed considerable success for the Housing First program in reducing both homelessness and psychiatric hospitalization for homeless individuals with mental illness. This study found that the Housing First model had an 80% retention rate (Tsemberis 2004).

The sustained success of the Housing First program over the full two years of the study is considered to have significant implications for interventions designed to reduce homelessness among individuals with psychiatric disabilities and substance use issues. Supporters of the continuum of care model have been concerned that giving homeless individuals apartments directly from the street before they were "housing ready" was essentially setting them up for failure. The present study provided no evidence of that. It was also noted that ironically, individuals who use substances or engage in disruptive behaviour may be more easily housed in private apartments than in congregate settings where their behaviour directly impinges on others (Gulcur 2003).

The Direct Access to Housing (DAH) program, established in 1998 by the San Francisco Department of Public Health is another US program that provides permanent housing with on-site support services to approximately 400 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. DAH is a 'low threshold' program that accepts single adults into permanent housing directly from the streets, shelter, acute hospital or long-term care facilities.

Since opening the first DAH site in 1998, over two-thirds of the residents have remained housed. Of the people who moved out, about one-third went to market rate housing,

(some with rent subsidies), to other supportive housing, or moved in with family or friends. Fifteen percent of people who moved out went to higher-level facilities such as skilled nursing facilities, acute hospital or residential care facilities. Approximately 11% of residents died since the program began, while approximately 8% of residents were evicted. The program has resulted in a significant reduction in emergency department use among the residents. Approximately three-quarters of the residents went to the emergency department at least once in the two years prior to entering the DAH facility. In the two years after placement, less than half of the DAH residents went there. Approximately one third of the DAH residents were hospitalized for medical conditions in the two years prior to placement and less than one-quarter were hospitalized in the two years after placement (National Alliance to End Homelessness).

While the National Homelessness Secretariat has adopted a “continuum of supports” approach (prevention, emergency shelter, outreach, support services, transitional, supportive and permanent housing) practice in Canada remains mixed. Not as well documented as American experiences, there have been successful programs that take a “housing first” approach (although not identified as such). For example, the Canadian Mental Health Association - Ottawa Branch has been housing clients with concurrent disorders in permanent housing for years. Other examples are in Montreal, Peel Region, and Hamilton (Shepherds of Good Hope).

In the UK Local Authorities have a responsibility to provide housing to people who have a 'priority need' and are not 'intentionally homeless' (i.e. having made themselves homeless through their own actions). Households in priority need include those with children, and persons who are vulnerable because of old age or mental or physical disability. However, housing offered can be temporary and minimum statutory standards for temporary accommodation have been set in the act. The shortage of affordable housing has resulted in a record number of households living in temporary accommodation.

The 2002 Homelessness Act furthermore has targeted bringing housing and social services departments together to house vulnerable people. According to research undertaken in 2003 this goal is proving difficult in part because social services are reluctant to share information about clients on a range of issues including mental health problems, drug abuse, HIV and Aids or a history of violent behaviour (Shelter n.d.).

A study in the borough of Lambeth in London involved interviews with 166 persons with a history of substance abuse who had applied for Local Authority Housing (Rutter 1999). About 75% had passed through temporary accommodation arranged by the housing authority. One quarter lost contact with the local authority during this period. Temporary accommodation was disliked by most. The “unpredictable” mixture of clients was a major source of anxiety as was security of possessions. Most of the substance users wished to stabilise their intake but were aware of drug and alcohol use of other tenants, which they regarded as temptation. But the study found that “the general state of mind and moral” of the residents was more significant compared to use. Moral was linked to length of time and the type and quality in temporary accommodation. The key factors in

increasing use are found to be "insecurity and uncertainty, including lack of confidence in the future, and boredom and depression deriving from the limitations of the environment."

Persons who gained access to permanent housing also were interviewed. Some of the problems identified for this group included the inability to stop having their units "misappropriated" by others, often persons with whom they had been on the street and consumed. Other issues included feelings of insecurity, unexpected absences because the person was in prison or in treatment, and isolation and social difficulties. Having housing appears to have had a profound impact with people, housing being an indicator of "normality" and "adulthood", and for those who had been in residential treatment, a sign that they had overcome "institutionalization".

The study compared the impact of temporary and permanent housing on substance use:

Substance use	*Permanent housing*	*Temporary housing*
Use increased, then decreased	-	10%
Use decreased, then increased	3%	13%
Use increased	9%	20%
Use decreased	21%	17%
Use stabilised	43%	20%
Abstinence was maintained	24%	20%

Source: Rutter 1999

The study concludes that clients who are housed are "motivated to move on to tackle other areas of their lives" but also finds that the "lack of community resources frustrates these desires, and promotes substance use as a substitute for meaningful progress" (Rutter 1999).

4. Conclusion

As the introduction points out, there still remains much that is unknown about concurrent disorders, and even more about how this affects homeless persons. The literature review underscores the limited knowledge for prevalence in Canada, and the need for further research in this country. The research and literature reviews undertaken in Australia and the UK is also limited, and suggest that applying American prevalence data could lead to erroneous conclusions.

Based on the literature, it is clear that more work needs to be done to integrate treatment for individuals with concurrent disorders. However, there are different ideas as to what integration means, and how it can best be achieved. According to the US definitions found in this literature review, integrated treatment means that both mental health and substance use services are provided by the same clinicians or team of clinicians, working in one setting to provide appropriate mental health and substance use interventions in a coordinated fashion. Health Canada supports integration through the development of enduring *linkages* between service providers or treatment units within a system, or across multiple systems to facilitate the provision of services to individuals at the local level. An integrated system of care is currently being implemented in Manitoba.

US research would indicate that comprehensive integrated programs that include residential services/housing, an appropriate model of case management (e.g., ACT), stage-wise treatment (tailored to the person's stage of recovery), assertive outreach, motivational interventions, harm reduction, active treatment such as counselling and medication, and social support achieve positive outcomes for individuals with concurrent disorders. However, research into the application and the outcomes of such comprehensive initiatives is still lacking for the Canadian context.

Perhaps the clearest conclusion that emerges from this literature review is the need for research on housing and services for people who are homeless and have concurrent disorders. There is clear evidence that housing plays a critical role and is the "cornerstone of care". While some of the older thinking and literature advocated treatment before independent living, more recent research is demonstrating that homeless individuals with a concurrent disorder can maintain independent housing, providing appropriate supports are in place. Some of the US examples, notably Pathways to Housing in New York, indicate that the combination of housing and ACT are highly successful.

The next stage of research for this project should contribute to better knowledge of the Canadian situation. This next stage will involve documenting initiatives in Canada that provide housing and support to serve individuals who have been homeless or at risk of homelessness and who have concurrent disorders. This work may help clarify some issues that have been raised in the literature review, and will certainly shed some light on what approaches seem to be working in Canada.

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APPENDIX D

Innovative Approaches for Providing Services to Homeless People with Concurrent Disorders

Interview Guide for Agency Key Informants

For Initial Telephone Contact

Hello. My name is_____. I am calling from Vancouver/Montreal/ and am part of a research team that has been funded by the National Secretariat on Homelessness to:

- Investigate innovative approaches to providing housing and services for people who are homeless or at risk and who have concurrent disorders (mental illness and substance use issues); and
- Prepare case studies to document programs and services that serve individuals with concurrent disorders.

We understand that your program serves people who are homeless or at risk and who have concurrent disorders. Is that right?

Yes No If no, thank the person very much. End the call.

We would like to arrange an on-site interview with you. We would like to interview you – or someone else that you recommend, **interview a few individuals who are or have been participants in your program,** and tour your project. It may also be a good idea to **meet others** who are involved in this initiative (e.g. service agencies, property managers….)

We recognize that this will take a substantial amount of your time, and would like to offer your organization a small honorarium, $250 to show our appreciation. We will also offer each program user $25 for their time and expertise. The interview with the program users should be about 1 to 1.5 hours.

1. Do you think your organization would be willing to participate?

   ☐ Yes ☐ No

2. Would you be able to approach 4 program users that we could interview when we are at your project?

   ☐ Yes ☐ No (if outright no, arrange to call back)

3. Who would you suggest we speak with about your program - would it be you or would you recommend someone else?

   ☐ Person on phone ☐ Someone else

   If someone else, who should we contact? _____

4. We will be conducting interviews between January and the end of March. Is there any time period that is best for you? Any time away on holidays?

   Weeks that are good_____
   Weeks on holiday_____

5. [Note that we may want to meet with people from other organizations. We need to decide who, and if the interviews should be together or separate. Need to ask if we should meet with other staff from the SAME organization, and we may want to ask if there are people from other organizations we should meet with.]

6. We will send you a copy of the questions in advance. And we will also send the questions we plan to ask to the participants in your program. Would you prefer receiving the questions by fax or email?

   Email address:_____ Fax:_____

7. I would like to be as prepared as possible before we meet and would like to be able to read:
   a) Any write-ups that have already been done of your project
   b) Your annual report and financial statements (that show the particular program we are documenting)
   c) Any evaluations that have been prepared
   d) Any tenant satisfaction surveys
   e) Policies and house rules
   f) Your lease (if different from standard lease agreements)
   g) Anything else you think is important

8. Are any of these available on your website or electronically? If yes, which ones. If not, would you be able to send me this information?

Documents of interest	On internet	Will send
Any write-ups of the program		
Annual report with financial statements		
Evaluations		
Tenant satisfaction surveys		
Policies and house rules		
Lease (if different from standard agreements)		
Other		

Thank you very much. I will get back to you to arrange a specific date and time.

Innovative Approaches for Providing Services to Homeless People with Concurrent Disorders

Interview Guide for Agency Key Informants

Email – to confirm interview and send info

Thank you for agreeing to an interview for the research project on innovative approaches to providing services to homeless people with concurrent disorders. I would like to confirm that our interview will take place as follows:

Date:
Time:
Place:
Others who will attend:
Date and time for interviews with program participants/residents:

Attached are the following:

- Background information about our research;
- The interview guide for our interview with you;
- A consent form that we will ask you to sign; and
- Information and questions for the interviews with program participants/residents.

If you have any questions or if you need to change the interview times, you can reach me at…….

Innovative Approaches for Providing Services to Homeless People with Concurrent Disorders

Interview Guide for Agency Key Informants

I. Background

The purpose of this project is to:

- Investigate innovative approaches to providing housing and services for people who are homeless or at risk and who have concurrent disorders (mental illness and substance use issues); and
- Prepare case studies to document programs and services in Canada that serve individuals with concurrent disorders.

Our team includes:

- Michael Goldberg, Research Director, Social Planning and Research Council of British Columbia (SPARC BC) , 604-718-7738, mgoldberg@sparc.bc.ca
- Deborah Kraus, 604-221-7772, dkraus@shaw.ca
- Luba Serge, 514-525-0827, lserge@videotron.ca

SPARC BC is a non-profit registered charitable organization. It was established in 1966 to work with communities in building a just and healthy society for all. For close to 40 years, SPARC BC has undertaken a wide range of research initiatives and community development activities.

This research is being funded by the federal government - National Secretariat on Homelessness.

Our method includes:

- A literature review (which we have completed);
- On-site, face-to-face interviews to prepare case studies of 6 programs/facilities. This will include interviews with service providers who are most knowledgeable about the initiative and with people who have participated in using the services; and
- Telephone or on-site interviews to prepare case studies of two additional programs/facilities.

We expect the interview to last approximately three hours. Attached is a list of our questions. We may be able to save a bit of interview time if you could prepare comments to the questions prior to our meeting face-to-face. If you have any questions or concerns, please do not hesitate to contact:

Michael Goldberg, Research Director, Social Planning and Research Council of BC at 604-718-7738 or mgoldberg@sparc.bc.ca

Thank you for agreeing to participate in this research project on providing services to homeless people with concurrent disorder

II. Contact Information

1. Name of organization:_____
2. Name of program:_____
3. Person completing the interview:_____
4. Place and Date of Interview:_____
5. Time started/Time ended:_____

Name of person	**Position**	**Organization**	
Street address	**City**	**Province**	**Postal Code**
Phone	**Fax**	**E-mail**	

III. Background Information

Background on organization

1. In what year was your organization established?
2. What is your organization's mission/mandate?
3. Who was your organization **originally** created to serve? (Check all that are applicable)

People who are homeless
People at risk of homelessness
People with a mental illness only
People with substance use issues only
People with concurrent disorders

Background on the program

4. If different from Q1, When was your **program** [name of program] first implemented?

IV. Operational Questions

Reason for this program

5. Why did your organization decide to go ahead with this program? (I.e. what factors prompted this initiative? – What was going on?)

6. Was the initiative originally designed to serve individuals with concurrent disorders or did this focus evolve over time?

7. Do you use the term "concurrent disorders" to describe your target population?

   Yes No. If no, what term do you use?

8. What are the goals and objectives of your program – i.e. what does your organization hope to achieve?

9. How does this program link up/relate to other programs offered by your organization [to homeless individuals with concurrent disorders]?

Pathways to the program

10. Could you please tell me the different ways in which people come to (access) your program? *Prompts: (E.g. What kind of agencies refer people to you? Drop-in centres? Outreach workers? Shelters? Do potential residents require a referral or can they just walk in?)*

11. Are there any eligibility criteria for people to obtain services through your program? If yes:

    a. What are the criteria?
    b. Under what conditions would potential clients be denied access to your program?

12. What is the application or selection process?
    a. What steps does one have to go through to get accepted into the program?
    b. Do applicants need to be referred by a mental health or substance use agency?
    c. Are assessment tool used to determine mental illness and/or substance use? If yes, what kind of tools are used?

13. What kind of mental health issues/challenges do most of your clients have?

14. What is expected/required of program participants? *Prompts:* E.g.: What are expectations regarding:

    a. Abstinence/use of substances?
    b. Taking medication?
    c. Other?

15. Do you maintain a waiting list for your program? If yes, how many people are on it? How long is the average wait?

Type of housing –the housing component of the program

16. How do participants in your program access housing? (Prompt: Housing both within and outside of the agency's jurisdiction.)

17. How many units/beds are currently used to provide housing for residents/participants in your program?

18. What type of housing is provided to the people currently housed through your program?

Type of housing	Max length of stay permitted	Total # Beds/ Units	Tenants sign a lease with a landlord Yes/No	Indicate if: **Self contained** unit, **Private bedroom** or **Shared bedroom** (# people/bedroom)	Indicate if: Purpose built **dedicated** building operated by non-profit **Scattered** sites operated by non-profit **Scattered sites** operated by private sector Other (please describe)
Emergency shelter					
Transitional housing[1]					
Permanent housing with support/ Supportive housing[2]	N/A??				
Permanent housing (no support)	N/A				
Other (please specify)					
Total units (should be the same as Q 17)					

19. Could you please tell me about the quality (physical) of the housing? For example, is it the kind of place people might like to stay on a permanent basis?

Substance use issues

20. What are the most common substances used by the people entering your program (e.g. alcohol, marijuana, crack cocaine, heroin, prescription drugs etc.)

    a. Has the type of substances used by people seeking treatment changed over the last 3 years? If yes, what do you think the cause of this change has been?
    b. Are there particular problems that stem from specific substances (i.e. drugs vs alcohol or different types of drugs)? How do you cope with these problems (e.g. extra staff, different programs)?
    c. Do persons with concurrent disorders pose different kinds of challenges compared to people with substance use only? Mental health issues only? Do they require different kinds of supports/services? How are these provided?
    d. Do different kinds of mental illnesses present different kinds of challenges?

[1] The intent is for residents to stay 30 days to 2-3 years. Support services are generally provided.
[2] Affordable permanent housing with no limit on length of stay. Provides residents with the rights of tenancy under landlord/tenant legislation and is linked to voluntary and flexible support services designed to meet resident's needs and preferences. This definition is based on one provided in the National Health Care for the Homeless Council Newsletter. *Healing Hands*. December 2003, 7(6).

Policies

21. What are your policies/rules and how they are enforced regarding:

    a. The use of alcohol and/or drugs in private living space?
    b. The use of alcohol and/or drugs in common areas inside the building, and common areas outside the building?
    c. The selling of drugs on the property?
    d. Behaviour that might disturb other residents?
    e. Special security measures to promote the safety and security of residents?
    f. Having visitors and guests?
    g. Handling conflicts among residents?

22. In an abstinence-based program - What happens if a person relapses? E.g. what are policies/procedures/strategies?

23. In housing where use is permitted - What happens if someone becomes abstinent? Do they continue to live here? Do they move elsewhere? Do you provide support/help to move them?

24. In housing where residents may use substances - Have there been any legal issues arising from the use of illegal substances. How do the police treat your residents? Can you tell me about the relationship between your building (project/initiative?) and the police?

25. Can you tell me about the relationship between the staff and residents? What kind of contact would staff have with residents on any given day or week? Are there ways in which staff are able to watch out for residents? Make sure they are doing OK? Do staff have a role in encouraging residents to participate in services? What strategies, if any, do staff use to engage residents in services? What have they found to be most/least effective?

Housing termination – evictions - move-outs

26. How long do most people stay in their housing?

27. Can people stay in their housing after they have completed the program?

28. Can people continue to receive services after they move out of the housing?

29. What kind of circumstances would be reasons for a resident to be asked to leave the program or move out (prematurely)?

30. What steps would be taken to try and prevent the premature termination of services?

31. Where do program participants generally go:
    a. After they have stayed the maximum length of time? Completed the program successfully?
    b. If they leave prematurely?

Types of services

32. What is the overall approach to providing mental health **and** substance use services? How are services coordinated? What term do you use to describe this approach?

33. What kind of mental health services do you provide/make available to the people in your program? Please address:

    a. Please describe the model of service delivery. Does this model have a name? E.g. Case management? Intensive case management? Assertive Community Treatment? Other?
    b. What kind of mental health services are provided?
    c. How often do clients access services?
    d. Are services available evenings? weekends?
    e. Who/what agency provides the services?
    f. Are these available on site? Off site? Outreach?
    g. What is the case management ratio (number of clients to a case manager)?
    h. Who funds the service?

34. What kind of substance use services do you provide/make available to the people in your program? Please address:

    a. What kinds of services are provided?
    b. Who/what agency provides services?
    c. How often do clients access services?
    d. Are services available evenings? weekends?
    e. Are services available on site? Off site? Outreach?
    f. What is the case management ratio (number of clients to a case manager)?
    g. Who funds the service?

35. What (other) strategies, if any, are used to encourage participants to reduce their use of substances or move to less harmful substances?

36. Do clients have access to any programs specifically targeted to people with concurrent disorders, such as:
    a. Employment training/preparation
    b. Lifeskills
    c. Social skills
    d. Family counseling and education
    e. Other

37. Have there been any changes in the types of services provided over the last 3 years?

38. Does your program have connections (e.g. formal or informal arrangements) to other programs that are available in the community, e.g. needle exchange, emergency accommodation, hospital or other health care provision, etc? Please describe.

Outcomes

39. If not covered in an evaluation or already addressed – Can you tell me what changes have occurred with residents/program participants in terms of the following:

Outcomes	Examples of Changes
Residential stability (e.g. length of time housed)	
Substance use (e.g. decreased use/participation in treatment programs?)	
Mental health (e.g. maintaining medication, reduced hospitalizations)	
Physical health (e.g. less use of emergency services)	
Employment (e.g. part time or full time work)	
Income (e.g. increase)	
Education /Training	
Improved self care	
Personal networks (e.g. more contact with family, new friends)	
Other	

40. What do you think are the top 2-3 features of your program that make it possible for the residents/people who are housed through your program to keep their housing or achieve the degree of housing stability that they do?

Staffing and personnel issues

41. What are some of the critical staffing needs/requirements to run your program?

Current staffing	**Ideal/recommended level of staffing**	**Comments**

42. Do you have any policies about hiring formerly homeless individuals or hiring persons with a history of substance use? If you do hire these individuals, for what positions?

43. Do you provide any professional development training for your staff? If yes, what kind of training? What kind of professional development training do you think is needed?

Funding

43. Obtain information re total revenues (including sources of revenue) and costs for the program. Determine the amount of funding from various levels of government, the private sector and private foundations/charitable organizations.

44. What is the per diem cost of your program?

45. How much rent do the residents pay – is it a fixed amount or a percentage of income? For the emergency shelter, are residents expected to pay anything? If so, how much?

46. How stable is the funding for this program – is funding provided on an annual basis or over a certain number of years? Has the level of funding changed over the last 3 years?

Factors and conditions for success

47. How do you define success for your program?

48. Using that definition, how successful do you think your program has been?

49. In your opinion, has the initiative achieved the goals originally intended?

☐ Yes ☐ No

If yes, what are the top 2-3 reasons for success of the initiative?

If no, please explain_____

Challenges and community issues

50. a. What would you say were the top 2-3 obstacles or challenges to implementing this initiative?
b. How were these challenges addressed?

51. a. For dedicated buildings - In providing housing for the particular client group you work with, what issues – if any – have arisen with the neighbours or others in the community? How have these issues been addressed? *Probe: NIMBY, negative publicity, complaints stigma re substance use/mental health.*

b. For units in scattered buildings. Have there been complaints by others living in the building? How are issues addressed?

Lessons learned

52. Do you have any other words of wisdom or advice for other organizations interested in doing a similar project? (E.g. conditions necessary for others to replicate this model successfully?)

Evaluations

53. Review/clarify any questions arising from any evaluations that you received. Are there are any [other] reviews or evaluations of your program? ☐ Yes ☐ No. If yes, can we have a copy?

54. Review/clarify any questions arising from resident satisfaction surveys already provided. If none provided, have any resident satisfaction surveys been undertaken? If yes, can we have a copy of this report? If not, do you have any indication of the satisfaction levels?

V. Basic Information

Number of people served

55. How many people (families and individuals) did you work with last year in your program?

Types of people served

56. What kinds of households are currently housed/served through your program?

Type of Household	**Number or Proportion of Households**
Single men	
Single women	
Single people who are transgendered	
Couples	
Families with children	
Other – please comment	
Total Households	

57. Is this typical of the people you have housed/served over the last 3 years?

☐ Yes ☐ No

58. What is that age range of the people currently housed/served through your program?

☐ Children under 16 with parents ☐ 16-22 ☐ 23-50 ☐ 51 and older

59. What visible minorities are currently housed/served through your program?

Visible Minorities	**Number or Proportion of Residents**
Aboriginal	
Visible minority (please specify)	
Other – please comment	
Caucasian	

60. Is this typical of the people you have housed/served over the last 3 years?

☐ Yes ☐ No

61. What types of challenges do the people who are housed/served through your program have?

Types of Challenges	Number or Proportion of Residents
Substance use only	
Concurrent disorder (mental health and substance use)	
Mental health only	
Other (please specify)	

62. Are these challenges typical of the people you have housed or helped find housing for over the last 3 years?

☐ Yes ☐ No

Income of residents

63. What is the main source of income for the people who are currently housed through your program?

Primary source of income	Number or Proportion of Residents
No income	
Income assistance (welfare) only	
Both welfare and employment	
Employment only	
Other (please specify)	

64. Has the source of income for the people currently housed through your program changed over the last 3 years?

☐ Yes ☐ No

Contact Information

65. Do we have your permission to include your contact information in our report? OR is there another person in your organization who should be designated as the contact person?

☐ It is OK to include my contact information in the report.

☐ You should include someone else as the contact person in the report.

Designated contact person to be published in the report (if different from the person interviewed)

Name of person	**Position**	**Organization**	
Street address	**City**	**Province**	**Postal Code**
Phone	**Fax**	**E-mail**	

Conclusion

- Thank you for participating in this project. Is there anything you would like to add?

- We will send you a draft of what we write up about your project for your review and approval – so that you can review and correct it before it is submitted. Would you be willing to do this? And we will send you a cheque for your honorarium. (Note: we will send the cheque with a thank you letter).

- We will provide your mailing address to the National Secretariat on Homelessness so that you can be sent a copy of the final report.

Supporting information

Check if there is any additional information to be provided:

Information	**Date received**
Evaluations	
Resident satisfaction surveys	
Annual report/financial statements	
Policies/Rules	
Lease	
Other	

Innovative Approaches for Providing Services to Homeless People with Concurrent Disorders

Approach and Interview Guide for Interviews with People Using Services/Housing

Part 1. Approach to the Interviews with People Using Services

The method and approach for conducting interviews with people participating in your program is outlined below.[3]

1. Number of interviews

The consultants plan to obtain qualitative information from four individuals for each of 6 case studies where information gathering will take place on-site, for a maximum of 24 interviews.

2. Program users to be interviewed

The consultants will rely on each participating agency to recruit individuals who are involved/housed in the program. We recommend interviewing individuals who are currently involved in the program because once a person has left the program it is often difficult for agencies to track them down.

We will ask the agencies to recruit individuals with concurrent disorders (mental illness and substance use) who are representative of their clients and:

- Who may be at different stages in addressing their substance use and/or mental health issues;
- Have been involved with the program for different periods of time (but have been there long enough to be able to comment on the existing program); and
- Who would be able to complete an interview.

3. Training

All interviewers will participate in a training session (to take place by telephone) to review the purpose of the study, the goals of the interviews, the method and approach, and the interview questions.

[3] This method is based on the report prepared by Jim Woodward and Associates Inc., Eberle Planning and Research, Deborah Kraus Consulting, Lisa May Communications, and Judy Graves, for the Greater Vancouver Regional District, entitled: *Greater Vancouver Research Project on Homelessness, A Methodology to Obtain First Person Qualitative Information from People who are Homeless and Formerly Homeless*, April 2002. It is also consistent with a report prepared for the National Homelessness Secretariat, entitled *Ethical Guidelines for Conducting Research Involving Homeless People, 2004*.

Training will also address issues such as the role of the researcher, confidentiality, anonymity, body language, clothing, compensating the interviewee, recording and note-taking.

4. Ethical Concerns

In approaching program users to participate in an interview, the consultants (and recruiting agencies) will explain the nature of the study. They will also explain to each individual that their participation is completely voluntary and that they may end the interview at any time if they are uncomfortable. Participants will also be assured that the information will be kept confidential and will be reported on in such a way as to protect their identity and privacy. Each interviewer will be required to sign an Oath of Confidentiality (attached Appendix A).

5. Interview guide

A copy of the Introduction and Consent Form and Interview Guide are attached. The interview guide has been designed to find out *how the program has affected the lives of the participants.*

Interviews with the first few participants in the first case study completed will serve as a test of the interview guide. [4]

6. Protection of privacy

It is necessary to respect and protect the privacy of study participants. Participants will be asked to provide their initials, and the report will use made up names if individual situations are described. The interviewer will advise participants how confidentiality will be handled in reporting the research findings.

7. Location of interviews

Interviews will take place where both the participant and the interviewer will feel most safe and comfortable. One possible location may be in the offices of a recruiting agency. The location should be safe, reasonably quiet, private and offer few distractions.

8. Recording of interviews

Each interviewer will record interviews by taking hand-written notes during the interview. If an interviewer wishes to have a second person to assist with note-taking this will need to be accommodated within the allocated budget.

[4] The interview guide is similar to the one used for the CMHC study, *Stable Housing for People Who Use Substances*.

9. Reporting of information

The information obtained from interviews with program users from all the case study sites will be amalgamated and reported on collectively to further protect the privacy of individuals.

10. Honorariums

A budget has been set to provide each participant with an honorarium of $25 per interview to show respect for the time and information provided by the participant. Additional amounts spent for refreshment or a small snack will be reimbursed. (A maximum amount to be determined).

11. Oath of Confidentiality

The researchers will sign an Oath of Confidentiality with the Participating Agency. (Attached next page).

Oath of Confidentiality

Research Title: Innovative Approaches for Providing Services to Homeless People with Concurrent Disorders

Agency funding the research: National Secretariat on Homelessness

Principal Researcher: Michael Goldberg, Research Director, Social Planning and Research Council of BC, Vancouver, B.C. Canada
Phone: 604-718-7738
Email: mgoldberg@sparc.bc.ca

Researcher conducting the interview:

Confidentiality agreement:

As a member of the research team, I understand that I may have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research study that could identify the persons who participated in the study.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor to ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research study.
- I understand that a breach of confidentiality my include termination of the study.
- I agree to notify the principal researcher immediately should I become aware of an actual breach of confidentiality or a situation which could potentially result in a breach, whether this is on my part or on the part of another person.

Signature of Researcher Date Printed Name

Part 2. Request for Assistance from Participating Agency

The Government of Canada's National Secretariat on Homelessness has commissioned our research team to investigate innovative approaches to providing housing and services for people who are homeless and who have concurrent disorders (mental illness and substance use issues). Our team includes:

- Michael Goldberg, Research Director, Social Planning and Research Council of British Columbia (SPARC BC), 604-718-7738, mgoldberg@sparc.bc.ca
- Deborah Kraus, 604-221-7772, dkraus@shaw.ca
- Luba Serge, 514-525-0827, lserge@videotron.ca

SPARC BC is a non-profit registered charitable organization. It was established in 1966 to work with communities in building a just and healthy society for all. For close to 40 years, SPARC BC has undertaken a wide range of research initiatives and community development activities.
As discussed, the research team would like to conduct face-to-face interviews with four participants who are using your service/program who have concurrent disorders (mental illness and substance use).

The purpose is to find out *how the program has affected the lives of the participants.*

We are asking you to recruit individuals who are most representative of your clients and:

- Who may be at different stages in addressing their substance use;
- Have been involved with the program for different periods of time (but have been there long enough to be able to comment on the existing program); and
- Who would be able to complete an interview.

We expect each interview to last approximately 1 to 1.5 hours.

Each participant will be given an honorarium of $25 for participating in this research project on innovative approaches to providing housing and services for people who are homeless and who have concurrent disorders.

Attached is our approach and list of our questions. If you have any questions or concerns, please do not hesitate to contact me or Michael Goldberg.

Thank you for agreeing to participate in this research project on innovative approaches for providing services to homeless people with concurrent disorders.

Part 3. Notes for Participating Agency to Recruit Program Users

The Government of Canada's National Secretariat on Homelessness has commissioned our research team to investigate innovative approaches to providing housing and services for people who are homeless and who have concurrent disorders (mental illness and substance use issues). The purpose is to learn more about good programs that help people have a place to live where they feel safe and can afford the rent.

The researchers want to interview some people from this program to find out how it has affected their lives.

When speaking to potential interview participants, some important information for them is that:

1. Participation is entirely voluntary.

2. The researchers will not ask for the participant's name, so their identity will be anonymous.

3. Participants can choose not to answer any question or can stop the interview at any time.

4. Participation will not affect their use of services in any way.

5. The interview will be kept anonymous. (All notes will be stored securely in the researcher's office and destroyed when the report is completed.)

6. Participants will be given $25 per interview for their time and expertise to complete an interview.

7. The interview is expected to take about 1 to one and a half hours.

Please ask the person if they would be willing to participate.

Let participants know where and when the interview will be held.

Date: Time: Place:

Part 4. Introduction by Interviewer and Consent Form

Hello, my name is_____[and this is my associate if applicable]_____.

1. The Government of Canada's National Secretariat on Homelessness has commissioned our research team to learn more about good programs that help people have a place to live where they feel safe and can afford the rent.

2. We are interviewing people who are using different programs and services to find out how they feel about them and how they have affected their lives.

Offer some sort of refreshment (small snack or coffee)

3. The research will take about 1 hour of your time. I will ask the questions and write down your responses.

4. **We will give you $25 for your time and expertise in completing the interview.**

5. Your participation is entirely voluntary, and you can stop the interview at any time. You don't have to answer a question if it makes you feel uncomfortable.

6. We will protect your privacy and not release your identity to anyone. (All notes from your interview will be stored securely in the researcher's office and destroyed when the report is completed.) Information from all our interviews will be put together and reported on in such a way so that nobody will know who has said what.

7. Before we proceed, do you have any questions about the study or about this interview?

8. Do you agree to participate: Yes ☐ No ☐

9. Would you like to make up a name (Pseudonym) to put on your survey so that we can both identify you?

10. Would you please use your initials or pseudonym to show that you have agreed to participate? We are not asking you to sign your name so your identity can be kept confidential and anonymous. I will also sign my name to indicate that you have agreed to participate.

_____ _____

Date Researcher

_____

Participant's initials

11. If you have any questions, concerns or complaints about the research or researchers, please contact: Michael Goldberg, Research Director, Social Planning and Research Council of BC at 604-718-7738 or mgoldberg@sparc.bc.ca OR, contact

_____

Name Recruiting Agency Phone Number

Give a business card – This will be the card of the person responsible at the local recruiting agency. If problems or concerns arise, the agency will be expected to follow up with the Consulting Team Leader, Michael Goldberg, Social Planning and Research Council of B.C.

Part 5. Questions

Ask participant if he/she would like a copy of the questions]
Reminder that all information will be kept strictly confidential and anonymous

Interviewer Name:_____

Date of interview:_____

Place of Interview:_____

Time started/Time ended:_____

Background

1. **Where were you born (what city/ country)?**

2. a) If not born in city where interview taking place – how did you get to [place where the interview is].

   b) If same city, did you always live here or have you travelled around?

Current living situation

3. How long have you been living in the [place where person currently lives].

4. Can you describe the place where you are living/staying? Do you share a bedroom, have your own private bedroom? Your own apartment?
5. Are there any rules or conditions for living here? What do you think of these rules?

6. On a scale of 1 to 5, how satisfied are you with the current place you are living - 1 is the **least** satisfied **and** 5 is the **most satisfied**

   Least Most

   1 2 3 4 5

7. What do you like **most** about the place where you are living? Probe: comfort, safety, spaciousness, privacy, location, etc.)

8. What do you like **least** about the place where you are living? Probe: comfort, safety, spaciousness, privacy, location, etc.)

Current programs/services

9. Describe a typical day for you. What kinds of things do you do?

10. Are you involved in any mental health kinds of programs or activities? Yes No

    If yes: Please tell me about it/them.

What do you like or not like about it/them?

11. Are you involved in any substance use programs Yes No

If yes: Please tell me about it/them. (Probe: Clarify if programs are for drugs or alcohol)

What do you like or not like about it/them?

12. Are you involved in any other activities/programs – e.g. run by [sponsor group]? E.g. Employment or other programs? Yes No

If yes: Please tell me about it/them
What do you like or not like about them??

Previous situation

13. What was your life like before you came here? For example, how is your typical day different from a typical day before you became involved with [sponsor group]?

    a. Where did you live/sleep most of the time?
    b. What was your physical health like? Probe: Health conditions such as back problems, high blood pressure, etc? Did you have any problems?
    c. Did you have problems with your mental health before coming to [sponsor group]?
    d. Did you tend to use more drugs or alcohol than now? Can you tell me about the drugs you were using e.g. alcohol, crack, heroin, marijuana, solvents, prescription drugs, non-prescription drugs, – some or all of these? How much? How often?

14. Did you try any substance use treatment programs before coming here? Tell me about them? How did they work or not for you? What was good about them? What was not so good about them?

15. How did you come to be involved with [sponsor agency].

How life has changed

16. Can you tell me about how your life has changed – or if anything has changed for you since and became involved with [program run by the sponsor agency] and started living here?

    a. Has your income changed?

    b. Are you currently employed or looking for a job?

    c. How has coming here affected your physical health?

    d. How has coming here affected your mental health?

    e. What about friends and family?

f. Since you have been involved with [the sponsor agency] has there been any change in your use of drugs?

g. Do you think you use emergency services more less or about the same since you became involved in the program?

h. Have you noticed any other changes?

17. If there have been changes:
    a. What would you say are the factors most responsible for these changes?
    b. In what way has being involved with [sponsor agency] or living here been a reason for these changes?

18. What kind of changes would you like to see for yourself over the next year, if any?

Recommendations

19. What, if any, words of wisdom or advice do you have for any other organization that might be interested in doing a similar project to the one like [sponsor agency]?

20. What words of advice would you have for someone who wanted to live in this similar project?

21. If there are one or two things you would like to be different about the way the program works or about the housing what would they be?

22. If there are one or two things that should definitely stay the same, what would they be?

Demographic questions

I have just a few last questions about your age and background. We are asking everyone these questions so we can describe the range of different people we are interviewing in this study. Again, this information will be anonymous.

1. Gender	
2. How old are you?	
3. What would you say is your ethnic/cultural background? [It is up to each individual to self-identify].	

22. Ask if any comments about the interview process/questions

Thank you very much for your time and participation.

Is there anything else you would like to add?

Put on separate sheet

 Pay honorarium

_____
Signature of interviewer to confirm payment of honorarium

_____
Initials of participant to confirm receipt of honorarium

Put on separate sheet

H. Interview and Note-Taker Comments

Record observations, thoughts, impressions, or questions arising from the interview.

1. Interviewer's Perceptions and Comments
2. Length of interview (minutes)
3. Perceptions of Quality of Responses/Interview
4. Any other issues to be noted that might affect responses
5. Rate quality of interview (excellent, acceptable, or poor)
6. Were there any questions with which respondent had difficulty? Please specify

Housing First Improves Residential Stability in Homeless Adults With Concurrent Substance Dependence and Mental Disorders

Anita Palepu, MD, MPH, Michelle L. Patterson, PhD, Akm Moniruzzaman, PhD, C. James Frankish, PhD, and Julian Somers, PhD

Objectives. We examined the relationship between substance dependence and residential stability in homeless adults with current mental disorders 12 months after randomization to Housing First programs or treatment as usual (no housing or support through the study).

Methods. The Vancouver At Home study in Canada included 2 randomized controlled trials of Housing First interventions. Eligible participants met the criteria for homelessness or precarious housing, as well as a current mental disorder. Residential stability was defined as the number of days in stable residences 12 months after randomization. We used negative binomial regression modeling to examine the independent association between residential stability and substance dependence.

Results. We recruited 497 participants, and 58% (n = 288) met the criteria for substance dependence. We found no significant association between substance dependence and residential stability (adjusted incidence rate ratio = 0.97; 95% confidence interval = 0.69, 1.35) after adjusting for housing intervention, employment, sociodemographics, chronic health conditions, mental disorder severity, psychiatric symptoms, and lifetime duration of homelessness.

Conclusions. People with mental disorders might achieve similar levels of housing stability from Housing First regardless of whether they experience concurrent substance dependence. (*Am J Public Health.* 2013;103:e30–e36. doi: 10.2105/AJPH.2013.301628)

The combination of homelessness, substance use, and mental illness is challenging for affected individuals and society to address. Estimates of the prevalence of substance use disorders among homeless populations vary between 29% and 75%.[1–4] Substance use among persons who are homeless has been associated with lower treatment retention,[5] higher rates of posttreatment relapse,[6] premature mortality,[7] and longer periods of homelessness.[8] Therefore, problematic substance use is a substantial barrier to existing homelessness[9] and contributes to social marginalization.[10–12]

In recent years, Housing First programs have demonstrated increased residential stability among those who are homeless and have a mental illness.[13,14] More recently, Housing First has been shown to be effective among homeless individuals with active substance use disorders.[4,15] However, it is unclear whether Housing First interventions are effective in the context of active and severe polysubstance use.[16] In one of the original Housing First studies,[14] heavy use of drugs was defined as using for 4 days in the previous 6 months and heavy alcohol use as drinking for 28 days in the past 6 months. This level of use does not represent the experience of homeless individuals with substance use and mental disorders in Vancouver, British Columbia, many of whom engage in frequent and severe polysubstance use.[17–19]

Kertesz et al.[16] cautioned that the currently favored policy approach of Housing First might be overreaching the evidence when applied to active substance users and those with severe addictions. Housing First has been successful in improving residential stability among refractory alcoholics,[20,21] but no data have yet been reported among homeless persons with active illicit drug use. A number of studies have found that ongoing substance use was associated with lower residential stability among previously homeless persons who received housing.[22–26] For example, a multisite observational study compared Housing First versus residential treatment or transitional housing before being placed in supported community housing among chronically homeless adults. The authors reported no advantages for participants who received treatment before being assigned supported community housing compared with the Housing First group in terms of days housed and self-reported health status. However, the group that received residential treatment before community housing incurred higher total health service costs.[27] Furthermore, requiring abstinence as a criterion for admission to transitional housing has not been found to be predictive of better housing outcomes postdischarge.[28,29] Interestingly, abstinence-oriented contingency management has been shown in a series of studies to improve housing stability among individuals who are homeless and dependent on crack cocaine.[30] These studies, however, did not include individuals with psychosis or other forms of substance dependence, and their housing time was limited, making comparisons between their research and Housing First studies difficult.[31]

To date, there have been no randomized controlled trials of Housing First among persons who are homeless with concurrent disorders (cooccurring substance dependence and mental disorders). We hypothesized that these individuals would have lower levels of residential stability than those without substance dependence. We therefore examined the relationship between substance dependence and residential stability in homeless adults with current mental disorders who participated in The Vancouver At Home study.

METHODS

The Vancouver At Home study comprised 2 randomized controlled trials that investigated Housing First interventions in homeless adults with mental disorders

based on their level of need: high need (ISRCTN57595077; http://www.controlled-trials.com/ISRCTN57595077/57595077) and moderate need (ISRCTN66721740; http://www.controlled-trials.com/ISRCTN66721740/66721740). The Vancouver study was a collaborating center along with 4 other Canadian cities.[32,33] We report the findings from the recruitment period, using data collected between October 2009 and June 2011, and 12-month follow-up data from the Vancouver site. We pooled the data from the 2 trials to examine the relationship between substance dependence and residential stability.

Participants were eligible if they were 19 years of age or older, met criteria for a current mental disorder (at least 1 other than a substance use disorder) on the Mini International Neuropsychiatric Interview (MINI 6.0),[33] and were homeless or precariously housed.

Written material about the study, eligibility criteria, and the referral process was distributed to community agencies. Most participants were recruited from homeless shelters, drop-in centers, homeless outreach teams, hospitals, community mental health teams, and criminal justice programs. Service providers in the community initiated referrals to the study, and general eligibility criteria were assessed by a brief telephone screening with the referral agent. Self-referrals were also accepted, but collateral clinical information was obtained to confirm eligibility criteria. If appropriate, a face-to-face interview was scheduled with potential participants to formally assess eligibility. Trained interviewers explained procedures, obtained informed written consent, and conducted all interviews.

A total of 800 individuals were screened for eligibility. Approximately 85 (10.6%) individuals did not meet eligibility criteria in the telephone screening with the service providers. Approximately 100 (12.5%) individuals were invited to meet with an interviewer for further eligibility screening or to begin the baseline questionnaire but did not show up for an appointment. Finally, 92 (11.5%) individuals completed the formal eligibility screening process but were deemed ineligible, most often because they did not meet the inclusion criteria for a current mental disorder. When these individuals were compared with participants who were enrolled in the study, there were no significant differences in terms of age or gender.

At baseline, enrolled participants completed a series of detailed interviewer-administered questionnaires that included questions on sociodemographic characteristics, symptoms of current and past mental illness, suicidality, substance use, physical health, service use, and quality of life. The interview time typically ranged from 80 to 120 minutes. After completing the baseline interview, participants received a Can $35 honorarium. Participants were designated as high need if they scored 62 or lower on the Multnomah Community Ability Scale,[34] met criteria for current manic episodes or psychotic disorders on the MINI, and at least 1 of the following: legal involvement in the past year, substance dependence in the past month, and 2 or more hospitalizations for mental illness in the past 5 years. All other eligible participants were designated as moderate need.[32]

Detailed description of the study intervention arms were previously published.[35] In brief, participants designated as high need were randomly assigned to 1 of 3 study arms: (1) Housing First with assertive community treatment (ACT), in which participants could choose from up to 3 market lease apartments in a variety of neighborhoods with services provided by a transdisciplinary outreach team, including a psychiatrist, nurse, occupational therapist, substance abuse counselor, vocational counselor, and peer specialist; (2) congregate housing with on-site support (CONG), in which participants had their own room and bathroom but shared amenity space with 100 other program participants and received 3 meals per day, as well as activity programming and various health and social services on site; and (3) treatment as usual, which provided no additional housing or support services beyond what was already available in the community. Participants who met the criteria for moderate need were randomly assigned to 1 of 2 study arms: (1) Housing First with intensive case management (ICM), in which participants could choose from up to 3 market lease apartments in a variety of neighborhoods with services provided by a team of case managers who connected participants to existing services, and (2) treatment as usual as previously described. Assignment to intervention arms was conducted using a real-time computerized adaptive randomization procedure. For the Housing First intervention arms (ACT, CONG, and ICM), support services were available to participants but were not mandatory. The only requirement for housing was compliance with the terms of the rental lease and weekly visits with a case manager to ensure safety and well-being.[36]

A team of field interviewers met with participants at 3-month intervals. A field research office was open daily throughout the study period, and participants were encouraged to drop in regardless of their interview schedule. At each follow-up interval, interviewers updated information regarding participants' routines and typical whereabouts, as well as detailed collateral contact information.

Variables of Interest

We used the Residential Time-Line Follow Back Inventory[37] to derive our primary outcome variable, residential stability, which we defined as the number of days in stable residences after randomization into the study, up to the participant's 12-month follow-up visit. Stable residence was defined as housing where the individual held tenancy rights for at least 6 months and included living with family or someone else, group homes, independent apartments, and congregate residences. Our primary independent variable, substance dependence (yes or no), was identified using the MINI 6.0.[33] We also captured the self-reported frequency of substance use over the past month using the Maudsley Addiction Profile.[38] We dichotomized the frequency of substance use to capture daily substance use versus less than daily or none; this variable was used to reflect severity of substance use.[39]

Housing First intervention was the combination of the 3 housing intervention arms (ACT, ICM, CONG) compared with the 2 treatment as usual arms. Mental health symptoms and severity were collected through the Colorado Symptom Index (CSI).[40,41] With regard to mental disorders, the Severe Cluster includes at least 1 episode in the past month of psychosis, mood disorder with psychotic features, and manic episode, as identified through the MINI [33] or by current documented physician diagnosis, when available. The Less Severe Cluster includes at least 1 current major depressive episode, panic disorder, and posttraumatic stress disorder, which are also identified through the MINI.[33] Participants were also

asked to report any chronic health conditions that were expected to last or already had lasted 6 months or more. Chronic health conditions listed in the survey tool were adapted from the Canadian Community Health Survey[42] and the National Population Health Survey.[43] Additional study details, such as interviews and measures not included in the present study, were previously published.[32,35]

Statistical Analysis

Comparisons of variables between groups were conducted using a parametric (Student *t*-test or 1-way analysis of variance for continuous variables) or nonparametric test (Pearson χ^2 test for categorical variables) as appropriate. To evaluate the effect of the interventions, an intention-to-treat analysis was conducted. Negative binomial regression models were fit to examine the independent association between the residential stability (number of days in stable residences after randomization) and the primary independent variable substance dependence. We also conducted a subanalysis fitting a model for the association of daily substance use and residential stability. We chose negative binomial regression because of its overdispersion of outcome data and better goodness-of-fit statistics compared with Poisson regression. Postrandomization periods that varied across individuals were used as an offset variable in the regression analysis. We included variables that were selected a priori to be potentially associated with residential stability (Housing First intervention, employment, age, gender, ethnicity, education, marital status, length of lifetime homelessness, mental disorders, mental health symptoms, and chronic health conditions). The interaction term between substance dependence and the Housing First intervention was nonsignificant and not included in the final model. Incidence rate ratios (IRRs) obtained from the negative binomial regression model were reported as effect sizes. All reported *P* values were 2-sided. Mean substitution for missing individual items of the CSI scale was used to obtain the combined CSI score. The missing values for other covariates that ranged from 0% to 2% were excluded from the analysis. IBM SPSS Statistics (version 19.0; IBM, Armonk, NY) and STATA 12 (StataCorp., College Station, TX) were used to conduct these analyses.

RESULTS

We recruited 497 participants between October 2009 and June 2011; 58% (n = 288) met the criteria for substance dependence, and 29% (n = 143) reported daily substance use (alcohol and illicit drugs). There were 472 participants who had at least 1 follow-up visit at 6 or 12 months (96%). There were no differences in the characteristics of participants

TABLE 1—Comparisons of Baseline Sociodemographic Characteristics, Mental Disorders, and Physical Illness Between Vancouver Participants, by Current Substance Dependence: The Vancouver At Home Study, Vancouver, British Columbia, 2009–2011

Variable	Substance Dependence (n = 288), Mean ±SD or No. (%)	No Substance Dependence (n = 209), Mean ±SD or No. (%)	*P*
Male gender	203 (71)	156 (74)	.28
Age at enrollment, y	38.4 ±9.6	44.3 ±11.9	< .001
Ethnicity			.007
Aboriginal	57 (20)	20 (10)	
Caucasian	156 (54)	124 (59)	
Mixed/other	75 (26)	65 (31)	
Lifetime duration of homelessness, mo			< .001
≤ 12	48 (17)	86 (42)	
13–60	133 (47)	70 (34)	
> 60	104 (36)	50 (24)	
Duration of longest single episode of homelessness, mo			< .001
≤ 12	121 (42)	125 (61)	
13–60	121 (42)	61 (30)	
> 60	44 (16)	19 (9)	
Did not finish high school	186 (65)	94 (45)	< .001
Single/never married	197 (69)	146 (71)	.694
Have children younger than 18 y	89 (32)	33 (16)	< .001
Precariously housed	70 (24)	39 (19)	.133
Employed	12 (4)	6 (3)	.377
High need level	183 (65)	114 (55)	.043
Age of first homelessness < 25 y	145 (51)	69 (33)	< .001
Mental disorder			
Less severe cluster	173 (60)	91 (43)	< .001
Severe cluster	196 (68)	167 (80)	.003
≥ 2	156 (54)	84 (40)	.002
Chronic health conditions			.009
None	16 (6)	28 (13)	
1	29 (10)	22 (11)	
2	30 (10)	28 (13)	
≥ 3	213 (74)	131 (63)	
Infectious disease[a]	126 (44)	31 (15)	< .001
Daily substance use in past mo[b]	107 (37)	36 (17)	< .001
Arrested in past 6 mo	115 (41)	58 (29)	.008
CSI total score	39.4 ±11.5	34.1 ±13.3	< .001
Age of first homelessness, y	27.0 ±11.2	34.9 ±14.6	< .001

Note. CSI = Colorado Symptom Index. The total sample size was n = 497.
[a]HIV, hepatitis B or C.
[b]Including alcohol.

who had at least 1 follow-up visit and those who did not.

There were significant differences between participants who met criteria for substance dependence and those who did not (Table 1). As a group, participants with substance dependence were younger (38.4 vs 44.3 years; $P<.001$), had lifetime durations of homelessness of more than 5 years (36% vs 24%; $P<.001$), did not graduate from high school (65% vs 45%; $P<.001$), first experienced homelessness at younger than 25 years (51% vs 33%; $P<.001$), had a higher prevalence of mental disorders (both less severe and severe clusters), had chronic health conditions and viral infections, and had been arrested in the past 6 months (41% vs 29%; $P<.001$).

Table 2 displays the residential stability by study arm and substance dependence. There was no difference in the proportion of days stably housed at 12 months by substance dependence status (51% vs 52%; $P=.89$) or by daily substance use (49% vs 53%; $P=.29$). In other words, whether participants met the criteria for substance dependence or daily substance use did not influence housing stability. We also observed no difference in residential stability within the Housing First intervention groups by substance dependence (72% vs 71%; $P=.72$) or by daily substance use (70% vs 73%; $P=.42$). The number of days in stable residences did not differ by substance dependence (183.2 days vs 183.9 days), and we found no significant difference in residential stability when stratified by need level status and substance dependence. The multivariable negative binomial regression models revealed no significant association between substance dependence and residential stability (adjusted IRR = 0.97; 95% confidence interval [CI] 0.69, 1.35) or between daily substance use and residential stability (adjusted IRR = 0.84; 95% CI = 0.59, 1.20) after adjusting for the housing intervention, employment, sociodemographic characteristics, chronic health conditions and mental disorder, mental health symptoms, and lifetime duration of homelessness (Table 3). The intervention (i.e., Housing First vs treatment as usual) was the only variable significantly associated with residential stability (adjusted IRR = 4.05; 95% CI = 2.95, 5.56).

DISCUSSION

Our findings demonstrated that Housing First can achieve residential stability in adults who are homeless and have mental disorders, even if they are substance dependent. Interestingly, this subgroup of individuals with concurrent disorders was less educated, experienced their first episode of homelessness at an earlier age, and had a higher prevalence of mental disorders and chronic health conditions as well as arrests in the previous 6 months compared with those without substance dependence. Despite these disadvantages, they were able to achieve similar levels of residential stability as those without substance dependence. Furthermore, we found no differences in residential stability among those in the Housing First intervention (scattered-site apartments with outreach support or CONG) by substance dependence or daily substance use. The Vancouver At Home Study was able to provide good quality housing, and the additional supports provided were at considerably higher levels than what was typically available to most other housing programs in the region. The client-to-staff ratios for the ACT and ICM teams were approximately 9:1 and 16:1, which was substantially lower than the typical client-to-staff ratios of case management services in Vancouver that frequently exceed 25:1. It was likely that the level and quality of outreach support available to our study participants contributed to the residential stability of the individuals with substance dependence.

We previously described the pattern of self-reported daily substance use in this cohort, with marijuana being the most frequent substance used on a daily basis (49%), followed by crack cocaine (27%), and heroin (15%).[18] The high prevalence of substance dependence and substance use in Vancouver was also reported in other studies of homeless persons.[17,19,44] Furthermore, British Columbia has the highest provincial lifetime reported use of illicit drugs in Canada (47.9% of the general population),[45] which might, in part, explain the higher prevalence of substance dependence in our sample.

TABLE 2—Residential Stability, by Study Arm and Substance Dependence: The Vancouver At Home Study, Vancouver, British Columbia, 2009–2011

	Substance Dependence–Yes (n = 279)		Substance Dependence–No (n = 199)	
	Days in Stable Residences, Mean (SD)	% in Stable Residences, Mean (SD)	Days in Stable Residences, Mean (SD)	% in Stable Residences, Mean (SD)
All participants	183.2 (139.6)	52 (39)	183.9 (144.1)	51 (39)
HF interventions[a]				
Yes	255.9 (103.8)	72 (28)	254.3 (113.1)	71 (30)
No	68.1 (108.0)	19 (30)	72.3 (114.7)	20 (30)
Need level status				
High	189.3 (134.6)	56 (38)	193.3 (141.5)	54 (38)
Moderate	172.1 (148.3)	46 (39)	166.0 (146.0)	48 (41)

Note. HF = Housing First.
[a]All 3 housing first interventions were collapsed into 1 group (yes), and the 2 treatment as usual groups were collapsed into another group (no).

TABLE 3—Bivariate and Multivariate Negative Binomial Regression Model for Current Substance Dependence and Other Variables Associated with Residential Stability at 12 Months: The Vancouver At Home Study, Vancouver, British Columbia, 2009–2011

Variable	Unadjusted IRR (95% CI)	Adjusted IRR (95% CI)
Substance dependence at baseline	1.01 (0.74, 1.38)	0.97 (0.69, 1.35)
HF intervention vs TAU	3.69 (2.75, 4.96)	4.05 (2.95, 5.56)
Age at enrollment, per y	1.00 (0.99, 1.01)	1.00 (0.98, 1.01)
Male gender	1.05 (0.75, 1.47)	0.90 (0.62, 1.28)
Ethnicity		
Aboriginal	1.03 (0.63, 1.67)	0.82 (0.49, 1.38)
Caucasian	1.17 (0.82, 1.66)	0.92 (0.64, 1.32)
Mixed/other (ref)	1.00	1.00
Incomplete high school	1.02 (0.75, 1.40)	0.98 (0.71, 1.34)
Single/never married	0.90 (0.64, 1.26)	0.82 (0.58, 1.17)
Employment		
Unemployed (ref)	1.00	1.00
Employed	1.19 (0.52, 2.73)	1.04 (0.43, 2.50)
Other[a]	1.03 (0.47, 2.26)	1.07 (0.50, 2.26)
Mental disorder		
Less severe cluster	0.98 (0.72, 1.34)	0.91 (0.63, 1.30)
Severe cluster	1.08 (0.77, 1.53)	1.04 (0.72, 1.49)
Chronic health conditions		
None (ref)	1.00	1.00
1	1.20 (0.60, 2.42)	1.39 (0.69, 2.79)
2	0.97 (0.49, 1.91)	0.84 (0.42, 1.65)
≥ 3	0.92 (0.54, 1.58)	0.87 (0.50. 1.52)
Colorado Symptom Index, per point	1.00 (0.99, 1.01)	1.01 (0.99, 1.02)
Lifetime duration of homelessness, per y	1.00 (0.98, 1.03)	1.01 (0.99, 1.02)

Note. CI = confidence interval; HF = Housing First; IRR = incidence risk ratio; TAU = treatment as usual.
[a]Defined as nontraditional employment or employment in the underground economy.

Our findings were consistent with a number of observational studies that found that housing retention among persons with concurrent disorders could be achieved. Tsemberis et al.[46] examined the outcomes of persons who were chronically homeless with alcohol use and psychiatric disorders, and reported a 97% housing retention rate and a reduction in psychiatric symptoms at 12 months. The Collaborative Initiative to Help End Chronic Homelessness also found improved residential stability and reduced substance use among the 734 participants who received housing and comprehensive services intervention at 12 months.[47] One study using the Housing First approach to improve residential stability and treatment retention of mentally ill patients (n = 31) on methadone compared with usual care (n = 30) reported better housing retention (67.7% vs 13%; $P < .02$) and methadone treatment retention (51.6% vs 20%; $P < .01$) among the Housing First group.[48]

Our results support the integration of housing and intensive support services for persons who are homeless and had substance dependence. Despite the expansion of clinical services in Boston, Massachusetts, there has been no reduction in the all-cause mortality rate among homeless adults since the early 1990s. Drug overdose replaced HIV as the leading cause of death.[49] It appeared that access to clinical services alone for persons who were homeless was insufficient to prevent mortality, given the prevalence of substance dependence. This underscored the challenges of addressing addiction issues in this population, which might be improved by providing case management[50] and housing services[51] in addition to other supports to reduce this risk. Housing First interventions clearly have an important role in engaging persons with addiction issues who are also homeless.

Limitations of our study included self-reported measures of substance use, which might be underreported, particularly given that the baseline interview was conducted before individuals were randomized to a housing intervention, and participants might have felt hesitant to disclose the amounts and frequencies of illicit substances used. We did, however, use substance dependence as our main independent variable, which was determined by the MINI 6.0 and had high validity. Our study design addressed limitations of previous studies dealing with the issue of Housing First participants with active addictions.[16] We used standardized measures, included persons with active addictions, and achieved a follow-up rate of 96%.

In conclusion, persons who are homeless with mental disorders may achieve similar levels of housing stability from Housing First regardless of whether they experience concurrent substance dependence. By contrast with some interventions, Housing First does not require abstinence from drugs and alcohol among clients. Given the morbidity and mortality associated with homelessness and substance dependence,[49] our findings contribute to the growing evidence that Housing First is a viable and effective strategy for this population. ■

About the Authors

Anita Palepu is with the Department of Medicine, University of British Columbia, Vancouver, British Columbia. Michelle L. Patterson, Akm Moniruzzaman, and Julian Somers are with the Faculty of Health Sciences, Simon Fraser University, Burnaby, British Columbia. C. James Frankish is with the School of Public and Population Health, University of British Columbia, Vancouver.

Correspondence should be sent to Anita Palepu, Department of Medicine, Centre for Health Evaluation and Outcome Sciences, St. Paul's Hospital, 588B-1081 Burrard Street, Vancouver, BC, V6Z 1Y6, Canada. (e-mail: apalepu@hivnet.ubc.ca). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted August 14, 2013.

Contributors

A. Palepu, M. L. Patterson, C. J. Frankish, and J. Somers made substantial contributions to conception and design of the article. M. L. Patterson acquired the data. A. Palepu,

M. L. Patterson, A. Moniruzzaman, C. J. Frankish, and J. Somers analyzed and interpreted the data. All of the authors drafted the article or revised it critically for important intellectual content, and approved the final version to be published.

Acknowledgments

This research was supported by a grant to Simon Fraser University, made possible through a financial contribution from Health Canada to the Mental Health Commission of Canada.

The authors gratefully acknowledge the study participants, and the support of colleagues and collaborators on this project.

Note. An abstract of these results was presented at the Society of General Internal Medicine Annual Meeting, April 27, 2013 in Denver, CO.

Human Participant Protection

Institutional research ethics board approval for the study was received from Simon Fraser University and from the University of British Columbia.

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