Notes on Homelessness, Mental Illness and Substance Abuse

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1. Introduction:

There is an abundance of material on homelessness, mental illness and substance abuse. The Profiles paper, Pathways to Homelessness, Homelessness, Social Isolation and Mental Health Reform: "Meeting the Needs" (1995) are examples of what is available locally to provide important local and provincial context for the deliberations of the Task Force. The papers commissioned by the Task Force such as the reports on poverty, mental health and supportive housing which are now being submitted, will give the Task Force an additional fact base on which to draw conclusions and recommendations.

There is also an abundance of US material. In particular, papers developed as a result of the McKinney research, material developed by the National Resource Centre on Homelessness and Mental Illness and the National Coalition for the Homeless are excellent sources on facts and learnings over the past 10 years.

I will attempt to summarize the themes from the Ontario, Toronto and US material I have reviewed, supplemented by some discussions I have had with people who work in the field. The summary will include what is known about the populations, an overview of problems from a systems perspective, and a review of what is known about promising practices with a view to setting the stage for the development of workable strategies which are likely to reduce homelessness as well be supported by most stakeholders.

After I have had an opportunity to review Carolyn's paper on Mental Health and Homelessness, as well as other papers prepared for the Task Force, I may have further comments to offer.

2. What is Known About the Populations

People with mental health and substance abuse problems are a heterogeneous group who make up a portion of the homeless. As the Profiles study indicated "only 11 to 33% of the homeless populations described in the literature have been diagnosed as having severe mental health problems…for two thirds of the populations using hostel services the primary issue is <u>not</u> mental health".

This finding is supported by the US literature (Who Is Homeless, NCH Fact Sheet # 3, National Coalition for the Homeless May 1998) which states: "Approximately 20-25% of the single adult homeless population suffers from some form of severe and persistent mental illness… only 5-7% of homeless people with mental illness require institutionalization; <u>most</u> can live in the community with the appropriate supportive housing options."

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For the portion of the homeless who have substance abuse or mental health problems the following is known:

- 3% of Toronto hostel users had been discharged from a psychiatric facility (Profile)
- 6% had been inpatients in a psychiatric facility in the past year ; only 25% had received any mental health services in the previous year (Pathways)
- 66% had a lifetime prevalence of mental illness, with depression being the illness most frequently reported (Pathways)
- 75% of the people with mental illness had a substance abuse problem (Pathways)
- 30% had spent time in police custody or jail in the previous year (Pathways), although only 2% of hostel users came from the corrections system (Profile)
- 29% meet the criteria for anti-social personality disorder, often in addition to an Axis 1 diagnosis (Pathways)

US studies cited in the Profile paper identify 36-68% of homeless men as abusing alcohol and the Committee on Health Care for Homeless people identified alcoholism as the "most pervasive problem of the homeless" (Profile)

The Clarke Pathways study quoted in the Profile paper, found that the prevalence rate for substance abuse was 66%. As well the Pathways study found high rates of sexual and physical abuse among the sample. The US study, Risk Factors for Homelessness among People With Serious Mental Illness, (National Resource Centre on Homelessness and Mental Illness) notes that " research findings point to high prevalence rates of sexual abuse trauma in the lives of homeless women with serious mental illness. These factors complicate treatment planning and point to the need for program planners and clinicians to adapt interventions for trauma survivors."

The Pathways study found a higher incidence of homelessness among visible minorities (15%) and Aboriginal people than the general population. The Metro Toronto District Health Council report on the Aboriginal Community Consultation (1996) found a high incidence of concurrent disorders and other serious psychiatric problems along with a serious gap in the capacity of aboriginal or mainstream services to provide the range of interventions required in a culturally appropriate manner.

3. Systems Issues

" Two trends are largely responsible for the rise in homelessness: a growing shortage of affordable rental housing and a simultaneous increase in poverty. Persons living in poverty are more at risk of becoming homeless and demographic groups who are more likely to experience poverty are more likely to experience homelessness."

This statement by the US National Coalition for the Homeless (NCH Fact Sheet #3 May 1998) could well be applied to Canada and Toronto. People who have mental illness and or substance abuse problems are identified as members demographic groups who are more likely to experience poverty and be at greater risk of homelessness.

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The previously cited study, Risk Factors For Homelessness Among People With Serious Mental Illness, (National Resource Centre on Homelessness and Mental Illness) identifies a series of environmental risk factors that can be summarized as follows:

- Inadequate discharge planning: individuals released from hospital or jails to tenuous community situations with no single agency designated as responsible for helping them secure housing, treatment and support services

- Lack of community based crisis alternatives: hospitalization often far from home is the only option given the lack of crisis outreach teams, emergency residential services immediate access to respite or transitional housing

- Lack of attention to consumer preferences: Current research provides strong evidence that people with mental illness do not want or need supervised, treatment oriented group living arrangements. Success of people with severe disabilities is based on consumers choosing their own housing, living in regular rather than segregated housing, and the provision of flexible individualized services

Structural factors identified in the paper include:

- The lack of affordable housing
- Insufficient disability benefits
- Lack of coordination between mental health and substance abuse systems: the apparent role of substance abuse in the loss of housing suggests that substance abuse treatment for persons with serious mental illness is critical but compromised by the inability of both systems to work together to treat both disorders simultaneously.

Many of the factors identified in the paper are at play here in Toronto and have been identified in studies for the Task Force, United Way, the Metro Toronto District Health Council, Metro Council and the Ministry of Health. Key themes will be summarized to provide a comparison with the US studies.

The report Homelessness, Social Isolation and Mental Health Reform “Meeting the Needs” prepared for the Ministry of Health (1995) and the report of Metro Toronto District Health Council Work Group on Homelessness and Mental Health made special efforts to consult with consumer/ survivors about their needs and front line staff who work with the homeless population. In particular the Meeting the Needs paper reported on focus groups with homeless and socially isolated people who experience mental illness.

“People often identified poverty and limited income as barriers to meeting basic needs and enjoying satisfactory quality of life… people also talked about the need to eventually find suitable employment in order to become self supporting and better meet their personal needs. Finally it should be noted that the need for safe, affordable, housing with individualized support services was seen as critical in assisting homeless/socially isolated people achieve personal stability.”

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The paper identified "systemic" barriers such as:

- Lack of access to and availability of appropriate services and supports: including user friendly access to affordable housing and inflexible service requirements on the part of some community services. This also includes racism and discrimination against people of color and the lack of alternative services for women who are dealing with abuse in their lives"
- Lack of informal linkages or service agreements among service providers, which discourage the movement of a person from one type of service to another.

The report called for:

- Provision of outreach and intake services where people are located (in drop-ins, shelters)
- Provision of a range of housing types including self contained units and shared accommodation based on the needs and wants of the consumer
- Recognition and support for the role of drop-ins
- Expanded outreach by crisis and case management services
- Development of informal and formal service agreements between shelters, hospitals, community support services, medical services, drop-ins.

The Metro DHC report on Homelessness developed 40 recommendations that are consistent with the provincial report including:

- Recognition of drop-ins as an entry point to other parts of the mental health system
- Recognition of the interdependence between substance abuse and mental health problems
- Outreach focused case management with a focus on relationship building
- Development of a range of housing options along with a multiple point access bed registry
- Improved cooperation among service providers and linkages with schools of Social Work and Medicine
- Anti-racism education and organizational change
- Adequate funding for community care and monitoring of the shift from hospital based care
- Development of a separate Aboriginal Homelessness initiative

To date there has been limited action on the Provincial or the DHC Homelessness reports.

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This needs to be seen in the context of a public policy failure to provide adequate resources to both the mental health and addictions systems and shift funding to community support systems over the past twenty years despite numerous studies and commissions at the provincial and municipal level. Recent provincial government actions such as the cancellation of the not for profit housing program have affected the supply of affordable housing .The recent decision to eliminate substance abuse as a criterion for provincial disability payments may lead to increased homelessness among people with addictions if the US experience with similar legislation holds true. (Addiction Disorders and Homelessness, NCH Fact Sheet #6, National Coalition on Homelessness October 1997).

The preceding paragraph could be the subject of a complete paper, but I will restrict my self to highlighting a few key themes that will hopefully be covered in more detail in other papers prepared for the Task Force.

The Ontario Mental Health Supplement (Ministry of Health 1994) is a comprehensive database looking at the prevalence of mental disorder among Ontarians including substance abuse. It found:

- 18..6% of the population could be identified as having a mental health or substance abuse disorder in the previous 12 months
- 2% had a serious/severe mental illness
- 8% were identified having substance abuse /dependence
- 8% of Ontarians used services for mental health reasons in the previous year.

Of those Ontarians who did use services:
59% visited a doctor's private office, 12% used drop-in centers, 12% used social service agencies, 6% used hospital emergency departments, 4% used inpatient services and 16% made use of self help groups.

Of those Ontarians identified as having severe mental illness, 69% have used inpatient or outpatient care in the past year, 16% have never used any psychiatric service. 38% reported using inpatient services at some point in their lives, while 46% have only used psychiatric outpatient services. 22% have used self-help groups and 25% have used drop in centers or social clubs. Only 5% have used vocational supports.

These findings which represent service use patterns of people seeking help for mental health or addictions problems, do not necessarily describe service usage of the homeless population. However a few interesting patterns emerge that likely do need to be taken into account in planning mental health and addictions service for the homeless.

- Physicians are major source of mental health support
- More people use outpatient care than inpatient care
- Except for self-help groups, drop-ins and social clubs (social recreation/rehab programs), there appears to be an absence of specialized community support services

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for people with serious mental illness or substance abuse. (It is possible that some services have been characterized as social services or outpatient services).

It can be said that there is an absence of community capacity to provide a full range of services to people with serious mental illness or substance abuse. Spending in both systems is still weighted to beds and doctors rather than organized systems of community care.

An analysis of mental health spending shows that the mental health share of health spending has declined from 11.5% in 1979 to 8.9% in 1993/4. According to Putting People First 1993, 80% of spending was on institutional care and 20% on community services (excluding OHIP). The goal, by 2003 is 60% community, 40% institutional. According to provincial government estimates, in 1996/7 institutional spending including general hospitals was 80.5% and community mental health spending was 18.8%. 1997/8 interim actuals show a slight decline in institutional spending to 79.78% and a slight increase to 19.55% for community mental health services. By 1998/9, based on the commitment to spend $60 million to increase the supply of community mental health services the spending ratio will change to 76% hospital and 23% community.
Simply put, the public policy objective of shifting funding to community supports has yet to be realized.

Mental health spending in the City of Toronto is still weighted in favor of institutional services. While over $40 million is spent on community mental health services, $61 million was spent providing inpatient psychiatric care in general hospitals and approximately $90 million is spent by the Queen Street and Clarke Divisions of the Centre for Addictions and Mental Health. Most of the mental health spending (hospital and community based) occurs in what was the old city of Toronto. There is a limited supply of community mental health services in North York, Etobicoke, Scarborough, York and East York. There is currently limited funding for drop-in programs or alternative supports.

The Metro District Health Council System Design Report (1996) identified a short fall of 236-371 case managers to meet provincial targets for 2003 and a need for 5,128 supportive housing units by 2003. It called for a $51 million reinvestment along with a mental health authority to oversee systems change, including the enhancements of services to the homeless population. It also called for the development of case management and housing registries.

The Health Services Restructuring Commission has called for the closure of 159 long term mental health beds by 2003 with the savings to be invested in community supports. Both the HSRC and the Minister of Health have agreed that service must be in place before beds are closed and if services are not in place the closure timelines will be adjusted. The Provincial Advisory Committee has called for an investment of $400 million by 2003 in community supports. Based on share of the provincial population the Toronto share could be $100 million. To date the Ministry of Health has announced $60 million in provincial

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funding for this fiscal year with no specifics as to funding earmarked for Toronto beyond forensic beds, diversion services and capital funding of approximately $5.4 million.

The recent announcement concerning the Ministry of Health assuming responsibility for supportive housing, while welcome, may prevent further loss in affordable housing for people with mental illness, but it does not address the need to increase the supply and availability of a range of housing options for the homeless or other people with mental illness or substance abuse problems.

Before summarizing the system issues I want to provide some statistics from recent reports to capture the current situation.

Community Resources Consultants, which is a community mental health service agency, forwarded some statistics from their operating plan.

- 12% of the clients admitted to their community rehabilitation services (case management) were homeless, up from 10% last year
- Statistics from their Hostel Outreach Program, which serves the homeless, indicates that 21% were still homeless at the end of the year. While they were able to find housing for 79% of their clients, and support them in maintaining it, they note " decent, safe and affordable housing, continues to be a high need resource"
- 9% of the clients accessing their College park or Metro North court diversion services were homeless
- 21% of the people ineligible for diversion programs at the courts were homeless or had no fixed address.

In 1996, the Metro Toronto District Health Council published findings from a mental health survey of programs providing ambulatory (non inpatient) mental health services in Metro Toronto. (Findings From Mental Health Programs Mental Health Survey, 1996) It paints an interesting picture of system capacity. In 1994/5 community mental health services reported serving 47,564 people.

- Only 4,337 accessed case management services
- 843 received housing support services
- 1,927 people received supportive housing services.
- Access to housing topped the list of services/ supports that people were having difficulty accessing.

The recently completed report on the Minimum Data Set (Minimum Data Set Overview and Tables CMHA Metro Toronto 1998) which compared client characteristics across service settings for 26,736 clients across the province, including Toronto, provides further evidence concerning the need to expand access to community supports and housing.

- 227 people were identified as homeless and an additional 395 people were living in shelters.
- 2,383 people were living in supportive housing, non-profit housing or Ontario Housing
- 1,911 were living in boarding or rooming houses

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- 42.73% of the homeless were in hospital on the day of snapshot, compared to 4.71% of the people reported as living in supportive housing.
- Less than 1% of the people who were living in not for profit housing or Ontario housing were inpatients on the day of the snapshot, compared with 5% of those living in boarding homes rooming houses or shelters.
- 1.81% of the clients who were receiving case management services were in hospital.

In March 1997, Shea and Associates published a draft Plan for the Rationalization of Addiction Treatment Services in Central East Region, including Metro Toronto. They were retained by the Ontario Substance Abuse Bureau to develop a report and recommendations. The Plan's goals and assumptions summarized below are consistent with the system themes identified in the literature and mental health planning reports.
Themes include:

- A need for greater coordination and integration of addiction treatment services to make navigating the system easier for consumers
- Services need to be accessible and transparent to consumers and referral agencies
- Continued support for services that are at the street level and are delivered in locations and ways that best suit their particular consumer populations
- Many people can be treated just as effectively on an outpatient basis at a lower cost
- Metro Toronto continues to experience a significant level of complexity of issues such as homelessness, multicultural populations, opiate use etc.

With regard to services for the homeless the report says: "Homeless and socially isolated individuals are at risk of serious problems related to addictions. Access to treatment is difficult because many find barriers in traditional medical and twelve step models. Outreach and support to these clients and a harm reduction approach should form the basis of any new initiatives."

To sum up, the system themes identified for meeting the needs of homeless people with mental health or addictions problems are:

- Need for improved access to affordable housing options
- Need for a wider array of flexible community support services with a variety of access points including drop-ins
- Need to develop mechanisms such as service agreements, registries and authorities to improve access, connect people to service networks and develop a shared accountability to consumers and funders.
- Need to integrate services for homeless persons with concurrent disorders of substance abuse and mental illness

While access to a range of supports including clinical treatment is identified, the emphasis is on the provision of services in community rather than inpatient settings.

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4. Promising Practices

The US Department of Human Services has published a number of reports on successful approaches to meeting the needs of homeless people with mental illness and substance abuse problems.

The McKinney Research Demonstration Program For Homeless Mentally Ill Adults has found:

- Homeless people with severe mental illness will use accessible, relevant community treatment services and that appropriate services will decrease homelessness
- Housing stability, appropriate mental health treatment, and increased income led to an improved quality of life
- Substance Abuse is a major factor in homelessness among people with severe mental illness and substance abuse treatment must be an integral part of comprehensive services
- A range of housing options is required to respond to the needs and preferences of the homeless.

McKinney Act funding has also encouraged the development of community service networks and partnerships to meet the needs of the homeless. “There are many ways to expand service linkages, from using case managers and outreach workers to span the boundaries between agencies, to developing formal interagency agreements, to creating a separate coordinating entity that brings all the stakeholders together.” (Oakley, McKinney Act Fosters Collaboration and Partnerships, National Resource Centre on Homelessness and Mental Illness).

Oakley and Dennis (1996) report that housing stability is “essential for successful treatment and recovery” for homeless people with substance abuse problems. “When combined with supportive services, meaningful daily activity, (including work) and access to therapy, appropriate housing can provide the framework necessary to end homelessness for many individuals. Without a stable place to live, recovery often remains out of reach.”

There is also evidence coming out of Switzerland that harm reduction strategies for injection drug users can reduce homelessness. (Globe and Mail, June 3rd 1998).

A number of promising program approaches have been identified in the literature, including ACT teams, supportive community programs like LAMP in Los Angeles, Toronto’s own Hostel Outreach program and others. There is anecdotal evidence that Toronto programs such as Street City, or the harm reduction residences recently developed at Seaton House are effective. There is also evidence that the work of case management programs and housing support programs to help people choose get and keep the housing of their choice, reduces homelessness and the need for hospitalization.

Implementation of the Psychosocial Rehabilitation Tool kit to measure outcomes in community mental health programs and the Ministry of Health funded Community Mental

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Health Evaluation will produce more evidence about effective local interventions in the years ahead as will the DATIS project for substance abuse programs.

Based on the literature and experiential knowledge of consumers and service providers in our mental health and addictions systems, the Task Force is well positioned to recommend service enhancements to complement the necessary expansion of affordable housing options.

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