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HOMELESSNESS PARTNERING STRATEGY

Summary

Homelessness Housing Practices

Good, Better, Best (Homelessness and Concurrent Disorders: Housing with Support)

Van Wyk et al., Mennonite Central Committee, 2011

The study explores long term supportive housing practices that help with positive outcomes for people who have mental health issues and drug addiction and who are chronically homeless, in order to strengthen the knowledge base around long-term supportive housing.

Key terms

Concurrent disorders refer to when a person experiences a mental health issue as well as a substance use problem.

Who was involved in the study?

- Homeless persons who had concurrent disorders.
- Staff working in housing facilities and support programs in British Columbia.

How was the study done?

- A literature review to provide background and context for the research and to inform the findings of the study.
- Two focus groups were conducted:
  - one involved service providers; and
  - one involved current or former homeless persons.
- Forty interviews with chronically homeless persons in Abbotsford, Mission and Chilliwack (representing approximately 10 to 15% of the homeless population).
- Eighteen qualitative interviews with service providers and professionals.

Results – General

- Homeless people with concurrent disorders are more likely to experience barriers to stable housing than homeless people without these issues. Without housing, mental health and addiction issues are harder to address.
- Service providers feel that the separation between housing support and health care for those with concurrent disorders is problematic. One client might have to navigate a number of services to get help with addictions and mental health issues, rather than be treated for both issues in one setting.
- Homeless people with concurrent disorders have better outcomes when they have control over their housing.

Results – Shift in philosophy in British Columbia

- In British Columbia, support workers have seen a shift in treating people with concurrent disorders who are homeless or at risk of becoming homeless. There is no longer a belief that people must become clean and sober before they are given housing. Instead, there is a move toward a "Housing First" approach and deinstitutionalization. This harm reduction philosophy is included in everything from housing to medical care. There is no time limit on shelter stays, and clients are not forced to become sober before they are housed.
- There is a new understanding that people do not need to go through a program in a linear fashion, moving from emergency housing to independent housing. Service providers are moving away from shelters to "housing plus"—long term housing with support services where clients are provided with housing first, and then the other issues are tackled.

Practices

As integrated models of care become the norm for supporting persons with concurrent disorders, there is a greater recognition of the multiple needs of those experiencing homelessness and of the need for access to an array of services based on individual needs. The following leading practices are examples of supported housing and care based on integrated service delivery.

Critical time intervention

- Involves a time-limited case management model designed to prevent homelessness when people with mental illness are discharged from hospitals, prisons, etc. by facilitating relationships with social supports and community resources.
- Includes access to stable housing, psychiatric care, medications, counselling, outreach, case management, family, work and rehabilitation groups on an ongoing basis for up to 10 years.
- Consists of three phases:
  - **transition,** which focuses on providing dedicated support, as well as the formalization and implementation of a transitional plan;
  - **try out,** which focuses on the development of problem-solving skills; and
  - **transfer of care,** which focuses on the process to create ongoing support networks.

Supportive housing and Assertive Community Treatment

- Encourages self-sufficient living through mental health services, financial aid, regular home visits, daily team meetings, individualized treatment plans, staff availability 24/7 and medication management.
- Uses Assertive Community Treatment (ACT) teams with a low client to staff ratio (10:1) to share caseloads and provide outreach.

Comprehensive, continuous, integrated system of care

- Includes integration of care, empowerment of clients, disease diagnosis and individualized recovery treatment.
- Uses counselling and one-on-one contact as cornerstones of this model.
- Identifies six promising program strategies to reduce mental health and substance use problems:
  - Client choice in treatment decision-making
  - Positive interpersonal relationships between client and provider
  - Assertive community treatment approaches
  - Supportive housing
  - Supports for instrumental needs
  - Non-restrictive program approaches

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