

**DUAL-DIAGNOSIS ASSERTIVE COMMUNITY OUTREACH TEAM**

**PROGRAM COMPLETION REPORT**

**October 2002 (Revised)**

**A Partnership Project:**

**Triage Emergency Services & Care Society  
Lookout Emergency Aid Society  
Vancouver Coastal Health Authority**

# **DUAL-DIAGNOSIS ASSERTIVE COMMUNITY OUTREACH TEAM**

## **Program Completion Report**

### **Introduction**

The Dual Diagnosis Assertive Community Outreach Team was a demonstration project funded in partnership by Human Resources Development Canada and the Vancouver Coastal Health Authority. Triage Emergency Services & Care Society administered the project, with Lookout Emergency Aid Society supporting the project with referrals and support from their existing programs.

Funded from October 26<sup>th</sup>, 2001 to May 24<sup>th</sup>, 2002, the outreach team was comprised of a professional program coordinator and four outreach workers. The team provided comprehensive outreach services to 50 homeless/at risk individuals, at least 30 of whom had a dual diagnosis of mental illness and substance use, and the remaining 20 with one or more health diagnosis. The project used the Assertive Community Treatment (ACT) model of service delivery as articulated in the BC Mental Health Reform Best Practices for Assertive Community Treatment report.

### **Main Activities**

- ❖ Assessment, planning, linking and monitoring of each client.
- ❖ Development of skills of Outreach Workers and partnered organisations.
- ❖ Development of knowledge base regarding dually diagnosed individuals.
- ❖ Development and improvement of community response to dually diagnosed individuals.

### **Goal**

- ❖ To enable chronically homeless/at risk individuals with a dual diagnosis of mental illness and addictions to acquire and retain safe, affordable, and stable housing and receive appropriate treatment.

### **Objectives**

1. To reduce the reliance on shelters by securing stable accommodation.
2. To improve quality of life, health, and safety for the consumer.
3. To improve our community response to the needs of homeless/at risk individuals with a dual diagnosis who are not able to link to other existing services.
4. To develop a base of knowledge about understanding and working with homeless individuals with a dual diagnosis and share it with relevant stakeholders.

The following report provides information on client profiles, worker output, client outcomes, and a program summary. As this project was a demonstration project, a series of recommendations have also been included for reference by future programs. Note that the recommendations and conclusions contained within the original report submitted to HRDC in July 2002 have been revised and expanded in this version.

This report was prepared by Greg Richmond, Community Housing Manager at Triage (604) 254-3700.

## **CLIENT PROFILES**

### **Total Clients:**

- Total clients who received service from outreach team: 44 \*

\* Note: the total number of clients served was affected by the resignation of the project coordinator in early February. While the team was able to exceed its target regarding ratio of clients to staff (10:1), it was unable to achieve its goal of serving 50 individuals due to the shortage of staffing.

- Number of clients deceased during program: 1

### **Age**

- Average Age: 37.3

	number	percentage
18-34	15	34%
35-64	29	66%
65+	0	0%

### **Gender**

Female	13	29.5%
Male	31	70.5%

### **Aboriginal Clients**

Number of Aboriginal Clients	8
Percentage of Clients who were Aboriginal	18.2%

Note that individuals of aboriginal ancestry comprise approximately 2% of the population in greater Vancouver. The high number of aboriginal individuals served by this outreach project is yet another indicator that aboriginal individuals are over-represented in the homeless population.

### **CHA (Community Health Area)**

	At Intake		At Program End/Discharge	
CHA 1	1	2.3%	3	6.8%
CHA 2	41	93.2%	33	75%

CHA 3	-	-	-	-
CHA 4	-	-	-	-
CHA 5	1	2.3%	4	9.2%
Out of Province	-	-	2	4.5%
Hospital	-	-	2	4.5%
Corrections	1	2.3%	0	

## Income

- Average income pre-intake: \$736.18
- Average income program completion: \$744.56

## Income Source at Program Completion

Regular IA	13	29.5%	Pension: Private	1	2.3%
DB2	28	63.6%	Pension: Other	1	2.3%
Supplementary	2	4.5%	Public Trustee	-	-
EI	-	-	Employment	-	-
OAP	-	-	Band	-	-
CPP	1	2.3%	Other	1	2.3%

## Health

### Health Issues

	Number of clients	Percentage of all clients
Mental Health	39	88.6%
Substance Use	41	93.1%
HIV	7	15.9%
Hep C	12	27.3%
Physical Illness/Disability (excluding HIV and Hep C)	20	45.5%
Dual Diagnosis (MH and SU)	38	86.4%

### Suicide

Current or recent suicide attempts and /or suicidal ideation:

Intake	11
Program Completion / Discharge	6

Medication Usage

	New	Total at Program Completion
Mental Health Medications	5	29
Physical Health Medications	2	6

## OUTCOMES

### **Housing Outcomes**

#### Client Survey Question

Do you think your current housing is:   π an improvement   π the same   π not as good as the housing you had when you first started working with the Dual Diagnosis Team?

#### Results

Number of clients who responded to this question: 25

	# of Responding Clients	% of Responding Clients
An improvement	17	68%
The same	8	32%
Not as good	0	0%

#### Housing Specifics: Intake vs. Program Completion\*

	Pre-Intake**			Post Intake***		
	Good	Adequate	Inadequate	Good	Adequate	Inadequate
Size	3	11	8	14	20	3
Noise	4	7	10	13	17	7
Cleanliness	6	12	4	20	15	2
Affordability	12	7	4	23	12	3
Proximity to Services	10	7	3	23	12	3
Proximity to Family/Friends	8	12	2	12	22	3
Exposure to Drug/Sex Trade	3	10	10	10	15	13
Exposure to Violence/Intimidation	2	8	11	10	15	13
Washroom	5	5	10	15	13	7
Kitchen	8	5	8	21	10	6

\* The numbers of housing pre-intake and post intake are not equal due to a number of people not having any pre-intake housing, some not having any post-intake housing ,and some having more than one post-intake residence.

\*\* The numbers here represent program client's last paid residence before intake.

\*\* The numbers here represent all paid residences by all clients after intake into the program.

#### Housing Location

	Intake		Program Completion	
DTES	37	84%	29	65.9%
Vancouver (excluding DTES)	4	9%	11	25%
Out of Province	0	0%	2	4.5%
Not Applicable	1	2.3%	2	4.5%

- Moves into the Downtown Eastside: 2
- Moves out of the Downtown Eastside: 11

Housing Type

	At Intake		At Service Completion	
Hotel/Lodging House	10	22.7%	19	43.2%
Self-Contained Apartment	2	4.5%	5	11.4%
Room In house	0	0.0%	1	2.3%
Self-Contained Suite in House	0	0.0%	1	2.3%
Transitional/2 <sup>nd</sup> Stage	4	9.1%	7	15.9%
Shelter	21	47.7%	4	9.1%
Family/Friends	1	2.3%	0	0.0%
Residential Facility	0	0.0%	1	2.3%
Hospital	0	0.0%	2	4.5%
Corrections	1	2.3%	0	0.0%
No Fixed Address	5	11.4%	2	4.5%
Out of Province	0	0.0%	2	4.5%
On-site Support	4	9.1%	9	20.5%

Waitlists

	Intake	Program Completion
Total Waitlists	10	94
Waitlist per client	0.23	2.17

	Pre-Intake		Program Completion	
	#	%	#	%
Clients Waitlisted	7	15.9%	28	63.6%

Shelter Use

These numbers are taken from the records of Triage Centre and Lookout's Downtown Eastside shelter. Note that client usage of other shelters is not documented.

One year Pre-Intake:

	Admissions	Total days
Shelter use in year prior to intake	120	1511

- Number of Clients who were admitted to Triage or Lookout shelter in the year prior to intake: 40

- Average number of admissions per year of those who used a shelter: 3.0
- Average length of admission: 12.6 days

Post Intake:

	Admissions	Total days
Shelter use post intake	27	270

- Number of Clients who were admitted to Triage or Lookout shelter after intake: 14
- Average length of admission: 10.0

### Substance Use Outcomes

#### Client Survey: Substance Use

	Number of Responses	Increased		Same		Decreased	
Amount of Use	31	2	6%	15	48%	14	45%
# Substances Used	29	0	0%	22	76%	7	24%
Safety of Use	29	12	41%	17	59%	0	0%

The data for this table was obtained via a client survey at the completion of the project. 31 of the program's 44 clients answered at least one of these questions.

#### Detox Usage

23 of the outreach clients consented to provide information on their use of detoxes. The data below includes use of daytox and detox:

#### Admissions

3 months Pre December 1, 2001	1	6 months Post December 1, 2001	6
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#### Completions

3 months Pre December 1, 2001	1	6 months Post December 1, 2001	5
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Note that the "pre" period is half the length of the "post" period.

Comments:

The outreach team used a variety of responses to substance use, including harm reduction, motivational interviewing, and referrals to substance use services. Given that most clients were in the pre-contemplative stage of recovery, most of the work involved harm reduction, working with clients to understand the role substance use plays in their lives, and remaining positive, welcoming and hopeful after relapses or in the face of continued high levels of use. Similar approaches with this population are also recommended by Tsemberais (2000) and Lipton (2000).

Crack was the most widely used drug (19), followed by marijuana (18), alcohol (15), cocaine (13), heroin (7), and amphetamines (4). The low rates of heroin use were somewhat surprising, though when combined with the high rates of crack use, is similar to patterns common in North American urban centres.

The results of the client survey re: substance use, are, in our opinion, largely due to the client's increased stability. As the clients accessed better housing and resolved barriers to getting their basic needs met, their level of drug use decreased, as did the number of drugs used, and the safety of their using increased.

**Service Linkage/Utilization Outcomes**

	Enhanced*	New	At Program Completion
Mental Health Team	7	3	20
Mental Health Treatment	7	5	8
Mental Health Drop-In	3	4	11
MH Medication Administration	5	6	10
Private Psychiatrist	1	1	2
Community Outreach Team	2	15	13
HIV Treatment	0	0	3
HIV Service	0	0	4
HIV Outreach	0	0	1
HIV Medications	0	0	3
HIV Medication Service	0	0	2
Harm Reduction Service	2	0	0
Methadone Service	0	0	5
Substance Use Treatment Facility	0	1	3
Substance Use Counselling	3	3	9
Dual Diagnosis Program	1	0	1
GP	1	4	21
Physical Disability Support	3	0	4
Physical Health Medications	4	2	6
Physical Health Med Admin	2	1	0
Physical Health Support service	3	2	1
Legal Services	3	1	3
Financial Advocacy	0	6	6
Financial Administration	2	5	9
Meal Service	1	3	4

Home Support	1	3	3
Other		14 **	14

\* Enhanced Links are consumer links with community services where the rate of usage increased or the strength of the relationship increased after contact with the program..

\*\* includes anger management, vocational service, Ministry of Human Resources, housing registries, etc.

- Total Enhanced Links: 51
- Average number of enhanced links per client: 1.16
- Total New Links: 65
- Average number of new links per client: 1.36
- Total New and Enhanced Links: 116
- Average Number of new and enhanced links: 2.63
- Total links at program completion: 166
- Average number of links per client at program end: 3.77
- Number of individuals with links to both MH and SU treatment services:
  - At Intake: 2
  - At service completion: 4

### Comments

While many clients did not have knowledge of the community resources they required, many clients had some connection with many of the resources in the community, yet continued to remain homeless/at risk and receiving little or no mental health or substance use treatment. Note also that only four individuals were linked with both mental health and substance use treatment services. The simultaneous treatment of both disorders is highly recommended (Drake and Noordsy 1994; Minkoff 1989; Ridgely 1991) yet in Vancouver this remains unlikely.

This suggests that while traditional services serve many individuals well, they serve dually diagnosed chronically homeless individuals poorly. Until services are created specifically for this population, success is likely to continue to be sporadic and elusive, with the most ill dually diagnosed individuals remaining homeless and at risk in the community.

## **SERVICE PLANS: GOALS, INTERVENTIONS AND OUTCOMES**

Service plans were created in collaboration with each client. Each service plan was broken down into goals, interventions, and outcomes.

### **Goals**

Goals were identified via collaboration between the client and the worker. While many goals were identified at intake, many were also identified through the course of the working relationship.

- Total Goals: 415
- Average Number of Goals per Client: 9.4
- Total Goals in Each Service Area:

	Number	Percentage of all goals
Housing	100	24.1%
Mental Health	67	16.1%
Physical Health	60	14.5%
Substance Use	56	13.5%
Financial	36	8.7%
Legal	3	0.7%
Personal*	59	14.2%
Community**	10	2.4%
Global***	24	5.8%

\* “Personal” goals include goals in personal care, home management, and relationships.

\*\* “Community” goals include educational, volunteer, employment and activity goals.

\*\*\* “Global” goals include the initial engagement and overall case planning and monitoring.

### **Interventions**

Interventions are tasks done by a worker regarding a particular client. An intervention may include the client, other service providers, or the worker working alone. A single visit with a client might involve several tasks, and so would be documented as several specific interventions.

- Total Interventions: 1965
- Average Number of Interventions per Client: 44.7
- Number of Interventions in Each Service Area:

	Number	Percentage of all interventions
Housing	632	32.2%
Mental Health	459	23.4%
Physical Health	193	9.8%

Substance Use	165	8.4%
Financial	204	10.4%
Legal	79	4.0%
Personal	166	8.4%
Community	28	1.4%
Global	39	2.0%

- Number of Each Intervention Type:

	Number	Percentage of all interventions
Assessment	87	4.7 %
Planning	315	17.1 %
Services: including searches, links, escorts, reinforcing use, advocacy, and liaison.	738	40.3 %
Education: skills/treatment/misc. issues	85	4.6 %
Crisis Intervention	183	10.0 %
Monitoring	330	18.0 %
Assistance on Tasks	195	10.6 %

## Outcomes

Each goal was assigned a current status/outcome label by the worker as the service delivery progressed. The following labels were assigned at the completion of the program:

	Number	Percentage of all outcomes
Goal Unengaged	26	6.3%
Developing Plan	9	2.2%
Implementing Plan	6	1.5%
Plan in Place: Monitoring	82	19.9%
Attempting New Skill	30	7.3%
Using New Skill	14	3.4%
New Skill Learned	2	0.5%
Goal Completed	206	49.9%
Goal Changed	5	1.2%
Goal Abandoned	33	8.0%

## **PROGRAM SUMMARY AND RECOMMENDATIONS**

The Dual Diagnosis Assertive Community Outreach Team provided a range of outreach services, including (and as necessary) case management, brokerage and rehabilitation services. The intensity of the involvement with each client varied widely, with some clients receiving limited, task-oriented brokerage services, and others receiving case management and rehabilitation services, with brokerage for treatment and miscellaneous community services. The team used the ACT model as articulated in the BC Mental Health Reform Best Practices for Assertive Community Treatment report. This model we found to be more effective than the conventional one worker / one caseload outreach model, both in terms of service delivery, and in terms of creating a team environment that offered high levels of support, education and debriefing. The following summaries and recommendations focus on key areas of service delivery.

### **ACT Model**

The outreach team employed the ACT model of service delivery, with the five key components being:

- Low staff-to-consumer ratio: 10:1
- Team approach/shared responsibility for caseloads
- Consumer-directed delivery of care
- Assertive Outreach (services are delivered to the client's location)
- Continuous services (24 hours a day, seven days a week)

The outreach team found following the ACT model required creating a well-defined set of procedures and principles, commitment to these procedures and principles, and consistent monitoring. The team met every morning for a case planning discussion and at the end of every day for debriefing and documentation. This allowed for the high levels of communication and creativity necessary for effectively sharing caseloads, and provided regular opportunities for team support, integration, and debriefing. The team also reviewed all client files once weekly, and in the absence of the Program Coordinator arranged for consultation with Judi Burtnick of the Dual Diagnosis Program on particularly difficult files.

Of the five key components listed above, the team only had difficulty achieving the continuous service component. The relative inexperience of the team at the program's beginning and the subsequent resignation of the Program Coordinator precluded offering weekend service for clients, though some off-hours support and crisis intervention was available via the staff of Triage's and Lookout's shelters, and some clients were housed in Triage's Princess Rooms Transitional Housing Program, which had daily support as late as 4 am.

Perhaps the most salient characteristic of the outreach team's service delivery was the focus on basic needs and practical goals identified by the clients. For some clients this meant bringing the workers into their lives to work on more complex issues involving lifeskills goals; for other clients this meant more task oriented work such as advocacy with the Ministry of Human Resources or housing searches. The need to honour client basic needs and preferences is clearly articulated by Drake, Osher, and Wallach:

Another barrier to service utilization is the mismatch between available resources and individual client preferences. Homeless persons, even those with psychiatric and addictive impairments, want help with basic amenities like food, clothing, shelter and

jobs, but may have little interest in mental health treatment. Even those who seek hospitalisation are typically interested in the basic comforts of food and shelter rather than treatment. As Mulkern and Bradley observed, the problem is often acceptability rather than accessibility. The realities of what clients want may need to be taken more into account in what professionals offer (1991).

In the chaos of homelessness, poor nutrition, relapse, hospitalizations, decompensation and extreme substance use, the client's interest in treatment, recovery, rehabilitation—all the things service providers want for their clients—is often fleeting or simply non-existent. Barrow notes that the APA Task Force stated that “clinical needs must be met in a context that provides for basics such as food and shelter” (1991). To this we would add the basics of safety, respect, honouring lifestyle and difference, the alleviation of poverty, and hope. In such an environment engagement in treatment and recovery are far more likely.

This team brokered with treatment services rather than providing them internally. We found this arrangement to be effective, especially if communication was good, respective roles were clear and the working relationship was collaborative in nature. ACT literature also describes models where treatment is provided by the team itself. Barrow suggests that “treatment linkages can be facilitated when ‘linking’ programs offer direct psychiatric services, which tend to be more accessible and less threatening than more traditional clinic programs (1991). In our view, the fact that only 4 of the team's 38 dually diagnosed clients were receiving concurrent treatment for both diagnoses is in itself a substantial argument for the creation of treatment programs that integrate both mental health and substance use treatment. And the low rates at which clients were linked to treatment and/or low quality of the links to traditional office-based services is an argument for treatment and intensive outreach services to be integrated into single program. The challenge would be to maintain a highly consumer directed service that focuses on the practical needs of the client first and foremost.

### Recommendations

- 1) Future outreach programs working with this population use the ACT model
- 2) Future programs include regular (preferably daily) opportunities for debriefing to minimise worker oversaturation, staff turnover, and the erosion of client centred / consumer directed service delivery.
- 3) 7 day per week coverage by a member of the outreach team is recommended; 24 hour coverage would be ideal.
- 4) In the absence of 24 hour outreach coverage, relevant community services (i.e. shelters, drop-ins, etc.) could be approached regarding a more formal link for after hours support and crisis intervention.
- 5) The creation of concurrent treatment programs for individuals with a dual diagnosis, preferably with intensive outreach.

### **Client Links with Community Resources**

The intervention data listed above indicates that over 40% of the worker's activities involved some form of interaction with community services. Furthermore, advocacy interventions totaled 176, and 51 of the client's links with community services were enhanced during the client's involvement with the outreach team. Indicated here is that one of the dominant themes of outreach work with this population is mobilising the community on the client's behalf. McQuiston states “considering the adversity a mentally ill homeless person experiences,

clinicians need to be prepared to clear barriers to other services” (1991). The outreach team reported a level of frustration and cynicism was evident in many of the community service providers who worked with the program’s clients. The rates at which the clients were already linked to service providers, combined with their rates of homelessness, shelter use, and poor or non-existent engagement with treatment services, indicates that current services are not effective with this population, which is to be expected as these services are not designed with this population in mind. Unfortunately, this can result in the opinion—fairly widespread within the DTES and in the wider region--that these people are essentially beyond help, rather than the opinion that we need to design and implement a service that will properly meet their needs.

Thus much of the work of the outreach team was to educate clients on relevant resources (particularly those that might better meet their needs), mediate and resolve conflicts between clients and service providers, encourage clients to form more authentic relationships with service providers, encourage skill building in areas that are barriers to effective links, or advocate with service providers to provide service or to provide service in a different way. The outreach team prioritised this work as part of the ACT model, but also because the program’s short duration meant that continuity of care had to be provided using other community resources.

### **Integration with Other Services**

Upon formation the outreach team extensively toured relevant community resources. The team made it a priority to create and sustain good working relationships with these resources, which played a key role in ensuring clients needs were met in a comprehensive and coordinated manner.

The team’s links and working relationship with Triage Centre and Lookout Shelter were good, though more close with Triage than with Lookout due to Triage administering the project and two of the four workers being previously employed by Triage. Similarly, referrals from within Triage were more likely to engage or engage more quickly with the team than referrals from Lookout, and referrals that had not previously engaged with the shelter system were slower yet to engage, if at all.

The literature stresses the need to integrate and coordinate outreach teams with the wider service provision community. Osher and Dixon recommend “housing strategies for homeless or marginally-housed persons with dual diagnoses must be developed in tandem with clinical strategies” and the establishment of “cooperative agreements between providers and housers, outlining respective roles and responsibilities (1996). More broadly, Stein states that working with members of the community who are in contact with the client is just as important as working with the client themselves (1998). In a formal sense, though, this means regular forums at all levels involving relevant stakeholders, including case conferences, interagency meetings, multi-systems meetings, etc. It is worth pointing out that we know of no forums in the Vancouver region that bring together a comprehensive range of stakeholders for the express purpose of providing better service to the homeless dually diagnosed population. At this point these people largely remain “special needs” problems within the various systems--problems that don’t really fit anywhere, are awkwardly accommodated rather than welcomed, and are not likely to achieve stability and recovery.

### Recommendations

- ❖ Staff training should include advocacy skills and extensive knowledge of community resources.

- ❖ Forums should be created on a number of levels and involving a comprehensive range of service providers to address the complex needs of chronically homeless individuals with mental illness and substance use issues.

### **Human Resources: Hiring**

There were very few applicants for the program coordinator position and we were fortunate that a highly qualified individual did apply, particularly as the outreach workers were relatively inexperienced.

While this position was only filled for three months, the program coordinator organised the staff training and organised the team and their administrative procedures such that the team was able to stay focused on their mandate and their principles of care and case management. While Triage's Community Housing Manager did fulfill the administrative and supervisory duties once the program coordinator resigned, the missing piece was having the program coordinator deliver direct service alongside the workers. Research indicates this to be of benefit via providing the supervisor with a consistent understanding of the every day challenges facing the clients and the staff (Stein, 1998).

The applicants for the outreach jobs varied, from experienced yet philosophically unsuited to these particular positions, to inexperienced yet naturally client centred. Interesting, the difficulty in hiring a workforce with experience in providing dual diagnosis interventions has been noted in the literature (Drake 2000). Consequently the workers were all relatively inexperienced at the beginning of the program, which then required extensive training (see below). The workers had a range of backgrounds (both personal and academic), were divided equally by gender, and had some personal experience in substance use recovery and mental health issues. Both Stein (1998) and Phillips (2001) advocate for the idea of some form of consumer involvement, whether hiring consumers as team members or hiring consumer advocates. Our experience was that having individuals with experience of mental illness, substance use and/or the respective systems provides the team with more comprehensive and meaningful understanding of the service recipient's experience and point of view.

#### Recommendations:

- Workers are hired primarily on the basis of being able to work in a rigorously client centred model, with experience being valued but subordinate to ability to work using client centred values.
- At least one member of the outreach team has in the past or is currently a consumer of mental health or substance use services. Alternatively, a consumer advocate position could be included as a member of the team.
- Given that 18.2% of the outreach team's clients were aboriginal, future programs should strongly consider hiring an aboriginal worker.
- The supervisor / team leader participates in direct service.

### **Human Resources: Training and Development**

Given that the workers hired for the project were relatively inexperienced, the program coordinator provided extensive training in a multitude of relevant areas, including tours of community resources. Specific training initiatives included: Psychosocial Rehabilitation, Rational

Emotive Therapy, the Transtheoretical Model of Change, Motivational Interviewing, the ACT model of service delivery, dual diagnosis, personal safety, conflict resolution, assessment skills, self-care, ethics, boundary setting, and team building.

The effect of the training was visible in the ability of the workers to:

- maintain a detailed, patient, persistent and recovery-oriented case management focus.
- maintain a hopeful and positive regard for the client and their struggles.
- handle the stress inherent to the work and avoid oversaturation and burnout.

#### Recommendations:

- A substantial training component is necessary to provide workers with the conceptual tools required to deliver client centred care and case management services to multi-challenged individuals via the ACT model. Suggested training areas include those listed above and also the areas of HIV, suicide and Harm Reduction.
- Extensive knowledge of relevant community services is also required.

### **Housing**

The need for a range of housing options—especially supported housing—for individuals with a mental illness and substance use has been articulated in numerous regional and provincial reports:

- The Regional Homelessness Plan for Greater Vancouver (2001).
- Final Report of the Inter-Ministry Task Group: Meeting the Challenge of Serious Mental Illness and Substance Misuse (1999).
- Vancouver Richmond Health Board's Mental Health Housing Operational Review (2000).
- BC's Mental Health Reform Best Practices: Housing (2000).
- Visions: BC's Mental Health Journal, Housing. (No 10, Spring/Summer 2000).

Research from other jurisdictions also indicates that the dually diagnosed are the “least likely subgroup of the homeless population to gain access to housing programs” (Tsemberis 2000). Moreover, Drake, Osher and Wallach state, “homeless people with either mental illness or substance abuse problems are more likely to return to institutional care if they are not provided with adequate housing. For those with alcohol and drug problems, including those dually diagnosed, maintaining sobriety may be impossible practically without adequate housing” (1991). In our experience, securing adequate housing is perhaps the most crucial issue, and certainly the first order of business when working with the population.

The challenge of providing chronically homeless dually diagnosed individuals with safe, affordable and supported housing in Vancouver is complex. Barriers include:

- Almost no supported housing for individuals who use substances.
- There are no supported housing resources that we know of whose mandate is to house dually diagnosed individuals. While many mental health supported housing programs do house dually diagnosed individuals, the lack of housing targeted to this population remains a core determinant of their instability.
- Insufficient overall supply of supported housing units.
- VCHA's Mental Health Residential Services Access Team requires that applicants are linked with treatment in order to be eligible for supported housing. Conversely, many

homeless dually diagnosed individuals are not stable and have marginal or no links with treatment. Thus they are caught in a “Catch 22” of service provision, with chronic homelessness the result.

- Lack of timely access to supported housing units. The wait list for mental health supported housing contains over 2800 names, and with the recent changes to how units are allocated, the time between application and receiving a unit will likely far exceed the previous time of three to four years. However, it is possible that dually diagnosed clients could receive housing in a more timely manner through the Community High Risk priority placement stream.
- In 2000, John Russell, former Director of Greater Vancouver Mental Health Services, stated that “current policies with respect to substance misuse in many [mental health] housing and residential programs are an ineffective response to substance misuse” (2000). However, this may be changing, as some mental health housing providers are initiating training in addictions and are incorporating harm reduction strategies into their policies and practices. Nonetheless, it remains to be seen if a full continuum of housing for dually diagnosed individuals will emerge.
- There is an inadequate supply of housing resources that have the high tolerance policies required to effectively house dually diagnosed individuals with a history of homelessness; those that do are difficult to access due to high demand.

Given these barriers, the outreach team concentrated on SRO’s and transitional housing as immediate options for individuals coming out of emergency shelters. The transitional programs are all relatively new (all instituted in 2001 or 2002), and include Lookout Emergency Aid Society’s Sakura-So and 5<sup>th</sup> and Yukon buildings, and Triage’s Princess Rooms. These programs were the most useful housing resources for the outreach team, as they were the only housing resources with on-site support that could be accessed in a timely manner (usually within one month of application). Seven of the program’s clients were living in one of these three transitional housing programs by the program’s completion. Note, however, that other than the transitional programs, not one outreach client was placed in mental health supported housing. And the challenge remains to find these individuals more permanent options, in particular to secure options at a time that is appropriate for the person’s stage of recovery and/or level of exposure to risk.

Given that the most likely housing option for an individual with a dual diagnosis leaving a shelter is a Downtown Eastside hotel, clearly these individuals are not being well served by the current housing system. A survey of the literature suggests that a housing system that could properly meet the diverse housing needs of chronically homeless dually diagnosed individuals would have the following characteristics:

- a) Timely access (Osher 1994).
- b) On-site or outreach support (Osher 1994), (Tsemberis 2000).
- c) Honour the housing choices and treatment choices of the consumer (Barrow 1991), including the choice to not link with treatment (Tsemberis 2000).
- d) Worker activities would be focused on the practical every day needs of the consumer first and clinical goals second (Barrow 1991), (Drake, Osher and Wallach 1991).
- e) Coordinated and integrated with case management and treatment services, while retaining the principles of consumer choice and minimal demand (Stein 1998).
- f) Contain a diversity of options (Lipton 2000), including:
  - a. Programs with varying levels of demands and structure, especially minimal demand programs (Barrow 1991).

- b. Transitional programs (Barrow 1991) (Lipton 2000).
- c. High tolerance programs (Osher and Dixon 1996).
- d. Supported Independent Living units (Russell 2000; Tsemberis 2000).
- e. Providing a rehabilitation and recovery focus (Ministry 2000).

While the housing system in Vancouver does have some of these characteristics, they are rarely combined together in ways that are effective for housing dually diagnosed homeless individuals. What is required, then, to provide an effective continuum of housing options for dually diagnosed homeless individuals, are shifts in policy (on multiple levels), improvement in inter-agency and inter-system coordination and integration, a sufficient number of housing units allocated specifically to individuals with a dual diagnosis, and housing programming dedicated to facilitating on-going stability and recovery for individuals with a dual diagnosis. Our specific recommendations revolve around four initiatives, some of which pertain to a permanent outreach team, and others which are independent of such a program being funded.

### Recommendations:

#### 1) SIL units for Dually Diagnosed Homeless Individuals

An outreach team working with dually diagnosed homeless individuals could have a number of SIL units to be allocated exclusively to its clients (Russell 2000; Tsemberis 2000; Ministry 2000). The funding could be permanent and on-going or be until a regular mental health SIL vacancy or other high quality housing option becomes available, or both. The advantages of this program would be:

- a) The outreach team would be able to offer the client housing at the time in their recovery when the client is most likely to succeed and benefit, or at a time when the individual needs a “risk management” housing intervention e.g. needs affordable housing outside the Downtown Eastside ASAP.
- b) Clients could be transferred between the Dual Diagnosis outreach team SILs, VCMHS’ SIL and Super SIL programs as required by changes in support needs without requiring a change of residence.

Alternatively, SILs dedicated to dually diagnosed clients could be funded independent of an ACT model outreach team.

#### 2) Work With Transitional Housing Providers to Ensure Access for Dually Diagnosed Homeless Individuals and a Diversity of Programming.

Research indicates that transitional housing can play a pivotal role in the continuum of supports and housing for dually diagnosed individuals by providing a mediated introduction to normalized conditions (Lipton 2000), and a mediated introduction and engagement with treatment processes (Barrow 1991). The outreach team found transitional housing the most useful housing option for their clients, especially when it was: a) immediate; b) a safe, affordable and supported environment; c) reinforced linkages with treatment and community resources; and d) offered a high tolerance environment for the challenging behaviours that are common when transitioning

from homelessness to stability. The interests of homeless dually diagnosed individuals could be furthered by:

- a) Ensuring that dually diagnosed clients are provided equitable access to transitional units.
- b) Ensuring at least one transitional housing program is high tolerance with a flexible structure that includes minimal demand options.
- c) Working with transitional housing providers in creating an integrated and coordinated response to the needs of dually diagnosed homeless individuals.
- d) Working with transitional housing providers and permanent housing providers to ensure transitional clients have timely access to permanent units.

### 3) Mental Health Residential Services Access Team

The system responsible for allocating mental health supported housing units has recently undergone fundamental changes, with Mental Health Residential Services' Access Team now responsible for the allocation of supported units. The interests of homeless dually diagnosed individuals could be furthered by:

- a) The creation of evidence-based substance use policies for VCHA's Mental Health Supported Housing system to ensure effective responses to the needs of dually diagnosed individuals.
- b) Allowing access to supported housing for individuals not linked to treatment. This would require the removal of Mental Health Residential Service's policy requiring that applicants must be linked with treatment to be eligible for housing. It is worth noting that MHRS's policy is contradicted by numerous studies which have found greater success via honouring consumer choice (Barrow 1991), noting that individuals are more likely to link with treatment once they have stabilised in housing (Tsemberis 2000).
- c) The creation of a dedicated priority placement stream for dually diagnosed individuals and individuals with a history of chronic homelessness within the Access Team's unit allocation rotation.
- d) VCHA addictions or dual diagnosis representation on the Access Team Implementation Committee and the Access Team weekly round table.

### 4) Hard to House / High Tolerance Programs

There are a number of hard to house programs in Vancouver, though almost all are congregated in the Downtown Eastside.

- a) A future outreach team could work with hard to house resources to ensure dually diagnosed individuals have appropriate access to hard to house units.
- b) More hard to house units located outside of Vancouver's Downtown Eastside are required.

## Conclusions

Given the outreach project's outcomes, rates of client satisfaction and the knowledge gained regarding working with this population, this project was a success on many levels. Better housing was found for almost all clients. The program's clients have more and better links with the community. Lifeskills were learned. Many barriers to stability were removed. The only limitation of the program was its duration—research indicates a minimum of two years is required for many dually diagnosed homeless individuals to stabilise and engage in treatment. Correspondingly, a number of the program's clients did not stabilise or did not fully engage with the program within the program's 6 month service delivery duration.

We learned that the ACT model provides a more effective framework for working with this population than do generalist outreach approaches. The intensity of involvement, consumer-oriented philosophies, and shared case management responsibilities are indispensable components of an effective, creative and stable service delivery.

We also learned that to be a person living in Vancouver with a mental illness, using substances and chronically homeless/at risk means that you are unlikely to get the help you need to make real changes in your life. There are no housing, outreach or treatment services targeted specifically to the intersection of mental health, substance use and homelessness, and those services that do serve individuals with these complex needs struggle to provide care using models of service delivery that are not designed for this population and thus are only sporadically effective.

Most significantly, however, the creation of an intensive outreach program will not, in and of itself, resolve the comprehensive array of barriers facing chronically homeless dually diagnosed individuals. An effective response requires the implementation and coordination of these three initiatives:

### 1) Intensive Outreach Programs

The individuals served by this program were linked with a range of treatment and community services yet remained chronically homeless and unstable. This indicates the need for case management services of a higher intensity than those currently available from mental health teams and other community based outreach teams.

### 2) Integrated Treatment for Mental Health and Substance Use.

While research on this population argues strongly for concurrent and integrated substance use and mental health treatment, only 4 of the program's 38 dually diagnosed clients were receiving concurrent treatment for both disorders. In Vancouver, then, homeless individuals with a mental illness and substance use issues rarely receive concurrent treatment for each of their disorders, and, equally significantly, even when an individual does link with treatment for each disorder, the treatment plans are, in our experience, neither integrated nor coordinated.

### 3) Continuum of Housing for Dually Diagnosed Homeless Individuals

Appropriate housing plays a large role in the stabilisation, quality of life and the initiation of treatment for homeless dually diagnosed individuals, yet not a single outreach client was able to access supported permanent housing. An effective continuum of housing for this population is essential.

More positively, this demonstration project made several contributions to Triage's organisational capacity. The training models taught to the workers in the outreach program are now being

integrated into a number of Triage's other programs. And many of the principles of care articulated in the ACT research and enacted in this outreach program are also being integrated into policy and practice in other program areas.

And finally, the tenacity and perseverance of the clients themselves deserves our recognition. Despite multiple challenges and facing a myriad of barriers every day, they continue to survive and live their lives the best they can. They do, however, deserve our help.

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