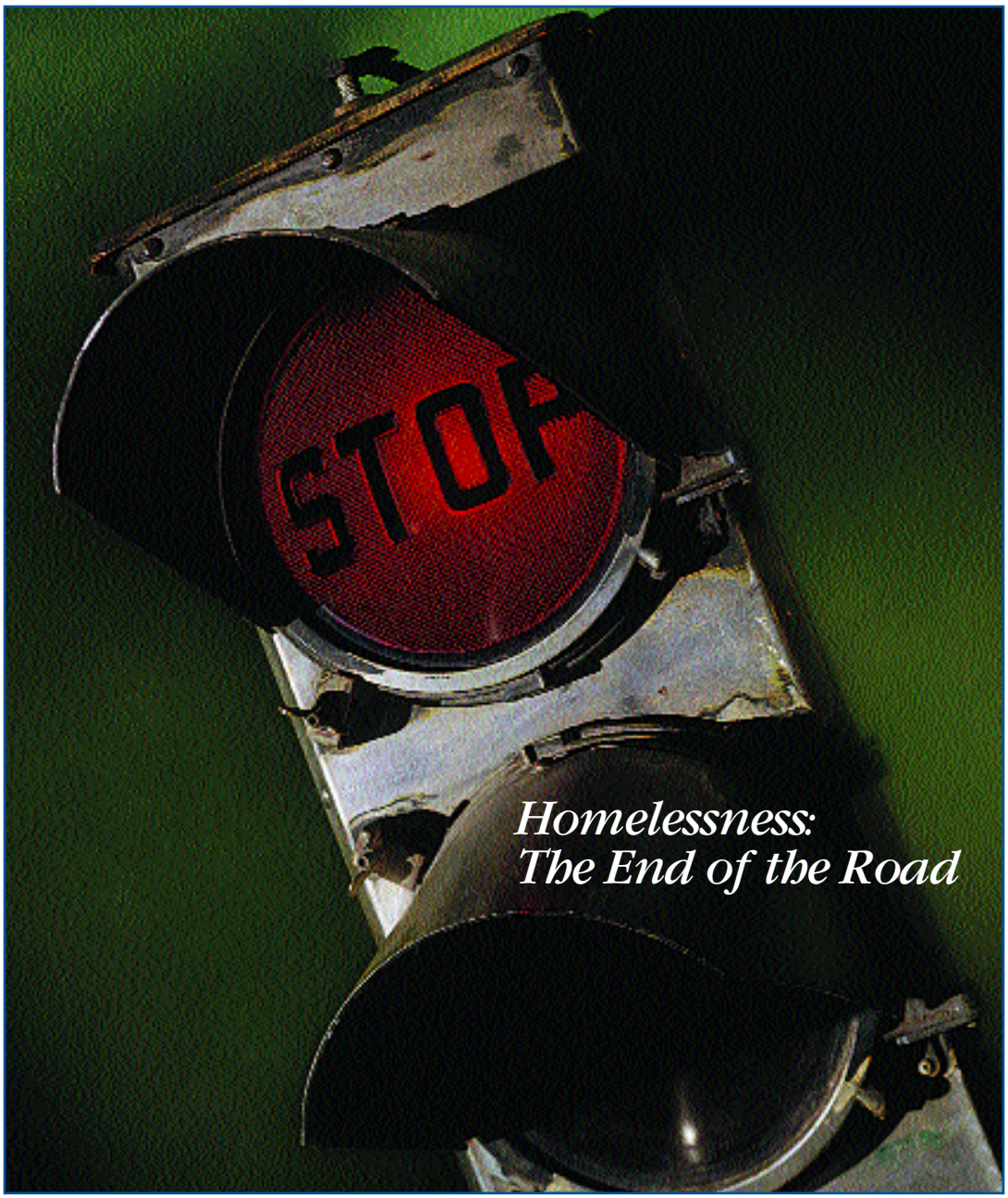
Network

VOL 14 NO. 3 FALL 1998



Homelessness: The End of the Road

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
Ontario Division/Division de l'Ontario

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Vol. 14 No. 3 Fall 1998

CANADIAN MENTAL HEALTH ASSOCIATION
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OUR MISSION:
To advocate with and provide programs and services for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

Network magazine is published 4 times each year by the Canadian Mental Health Association, Ontario Division, 180 Dundas Street West, Suite 2301, Toronto, Ontario M5G 1Z8.

Statements, opinions and viewpoints made or expressed by the writers do not necessarily represent the opinions and views of the Canadian Mental Health Association, Ontario Division or its Branch offices. Readers' views are welcomed and may be published in Network. Comments and views should be forwarded to the Communications Department, c/o Network magazine, at the above address, or:
Telephone (416) 977-5580/Fax (416) 977-2264
E-mail: cmhaon@ican.net

Printed in Canada ISSN 1181-7976

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Homelessness and Mental Health

GLENN R. THOMPSON
Executive Director

This issue of *Network* looks at homelessness – particularly as it relates to those who suffer from a mental illness. Two in-depth reports are presented: *Breaking the Cycle of Homelessness*, which is an interim report recently published by the Toronto Homelessness Action Task Force and *Pathways to Homelessness*, a project conducted over a period of 18 months in the City of Toronto, spearheaded by the Health Systems Research Unit at the Centre for Addictions and Mental Health. Although both of these reports include statistics gathered from the Toronto area, the problem of homelessness itself, and of the changing profile of the homeless population – specifically a greater prevalence of severe mental illness and substance abuse – is not unique to any one community in Canada.

In an interview conducted with Sheryl Lindsay, Program Manager of the Hostel Outreach Program in Toronto, she indicated that many of those who have serious mental health problems are not in shelters at all, they live out on the street. They have truly come to "the end of the road". Living on the street has become their "place" in our society. Yet being homeless will likely increase the duration and seriousness of their mental illness, and their mental illness increases the likelihood of longer periods of homelessness. It can be a tragic cycle from which there appears to be no escape, but solutions must be found.

IDENTIFYING THE BARRIERS

The Public Policy Committee (PPC) of the CMHA, Ontario Division has identified barriers to homelessness *(see page 9)* and in their Homelessness Task Force report have established the areas that need work to help break down these barriers. Some of these areas are the development of street outreach skill training for providers working with people who are homeless; the review of legislation concerning housing and social benefits to assess how they affect homelessness; and collaborating with the Ontario Hospital Association in developing a provincial policy and programme which would ensure that no person admitted for psychiatric care would be discharged from hospital without a housing plan. *(See pages 8 - 10 for a complete summary of the CMHA, Ontario Division position paper.)*

SOCIAL POLICY

Every year in Canada at least 4% of Canadian seniors living in private dwellings may be abused by family members or other intimates. (Statistics based upon a telephone survey conducted by Podnieks, Pillemer, Nicholson, Shillington, and Frizzel.) Fortunately, there is a rapidly growing awareness of this "hidden" abuse of older persons in our society and the need for prevention and intervention. On page 17 we carry an Executive Summary of the CMHA, Ontario Division's Position Paper respecting Mental Health Issues in the Abuse of Older Adults, which recognizes the need to increase awareness and action concerning this form of mistreatment. It presents one of the most formidable challenges for our mental health sector and our communities. In addition the Social Policy column presents an Executive Summary of the CMHA, Ontario Division Position Paper respecting Dual Diagnosis. While significant work has been done in the recognition and understanding of dual diagnosis during the last few years, much still remains to be accomplished. We believe that our position paper can help chart the journey.

THANK YOU FOR YOUR LETTERS

I want to thank our readers for sending in their feedback on topics we cover in *Network*. In this issue we publish two of the letters we recently received on the subject of Community Treatment Orders. Please continue to send us your comments to keep up the debate on these vital mental health issues.

HOMELESSNESS:

"Among the most seriously mentally ill are individuals struggling with feelings of paranoia, persecution and psychic malaise. For them, even the best of supervision, support and caring may be experienced as aversive to the point that walking away, into the streets, is necessary for survival. Homelessness may be the first and only arena in which they feel a sense of efficacy and mastery. Understanding this melding of illness and adaptation is necessary to appreciate that needs beyond shelter, work and income must be addressed in finding a solution to homelessness." *

For some of those who suffer from mental disorders, the street becomes their final refuge – their only "choice" in gaining control over their lives. A lack of affordable housing and adequate shelter, combined with overcrowding in the shelter system, may have a significant impact on persons with mental health problems. The stability and security of a home is important to everyone, and for persons with mental health problems control over their environment is especially important, as it has been shown that satisfaction with housing is correlated with an increased ability to cope in the community. This cannot happen when the only option for shelter is overcrowded emergency hostels or hotel rooms.

Homelessness is not a major cause of mental illness, but being homeless will likely increase the duration and seriousness of a mental illness, and mental illness increases the likelihood of longer periods of homelessness. It's a vicious cycle which once entered into can seem impossible to break. In the words of Sheryl Lindsay, a social worker with the Women's Hostel Outreach Program, "Those of us working on the front-line with homeless people, regardless of the capacity or focus of that work, have identified, and been attempting to address the fact, that we are in a crisis situation....." The following articles address that "crisis situation".

*Backlar, P. (1994) The Family Face of Schizophrenia, pp.126-144, G.P. Putnam's Sons, New York. Commentary to Slipping through the cracks: Failure of the Mental Health System. Marsha Martin, p.133.

THE END OF THE ROAD

PHOTO: TORONTO STAR

The End of The Road

The following interview was conducted with Sheryl Lindsay, Program Manager of the Hostel Outreach Program in Toronto.

At a workshop of the Mental Health Policy Research Group one of the participants made the following statement: "I am a consumer survivor, I am active in the area, and furthermore I am a mental health worker. For me it is not important what my "diagnosis" is but that I do the best I can with my life. However, I have seen shelters, and if I ever became homeless, I would suicide rather than go there." That's a pretty strong statement. As someone who is working in the field, what's your reaction to that?

SHERYL LINDSAY: Hostels were meant to be temporary shelters for people who were in a housing crisis, but because there is not enough housing people have come to rely on them as permanent housing – something they were never intended to be. The lack of housing – both availability and accessibility – has been of great concern to workers for the ten years that I have worked in this field. A shelter is not a permanent address, it's not somebody's home, and you have all the problems that go along with that: crowded conditions, a mix of people, a range of ages, and a range of issues.

One question that has caused quite a bit of debate is whether or not we have a high incidence of homeless people suffering from schizophrenia. The Pathways to Homelessness study conducted by the Centre for Addiction and Mental Health appears to de-emphasize this. Only 6% of their study sample had been in a psychiatric in-patient unit in the year preceding the interview, and the overwhelming mental illness most reported was depression.

SHERYL LINDSAY: I think the whole issue of the numbers and who is out there is highly controversial and very complicated in that of course someone's mental health is obviously affected, adversely, by being homeless. There's just no way around that. But it needs to be put into the context of people's situations. My experience is that it really depends on the hostel. There are certain shelters that will have a higher number of people who have what is labelled as schizophrenia. And that may be for a number of reasons. For instance many shelters have a practice of barring people who have disruptive behaviour, and so there are a couple of shelters, particularly the Metro run ones, that end up with probably a disproportionate number of people that have serious mental health issues. But I believe that this is a small portion of the overall homeless population. The difficulty is that their options are severely limited in terms of what kind of housing they can access, and of course over the last couple of years, with even less housing available, it makes their situation even more desperate. So if you walked into a shelter that was over-represented in terms of people who have multiple issues to deal with it might look as if everyone in shelters has serious mental health issues, but in another shelter you might see a much more representative view of who is out there. One of the problems of course with the shelter system is that it segregates the different stratas of our society: there are youth shelters, singles, single mothers, etc. I think that the people who do have schizophrenia and are homeless are really in high need, and in fact many of those who have serious mental health problems are not in the shelters at all, they live out on the street.

Why do some people prefer to live on the street and not go to a hostel?

SHERYL LINDSAY: I don't mean to make it too simplistic, but my experience has been that some people are too frightened to be in a shelter. They feel so withdrawn that whatever is going on for them internally makes it (the shelter) a very frightening place to be. There are too many people, too much noise, too many rules and regulations. And then there is another group of people who have been barred from so many shelters that they just think 'I'm not going to put

up with all the rules and regulations. It's too intrusive and I don't want to go through an intake interview where I have to have my possessions searched'. When people go from hostel to hostel they get known, and so certain people get characterized as being difficult. The only option left to them is to stay out on the street. It's not a choice: it's really that for them there is no other option. And so the street becomes the end of the road.

Do you see a high incidence of substance abuse related problems?

SHERYL LINDSAY: There are a proportion of the women I work with who also have substance abuse issues. I think this happens a lot after people become homeless; it becomes a way to cope with a really horrible situation and if street drugs or alcohol are available and people are feeling pretty hopeless about their situation they may decide to make use of them. But I wouldn't say that with the group of people I work with it is a huge issue. The mental health issue is a much more prominent issue. The majority of the people that we are working with have had some contact with the psychiatric system prior to becoming homeless.

What is the fundamental issue that has to be addressed? Is it finding homes, or accessing treatment?

SHERYL LINDSAY: The way our organization has always operated is that because we are not a medical or treatment based program, that is not a focus for us. If somebody is interested in treatment, we will help them to access that and refer them to services, but most people aren't interested because they've had past experiences with the mental health system that have not been good. And because they are not interested they are deemed non-compliant and so no-one is working with them. It's a vicious cycle. We come from a completely different tangent – we say that we don't require that they accept treatment to get help from us in finding housing. Basically what we offer is some initial support. We'll help people to get their basic needs met. For instance most people no longer have their identification papers, they've either been lost or stolen or misplaced at some point in time. They might not have appropriate clothing, they may have been disconnected from social assistance and need to be reconnected with general welfare, family benefits, etc. These things become the main focal points for us while we are trying to get to know the person and what their story is – how they ended up on the street or in the hostel. One of the studies that the Clarke did of our program showed that people's symptoms were reduced just through having a supportive relationship and stable housing. So that's been the premise that we work from: to build relationships and then find housing.

"When people go round from hostel to hostel they get known, and so certain people get characterized as being difficult. The only option left to them is to stay out on the street. It's not a choice: it's really that for them there is no other option. And so the street becomes the end of the road."

What percentage of people do you see getting out of this spiral of living on the street, living in shelters, and getting into more stable, long-term housing?

SHERYL LINDSAY: In terms of our program I think we've had a fairly good success rate in helping people get out of the hostel or off the street and into more permanent housing. The primary issue that's always existed, and which has become worse since the moratorium on building social housing over the last couple of years, is that there has been less and less housing stock.

Is your client base expanding?

SHERYL LINDSAY: Yes, and I think the worrisome thing is that the eviction rates have gone up in the last couple of years and what we are seeing now is more people being evicted for socio-economic reasons. That has always been a reason of course, but because of the 21% cut in welfare and benefits we are seeing more and more people affected. And again this is a mix of people with and without mental health issues, it goes right across the board. It's an overwhelming problem and unless we see more housing being built the problem for the homeless can only get worse.

CMHA, Ontario Division, Homelessness Task Force

It is obvious to even the most casual onlooker that among citizens who are homeless, there are a number who suffer from manifest mental disorders – this is the particular concern of the CMHA, Ontario Division. The Public Policy Committee (PPC) of the CMHA, Ontario Division Board of Directors approved the topic of homelessness for the development of policy recommendations in September 1996. The following is a summary of the position paper developed by the Homelessness Task Force of the PPC.

Among citizens who are homeless, there are a number who suffer from multiple mental disorders – and this is the particular concern of the CMHA, Ontario Division. For some of these citizens, support and caring may feel so aversive that living on the streets becomes the only "choice" in gaining control over their lives. However, the issue of serious mental illness in people who are homeless is usually just one part of a greater set of inter-connected events which push some of our fellow citizens into homelessness. There are a number of suggested "causes" of homelessness: some are universal in that they impact on every citizen and have operated for a number of years; other causes are unique to the individual. These universal and individual factors interact in varied combinations, creating a continuum of homelessness in which each person requires unique kinds of assistance to find their pathway out of homelessness. In general, however, there is a need for further research to determine the causes of both urban and rural homelessness in Canada, and, in particular, in Ontario.

The CMHA, Ontario Division has approved the following position statements:

RESEARCH

1 The CMHA, Ontario Division, through such avenues as the Mental Health Research Consortium (a group consisting of the Clarke Institute of Psychiatry, the Ontario Mental Health Foundation, and the CMHA, Ontario Division) should advocate for further research into the causes of both urban and rural homelessness in Ontario, and best practice models to support people who are homeless and have a mental illness.

GOVERNMENT LEGISLATION/POLICES

1 All current legislation concerning housing and social benefits should be reviewed by the CMHA, Ontario Division to assess how it impinges upon the issue of homelessness. Potential advocacy efforts should focus on changing aspects of legislation and/or policy which have a negative impact. All new government initiatives should also be reviewed to project the impact on homelessness, and changes advocated for, if necessary.

2 The CMHA, Ontario Division should examine innovative models for involving people who are homeless in the planning and building of their housing, and the ways in which this housing development is hindered by the remaining provincial and new and existing municipal, policies and regulations. The organization should consider the changes needed to the municipal and provincial governments' policies and regulations to make this development possible.

3 The CMHA, Ontario Division should review the provincial and municipal governments' decision to cease the development of non-profit housing. The organization should advocate for the following to the provincial government, as methods of investing in its citizens, and as a means of reducing health care costs, social assistance funding, and shelter costs:

➤ continued funding of existing social housing stock;

➤ provincial standards for social housing; and

➤ a shelter allowance system to use in the private sector.

INCREASED ACCESS TO HOUSING AND SUPPORTS

1 Agencies should aim to offer individualized and flexible supports to people who are homeless, including specific populations that are less inclined to access formal health care services, such as people with a serious mental illness, youth, Native Canadians, and ethnoracial groups.

2 The CMHA, Ontario Division should recommend developing local comprehensive inventories of resources that provide housing and/or support to people who are homeless, and developing strategies to address the identified gaps in prevention and intervention services. A user-friendly information system regarding resources for people who are homeless and how to access these resources should be available to help in negotiating "the system".

3 The CMHA, Ontario Division should develop linkages with other provincial organizations addressing homelessness, such as the Ontario Hostel Association, the Ontario Non-Profit Housing Association, the Ontario Association for Community Living, the Ontario Association of Interval and Transition Houses, the Ontario Brain

IDENTIFYING THE BARRIERS

Once an individual becomes homeless, a vicious process may be set in motion which, if it persists, decreases the chance that the cycle can be reversed. Many people can at first drift in and out of "normal" society. One night may be spent with a friend, the next in a shelter, the next in a hospital emergency room, and the next on the street. But to be homeless puts one at risk for dropping out of the "system" so that getting anywhere near what might be considered "regular" channels for accessing health care, receiving mail and keeping up a social network, becomes more and more difficult.

The following list of barriers, although not intended to be exhaustive, have been identified by the Task Force:

➤ inadequate supports for people with serious mental illness and many other complex difficulties from health/social service providers to find, obtain, and maintain their housing due to funding cuts;

➤ physical and mental health services that are often only accessible during a "crisis";

➤ lack of income for necessities such as: food, adequate clothing, medication, housing, and access to facilities and products for personal hygiene;

➤ few social supports from friends and family members;

➤ addiction to substances (e.g., crack cocaine, alcohol);

➤ inability to obtain stable employment due to structural economic changes, discrimination by employers, uncontrollable living arrangements, hygiene/clothing suitable for an interview, lack of education and skills;

➤ distrust of potential helpers due to past negative experiences with those in "authority", including health care providers;

➤ development of skills and behaviours adaptive only to living on the streets (e.g. talking out loud to deter crime) that are not acceptable social skills and behaviours;

➤ loss of papers (usually due to theft) required by social assistance workers, election officials, health providers, landlords, employers, etc. for identification;

➤ lack of a base for receiving calls or mail from informal supports, social and health service providers, potential employers, and landlords;

➤ lack of money for both first and last month's rent;

➤ inability to navigate the complex social security system;

➤ illiteracy.

CMHA, Ontario Division, HOMELESSNESS TASK FORCE

Injury Association, the Ontario Coalition Against Poverty, and the Ontario Federation of Community Mental Health and Addiction Programs to identify common concerns regarding homelessness, and to address these concerns through joint advocacy, public education, health promotion, policy development, etc., whenever possible.

4 The CMHA, Ontario Division should collaborate in the development of community coalitions consisting of citizens who are homeless and their family members, interested service organizations, businesses, housing providers, shelters, health and social service providers, faith communities and unions, to find local ways to address the needs of people who are homeless and have a mental illness.

5 The CMHA, Ontario Division should collaborate with the Ontario Hospital Association to develop a provincial policy binding on the attending physician stating that no person admitted for a psychiatric illness should be discharged from hospital without a housing plan to which the person has agreed. The CMHA, Ontario Division should retain non-identifying information on the characteristics of successful and unsuccessful implementation plans for the purpose of future systemic planning.

REVISING TERMINOLOGY

1 The CMHA, Ontario Division material which addresses homelessness should use the terms "citizens/people/individuals who are homeless", not "homeless people/the homeless".

STAFF TRAINING

1 The CMHA, Ontario Division should promote education regarding mental illness through mandatory training about mental illness for all workers who may come in contact with citizens who are homeless (for example those who work in shelters, emergency room nurses and physicians) to assist them in providing appropriate supports.

2 The CMHA, Ontario Division should advocate for the development of street outreach skills, such as trust-building and engagement, by any provider working with people who are homeless.

3 The CMHA, Ontario Division should support the cooperation and appropriate sharing, within the framework of government privacy legislation and CMHA, Ontario Division policies, of information and resources among agencies, hospital workers, shelters, psychiatrists, consumers and family members. Working with people who are homeless requires a variety of skills and information, and exchange of knowledge and data between agencies and workers is essential for effective service delivery.

> ***"I don't know why people find it surprising that homeless people are broken down and tired, and not always polite, friendly and articulate. Socially isolated people should not be assumed to be unable to analyze their own situations. There has been an attitude that homeless people are social problems and are unable to participate in solutions....There is a message from researchers that the only way to hear from homeless people is in a study where their knowledge is presented through anonymous, case examples."***
>
> Conference Participant at the Workshop of the Mental Health Policy Research Group

INCOME OPPORTUNITIES

1 The CMHA, Ontario Division should promote to all levels of government the development of mechanisms that encourage employers to provide training and employment for people who are seeking a pathway out of homelessness. The organization should also examine local community development initiatives and accommodation in the workplace for people with serious mental illness with a history of homelessness.

RE-ESTABLISHING AN IDENTITY

1 The CMHA, Ontario Division should promote increased accessibility to mail boxes, lockers, shower, laundry and eating facilities, and telephone message systems for citizens who are homeless.

2 The CMHA, Ontario Division should encourage the development of a simple system for people who are homeless to recover their lost or stolen identification papers.

A CHANGING PROFILE

The increase in severe mental illness within the homeless population

Breaking The Cycle of Homelessness, an interim report, prepared by the Toronto Homelessness Action Task Force, Chair Anne Golden, contains new data from eight research reports that provide an integrated and complete picture of homelessness. Included are the results of a longitudinal study of hostel use over nine years, the first analysis of its kind in Canada. Other research topics include poverty trends in Toronto; the supply of affordable housing; mental health and addictions; and evictions.

THE DATA

- 26,000 different people used the hostel system in 1996.
- 5,300 of them were children.
- Families and youth are the fastest growing part of the homeless population.
- About 4,400 people (17%) are chronic users who stay in the hostel system for a year or more on average, but this group uses about 46% of the resources – on any given night they occupy almost half of the beds.
- 75% of those using the hostel system are depending on it as a medium-term or quasi-permanent form of housing because there is an inadequate supply of affordable and supportive housing.
- 47% of shelter users come from outside Toronto, including 14% who come from outside the country. 80,000 people in Toronto are at risk of losing their housing.

POVERTY

- 1 in 4 families in Toronto live in poverty.
- For single female parents under 25 the poverty rate was 83%.
- Average incomes in Toronto fell by 12.5% from 1990 – 1995, the biggest decline in incomes in the province.
- Renters' incomes fell by 12.4%.
- More than 33% of renters live below the poverty line.
- Evictions are on the rise – those executed by the Sheriff's office have risen 78% over a 5-year period.

HOUSING SUPPLY

- There are 37,000 eligible applicants on the waiting list for affordable housing alone.
- 4,000 new affordable units are needed each year: 2,000 to meet the growth in demand and an additional 2,000 units to begin to make a dent in existing waiting lists.
- Non-profit and supportive housing can be more cost-effective than shelters and other forms of institutional housing, but it is uneconomic for the private sector to build new housing without government support.
- Current government policy is moving in the opposite direction of what's needed, both in terms of income support and supply.

MENTAL HEALTH

We have seen some marked changes in the homeless population in North America in the past two decades – specifically a greater prevalence of severe mental illness and the presence of concurrent substance abuse. There is broad agreement that at least 33% of the homeless have a mental illness, and a large number of this group have a substance abuse disorder.

The problems can vary by gender and age group. Hostel operators report that about 33% of single men in the hostels suffer from mental illness, and as many as 75% of single women do. Older people tend to have a higher rate of alcohol addiction, whereas, young people are more likely to be addicted to street drugs.

This changing profile of the homeless population goes back to the deinstitutionalization (and non-institutionalization) of psychiatric patients since the 1960s, combined with the failure to provide the required community alternatives and the lack of affordable housing. In the past year, 59 in-patients were discharged from Queen Street Mental Health Centre to a hostel or no fixed address – a practice which needs to change.

"A homeless prevention strategy must recognize that homeless people are not a homogenous group... A focus on prevention will require developing policies for the at-risk population and ensuring that affordable housing supply and adequate support services are available so that people aren't forced to substitute a hostel bed for a real bed."

ANNE GOLDEN
CHAIR
HOMELESSNESS ACTION TASK FORCE
TORONTO

PATHWAYS TO HOMELESSNESS

The Pathways Project, which was conducted over a period of 18 months in the City of Toronto, was spearheaded by the Health Systems Research Unit at the Centre for Addiction and Mental Health, and included researchers from Wellesley Hospital.

The project objectives were to:

1. Estimate the prevalence of mental illness among people who are homeless.
2. Describe pathways into homelessness.
3. Identify policy areas for reform.

All 300 people in the study sample participated in a two hour interview, which gathered socio-demographic and diagnostic data. An in depth, qualitative examination of individual pathways into homelessness, (defined in this study as people who were without housing for 7-8 nights or more in the prior month, and who also had no prospect of housing in the next month) from the perspective of the study participants, was conducted with 29 of those 300 people. Two supplementary studies were also conducted, one examining neuropsychological and personality factors, and the other looking at HIV prevalence among homeless people.

Four pathways to homelessness were identified:

1. HAVING A RELAPSE OF A PSYCHIATRIC ILLNESS

There is a relatively small group of people who are on the streets as a direct result of having a relapse of a psychiatric illness, with the symptoms themselves playing a major role as a precipitant. The individuals in this group do not have good social supports, often due to their illness and how it has affected their lives. Their symptomatology (particularly paranoia) precipitates disruptions in relationships, which then contribute to a lack of supports and homelessness.

Jessica, a middle aged woman, divorced with no children has a history of manic depression. For 10 years she lived almost as a member of the family with people who rented her a room in their house, but when she had a relapse, became depressed and then suicidal they asked her to leave. She also lost her job because of her relapse. "I became ill. I guess I was a burden to the people I was living with, and they just didn't

"Our findings have produced information that flies in the face of a lot of the conventional thinking in the mental health field about the causes of homelessness. I want to emphasize that the findings about mental illness in our study, if anything, tend to de-emphasize its importance as a contributor to homelessness."

DR. D. WASYLENKI
PSYCHIATRIST-IN-CHIEF, ST. MICHAEL'S HOSPITAL

THE FINDINGS

Two-thirds of the homeless population have a lifetime diagnosis of mental illness. This is 2-3 times the prevalence rate of the general population. Understandably, given the circumstances, depression is the mental illness most often reported. A sub-sample (29%) met the criteria for anti-social personality disorder, often in addition to a diagnosis of psychotic disorder, depression, or post-traumatic stress disorder. About 25% of the sample had received psychiatric outpatient services in the year leading up to the interview, and less than 20% had received any kind of services for substance abuse problems.

Only 6% of the study sample had been in a psychiatric in-patient unit in the year preceding the interview. The idea that large numbers of people are being discharged from psychiatric inpatient units and comprising a significant proportion of the homeless population in Metro Toronto is not supported by the data collected in this study. About 50% of

want to take care of me anymore and they evicted me. I got fired when I got sick. I'm only mean when I'm sick, I'm really sarcastic but that's part of the illness. I suspect everybody, I don't believe that anyone is a friend of mine and I get suspicious."

2. PREVIOUSLY WELL

Individuals in this group had reasonably stable lives prior to becoming homeless. Many also had a strong sense of independence, self confidence and pride which sometimes made it difficult for them to seek help when it was crucially needed. Often there was a serious communication problem between the individual and the welfare system which prevented them from being assisted in finding a place to live. The major issue was finding work, and sometimes the breakdown of relationships. The overwhelming feeling seemed to be that everything had been going smoothly in their life and then "the bottom dropped out".

Dave describes himself as always being in "good mental health" until a series of events that culminated in him ending up in a shelter. His business started to go downhill at the same time that he developed a kidney problem. He mortgaged his home to try to finance his ailing company, and ended up losing both the business and his house. Dave tried to provide for his family by visiting foodbanks and looking for work. His marriage began to deteriorate, and he described himself and his wife as always quarreling. He finally chose to leave his family because he decided they would be better off without him and would have more chance of getting emergency assistance if there was just a mother and children. He felt that nobody wanted to help him even though he had tried to seek assistance. "I lost every inch of pride that I had. I need to talk to somebody, I need some help, some guidance, so that I can get my focus and strength back."

3. YOUNG ADULTS IN TRANSITION

These individuals spoke of the difficulties in separating from their families and becoming independent adults. Many had troubled family backgrounds, including abusive situations. In leaving home and coming to a new city they needed to establish new relationships, find housing and work, and there were many circumstances where that didn't work out. When faced with becoming homeless, there was reactive depression at being unsuccessful in making a new start.

When Jennifer was three years old her baby sister died. "From that day forward my father ignored me.

"I hope that one of the accomplishments of our study is to shift the focus away from this emphasis on mental illness as a cause of homelessness, and to keep it focused on the more fundamental issues... I think the challenge to the mental health system is to figure out ways to help people in the community, which is where most of us want to be."
DR. D. WASYLENKI
PSYCHIATRIST-IN-CHIEF, ST. MICHAEL'S HOSPITAL

the people who had been in inpatient units had found this experience to be unsatisfactory, which brings into question the creation of more beds in psychiatric facilities as part of the solution.
Only 3% of those interviewed said they lost their housing because of mental illness.
Substance abuse (alcohol, marijuana and cocaine in particular) is a major problem in this population. When prevalence rates of substance abuse are added to prevalence rates of mental illness the overall prevalence rate rises to 86%. Only 14% of the study sample had no diagnosis of either mental illness or substance abuse. The prevalence rate of alcohol and substance abuse is almost identical to the prevalence rate of mental illness; roughly two thirds of the entire homeless population. This is 4-5 times the prevalence rate in the general population. Almost everyone with a lifetime diagnosis of mental illness also had a diagnosis of substance abuse. Three quarters of the people in every diagnostic category of mental illness also had substance abuse disorders. In contrast to mental illness, about 20% of the study sample identified substance abuse as the primary reason for loss of housing, and it was found to be an important perpetuating factor in maintaining homelessness.

PATHWAYS TO HOMELESSNESS

Treated me like I didn't exist. It was very hard to rationalize why, if I didn't do anything bad, my dad didn't love me anymore." She felt responsible for her sister's death. Now in her mid-twenties, Jennifer moved to Toronto and although she was able to find jobs she was unable to stay employed, and believes that was related to the depression, or dysthymia, she had experienced over much of her life, connected to the problems with her relationship to her father. "I find it very hard to keep a job. I work for a couple of months and then I just don't want to do it anymore. As soon as there's anything I don't like that I have to put up with, I'm out of there."

4. VULNERABLE GROUP

People in this group experienced parental alcoholism or abuse in childhood. Their pathway started with an unstable beginning, and then a rapid accumulation of events that overwhelmed their ability to cope.

Both Danny's parents were alcoholic and his father regularly beat his mother. When Danny was 7 his father died of alcoholism and Danny was then required to assume a parental role, responsible for taking care of his physically disabled brother. The main precipitant for Danny was the death of his mother, who had constituted his support system. "Right now it's very hard. She's gone, and there's no phoning and saying, Mom, can we have some help." The other precipitant was a one-time cocaine binge which seemed to be connected to the loss of his mother rather than a substance abuse problem.

The kind of interventions that would be of assistance to the people representing these four pathways to homeless must be multi-faceted – there is no one solution or approach that can address this problem.

Severely Mentally Ill: These individuals, to be able to manage their illness and maintain housing, must have personal support. This involves case management and assertive community treatment. More work must be done on discharge planning, and the interface between hospitals and shelters. There also needs to be a wider range of housing where they can live and be supported.

Previously Well: Intervention must include crisis intervention, which includes access to someone who can help them problem solve and find the resources they need. At issue is our general welfare assistance system, where workers are overworked and stressed, and their ability to counsel or recognize when someone is not getting the information they need is severely taxed. Employment opportunities and affordable housing are also critical. In addition to job opportunities, skill development opportunities are needed in some situations, to help people better access available employment.

Young Adults: Intervention must take place at an earlier stage in childhood and adolescence. Family counseling would probably be an appropriate intervention for people who lose contact with their parents or other supports because of unresolved conflicts. Individual psychotherapy may be helpful. Peer support is potentially valuable intervention. Affordable housing is critical.

The Vulnerable: Early primary intervention is critical. Some individuals may benefit from psychotherapy. Employment opportunities, skills development, tenant advocacy and affordable housing must be part of the response. Intervention must consider individual and personal issues.

"This research project had three objectives, one of which was to look at the prevalence of mental illness in Metro Toronto's homeless population. The Centre for Addiction and Mental Health is interested in mental illness as a possible issue for homeless people. The public is also interested in this issue, because mental illness and homelessness are commonly associated with each other. We certainly know that it is not the only important focus...mental illness and its influence as a factor in homelessness has been exaggerated... mental illness is just one part of the picture."

DR. PAULA GOERING
DIRECTOR, HEALTH SYSTEMS RESEARCH UNIT, CENTRE FOR ADDICTION AND MENTAL HEALTH

Ministry of Health Perspective

The following is an edited version of a speech given by Margaret Gallow, Regional Director- Mental Health areas, Ministry of Health, at a workshop conducted by the Mental Health Policy Research Group (CMHA, Ontario Division, Clarke Institute of Psychiatry and the Ontario Mental Health Foundation). The intent of the workshop was to discuss the Mental Illness and Pathways into Homelessness Project, its findings and implications, and to give the project research team a chance to receive input, answer questions, and respond to concerns.

As the Pathways into Homelessness study points out, mental illness is only one of a number of serious risk factors for the homeless. 86% of those surveyed had experienced some mental disorder or illness or problem, and/or some sort of substance abuse at some point in their lives, compared to just 32% of the general population. 11% had serious psychotic problems or disorders, with that 11% using up a fair share of our resources. 38% had mood disorders, predominantly major depression. When I look at the outcome of the research, it is certainly easy to see how, in this day and age, depression could contribute to a fair amount of the reasons why people find themselves in this situation.

The interesting thing was the number of people surveyed who had little or no involvement with the Provincial Psychiatric Hospital system, which is really where our money is today – not just in Provincial Psychiatric Hospitals, but in beds. The Ministry of Health currently spends $2.4 billion dollars, or just 14% of our total budget, on mental illness. But among other Ministries, $1.2 billion is spent on things like drugs and general welfare.

The questions to be asked by all of us are:

1. Is it enough money?
2. Do we spend it on the right people at the right time and in the right way?
3. Do the current policies support the need for change?

In 1993 the Ministry of Health announced *Putting People First*, a reform document spanning ten years, to reform the system from an inpatient to an outpatient system of care. In October 1995, the Mental Health Reform Workgroup on Homelessness, Social Isolation and Mental Health Reform completed a document entitled *Meeting the Needs*. As a result of that work the Ministry developed a policy guideline to give direction for planning mental health services and supports, and to improve access to these by mental health consumers who are homeless.

This policy guideline must now be reviewed in light of this recent study. Do our reform initiatives provide outreach services that meet the needs identified in this study such as the need for personal support and safe and secure shelter?

> ***"What is happening on our streets today is shameful...There are no cookie cutter solutions. Everything we do is predicated on the belief that safe, affordable housing is a right, and we should work to make it real."***
> Former Mayor of Toronto Barbara Hall

The mental health system needs to implement proven intensive outreach, to help those with chronic mental illness who are not comfortable with conventional services.

There are many barriers that prevent homeless or socially isolated people from receiving the necessary service and support, including lack of access to and availability of supports and services; the current structure of services and approaches to service delivery that do not meet the needs of people who are homeless; and an absence of linkages and coordination among service providers. Access to services and supports can be improved when case management, crisis response and supportive housing programs offer assertive outreach to people who are homeless and socially isolated. This means that such programs must have the capacity to provide service and support to people where they are located: on the street, in a hostel, or at a drop-in centre. In essence all of these efforts are designed to facilitate the means by which such programs provide service and support to people, regardless of where they are located.

Since the distribution of the homelessness policy guidelines in 1996 the mental health area of the Ministry has received a number of proposals from various mental health and community agencies, and two emerging themes or areas of need have

MINISTRY OF HEALTH PERSPECTIVE

been identified. First are individual supports or case management to hostels, shelters and drop-ins, and second are specialized mobile clinical teams. The $23.5 million Community Investment Fund strategy serves to mainly enhance services for people with serious mental illness. Of this approximately $5.6 million has been dedicated to case management proposals, which include supports to housing. The Ministry of Health and the Mental Health Unit currently fund 17 programs at approximately $3.5 million in annualized funding, specifically for the homeless and the hard to house population. Of these, nine programs are located in Metro Toronto. There is never enough money, it only scratches the surface, but that doesn't mean we shouldn't move forward in a positive way in maximizing the use of those resources in the most effective and efficient way possible.

It is hard not to talk about supportive housing when we talk about our hostel system, and our supports to the homeless population. We do fund, through mental health programs and services, a variety of supports for housing programs for individuals with a severe mental illness. The Ministry of Health budget for the support services is about $18.5 million, with housing providing almost $16 million in accommodation subsides. As of January 1, 1998 the Ministry of Municipal Affairs and Housing will be getting out of the housing business. The social housing portfolio being devolved is a done deal. However, the government is committed to looking at supportive housing for those clients with special needs somewhat separately, given the vulnerability of this client group. Those of us in the supportive housing business must look at this change in housing direction as an opportunity to develop more forward thinking policies and also better ways to develop actual housing stock.

As Ontario continues the process of reforming mental health services, it is critical that the needs of those who are homeless or socially isolated, and dealing with a severe mental illness or a mental health problem, be considered and included in both planning activities and service delivery. The province's Mental Health Reform Strategy must address the needs of these individuals and ameliorate, not exacerbate the problem of homelessness. Simply focusing on one aspect such as the mental health system alone, will not be sufficient. Preventing homelessness among adults begins in early childhood with improved early identification, treatment, and follow up to childhood abuse. Equally important are income supports, employment, and retraining opportunities and first and foremost, affordable housing.

The study indeed points to the fact that mental illness is a contributing factor to this problem, but that it is actually fundamental deficiencies in our social fabric that form the basis for homelessness. Change is needed. the question is, what can you and I do to influence that change? How do we work together in a creative way, to meet the needs of this population within the framework of government policy?

It will take careful collaboration between Ministries, and partnerships with the federal and municipal governments, service providers and consumers, if the answers to the problem we are dealing with are to be found.

"A striking change in homelessness policy for Toronto will not happen on the local, municipal level. The new Megacity will, if anything, decrease the possibility of effecting a dramatic policy change, because Mega Toronto has an increased centralization of power, therefore decreased possibilities for political entrepreneurship. Homelessness policy is likely to continue to evolve incrementally at the Metro level. For non-incremental policy change, you must go to the provincial or federal level: to effect change in a centralized system, you must grab the centre of power. The centre of power in Canada is not at the local level, but at the provincial and federal levels. If the current policies of provincial or federal governments become discredited, a window of opportunity (such as an election) will open up to effect non-incremental change. Only a change at the provincial or federal level will allow for that kind of policy shift."

DR. THOMAS MAIN, BARAUCH COLLEGE, NEW YORK CITY, NEW YORK

Mental Health Issues in the Abuse of Older Adults and Dual Diagnosis

CMHA, Ontario Division's Position Paper respecting Mental Health Issues in the Abuse of Older Adults - Executive Summary. Chair: Tunde Szathmary, Member Public Policy Committee.

We take for granted our right to freedom from harm. Yet every year in Canada at least 4% of Canadian seniors living in private dwellings are abused by family members or other intimates. This translates into approximately 98,000 older adults across the country. Unfortunately, this abuse does not happen solely at home. Institutional abuse of older adults, including mistreatment perpetrated by staff, other patients, or visitors in nursing homes and other care facilities also occurs. A recent study of 31 nursing homes found that 36% of nursing home staff had witnessed the physical abuse of an older adult in the preceding year and that 81% had witnessed psychological abuse. The proportion of the population who are 65 years of age and older is growing which means that the number of older persons who experience abuse will, in all likelihood, also rise in the years to come. Clearly there is a great need for us to recognize and address the abuse of older persons in our society.

In the fall of 1996, a Task Force on Psychogeriatric Issues was struck by the CMHA, Ontario Division's Public Policy Committee to further study the issues surrounding older persons with mental health problems. One of the policy recommendations with respect to psychogeriatrics was the need to examine the issues surrounding elder abuse together with societal views on ageing - the deep and profound prejudice against the elderly, which has been identified as one cause of the abuse of older adults and a factor in the creation of situations in which abuse is more likely to occur. In response to this recommendation, a Task Force on Elder Abuse was struck in the fall of 1997.

As an organization we must prepare ourselves and others in the mental health field to deal with the systemic mental health implications involved in the abuse of older persons. The Elder Abuse Task Force identified three overriding systemic concerns in relation to mental health and elder abuse. Of particular importance is the common and pervasive belief that abusers are mentally ill. This borders on stigma and as such can be very damaging to consumer/survivors generally, and to consumer/survivors/family caregivers and their older family members in particular. A second concern highlights the complexity of understanding and delineating symptoms of abuse and symptoms of mental illness. The symptoms used to indicate abuse are also symptoms indicative of a mental health problem. The insensitive labelling of abuse may damage essential caregiving relationships. Individuals who have been abused require mental health support and the system needs to recognize that the prevention of mental health problems also requires prevention in regards to the abuse of older adults. Finally, efforts to address ageism and how this form of prejudice influences health /mental health and social policies are critical.

The CMHA, Ontario Division has a commitment to understand and respond to the complex and pervasive social issues associated with the abuse of older persons and hopes that the position paper will increase awareness about the profound implications this form of mistreatment has within the mental health sector and our communities.

CMHA, Ontario Division Position Paper respecting Dual Diagnosis - Executive Summary. Chair: Janet Paddison, Past President, Board Member, Barrie-Simcoe Branch.

There are approximately 80,000 individuals with a developmental disability in Ontario with a significant number living in the community with their families, in group homes, or receiving other residential services. A number of these people also suffer from a mental health problem. We must keep in mind that mental illness in persons with a dual diagnosis has traditionally been under-reported because it is often unrecognized, undiagnosed, and untreated. Using a conservative prevalence rate of 30% (some researchers have estimated the incidence of mental illness in a person with a developmental disability to be within the 50-60% range) it can be said that approximately 24,000 individuals in Ontario have a dual diagnosis.

In 1985, approximately 8,000 individuals with a developmental disability lived in institutions and nursing homes. By 1996 this number had been

reduced to 2,182 in six Ministry of Community and Social Services (MCSS) institutions. In 1975, 4,600 individuals with developmental disabilities were serviced in community-based settings. By 1995, an estimated 34,000 were receiving community-based supports and services. It has been estimated that a further 978 people with developmental disabilities will have moved from institutions into local communities across Ontario by the year 2,000. Many of these individuals will have complex medical and psychiatric needs and will present a difficult and complex challenge for communities to ensure that the appropriate supports and services are in place. Furthermore, there are many dually diagnosed individuals already residing in communities across Ontario who will continue to require supports and services, furthering the necessity of timely, adequate and appropriate community services for this unique population.

Defining dual diagnosis has been problematic over the years, particularly in terms of having a definition that enabled persons with a developmental disability and a mental illness to access both mental health and developmental services when needed. As such the CMHA, Ontario Division, Dual Diagnosis Task Force supported and proposes the following definition for dual diagnosis: Individuals with a developmental disability and mental health needs.

Although this definition is more inclusive, there are still barriers to services that the dually diagnosed commonly are required to overcome. Individuals with dual diagnosis frequently require services from both the developmental and mental health systems. However, there are few community-based programs providing an appropriate range of supports in Ontario that are comprehensive and integrated between the mental health and developmental services sectors that are fully accessible to the dually diagnosed. Often, individuals with developmental disabilities are excluded from existing generic mental health services for a number of reasons, ranging from exclusionary program admission criteria, misunderstanding the needs of this population, or stigma, to name a few. There may be restrictions on providing services to individuals with severe intellectual impairment, or a lack of expertise in addressing the needs of individuals with dual diagnosis. In recognition of these gaps in mental health services the Ministry of Health (MoH) specifically included dual diagnosis in its definition of priority populations for Mental Health Reform in 1993. One of the overriding issues facing persons with a dual diagnosis is the lack of information and understanding about the disorder. Service providers and communities are often uninformed and unaware of these issues. This not only can lead to misdiagnosis, it can also lead to the perpetuation of stereotyping as "hard to serve or treat" and increased stigma.

Conceptual and operational differences between the mental health and developmental service sectors and lack of inter-agency communication, information sharing, and expertise further decreases accessibility to services for the dually diagnosed. All these barriers, and more, demonstrate the need to examine the issues surrounding dual diagnosis and to plan for the elimination of barriers, and the creation of an integrated continuum of care, for individuals with a dual diagnosis.

Policy directed at developing community-based alternatives to traditional institutional care is now firmly in place in Ontario. Its implementation raises a number of concerns about the size and nature of the dual diagnosis population and effective and appropriate services; issues that are relevant to all sectors of the community including education, social services, health care and law enforcement, and to the families of, and advocates for, disabled persons. It is hoped that this paper will draw attention to the unique needs of persons with a dual diagnosis and the service systems, in order that jurisdictions designing services and supports will be able to do so in a co-ordinated, timely and responsive manner. While work has been done in the recognition and understanding of dual diagnosis during the last few years, much still remains to be accomplished. The CMHA, Ontario Division, would like to emphasize the need to maintain this momentum for change. It is imperative that organizations remain committed to attaining the best possible dual diagnosis system possible.

Both of these position papers – Mental Health Issues in the Abuse of Older Adults, and Dual Diagnosis – may be obtained in their entirety from the CMHA, Ontario Division office at: (416) 977-5580.

The debate over forced treatment continues

Dear Editor:
I read with great interest your article on Community Treatment Orders. Many statements were the fatuous echoings of the politically correct, but some remarks were right on.
I am for Community Treatment Orders because I know from my own experience that it frees the mentally ill from pain, suffering, and terror. In 1970 while in Northeastern Psychiatric Hospital after a suicide attempt, I developed schizophrenia. It was pure hell. I thought that I was being held for ransom in a prison by the Mafia or F.L.Q. Hallucinations appeared on the TV screen of hooded mobsters jabbing red hot irons in my ten-year-old daughter's eyes. For four long years these frightening delusions and hallucinations terrorized me. I was hospitalized four times, to no avail, because I was adroit at avoiding treatment. Fortunately I had trusted my family doctor and told him what was gong on in my mind. He had me committed and relayed this information to the psychiatrist at Northeastern. This led to proper treatment. Yes, I was forced into hospital, forcibly drugged, abused by attendants, and shocked unnecessarily. But in the end it was my salvation. On Valentine's Day 1974 I walked out of hospital, free of the spectres which had been terrorizing me, to lead a useful life. If this had happened today, I would be left in my pain for fear of violating my rights. A patient's right is to be sane – however that is achieved. The forced treatment of the old days rescued me from the dark night of terror and pain, and I will be forever grateful to the system and doctors who did it.
FLORENCE DENISON, SOUTH PORCUPINE, ONTARIO

Dear Editor:
The Psychiatric Patient Advocate Office (PPAO) wishes to express support for the position of the Canadian Mental Health Association opposing Community Treatment Orders, and for the informative coverage of this topic in the Summer '98 issue of *Network*.
Widespread calls for forced treatment of those who are mentally ill often neglect to include information about the serious, long-term and often permanent side effects which accompany psychotropic medications. Or information that these medications do not provide relief for a significant percentage of patients. They also neglect to mention the fundamental right of capable men and women to make their own decisions about medical treatment. In Ontario, funds are urgently required to develop community services and supports for those who are seriously mentally ill. Implementing initiatives that expand the system of community supports including decent housing, vocational and recreational activities, and therapies in addition to drugs, will move us toward a system where fewer tragedies for consumers, their families and the public occur. Education about mechanisms already available in the Ontario legal system, not more coercive legislation, is what is required.
V. KEHYAYAN, Director, PPAO

This column is designed for you, our readers. Please take a few moments to send your comments for publication to:
The Editor,
Network,
Canadian Mental Health Association,
Ontario Division,
180 Dundas Street West, Suite 2301,
Toronto, Ontario
M5G 1Z8

or fax them to
(416) 977-2264.

Letters may also be e-mailed to:
cmhaon@ican.net

CALENDAR

October 29, 1998

Tools for Mental Health Reform – a professional development day featuring workshops on anger management, complementary therapies, and bridging the gap between self and workplace. Elmhurst Inn, Ingersoll. Registration $85. Hosted by the Canadian Mental Health Association, London-Middlesex Branch, Elgin County Branch and Oxford Country Branch. For more information contact (519) 434-9191 (London); (519) 633-1781 (Elgin County); (519) 539-8055 (Oxford County).

January 24, 1999

Capture the action of the 3rd Annual All-Star Game Party in Toronto. Guests will enjoy delicious food and beverages, door prizes, a silent and live auction and the opportunity to mingle with NHL All-Stars, past and present and of course watch the NHL All-Star Game live from Tampa Bay, Florida. For more information and event locations contact CMHA, Ontario Division at (416) 977-5580 ext. 36. Tickets are limited. Proceeds to benefit the programs and services of the CMHA.

COMING UP IN THE NEXT ISSUE OF NETWORK.....

New technology – is it making it easier for the public and consumers to access the mental health information they need? The winter issue of *Network* looks at helpful mental health web sites and ways in which the Internet is being used to respond to the needs of the mentally ill.

Seasonal Affective Disorder

Two-thirds of the population find that their mood changes significantly with the seasons. The key feature of people who suffer from Seasonal Affective Disorder (SAD) is that sufferers face recurrent annual major depressive episodes that follow a seasonal pattern. The most frequent pattern is fall/winter onset of depression, with spring/summer remissions. More than the "winter blahs", SAD is a disorder that interferes with social and occupational functioning to a degree that mild seasonal fluctuations in behaviour do not.

One of the most fascinating aspects of SAD has been the discovery that winter depression can be treated by light therapy. Also known as "phototherapy", controlled studies with over 600 patients have shown that substantial improvement occurs in 40 to 67% of them depending on the severity of depression and type of light system used. There are side effects to light therapy, the most common being headache, eye strain and agitation. The long-term effects of light treatment are not known, so anyone with an eye condition should check with their ophthalmologist before beginning treatment. Patients with certain active eye conditions, particularly retinopathies, should consider alternatives to light therapy under medical guidance.

Many important questions still remain unanswered, and studies are underway to ascertain more accurately both the prevalence of this disorder and its impact on health as well as the availability of health care to SAD sufferers.

Network
Vol. 14 No. 3 Fall 1998

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
Ontario Division/Division de l'Ontario
180 Dundas Street West, Suite 2301
Toronto, Ontario
M5G 1Z8