

Mental Health and Addictions and Homelessness Think Tank

Final Report

**Prepared for: Toronto Central LHIN
September 2010**

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Background

Gap Analysis Project

The Toronto Central LHIN's first Integrated Health Service Plan (IHSP) 2007-2010 identified mental health and addictions (MHA) as a priority area. As part of this priority, the Toronto Central LHIN, supported by the Toronto Central LHIN Gap Analysis Advisory Committee, set out to determine baseline MHA services and capacity within the LHIN. The resulting report, entitled "Identification of Service Gaps and Priorities in the Mental Health and Addictions Sector in the Toronto Central LHIN: A Starting Point" identified gaps, population needs and planning priorities across the LHIN.

The Toronto Central LHIN Gap Analysis Advisory Committee selected a population-based planning approach to guide its work and focused on the needs of the most marginalized people in the Toronto Central LHIN. The priority population groups identified were:

1. People Who Are Homeless
2. Seniors
3. Immigrants; Refugees
4. Children and Youth
5. Aboriginal People

Evidence supports a focus on increasing capacity, coordinated access to services and supports, integration of MHA services and multi-sectoral collaboration to meet the needs of these clients. This involves cooperation beyond the health care system, including the mental health, social, justice, settlement, shelter and child/ youth sectors. The Advisory Committee identified two specific recommendations to support the development of initiatives and solutions addressing the priority issues for the five population groups:

1. The Toronto Central LHIN should continue to facilitate the work of the Advisory Group with the initiation and implementation of multi-sectoral forums to identify targeted opportunities, solutions and initiatives that address the issues of the five priority populations.
2. The Toronto Central LHIN should implement a data enhancement plan through the initiation of a data decision support group comprised of key MHA stakeholders to help with improving data collection, quality, interpretation, and monitoring and measuring performance in the MHA system in the Toronto Central LHIN.

The Toronto Central LHIN is moving forward to implement both recommendations; however the first recommendation is the focus of this report.

Focusing on People who are Homeless

In moving forward with planning for the first multi-sectoral ‘think tank’, several factors were considered. Criteria were developed to assist with the selection of the appropriate population to address through the “think tank” process. These criteria included:

- Existing momentum within the community to address the needs of the population
- Opportunity to leverage existing initiatives
- Opportunity to promote system partnership and integration
- Fit with TC LHIN priorities
- Ability to initiate and implement activities quickly

Based on these criteria and for the reasons outlined below, it was recommended to target the homeless population for the first think tank session.

- Addressing the health care needs of the homeless population aligns well with LHIN priorities related to emergency department (ED)/ Alternate Level of Care (ALC). Evidence shows that people who are homeless account for a notable percentage of emergency department (ED) use, and repeat ED use for MHA related visits.
- The service provider community is actively engaged in serving the homeless population resulting in significant momentum and opportunity to leverage exiting initiatives. Some of these initiatives include; the Mental Health Commission Homeless Research Demonstration Project, the Toronto Community Addictions Team (TCAT) project, the City of Toronto’s Streets to Home program including its mobile multi-disciplinary street outreach team (M-DOT), among many others.
- Within this population group, the prevalence of mental health and/or substance use related issues is significant. In 2007, not only were 35% of people who were homeless in Toronto living with a mental health or addiction issue, but people who are homeless are also more likely to have physical health conditions as compared to the general population.¹

After consideration of the options and the data, the Toronto Central LHIN MHA Steering Committee supported the proposal to move forward with this recommendation. Mark Aston, member of the MHA Steering Committee and Executive Director of Fred Victor Centre, was confirmed as the chair of the advisory group to support the project.

¹ Street Health. (2007). Street Health Report. From: www.streethealth.ca

Role and Contributions of the Advisory Committee

In January 2010, under the leadership of Mark Aston, an Advisory Committee was formed to guide the planning and implementation of the first MHA think tank session.

The Committee's mandate included;

- answering strategic questions in the development of the session;
- identifying effective initiatives addressing the needs of the homeless population;
- identifying potential participants for the session;
- leading and facilitating the session; and
- further exploring ideas resulting from the session and provide recommendations for next steps to the Toronto Central LHIN.

The Advisory Committee consisted of 10 members who had skills and experiences in a variety of settings that provide services to individuals who are homeless and experience mental health and/or addictions issues. This includes members experienced with:

- Homelessness
- Hospital/ED
- Community mental health
- Addictions
- Primary care/ CHC
- Youth sector
- Aboriginal community
- Consumers/ survivors
- Seniors
- Criminal Justice
- Immigrants and refugees
- Research and policy
- Social services
- Shelters & other homelessness services, and service system management (City of Toronto)
- Links to existing homeless advocacy groups (e.g. SETO, Solutions)

For a full list of members, please see Appendix A.

During the winter of 2010, the committee met on several occasions to discuss the values that framed the discussions, the format and content for the think tank session. The committee further refined the definition for the target population, explored barriers to accessing care, and identified successful initiatives currently underway that address the needs of this population, which in turn helped target the content for the think tank session.

Initially, the committee further defined homelessness as:

People who are experiencing homelessness (in shelters, outside or being discharged from hospital or detention centre with no fixed address), with mental health or substance use issues and have a history of cyclical or chronic use of the shelter system.

They also discussed at length the overarching themes and barriers impacting this population including:

- cycles between jails/shelters/emergency departments
- forms and formal processes can present barriers to some consumers
- lack of ability to follow client or share information means repetitive info gathering, missed opportunities, partially informed service delivery
- difficult to provide longer term sustainability when only sources of funding are pilot and/or one-time funds
- to some extent, roles and responsibilities have evolved reactively rather than pro-actively
- desire for greater accountability
- need for stronger links/better transitions between services – hospital discharge to community services, shelters and community MHA services, etc.
- resources are not always available in the most effective locations – need to rethink location of key services to increase accessibility and effectiveness
- capacity doesn't currently exist in some services which impacts on providers' ability to connect the consumer with what they need
- difficult to support consumers who needs care outside of "business" hours for example discharge from ER in middle of night
- lack of trust in relationships results in poorer outcomes (missed appointments, lack of information sharing, lack of openness to services)
- social exclusion/isolation negatively impact mental and physical health

The committee also acknowledged several initiatives already underway to address some of these barriers and themes. Though the list below is not exhaustive, it illustrates how some of the elements above can be put into action.

Mental Health Commission of Canada – At Home project:

Using a 'Housing First' approach, the research project focuses on first providing people who are homeless with a place to live, and then the other assistance and services they require. Recovery based ACT and ICM supports are provided. In addition, the Toronto project is developing and evaluating a Housing First ethno-racial intensive case management model for people who are homeless from different ethno-racial groups. 300 people who are homeless with severe and moderate mental illnesses will be provided with housing allowances and comprehensive supports. Key partners in the Toronto demonstration project include: the Government of Canada, COTA Health, Across Boundaries, the Centre for Research on Inner City Health – St. Michael's Hospital, Toronto North Support Services, the City of Toronto, and Housing Connections.

Health Outreach Workers Pilot Project:

Extensive training program for substance use peers who then use their newly developed skills to connect street involved drug users to mental health, harm reduction, substance use and primary care services, addressing the high reported rate of concurrent mental illness among persons using illegal drugs and their hesitancy to access mental health services. This project is sponsored by South Riverdale CHC in partnership with CATIE, CAMH and Street Health.

Toronto Community Addiction Team (TCAT) Pilot Project:

The TCAT team provides intensive case management (ICM) to a targeted sub-group of individuals with frequent re-admissions to the Withdrawal Management System (WMS) and to the ER. The TCAT team provides support to 80 individuals. See page 11 for further details.

HIV/AIDS, Homelessness and Substance Use Pilot Project:

Supportive housing and community support program for women and men, aged 16 and older, living with HIV or AIDS, who have mental health or substance abuse challenges or both, and are homeless or at risk of becoming so. McEwan offers a high-support residence in the downtown area and a low-support shared house. An extensive Community Support Program provides counselling, mental health and addiction support, advocacy, referral, network building and 24-hour crisis management to more than 60 clients living in the community.

The Rotary Centre:

An area of St. Michael's Hospital for patients who may be homeless or under-housed and have been discharged from the ER, but may not be ready to return to the street. The Rotary Club of Toronto donated funds for the facility. In the Rotary Centre clients can do laundry, watch TV, get a meal, use the phone or speak to a Social Worker. They may stay up to 18 hours.

Sherbourne Health Centre Infirmary:

The Infirmary is a short term health facility or unit where people of all genders who are homeless may stay while recovering from an acute medical condition, illness or injury. The Infirmary program provides a safe space where clients are able to rest and recover in a comfortable, supportive environment. Health care is provided by a team including nurses, community health workers, physicians, a nurse practitioner and a case manager.

ICAP:

A team based model designed to increase access and health supports to individuals residing in shelters and alternative housing. See page 11 for further details.

Mobile Multi-Disciplinary Outreach Team –MDOT:

The Mobile Multi-disciplinary Street Outreach Team (M-DOT) is a mobile team of professionals who have expertise in health, mental health, co-occurring substance use issues, street outreach and homelessness. The program aims to end street homelessness by providing timely assessment, consultation, access to medical treatment, service planning and advocacy. Services are provided to people living outside through referrals from the City's Streets to Homes program. It is a partnership between Toronto North Support Services, Fred Victor Centre, St. Michael's Hospital, CAMH, Sherbourne Health Centre, Inner City Health Associates, COTA Health, and the City of Toronto's Streets to Homes Program.

Given the wealth of new initiatives focused at addressing the needs of this population, the committee decided to format the think tank session on building on these activities and initiatives with an aim of supporting the strengthening of partnerships among hospitals, community services, primary care and others to reduce ER waits and avoidable hospital visits for people who are homeless living with mental health issues and/or problematic substance use.

Finally, the Advisory Committee discussed and identified foundational elements as a starting point for discussion at the think tank session that could be considered as new initiatives are developed:

- harm reduction continuum: starting where the client "is at" and working with them to best meet their needs
- recovery resulting in improved quality of life, independence
- low barrier services using flexible access models
- peer-led initiatives integrated into the service delivery system
- ability to obtain appropriate level of intensity of support when needed
- navigation support is important
- adequate income will support access to food, shelter and other important material necessities
- system(s) continue to clarify roles and responsibilities, coordinate and integrate in order to more effectively be able to respond to consumer needs

All of these elements were brought forward at the think tank session to create a context for the day and to focus the discussion on practical and implementable actions and ideas.

Finally, after the think tank session, the committee met to review the information generated at the session and developed the recommendations presented at the end of this report.

Toronto Central LHIN ISHP-2 Priorities

- ER / ALC key indicators of health system effectiveness
- Mental Health & Addictions Improve prevention, management and treatment of MH&A – targeting needs of most vulnerable & complex
- Value & Affordability providing services in most affordable setting, avoiding duplication, and improving coordination
- Health Equity actions intended to ensure everyone in the LHIN has equitable access to health care services that reflect individual needs and circumstances

Think Tank Day- Context and Objectives

The Mental Health and Addictions and Homelessness Think Tank session was held on Friday, April 16, 2010 at the Ryerson International Living Centre in Toronto. Sixty-five people participated in the session, including health service providers from across the continuum of care, social services providers and people with lived experience. Please see Appendix B for the complete list of participants. The session was facilitated by Tamara Eberle from Track Consulting.

Prior to the session all registered participants received an agenda and backgrounder document that included a description of the background work that led to the think tank session, the objectives of the day, information about the target population, barriers and challenges faced by this population and current initiatives in the Toronto area addressing the needs of this population.

The opening comments, provided by Lori Lucier, Senior Consultant at the Toronto Central LHIN and Mark Aston, chair of the Advisory Committee, summarized much of the information provided in the backgrounder and included the context for the

day, a review of the objectives of the session and its alignment with LHIN priorities.

Alignment with LHIN priorities

An action item within the LHIN MHA priority focuses on “*identifying and testing innovative integration approaches to target the needs of the most complex and vulnerable communities in the Toronto Central LHIN.*” The think tank was well aligned with its focus on the homeless population with mental health or addictions conditions to develop new and practical solutions to address the needs of this marginalized population group.



Objectives of the Session

In setting the context for the day, the chair presented the committee’s approach for the session, which included targeted discussions on developing practical solutions, reviewing how things can be done differently, using available resources more effectively, building and strengthening relationships to achieve a system that is more coordinated and integrated and finally, developing a shared commitment to changing what we know can be changed. It was also noted that the scope of the session did not include focusing on projects where significant financial investments were required.

Given these parameters, the afternoon breakout sessions would focus on where positive change could be affected at key transition points:

1. From Hospital EDs to the community, including shelters.
2. Appropriate response to people experiencing crisis in shelters but not needing ED services – diversion from ED.
3. Enhancing opportunities for chronic shelter users to transition to other appropriate community services.

Presentation Highlights

To further set the context for the afternoon discussions, four people with lived experience presented their experience with the health care system and two health service providers presented their successful projects that address the needs of this population. Their bios are included below.

Individuals with Lived Experience

James Bowser came to Toronto in 2009 and was soon one of the first clients of LOFT's service coordinator pilot project for homeless people living with HIV/AIDS and experiencing mental health crisis. James now resides at LOFT's St. George House and is receiving on-going case management from LOFT's McEwan Program.

Linda Chamberlain is a peer support worker at CAMH and a member of Voices from the Street, The Dream Team and Stand Up for Mental Health. She continues to embody the endless possibility and potential of people with mental health histories.

Terrance Williams is a consumer-survivor who currently works for the Parkdale Activity and Recreation Centre. Having experienced homelessness for a number years, Terrance is committed to improving the lives of people living in poverty through his involvement with Voices from the Street.

Troy Stapleton is currently employed by the Parkdale Activity and Recreation Centre and Fred Victor Centre. He has extensive lived experience with addiction, homelessness and imprisonment. He continues to work to change the system for those currently still out there struggling and those who are sure to fall.

Health Service Provider Presentations

Dr. Vicky Stergiopoulos, Inner City Health Associates

Inner City Health Associates (ICHA) is a group of physicians funded by the Ministry of Health and Long Term Care to work in homeless service settings. Over the past three years ICHA has developed health services at men's, women's, family and youth shelters, crisis beds, homeless outreach teams, a homeless infirmary and a palliative care home for the homeless. These services are based on integrated services and principles of recovery. The physicians work to remove barriers to access and provide inter-professional services collaboratively with other agencies, including the CCAC's Inner City Access Project (ICAP).

Dipti Purbhoo, Toronto Central CCAC- Inner City Access Project (ICAP)

The Toronto Central CCAC, in partnership with ICHA, has developed the Inner City Access Project (ICAP), which is a model of care where comprehensive teams that include CCAC nursing, personal support workers and care coordinators work collaboratively with ICHA physicians and local agency staff at three shelters and alternative housing locations to improve health outcomes and access to health and support services for people who are under housed and who have difficulty accessing health care services. The project is based on health support, information flow and connections to deliver a different model of care. The team meets on a regular basis to look at each client's individual needs and connect them to the appropriate resources. Through this program, they have served three times more clients without spending more money but rather by using financial resources more effectively.

Robin Griller and Tom Henderson, Toronto Community Addictions Team (TCAT)

The TCAT team provides intensive case management (ICM) to a targeted sub-group of individuals with frequent re-admissions to the WMS and the ED. TCAT supports better outcomes by providing a model of integrated care that provides system navigation services and offers assessment and referral, advocacy, transitional and supportive housing, financial trusteeship, income support, and ongoing addiction counselling and support, through a flexible, recovery oriented, harm reduction model.



Think Tank Session Presenters: (from left-back row): Terence Williams, Robin Griller, Tom Henderson, James Bowser; (front row) Linda Chamberlain, Lori Lucier, Mark Aston, Troy Stapleton (absent: Dipti Purbhoo & Dr. Vicky Stergiopoulos).

Break-Out Sessions

Scenario/Table Discussions

Participants were pre-assigned to tables based on their area of work and expertise in order to ensure representation from across the continuum of care for each discussion. Each table was assigned a specific service user profile and scenario, as well as a facilitator from the Advisory Committee. The group was then asked to consider the following question with respect to their group's scenario.

1. *What can WE do to adjust our services and programs so that people “transitioning” from one organization/institution to another do not ‘fall through the cracks’?*

For a review of each table discussion, see Appendix C. The groups were asked to categorize the ‘actions’ identified through their discussions and summarize them into strategies. Though each table discussed a different scenario, all of the discussions led to similar themes, which are outlined below.

- **Client-driven care:** Provide client-driven care by asking clients what they need and developing plans to address those needs, providing care to clients in non-traditional settings including mobile care to meet clients in familiar settings, and responding to basic needs (health, clothes, food, housing, and spiritual).
- **Create a different model for crisis intervention:** Implement 24-hour access to mobile crisis team and dedicated safe beds with medical monitoring for clients with substance use issues within a harm reduction model. Create more after-hours options such as phone lines and after hour drop-ins.
- **Change WMS model:** Provide medical clearance option at WMS locations or conduct clinical triage to reduce ED use for medical clearance to access WMS services.
- **Improve communication between the hospital ED and community services:** Develop partnerships, place community supports in hospital EDs and create formal information sharing opportunities between EDs and community services.
- **Modify hospital ED protocols/models for MHA:** Improve discharge planning between EDs and shelters, provide 24h social workers in the ED and advocate for emergency psychiatry and addictions protocols to better address needs of this population.
- **Improve collaboration between shelters and drop-ins:** Improve collaboration between shelters and drop-ins to coordinate resources and build awareness of the effectiveness of drop-in models in assisting people with MHA issues.
- **Improve access to primary care:** Assist clients with accessing primary care services (e.g. through Community Health Centres (CHC), Inner City Health Associates, CCAC, etc.). Provide on-site access to health services at shelters and drop-ins.
- **Support clients with navigating the health and social services systems:** Build staff capacity to help clients navigate system, implement 'warm hand-offs' and accompany clients to appointments, WMS or ED to provide advocacy or smooth transition.
- **Improve access to appropriate case management services:** Provide clients with a consistent, flexible support available 24/7 that addresses client needs and is age and culturally appropriate.



- **Peer Supports:** Implement permanent peer based positions and programs that will better support clients.
- **Better support clients in finding appropriate housing:** Be proactive with housing planning. Access transitional housing while waiting for longer-term housing, advocate for clients on housing wait lists.
- **Review organizational policies:** Conduct internal review of policies, review relevance of restrictions and develop cross-sectoral working group to identify barriers to accessing services.
- **Provide trauma informed services:** Become knowledgeable on providing trauma informed services, understand the type of trauma the client is experiencing and address trauma first.
- **Develop more harm-reduction based services:** Implement and understand the harm reduction philosophy and increase access to concurrent disorder safe beds, harm reduction programs for women and Aboriginal peoples and harm-reduction based housing.
- **Other:**
 - Develop contingencies at every point
 - Develop ‘community’ to address loneliness
 - Geriatric outreach
 - Incorporate issues of diversity/cultural competence into organization
 - Support solutions that are not traditional
 - Encourage service providers to adapt services
 - Conduct more anecdotal and qualitative evaluations and monitoring of funding
 - Champion collaboration over competition

Full group discussion

Participants were asked to review the themes identified by each table and identify (with stickers) which strategies stood out for them as being especially useful and important for moving forward. The key themes, as identified by the group, are outlined below:

Themes/Priorities to work better together that garnered the most support:

- Fund peer support and implement in organization
- Build partnerships between hospital and community
- Expand on or develop community resources to support ED users
- Develop short-term addictions/ crisis services
- Create more after hours options for service
- Expand safe bed program
- Implement mobile supports and portable case management
- Locate services in spaces where basic needs are being met
- Integrate trauma informed service provision in organization
- Develop multi-sectoral working group to address removing barriers to housing
- Provide housing and income support as a first step



The group was then engaged in a conversation about similarities and differences between each of the table discussions. Common topics across each table included the need for peer support, community support in hospital EDs, service integrations and medical services in a community setting, whereas a major difference between discussions was the identification of organizational strategies at some tables versus system-level strategies at others.

The group identified several strategies that were realistic to implement including; improving partnerships and communications between hospitals and community services, increasing knowledge about trauma informed service delivery and improving hospital EDs discharge protocols. Alternatively, addressing the lack of affordable housing, developing collective responsibility for clients and properly evaluating the success of pilot projects were identified as the more difficult strategies for implementation.

The group identified developing a short-term resting/sobering point with appropriate primary care as the strategy that would have the most positive impact. Finally, the group was asked which strategies could be implemented now within their organizations; three strategies were identified:

- Employ and support peer support workers
- Provide trauma informed training
- Expand rapid access to housing program

Pilot Project Ideas

The group spent the last part of the afternoon discussing ideas for a small pilot project that could be funded within this fiscal year. Four main ideas were generated and are described below.

- 1. Fund Peer Workers:** Fund emerging peer support programs especially for peek service use hours to provide support in the ED or to support community agencies. Suggested elements of the model include training peers to work in a variety of settings, have



a coordinator to support a group of peer support workers and evaluating the impact and affordability of the project.

2. **Develop discharge planning model from hospital ED to community services:** Elements of the model could include; plan for discharge, ensure appropriate services are available at the discharge location, provide accompaniment to the discharge destination, link community case management services to ED, develop network that would support improved communication between ED and community services.
3. **Increase capacity for addictions crisis services:** Elements include; an inter-agency community mobile team with dedicated access to safe beds, enhance existing programs with “beds to support substance users”, expand current scope of phone line services and weekend service coordination.
4. **Expand case management services:** Enhance existing case management services out of drop-ins to link with EDs and enhance coordination with CCAC and other services in-kind.
5. **Other:**
 - Convene group with agencies willing to put in assets and resources on the table for time limited pilot with housing, support array around specific segment among homeless MHA with evaluation
 - Expand pilot project for people with HIV, mental illness and addictions to include other physical illness who are high users of ED and in-patient services
 - Sponsor trauma training for MHA agencies
 - Showcase promising practices
 - Provide opportunities for information exchange
 - Create an inventory of services for mental health, addictions and homelessness

All of these ideas were brought back to the Advisory Committee for review in order to provide recommendations to the Toronto Central LHIN regarding next steps.

Recommendations from Think Tank Advisory Committee

The committee met in May 2010 to review the ideas and recommendations generated at the think tank session. The committee reviewed all of the ideas presented in this report and decided to develop two ideas further for recommendation to the Toronto Central LHIN:



1. Concurrent Disorders and Problematic Substance Use Crisis Response

It had been identified that a gap in crisis response services exists for people with substance use issues and concurrent disorders. The recommendation outlined by the think tank group and developed by the advisory committee was to build upon existing infrastructure to provide telephone support/response, mobile crisis response that includes de-escalation and support for immediate crisis issues as well as referrals to appropriate community services, and a short-stay residence for this target population.

The objectives of the proposed recommended initiative are to:

- Increase access to community-based problematic substance use crisis services.
- Demonstrate the impact of a harm reduction focused community crisis response for people with concurrent disorders or problematic substance use who frequently visit the ED and WMS.
- Provide low-barrier access to safe beds within a harm reduction model.

2. Community Outreach Workers -Peer Program

The second recommendation from the advisory committee was to develop a peer-based outreach worker pilot project. This project would be delivered through a lead agency, employing a team of community outreach workers whose key responsibilities would be to support system navigation, client accompaniment to appointments and other forms of peer support. The lead organization would provide training, education, supervision and employment support for the peer workers as well as provide support for partnering agencies to more effectively integrate services of community outreach peers.

The objectives of the pilot project would be:

1. To deliver effective service navigation support for targeted clients, in particular supporting transitions between hospital and shelters.
2. To provide meaningful employment to persons with lived experience in the continuum of care by providing positions that support health system service delivery.
3. To develop promising practices regarding use of community outreach peer workers in the delivery of MHA services.

APPENDIX A: Homelessness and MHA Advisory Committee Membership

Mark Aston, Fred Victor Centre, Executive Director

Jim O'Neill, St. Michael's Hospital, Executive Director, Community & Health Services Partnerships and Program Director, Inner City Health Program

Sheryl Lindsay, Sistering, Executive Director

Lynne Raskin, South Riverdale CHC, Executive Director

Greg Rogers, John Howard Society of Toronto, Executive Director

Laura Cowan, Street Health, Executive Director

Katherine Chislett, City of Toronto, Director, Shelter, Support and Housing Administration

Carolyn Dewa, Centre for Addiction and Mental Health, Senior Scientist/Health Economist, Health System Research & Consulting Unit

Becky McFarlane, Ontario Council of Alternative Businesses, Co-Director & Director of Voices from the Street

Jim McMinn, LOFT Community Housing, Director of Seniors' Services

Leslie Saunders, Meeting Place, Coordinator

Committee Support:

- Shirley Roberts, CAMH
- Popi Spyridis, CAMH;
- Andrea Demers and Lori Lucier, Toronto Central LHIN

APPENDIX B: MHA and Homelessness Think Tank Participant List

First Name	Last Name	Organization
Carlos	Aedo	Houselink
Robyn	Alexander	St. Joseph's Health Centre
Jason	Altenberg	South Riverdale CHC
Mark	Aston *(F)	Fred Victor Centre
Michael	Blair	LOFT Community Services
Jayne	Caldwell	Toronto Public Health
Sabina	Chatterjee	Youth Link
Katherine	Chislett *(F)	City of Toronto
Jo	Connelly	Toronto North Support Services
Laura	Cowan	Street Health
Brian	Davis	Toronto Community Housing
Carolyn	Dewa *(F)	CAMH
Akin	Falode	Toronto Central CCAC
Robin	Griller	St. Stephen's Community House & TCAT
Mary	Grondin	Sherbourne Health Centre
Tom	Henderson	St. Michael's and TCAT
Lynn	Hillman	Fred Victor Centre / Concurrent Disorders Support Network
Kimberly	Hunter	CAMH
Stephen	Hwang	Inner City Health Associates
Jaswant	Kaur-Bajwa	George Brown College
Katie	Keating	Streets to Homes
Jeannette	Kruger	COTA Health
Patricia	Larson	St. Joseph's Health Centre
Jessica	Lee	CMHA Toronto
Carolyn	Lessard	Concurrent Disorders Support Network
Sheryl	Lindsay *(F)	Sistering
Carol Anne	Lopresti	Streets to Homes
Linsey	MacPhee	Toronto Drop-In Network
Art	Manuel	Seaton House
Terry	McCullum	LOFT Community Services
Leslie	McDonald	Habitat Services
Becky	McFarlane *(F)	Ontario Council of Alternative Businesses (OCAB)
Jim	McMinn *(F)	LOFT
Susan	Meikle	Toronto North Support Services
Gautam	Mukherjee	Fred Victor Centre
Louise	Nimigon	Community Resource Connections of Toronto
Martha	Ocampo	Across Boundaries
Catherine	Perruzza	Seaton House
Sanford	Pheasant	St. Michael's

First Name	Last Name	Organization
Alexandra	Pinto	Inner City Health Associates
Dipti	Purbhoo	Toronto Central CCAC
Josie	Ricciardi	Regent Park CHC
Shirley	Roberts *(F)	Parkdale CHC
Kay	Roesslein	LOFT Community Services
Greg	Rogers *(F)	John Howard Society
Terrie	Russell	WEUHA
Eleni	Samartzis	Fred Victor Centre
Leslie	Saunders	Meeting Place
Muriel	Scott	The Salvation Army
Karen	Smith	Seaton House
Conny	Stefan	St. Joseph's Health Centre
Vicky	Stergiopoulos	Inner City Health Associates
Joanne	Walsh	St. Michael's
Diane	Walter	Margaret Frazer House
Aklilu	Wendaferew	Good Shepherd Ministries
Donna	Westman	Alpha House
Brigitte	Witkowski	Mainstay Housing
Ronny	Yaron	Margaret Frazer House

*(F)-facilitator

APPENDIX C: Summary of Each Table Discussion

Table/ Scenario 1: (concurrent disorder, ER discharge and linkages): There is a woman, 38 years old, homeless, living with schizophrenia, chronic physical ailments and crack addiction. She has an outreach worker who tries to monitor her status. She is brought into the ER by police because of her aggressive behaviour. She is seen and discharged once medically cleared. She is seen as an addict first and is therefore rarely referred to the psychiatric emergency program. There is nowhere for her to go upon discharge from hospital because she refuses to stay at shelters.

Activities/ideas to work better together and improve transitions:

- Harm reduction/concurrent disorder safe beds
- Access safe beds (dedicated) re: mental health OR addictions
- Community-based safe- beds/withdrawal with medical monitoring for safe place to crash with medical supervision or medical clearance for WMS
- 24 hour emergency medical clinic for the homeless
- More community support services in ER
- Extend police mental health team to 24 hr service
- Access to housing/outreach inside ERs
- TCAT/MDOT for ER (timely/short-term intensive/low barrier)
- Ask client what they need
- Advocate for emergency psych protocols and addictions
- Switch hospital SW to 24hr/7 days per week rather than 9-5pm
- Provide forum for discharge planner to connect with community workers
- ER develops partnerships with support services
- Community connect immediately with case management MH worker
- Ensure hospital SW connects with outreach/community worker
- Hospitals have access to database re: service coordination
- Work with CD program or psych unit in hospital to bypass ER if psych services is needed
- Connect with Inner City Health Doctor or CCAC in community setting
- Case management referral directly from ER

Overarching themes identified:

- Expand on community resources to support ER users
- ER system change
- Relationships and formalized information sharing
- Support solutions that are not traditional

Table/ Scenario 2: A 28-year old woman who is homeless has a long history of substance use. Her drug of choice is hand sanitizer. She overdoses regularly and is subsequently discharged from whatever shelter she happens to be residing in because she is considered a 'liability'. During a hospital stay, she took a bottle of hand sanitizer and was placed on a 'no trespass' from the hospital and was sent back to a shelter. Not long afterwards, she overdoses and is taken back to that hospital's ER. Once she is medically cleared, the hospital discharges her.

Activities/ideas to work better together:

- Address the no trespass order- (have it removed)
- Improve communication between hospital and agencies
- Have harm reduction program for women
- Connect to housing where alcohol accepted
- 24 hour access to supports
- Provide case management to address substance issue and housing
- Develop a substitution for hand sanitizer- with palatable alcohol
- Encourage service providers to innovate and create new services

Overarching themes/strategies identified:

- Building partnerships between hospital and community
- Create capacity for gender specific harm reduction
- Encourage service providers to adapt services
- Policy development to ensure individual service providers to help keep the links
- Create a stabilization plan between agencies to help individuals
- Diverting funding to follow client.

Table/ Scenario 3: (uses ER to get medications refilled- ER diversion/ ER discharge):A woman who is 42 years old of Aboriginal descent has experienced childhood abuse and has a family up north. She is HIV+, has an undiagnosed mental health issue, and has been in/out of shelters for last 5 years. She uses the ER to refill medical prescriptions.

Activities/ideas to work better together:

- Consider alternative housing option
- Consider 'At Home/Chez Soi' Project
- Income supports (ODSP, drug card)
- Bring the care she needs to her
- Referral to a physician/complete physical assessment
- Contact 'her' person at shelter/ER
- Provide at least one consistent support
- Consider referral to ICAP
- Refer to mental health outreach case manager
- Refer to service coordination pilot project
- Build trust with her first
- Find out what services she already received
- Deal with trauma first
- Find a peer support group
- Aboriginal peer support
- Reconnect to family (if she wants)

- Peer involvement
- Provide harm reduction supplies
- Connect with all of the shelters

Overarching themes/strategies identified:

- More anecdotal and qualitative evaluations and monitoring of funding
- Fund peer support and its implementation within organizations
- Own the responsibility
- Housing and income support as a first step
- Mobile support and portable case management
- Champion collaboration over competition
- Effective and appropriate individualized service coordination
- Supporting/facilitating trusting relationships specific to the individual

Table/ Scenario 4: (uses ER for medical clearance to access WMS beds- ER diversion/ER discharge) A 30 year old homeless man who is severely intoxicated is referred to central access to withdrawal management services (WMS) from the shelter. Central access tells them that they must have medical clearance in order to access WMS beds. He is sent to the ER where he waits for long periods and therefore leaves before being seen.

Activities/Ideas to work better together:

- Transitional housing for persons
- Aboriginal harm reduction facilities
- Refer to WMS community worker who can then do a lateral referral to residential crisis
- Work with client on long term goals in safe and supportive setting to address an ongoing issue/concerns (e.g. housing).
- Medical clearance is made available at WMS (Nurse practitioner/FHT)
- Clinical triage instead of central access
- Build staff capacity to help navigate system
- Have case managers accompany clients to detox
- Accompany to ER and advocate and support
- WMS clarifies rules for the need for medical clearance (or not) and supports intake works (re: fears related to these rules)

Overarching themes/strategies identified:

- Short-term addiction/crisis services (“Addictions Gerstein”)
- Coordination of post-WMS services and supports
- Primary care to WMS
- WMS clarifies emergency referral from Central Access
- Ensure capacity to advocate and accompany client

Table/ Scenario 5: (crisis in shelter- ER diversion): A man, 40 years old, has been in the shelter system for 1 year. He has a mental health issue and chronic health condition. He experiences a health crisis (shortness of breath associated with long term chronic health issue and high level of anxiety) while in a shelter. Shelter staff calls 911 to intervene in the situation. EMS brings client to ER.

Activities/Ideas to work better together:

- More general safe beds/longer stays
- Safe haven with health care
- Harm reduction philosophy
- Shelters to collaborate with other local shelters to fund after hours health care nurse
- Outreach worker great availability and liaise with ER
- Send to after hours clinic instead of ER
- Access mobile crisis
- Coordination of crisis response
- Follow-up with primary health care
- Provide on site health care
- Onsite- refer to case management for ongoing intervention
- Improve communication between ER and agency
- ER to monitor frequent users of ER and meet regularly with shelters to case conference (e.g. TCAT model) with outcome to reduce visits
- Better sharing of information (liaison ER worker (peer)
-

Overarching themes/strategies identified:

- Expand safe bed program- more general access longer stay harm reduction focus
- Developing strategies to improve communications between ER and other service providers
- Expand on-site health care at shelters/drop-ins (i.e. ICAP, Inner City Health)
- Create more after hours options for service (e.g. phone line/peers' after hours site/drop-ins)

Table/ Scenario 6: (long-term shelter user): A woman, 48 years old is a heavy drinker who has been on a housing wait list for 6 years. She has had 5 different workers over the last 5 years because she believes they are trying to harm her or they want to take her money. She is barred from most shelters and a number of drop-ins due to her aggressive behaviours. Her fear of being outside at night is increasing her mental and physical health decline.

Activities/ideas to work better together:

- Look at relevance of restriction
- Homeless ombudsman-looking at barriers, policies, re-entry
- Model to share relevant information
- Services go to the client
- Find the right worker
- Services available beyond 9-5pm
- Peer support
- Provide 'community' to address loneliness
- Find intensive follow-up supports
- Develop joint care plan from different agencies working to help client
- Accompany- don't send

- Implement 'warm hand-offs'
- Conduct case conferencing
- Try to amend SH application to improve chances for placement
- Advocacy and point person to address housing needs (is she on the right list)

Overarching themes/strategies identified:

- Keep her safe
- Engage creatively and flexibility
- Finding right supports at the right time (step in/out, re-engagement)
- Breaking barriers to agencies working together
- Housing first- getting proactive on housing plan
- Coordination of comprehensive services

Table/ Scenario 7: (Senior, addiction, long-term shelter user): A man, 65 years old, on methadone, crack and medical marijuana has been chronically homeless for over 10 years. He is on O.W. He has been refused supportive housing on several occasions due to his addiction and lack of follow-through on appointments. He also does not meet admission criteria to long-term case management programs.

Activities/ideas to work better together:

- Get him into seniors apartment
- Advocate for affordable access to TTC
- Assist with smooth transition to WMS
- Address basic needs (health, clothes, food, housing, spiritual)
- Locate access to a variety of services and supports in spaces he is already accessing to meet his basic needs
- Try understanding his story
- Narrative storytelling-successful tenancy action plan
- Direct access from street
- Short-term navigation or case management
- Find temporary/interim supports/start relationships
- Geriatric outreach
- Get him a case manager
- Committed support staff 'romance the tenant'
- Coordinate resource procurement and sharing between and among drop-ins
- Establish and implement long-term plan with him
- MOH or LHIN review drop-ins (or build on the city of Toronto drop-in review)
- Develop contingencies at every point
- Build awareness of effectiveness of drop-ins model in supporting people with MHA issues meet basic needs. Drop-ins have been recognized to be key in helping client find housing.

Overarching themes/strategies identified

- Accessible services in spaces where basic needs are being met
- Ensure person's story is told and heard (no judgement)
- Establish committed, engaged, individual supports
- Convene opportunity to coordinate, develop, review, plan, right services to meet client and system need

Table/ Scenario 8: (young man, trauma survivor- cyclical long-term shelter user): A man, age 22, is a trauma survivor with serious self-harm behaviour and alcohol abuse. He has lived independently in private housing for short periods. However, he feels anxious and unsafe in this environment and returns to the street/shelters. He often ends up in the ER due to his injuries. Supportive housing will not accept him until he stops the self-harm behaviour and is clean from drinking for a reasonable period of time. Currently, he is bouncing between shelters, the ER and inpatient units.

Activities/ideas to work better together:

- Find natural supports (formal and informal)
- Connect with appropriate worker
- Connect with a primary care team (NP, MD)- community health care
- Housing advocacy- need to be a supportive housing option- negotiation contracts
- Sector specific working groups to review policies around access
- Cross sector working groups to identify barriers to access
- Intensive housing worker (for advocacy/supportive housing)
- Increase resources to supportive housing
- Is supportive housing appropriate or is there other alternatives
- Incorporate issues of diversity/cultural competence into organization
- Case management that is cultural, age appropriate and flexible
- Understand what kind of trauma is experienced
- Trauma supports (adapt provide new services to meet the needs of this client population)
- Client centered and needs driven counseling
- Client driver (start with what the client needs now)

Overarching themes/strategies identified

- Implement permanent peer based positions and programs
- Develop multi-sectoral working group to address removing barriers to housing
- Develop equitable partnerships and social advocacy
- Integrate trauma informed service provision in organization