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Preventing Homelessness through Mental Health Discharge Planning

Best Practices and Community Partnerships in British Columbia

Volume 2: Case Studies

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1. Overview

As noted in Volumes 1 and 3, discharge planning can represent an important intervention point in reducing and preventing homelessness. Though discussed in greater length in Volume 3, the literature notes a number of challenges and barriers in using discharge planning as a point of intervention, including:

- Lack of community supports
- Lack of appropriate housing
- Diversity of community needs
- Diversity of client needs
- No internal 'ownership' of discharge planning
- Stigma associated with mental health
- Lack of cultural sensitivity
- Lack of partnership between health care and community service agencies
- Lack of staff knowledge of homelessness
- Lack of funding for discharge and transition planning
- Not enough time to plan appropriately

Best practices identified in the literature that can help address these challenges include:

- Developing appropriate housing resources
- Developing appropriate community support services
- Building partnerships across health care providers, community service agencies and peers
- Information sharing agreements between hospitals and community service agencies
- Early identification of client discharge needs
- Clearly established 'home' for discharge planning within a hospital/unit
- Discharge planning is adapted to patient needs
- All partners involved 'buy in' to the discharge process
- Discharge has a long-term focus for housing and services
- Discharge planning is culturally sensitive

The case study facilities implement many of these best practices, such as early engagement of clients in discharge planning, the use of culturally appropriate resources and the development of some mental health housing resources. However, many of the challenges noted above are also present in the BC communities studied through this research. Many interview participants noted a lack of affordable and appropriate housing and a lack of community supports, particularly for the hardest to house clients. Additionally, there are no formal connections between health care providers and community-based organizations working with mental health clients (e.g. community service agencies or peer support networks). In acute units the short stay and the

sometimes high volume of patients can also put time pressures on staff responsible for discharging clients. Finally, many community service agencies working with homeless populations and/or the mentally ill do so 'off the side of their desk,' attempting to address homelessness with limited capacity and resources.

2. Lions Gate Hospital—Acute Psychiatric Inpatient Unit

2.1 Description of Mental Health Unit

Program Description
Lions Gate Hospital is located in the City of North Vancouver, and serves the North Shore. It also serves as a regional hospital for the Sea-to-Sky and Sunshine Coast areas.[1] Lions Gate hospital has an acute psychiatric inpatient unit with 26 beds, and an additional 2 overflow beds dedicated to the unit. The unit provides "a structured therapeutic program (including assessment and treatment) to individuals suffering from acute or severe psychiatric illness."[2] Patients are admitted as soon as possible from emergency to the acute unit. If patients in the acute unit are no longer acute and can be safely discharged, they will be discharged to make space for new patients.

Staffing
The staff for the unit includes an interdisciplinary team, who provide medical, programming and client care support. The day shift for the unit includes five nurses (RNs and RPNs), while the night shift consists of three nurses. There are three inpatient psychiatrists, who work Monday to Friday.

There are two social workers on staff (1.8 FTE), and a full-time patient care coordinator. Other staff includes one occupational therapist who provides programming Monday to Thursday, and a program nurse who works during the day.

Client Characteristics
The unit sees a wide range of clients age 19 and up,[3] reflecting the demographic composition of the North Shore. Clients represent a broad range of ethnicities, with a relatively high incidence of First Nations and Persian ethnic groups. This is reflective of the North Shore's cultural composition. The unit largely sees clients with an Axis 1 disorder.[4]

Length of Stay
There is no maximum length of stay for clients on the unit; however, clients who are no longer acute and can be safely discharged will be released, if new intakes from the

[1] St. Mary's Hospital, on the Sunshine Coast, has an Acute Psychiatric Inpatient Unit, and is also one of the case studies in this project.
[2] VCH 2014b.
[3] In some situations the unit will see clients under the age of 19, but this does not occur often.
[4] See overview for definition of Axis 1 disorders.

emergency unit are required. The length of client stay varies widely depending on diagnosis and discharge options, including types of treatment (e.g. tertiary care, community care), and whether clients have housing or supports in place upon discharge. Clients with stable housing will often stay 1-3 weeks before being discharged. Clients without stable housing will often stay longer, until appropriate housing is identified.

2.2 Overview of the Discharge Planning Process

Discharge Planning Team

The unit takes a team approach to discharge planning. The number of staff involved in discharge planning depends on a client's needs. Typically, the team consists of the psychiatrist, client care coordinator, social worker(s), team leader at Adult Community Mental Health, the unit's Occupational Therapist and the unit's nurses. These professionals will work with the client and his/her family or support network in the discharge process, but the attending psychiatrist has sole responsibility for the final discharge.

Adult Community Mental Health is responsible for the client's long-term integration into the community. The Housing Coordinator will work to identify an appropriate housing placement with one of the five contracted housing providers, if a client being discharged does not have a stable housing situation to return to. ACMH also provides long-term mental health services to clients on the North Shore.

Discharge Planning Approach

The team will try to assess potential discharge issues, and develop a plan around how discharge will take place from time of admission. Staff members at Lions Gate do not receive specific training around issues of homelessness, and staff identified education on these issues as a possible area for improvement in treatment and discharge planning. The team holds weekly meetings regarding the client's treatment and discharge options.

The team currently implements a four-pillars approach to treatment and discharge planning:

- **Client-centred**: Discharge planning is conducted in consultation with clients by unit staff (particularly social workers and client care coordinators) as a way to support clients and facilitate a smooth transition.
- **Family-centred**: Whenever possible, family members are included in treatment and discharge planning, and additional supports are available for families through a family peer support program.
- **Recovery-based**: Treatment and discharge planning focus on recovery. A recovery-based approach means meeting clients where they are, supporting them in addressing their mental illness, and treating addictions where relevant.
- **Culturally competent**: Treatment and discharge in the unit strives to be culturally sensitive, making use of the Aboriginal Navigator Program available

through Lions Gate, and striving to recognize the role that culture can play in assessment, treatment and discharge.

In addition to these four pillars, the unit is currently studying the concept of trauma-informed practice[5] as a possible fifth pillar.

Ongoing Client Monitoring
Because the unit at Lions Gate treats acute psychiatric needs, unit staff do not monitor clients released into the community. Long-term monitoring of client outcomes through VCH is the responsibility of the Case Manager at Adult Community Mental Health.

Addressing the Needs of Individuals with Concurrent Disorders
When preparing for discharge, staff in the unit would ensure a client:

- Is medically (physically) evaluated
- Receives a mental health examination and subsequent diagnosis (to qualify for services)
- Receive a functional evaluation to determine the level of care required
- If eligible, clients would be assisted with applications for person's with disability (PWD) funding, which follows a diagnosis
- Acquired Brain Injury team or home health liaison would be brought in to assist with follow up care regarding trauma, diabetes management, as needed

Early on in treatment, the housing case manager (HCM) would meet with the client to work toward a placement in a group home (see resources described in Section 1.3). Expectations would be outlined and the housing case manager would provide direction to the social worker and occupation therapist. When the individual is medically stabilized, the HCM would tour a group home to assist in transition, and upon discharge the HCM would continue to support them in identifying with current and past supports. The challenges identified for individuals with concurrent disorders include readiness to stop drug and/or alcohol use. There is no damp housing on the North Shore. Additionally if a client has an acquired brain injury (ABI) there are few follow-ups or supports on the North Shore. This requires a collaborative approach from multiple teams in order to ensure effective support.

[5] See Overview for definition of 'trauma-informed practice.'

2.3 Resources Used in Discharge Planning

VCH-Association Resources

The discharge team may contact a number of community partners to support the discharge process. The team will contact the Housing Coordinator, who works with Adult Community Mental Health (ACMH) in cases where housing has been identified as a concern. The coordinator will assess the client to see if they are suitable for one of the five housing options currently funded through Vancouver Coastal Health (VCH) on the North Shore. These housing contracts are given to vetted non-profit housing and service organizations to provide residential care for clients being discharged from North Shore inpatient programs:

Housing Provider	Type of Care	Total Units
Marineview Housing Society	• 2 licensed care homes (25 units total) • 1 apartment building for independent living (21 supported units)	46 supported units
18th Street Community Care Society	• 5 group homes (25 units) • 100 independent living units •	125 units
Canadian Mental Health Association (North Shore)	• 3 group homes	19 units
Kimray Society	• 1 specialized staff facility for 1:1 rehab and support	4 beds
C&E Carehome	• 1 group home (custodial care)	6 units

In addition to the housing and support resources offered through ACMH (via Community Psychiatric Services), the team may access the following VCH resources:

- Assessment and Treatment Services
- Rapid Access Psychiatric Services
- Stepping Stones (alcohol and drug issues)
- Acute Home-Based Treatment Program
- Older Adult Mental Health
- Tertiary in-client programs

Community Service Providers
In some cases a community service provider may be contacted to provide additional support in discharging a client. This could occur when a client has identified that they have a relationship with that service provider, or in situations where a service may provide ongoing support and stability to a client. These services providers include (but are not limited to):

- Hollyburn Family Services
- CMHA
- Community Living BC
- John Howard Society
- Iranian Educators Society
- Family Justice Centre
- Legal Aid
- Victim Services
- Lookout Shelter Society

2.4 Characteristics of a Successful Discharge

Staff at Lions Gate identified a number of factors common to most successful discharges. **Recovery** is the first major factor. Clients are more likely to be stable over the long-term if they show **clear, positive change** from the state they were in when entering the unit. A client's ability to be aware of their mental illness and work to address it by committing to treatment is key to their success.

Strong support networks are also very important to ensuring long-term positive outcomes. Staff noted that the likelihood of readmission or risk of homelessness is greatly reduced where family or a close friend were engaged in the treatment and discharge of a client,.

The development of a **long-term treatment plan**, involving housing (either an established home to return to, or entry to one of VCH's contracted partners), follow-up with a case manager in ACMH, and access to other support services were seen as part of a successful planning and discharge process.

2.5 Barriers to Successful Discharge Planning: Hospital Perspective

A number of challenges arise in the discharge planning that can put clients at risk of homelessness, or even result in clients being discharged to a shelter. If a client **lacks a support network**, or has a negative relationship with their family, they may not have a stable home to return to when being discharged. In these cases, if they are suitable a client may be discharged to one of the mental health housing providers on the North Shore. In rare cases, if no suitable housing is found and there are no other discharge options, the client could be discharged to the street or a shelter.

Another barrier may be a client's **lack of commitment to treatment**. Positive long-term mental health and housing outcomes remain uncertain unless a client works with the staff on the unit and with ACMH after discharge,

Staff identified that clients with addictions issues (and therefore **concurrent disorders**)[6] who are unwilling to seek treatment as those most likely to be at risk of homelessness. Staff noted that clients can choose to live at risk, and if they do not pose an immediate threat to themselves or others they may choose to refuse treatment. The North Shore currently **lacks any 'wet' or 'damp' housing options** for individuals with mental illnesses, and staff cited this gap as a barrier to supporting clients with concurrent disorders.

Staff also noted that clients with **behavioural issues** were also a challenge for finding appropriate housing. It may be that current housing options (e.g. staying with family or friends) are not suitable in the long-term, or clients may already have burned bridges with their support network or other forms of supported mental health housing. Staff noted that resources are not available to develop a client-centred response that ensures the stability of their mental health and consequently of their housing situation for clients with concurrent disorders and/or behavioural issues.

Staff identified other **housing gaps** that make the discharge planning process more difficult. One staff member noted that there is not enough transitional housing which would provide a bridge from inpatient care to appropriate community housing. There is currently one housing option, Magnolia House, which provides transitional housing for approximately three weeks. Staff also identified a lack of appropriate housing for the elderly mentally ill, as seniors housing with minimal supports does not have the capacity to meet their needs. Staff also noted a lack of cluster care, which provides semi-independent apartments for clients. However, there is a pilot project exploring cluster care currently underway on the North Shore. Staff also noted a need for custodial housing to support individuals who may have plateaued in terms of building life skills and will need support in perpetuity. Staff felt these individuals may not be successfully reintegrated into independent community living.

Finally, staff noted that both **VCH and community resources are not always available to fully meet the needs of all clients**, due to a high volume of patients at certain times. Given the large geographic size of the North Shore, outreach teams (operated through ACMH) may not reach all clients as outreach resources are limited. Staff noted that outreach was valuable in terms of preventing admission to the acute unit, and ensuring long-term mental health and housing stability. Staff also noted that cuts to many of the life skills and education programs that clients accessed (e.g. through Capilano University, and the Work BC program) have led to reduced resources. The North Shore

[6] See Overview for a definition 'concurrent disorders.'

also lacks a rapid access outclient service (e.g. Car 87) to address the needs of clients in crisis. Staff noted that there are a number of resources for First Nations clients, including the Aboriginal Navigator and resources available through local bands. However, there are few cultural resources to meet the needs of the growing Persian community. Staff also acknowledged that there are a number of community service organizations working on the issues of both mental health and homelessness. Their resources, however, are limited, and therefore they are not able to fully meet the needs of the North Shore.

2.6 Community Housing/Service Providers

Interviews were conducted with three community service and/or housing agencies which work with mental health clients and/or the homeless population on the North Shore.

Marineview Housing Society
Mandate: Marineview Housing Society's mandate is to provide safe, comprehensive, affordable housing for people living with mental illnesses.

Housing/Services: Marineview manages 46 units for clients with mental illness. Marineview has two licensed care homes (full-time care), one in West Vancouver and one in North Vancouver, with a total of 19 beds, and one house that is staffed 15 hours a day with 6 more beds. Additionally, the society manages an apartment building for semi-independent clients with 21 support units (and 3 market units). Marineview is contracted by Vancouver Coastal Health to provide mental health housing. The licensed care homes generally aim for a client staying up to 2 years, while semi-independent living has no time limit.

Canadian Mental Health Association (North Shore)
Mandate: CMHA is a national organization that "promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness."

Housing/Services: CMHA North Shore provides a range of services, from advocacy to outreach, including one-on-one counselling, telephone counselling, employment services, community education and housing.

CMHA currently has three houses operating on the North Shore with a total of 19 beds. A 4th home is planned for 2014, which would add another 6 beds. All the houses are single-family dwellings in residential neighbourhoods. One house is for older men, one is for younger men with a serious mental illness (and often an addiction issue), and one home is for women. CMHA is contracted by VCH to provide mental health housing on the North Shore. Generally the units are intended to be transitional; however, clients do not have hard time limits imposed upon their stay should they require ongoing support.

Hollyburn Family Services

Mandate: Hollyburn Family Services is a large, multi-service umbrella agency serving the North Shore with a variety of services. However, their services for mental illness and homelessness are limited.

Housing/Services: Hollyburn Family Services Society currently employs a range of service workers, including a Seniors Outreach Coordinator who is engaged in the North Shore Homelessness Task Force. The Seniors Outreach Coordinator works directly with seniors (55+) who are homeless or at imminent risk of homelessness, and this staff member also sits on the North Shore Homelessness Task Force.

2.7 Community Service Provider Role in Discharge Planning

Marineview Housing Society and CMHA (North Shore)

As a contracted housing provider for VCH, Marineview accepts clients being discharged from the Acute Inpatient Psychiatric Unit at Lions Gate Hospital. This referral occurs through the Housing Coordinator, who conducts an assessment with a client who is being discharged and needs housing. While the housing providers have the right to refuse a patient, the key informants at Marineview and CMHA reported that refusals are rare, due to the level of consultation and involvement in discharge planning by both organizations.

Because of the contractual nature of the relationship, both Marineview and CMHA have access to a client's basic diagnosis, additional medical information (e.g. diabetes diagnosis or nutritional requirements) and medication information.

Hollyburn Family Services

As a service provider, rather than a housing provider, Hollyburn Family Services has no formal relationship with the discharge planning process. However, their outreach workers have been asked to intervene or support social workers in discharging clients. This relationship remains informal, and at times can be crisis-driven.

Because this relationship remains informal, Hollyburn Family Services may be provided with a basic overview of a client's situation (with client's consent); however, no additional contextual information (e.g. other medical diagnosis, medication information, etc.) is provided due to privacy concerns.

2.8 Barriers to Discharge Planning: Community Perspectives

Lack of Appropriate Housing

All housing/service providers agreed that there is a lack of appropriate housing on the North Shore. Housing affordability is a major issue for the North Shore, and therefore impacts even those clients who are able to live independently. Additionally, community agencies identified the following significant housing gaps:

- Long-term supportive care for clients who cannot return to independent living
- Appropriate housing for the geriatric population, with appropriate mental health supports
- Housing for individuals with concurrent disorders (low-barrier housing)

In general, the number of units available on the North Shore for mental health clients being discharged is sufficient or nearly sufficient. As noted above, challenges arise with the hard-to-house, the geriatric population suffering from a mental illness, and clients who need long-term support.

Discharge Timeframe and Bottlenecks

Community service and housing providers noted that once clients were admitted to the acute inpatient unit, they were likely to receive a high level of support throughout treatment and during the discharge process. However, staff at Lions Gate often face a high volume of patients because of the relatively few beds available in the inpatient unit. Additional beds (and possibly staff) *or* greater community resources (particularly housing) may be required to ensure that patients are not discharged without appropriate planning to address housing and other concerns.

Community agencies noted that they may not always have the time to connect clients with the appropriate community resources in a timely way. This shorter-than-ideal planning timeframe represents a significant challenge in finding appropriate housing, particularly if clients are not entering one of the contracted housing providers. One key informant noted that in some cases the discharge planning process and involvement of community agencies felt crisis-driven.

Communication and Inclusion in Discharge Planning

Adult Community Mental Health is the main point of contact that all three community agencies have with the mental health system. They therefore have strong links with the staff there. However, because of the nature of the inpatient unit, community agencies may not always be fully involved in the discharge planning process. In some cases they are brought in when appropriate (e.g. a client is identified as suitable for a particular housing situation). However, both Marineview and Hollyburn Family Services felt that they were not always adequately involved in the discharge planning process, despite having long-standing relationships with clients (e.g. providing housing or long-term service delivery to clients). There is no formal link between the acute unit and any of the community agencies. This was flagged as a concern for appropriate and timely discharge planning.

2.9 Opportunities for Change

Staff felt that overall the processes in place to address the housing needs of clients on discharge are in place. The main challenge from staff's perspective is the volume of clients moving through the health system, and that there may not be the resources to address their needs.

Staff cited the importance of additional resources to prevent homelessness, including:

- Additional transitional housing options
- Low-barrier housing resources for individuals with concurrent disorders
- Long-term housing for those who may need permanent support
- Additional community outreach workers
- Other 'soft' supports in place (e.g. support for clients with pets when in the hospital)

While respondents did not specify a total number of units for each of these types of housing, they generally conveyed that *any* units, particularly for long-term care and hard-to-house clients, would make a positive difference.

Community service and housing providers provided a variety of viewpoints on what could be improved. In general there was agreement with staff that the volume of clients moving through the system represent a significant challenge.

In particular, additional communication and cooperation amongst all involved, from acute staff to community service providers, would improve long-term outcomes for clients discharged from the acute unit. One participant in particular suggested an integrated case management model with formalized partnerships between the acute unit, ACMH, housing providers and community service organizations would allow existing stakeholders to share information. While the role for acute staff in that type of model might be limited, ensuring that there are established lines of communication to ensure that housing and community service providers are informed when their clients are admitted to the unit is key.

As with VCH staff, community service and housing providers felt that more housing and community service resources are needed to ensure long-term client stability. One community service provider also noted the importance of appropriate services for an increasing geriatric population with mental health issues.

Finally, both VCH staff and community service/housing staff felt that there might be a role for increased peer support, both in the discharge planning process and in supporting clients over the long-term.[7]

[7] There is currently a peer support program in place for Adult Community Mental Health clients, but they do not participate in discharge planning.

3. Kootenay Boundary Regional Hospital—Acute Psychiatric Inpatient Unit and Tertiary Residential Care

3.1 Description of Mental Health Unit

Program Description

Kootenay Boundary Regional Hospital (KBRH) is located in the City of Trail in the West Kootenays. KBRH serves the Kootenay Boundary Health Service Area, comprised of 7 local health areas: Kettle Valley, Grand Forks, Trail, Castlegar, Nelson, Arrow Lakes and Kootenay Lake.

The hospital has an Acute Psychiatric Short Stay Unit with 12 beds that provides "a structured therapeutic program (including assessment and treatment) to individuals suffering from acute or severe psychiatric illness."[8] There is an associated 9-bed tertiary residential care facility (Harbour House), that provides long-term psycho-social rehabilitation for clients that meet the criteria for tertiary care. This case study will discuss both the acute unit and the tertiary residential facility.[9]

Staffing

Staff for the acute unit consists of a interdisciplinary team. Baseline staffing includes 2 nurses (RPN or RN), who work 12-hour shifts (7am to 7pm and 7pm to 7am). A patient care coordinator (PCC) and social worker both work full-time positions. The PCC works Monday to Friday, 7am to 3:30pm. The social worker works 8:30am to 4:30pm; the social worker spends 1 day a week at Harbour House, and 4 days a week at the hospital. A recreation assistant works Tuesday to Saturday, full-time. The team also consists of a housekeeper and part-time nursing clerk. There are 4 psychiatrists who work on the unit, sharing cases. Additionally, two staff members share the role of urgent response nurses at KBRH, which is a 7-day-a-week resource that unit staff can call upon.

Harbour House staff is also a multidisciplinary team. Staff includes a nurse (RN or RPN) from 8am to 8pm 7 days a week. Life skills workers have three different scheduled shift: from 6:30am to 5:30pm, from 12:30-10:45pm and a night shift from 7pm to 7am. The social worker spends Tuesdays at Harbour House, working 8:30am:4:30pm (this represents 0.2FTE).

Client Characteristics

The acute unit at KBRH manages a range of clients with severe and persistent mental illnesses, aged 16 and up, generally reflecting the demographic composition of the

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[8] Interior Health 2014a.

[9] Because KBRH is a regional hospital, it serves a wide geographic area. Identifying community service providers from all communities served by the hospital was beyond the scope of this project. Instead, this research focuses primarily on services available in Trail, with some discussion of broader regional discharge planning practices.

region. The majority of clients have an Axis 1 diagnosis, and in many cases these clients have some housing insecurity.

Harbour House clients must meet the criteria for tertiary care, which is defined as "individuals with a mental illness who have not responded to treatment. These individuals have experienced ongoing difficulty with managing their illness and living in the community"[10] in a deinstitutionalized and "interactive community environment." Clients typically have Axis 1 diagnosis, brain injury, an addiction issue or cognitive impairment.

Length of Stay

The length of stay at KBRH's acute unit ranges from one to six weeks, depending on need and nature of illness. Clients may be discharged to their home community, or referred to tertiary inpatient care in Kamloops (Royal Inland Hospital),[11] which is responsible for long-term referrals to Harbour House. The length of stay at Harbour House is significantly wider: it can be as little as two months and some clients have stayed as long as seven years. In general the period of time from admittance to emergency is relatively short unless the unit is full. If the unit is full it can take longer; however, when staff know there's a patient waiting they can generally plan for admission.

[10] Interior Health 2014b.

[11] Royal Inland Hospital is one of two Interior Health 'tertiary referral hospitals' where any patients requiring tertiary mental health treatment would be transferred for assessment and treatment prior to entering tertiary residential.

3.2 Overview of the Discharge Planning Process

Discharge Planning Team

Both the acute unit and KBRH use a team approach to discharge planning. A weekly regional conference is held regarding the status of patients in the acute unit. The meeting includes unit staff (psychiatrists, nurses, a social worker and the PCC) and partners in the Community Mental Health and Addictions teams from Trail, Nelson, Grand Forks and Castlegar, and the Developmental Disability Mental Health team in Castlegar. These weekly conferences provide updates on treatment and discharge planning. In addition to weekly conferences, the PCC will prepare daily reports to client psychiatrists to brief them on the discharge planning process.

A team approach is taken for discharge planning at Harbour House as well. This planning includes the Tertiary Team Leader, nursing staff and life skills workers.

Discharge Planning Approach

Discharge planning on the acute unit begins at admission and is tailored to individuals' needs. The social worker engages clients in an open conversation to build trust. Over time as a client is stabilized, the social worker identifies needs the client may have upon discharge. This can include income assistance and housing supports. The social worker will also contact family and friends to identify a client's support network and involve them in discharge planning. Finally, the social worker will help clients with a plan to follow upon discharge; this includes identifying a suitable housing situation. As noted above, regular weekly meetings involving Community Mental Health staff are held, and Case Managers and Outreach Workers will be asked to provide input on patient discharge and prior treatment.

The longer-term nature of the tertiary residential facility means discharge planning takes place over a longer period of time than in the acute unit. As noted above there is a team discharge planning approach at Harbour House. Because tertiary care focuses on individuals who have faced challenges in returning to their communities, staff members will contact previous case managers, outreach workers and community psychiatrists in order to identify what treatments have not worked in the past, in an effort to ensure appropriate supports (e.g., housing, income support, etc.) are in place upon discharge.

Ongoing Client Monitoring

Because the unit at KBRH treats acute pschyiatric need, unit staff will hand responsibility for monitoring patients on an ongoing basis to Community Mental Health staff. This hand-over of responsibility also occurs at Harbour House, when discharging clients into the community. However, because of the long-term nature of Harbour House tertiary treatment, patients are often invited to drop by the facility informally after their discharge, or return for seasonal events (e.g., Thanksgiving and Christmas), thereby maintaining long-term therapeutic relationships with staff at Harbour House. In some

cases, patients may be 'stepped down' to McBride Manor, a supportive living facility operated by Interior Health.

3.3 Resources Used in Discharge Planning

Interior Health Resources

Staff members at both the acute unit and Harbour House have access to several housing supports run by Interior Health. Interior Health currently operates one 8-bed residential facility in Trail, McBride Manor. This facility uses a support service model to encourage life skills training and successful community integration. When patients leave McBride Manor they may move to McBeth Manor (see below).

Interior Health also provides the Choice in Supports for Independent Living (CSIL) program, a self-managed model of care where clients assume responsibility for coordinating their home care needs. This program is suitable for some high-functioning clients.[12]

McKim Cottage, operated by Interior Health in Nelson, also provides transitional housing for adults being discharged from the acute unit, and can serve as a step-down transitional apartment for clients.

In addition, some seniors are referred to Long-Term care because of their age and because they may have mental health issues that can't be addressed through tertiary rehabilitation or in the community.

Finally, the main modes of long-term support in communities across the Kootenay Boundary Health Service Area are the regional Community Mental Health teams (noted above in discussion of weekly regional conference).

Adult Community Mental Health also operates a clubhouse in Trail for clients, which can be accessed between 8:30am and 4pm during the week. There are also Acquired Brain Injury Services through Interior Health that provide supports for individuals with brain injuries.

Community-Based Resources

In discharge planning, acute unit and Harbour House staff may access the following community-based housing resources:

- McBeth Manor: Operated by CMHA in Trail is a seven-unit facility for independent adults with mental health needs. Residents receive one meal a day and light housekeeping assistance. Clients will often move from McBride Manor to McBeth Manor as they gain independence.

[12] Interior Health 2014c.

- Seniors Housing Information Program (SHIP): An informational resource coordinated by the Senior Services Society that provides an online directory for seniors' housing.
- Ward St. Place: Based in Nelson and operated by Nelson Cares Society, this facility provides 34 units of single residential occupancy.
- Stepping Stones for Success: An emergency shelter operated by Nelson Cares with 17 beds.
- WINS Transition Housing: Transition housing for women fleeing violence in Nelson, Grand Forks and Trail, with second stage housing in Grand Forks and Trail.

Additionally, when discharging from the acute unit, staff may look at inexpensive rental options in the newspaper or online with clients.

In addition to those housing resources, clients may be referred to the following community resources:

- Trail Family and Individual Resources (FAIR)
- Career Development Services (Trail)
- AIDS Network Kootenay Outreach and Support Society (Nelson)
- Kootenay Career Development Society (Nelson and Castlegar)
- Freedom Quest Regional Youth Services
- Trail's Extreme Weather Emergency Shelter, which operates between October and March during extreme weather

In some cases other relevant agencies, such as the Ministry of Social Development, or BC Corrections if a client is on probation, may be contacted.

3.4 Characteristics of a Successful Discharge

Staff at both the KBRH acute unit and Harbour House identified a number of common features in clients who are successfully discharged into the community.
Clients who **engage well in programming** and **respond well to treatment** (including adhering to medication and long-term treatment plans) are most likely to be successfully discharged.

Strong support networks are another key factor in positive long-term housing outcomes for discharged patients. Clients whose families or friends are involved with discharge planning and able to provide long-term support will be more likely to remain stable in their housing once back in their community.

Long-term planning, including a clear plan to access housing and income supports, is a third vital component to long-term client success. Ongoing engagement with community supports (support groups, case managers, clubhouses, etc.) represents an important part of a client's long-term plan.

3.5 Barriers to Successful Discharge Planning: Hospital Perspective

As noted above, support networks form an important part of a client's stability upon discharge. Clients who **lack support networks** or have a negative relationship with their family as less likely to find stable housing over the long-term.

A client's **lack of engagement with treatment and planning**, particularly medication compliance, represents another barrier to long-term success. Patients may leave Harbour House against medical advice, and in these cases there is a limited amount of planning that staff can engage in with them to ensure that they have appropriate housing and other supports. In other cases a patient may decline to engage in discharge planning. In these cases patients may resist finding appropriate or affordable accommodation in advance of the discharge process. In this case, unless the person is 'under certificate,' there is little staff can do.

Clients with **concurrent disorders**, particularly an addiction issue, are more likely to face housing instability in the short and long term. The lack of low-barrier housing in Trail and the broader region means that individuals with concurrent disorders who refuse treatment will often not have access to housing, or will find housing that is inexpensive but unsafe.

3.6 Community Housing/Service Providers

Interviews were conducted with three community service and/or housing providers who work with mental health clients and/or the homeless population in Trail.

CMHA Kootenays
Mandate: CMHA's mandate is "to promote mental health, wellness and emotional stability of all individuals within the communities we serve."

Housing/Services: CMHA Kootenays operates McBeth Manor in Trail, which has 7 long-term units for stable individuals with mental illness. They receive one meal per day, and life skills supports (e.g., groceries are provided and paid for through the program). Additionally, the Adult Community Mental Health outreach workers make regular visits to McBeth to support clients. CMHA also operates Silver City in Trail, a 34-unit building for independent seniors. CMHA Kootenays provides other housing (e.g., transitional housing for PWDs, etc.) elsewhere in the region, such as Golden and Cranbrook.

Career Development Services
Mandate: The primary mandate of CDS is to provide employment services to residents of Trail and the Lower Columbia Region.

Housing/Services: CDS does not directly provide housing to its client base. However, the organization works with landlords in the community to find rental housing for

clients, and maintains a list of about 50 units if a client needs low-rent accommodation. The organization also advocates to landlords on behalf of clients, for continued availability of low-rent housing and appropriate upgrades and maintenance. CDS also coordinates the Extreme Weather Emergency Shelter that operates in Trail during the winter, funded by BC Housing.

CDS has a variety of service contracts with organizations such as the Trail Skills Centre and Community Living BC for employment services and outreach work. Much of the work that CDS does is support for clients in accessing additional community services: CDS will work to ensure clients can access income assistance and other services that they may not be aware of in the Trail area.

Trail Family and Individual Services (FAIR)
Mandate: Trail FAIR is a community service agency, and as such provides a wide range of programming to meet the needs of Trail and the Lower Columbia Region.

Housing/Services: Trail FAIR operates the WINS Transition House, which provides 4 units of short-term housing for women leaving abusive situations. Trail FAIR also operates Nova Vita Second Stage Housing, which is 6 apartments for women leaving WINS, who can stay in these apartments for up to one year.

Trail FAIR provides a range of services that support clients with mental health issues. These include family support services, a mental health advocate, and children's support workers.

3.7 Relationship to Discharge Planning

CMHA Kootenays
CMHA Kootenays does not have any formal links to Interior Health for mental health clients, but maintains strong community connections. When clients leave McBride Manor and need some form of ongoing support, they may be referred to McBeth Manor. When a client of CMHA or a resident of McBeth is admitted to the acute psychiatric unit, staff on the unit will usually communicate informally with CMHA staff regarding patient status and notify them of discharge when it occurs.

Career Development Services
No formal relationship exists between CDS and Interior Health. However, CDS staff members have frequent direct contact with clients with severe and persistent mental health issues. Additionally, residents of McBride Manor may access the services provided by CDS.

Trail FAIR
No formal relationship exists between Trail FAIR and Interior Health. Trail FAIR may refer clients to case workers at Adult Community Mental Health. Additionally, if Trail

FAIR staff members know that a client has been admitted to KBRH (either emergency or acute psychiatric), staff may visit clients to provide ongoing support.

3.8 Barriers to Successful Discharge Planning: Community Perspectives

Lack of Appropriate Housing

Community service and housing providers all noted the lack of housing resources in Trail and the area around it. While rents are cheaper in Trail than in other areas of the Kootenays, rent for most units remains higher than the rental allocation for an individual on income assistance. Many of the low-rent units in Trail are of poor quality and may need significant maintenance. In addition to the increased cost of housing in the area, there is no formal low-barrier housing for the hardest to house.

The Lower Columbia Region's Attainable Housing Committee is currently working on addressing the lack of housing, and some units are planned; however, these have not come online yet.

Lack of Services

Interviewees noted that the Adult Community Mental Health outreach workers provide an important service in supporting clients in their homes. However, community service and housing providers felt that there were not enough outreach workers to meet the community's needs.

Trail has a mental health clubhouse that operates during the week from 8:30am to 4pm. While this is a valuable resource for many clients, it does not suit all clients' needs, and has limited operating hours.

Funding decisions have meant that some mental health services that were available in Trail no longer are. Lack of basic amenities, such as low-cost child care and transportation, can also significantly impact a client's stability in the community.

Discharge Timeframe and Bottlenecks

Two of the community service and housing providers noted that the limited capacity of the acute unit and the timeframe for client treatment can mean that clients may be released before they are fully ready to integrate back into the community. In particular, pressure to admit new patients may mean that patients who are stable may be discharged before they are fully prepared. Interviewees recognized that the mental health system faces significant pressure due to volume of patients moving through all parts of the provincial mental health system, but noted that this issue remains a real concern for local service agencies that struggle to serve the needs of these clients. Additional beds (and possibly staff) *or* greater community resources (particularly housing) may be required to ensure that patients are not discharged without appropriate planning to address housing and other concerns.

Communication and Inclusion in Discharge Planning
Two of the community service providers voiced a strong desire to be more involved in discharge planning for their clients. While all agencies have a strong relationship with the Adult Community Mental Health team, two noted that they could better serve their clients' needs if hospital staff engaged them more in discharge planning during the treatment phase, prior to discharge, in order to ensure that clients are properly supported in the community when released.

Communication with High Needs Clients
One interviewee noted that all staff may not always use the most effective communications tools for high needs clients. In particular, clients who may be illiterate or have non-conventional learning styles may not fully understand the language and approach medical staff use during the discharge process. This highlights different approaches used by grassroots organizations and medical professionals, in engaging with high needs clients.

3.9 Opportunities for Change

The above qualitative data shows a number of opportunities for improvement to the discharge planning process to ensure positive long-term housing outcomes for clients.

A primary concern is the development of appropriate housing supports for clients. In some cases these exist in Trail (McBride and McBeth Manors). However, additional low-rent apartment units would help support stable clients who are discharged from both the acute unit and the tertiary residential care. The Lower Columbia Region's Attainable Housing Committee is currently working with BC Housing and the Columbia Basin Trust to develop affordable units through the region, which may in part address this gap. However, the need for affordable non-market rentals currently remains acute.

Lack of low-barrier housing options in the area also represents a significant housing gap. Hard-to-house clients who do not successfully engage with treatment and medication lack transitional or supportive housing options in the area.

Additional community supports, particularly more outreach workers, would be another effective tool allowing clients to maintain their independence and stay stably housed upon discharge.

Developing stronger relationships between the mental health system (both the acute unit and Adult Community Mental Health) and community stakeholders represents another opportunity to improve discharge planning to meet client needs. While informal relationships have been effective in some cases, they have not fully engaged all stakeholders. Developing a formal mechanism for community service providers to prepare for the discharge of high needs clients would strengthen their ability to meet those clients' needs, and possibly reduce the likelihood of readmission. If community-based service and housing providers were more fully included in discharge planning processes (where appropriate) they could more fully participate to ensure that all community-based supports are in place for discharged clients.

4. St. Mary's Hospital—Psychiatric In-patient Unit

4.1 Description of Mental Health Unit

Program Description
St. Mary's Hospital is located in the District of Sechelt on the Sunshine Coast, and serves as a small regional hospital for the Sunshine Coast Regional District. The hospital has a 6-bed psychiatric in-patient unit (PIPU) (expansions are currently underway at the hospital, including for the psychiatric inpatient unit, which will likely see an expansion to at least 10 beds by 2016). The unit provides "inpatient psychiatric care, including individual work and groups [and f]ocuses on active short-term assessment and treatment."[13]

Staffing
The unit staff is an interdisciplinary team. A nurse position is present in the unit 24 hours a day, in 3 shifts (7:30am-3:30pm; 3:30pm-11:30pm; 11:30pm-7:30am). A second staff position rotates between a Patient Care Coordinator (7:30am-3:30pm), a licensed nurse practitioner (3:30pm-11:30pm) and a care aide (11:30pm-7:30am). This staffing is maintained seven days a week. One psychiatrist serves the inpatient unit.

A safety backup nurse is available at night on an on-call basis. As of October 2013 a social worker was available on an on-call basis to the unit. The unit had access to auxiliary staff from Adult Community Mental Health, though this happens less frequently, and an occupational therapist (OT), but this position has been eliminated, and OT services are now available on an on-call basis.

Client Characteristics
The unit accepts patients as young as 14 years old and up to approximately 90 years old. Patients are primarily Caucasian; however, the unit also admits a number of First Nations clients. Both First Nations clients and clients under 30 are often diagnosed with an Axis 1 disorder. A majority of these clients (approximately 60 to 70%) have a concurrent addiction issue. The unit is increasingly seeing older clients with who have adult mental health issues combined with dementia, and staff expect to see this increase as the population of the Sunshine Coast ages.

Length of Stay
There is no maximum limit to the length of stay in the unit; however, the longest most clients do not stay in the unit past 3 months and are discharged or transferred prior to this deadline. Because of the small nature of the unit, clients may be transferred to tertiary care in Gibsons (Sumac Place), or discharged to their homes or elsewhere to be monitored by the Adult Community Mental Health Team if a bed is needed for another patient.

[13] VCH 2014c.

4.2 Overview of the Discharge Planning Process

Discharge Planning Team

Discharge planning falls to all members of the interdisciplinary team, with the unit psychiatrist approving final discharge. The psychiatrist, nurses, Patient Care Coordinators (PCCs) and the Adult Community Mental Health (ACMH) case manager develop a discharge plan for each client, which is reviewed with the client. If the he or she needs additional resources (e.g. housing support, income support), the PCC will assist in accessing these, while case managers at ACMH will work to identify the situation that led to admission.

Discharge Planning Approach

Discharge planning begins when a client is admitted to the unit. The PCC will often work with clients to identify their needs and vulnerabilities, including working through a housing checklist to determine their housing status. Staff on the unit will identify any community resources that clients may have accessed, as well as family members or other appropriate support systems the client may have in place. Much of the information staff members receive comes from clients themselves. This can present a challenge to discharge planning as in some cases a client does not provide relevant information.

Ongoing Client Monitoring

Adult Community Mental Health is responsible for long-term client monitoring. As part of the discharge process, clients with higher needs are assigned an outreach worker, who provides ongoing outreach services to the client. Client engagement with Adult Community Mental Health is mandatory only for clients on Extended Leave.

Addressing the Needs of Individuals with Concurrent Disorders

When preparing for discharge, staff in the unit would work to:

- Identify and connect the client to the most appropriate community mental health resource. (i.e. long-term mental health case management or Addictions clinician with access to drug treatment)
- Find out how much money the client has and where it comes from (provincial Income Assistance can be diverted directly to housing costs rent, but Canada Pension cannot unless the client is certified and/or deemed incompetent).
- Assess what the client might spend their money on (if it is diverted away from housing)
- Identify whether the client is suitable for tertiary mental health which significantly improves there chance of success with respect to both housing and employment.

- Assess if they are appropriate for any of the mental health housing (see Section 3.3) on the Sunshine Coast

If staff sees that a client may need additional support transitioning back into the community, a graduated discharge program (longer passes, overnight passes, increased independence with medication, additional outreach services) would be implemented. While the community mental health team has an ongoing role in reaching out to clients as they return to the community, currently the role for all housing providers (both mental health housing and landlords) is very limited. Particular barriers for these clients include lack of supportive housing (particularly wet or damp housing), lack of income and negative peer influence.

4.3 Resources Used in Discharge Planning

VCH Resources

VCH currently provides several options for long-term supports for individual discharge from the PIPU. Sumac Place in Gibsons provides tertiary mental health treatment based on a rehabilitation and recovery model. Additionally, VCH operates 2 supportive housing facilities on the Sunshine Coast:

Housing Provider	Type of Care	Total Units
Chapman House (Wilson Creek)	• 24-hour licensed care	6 beds
Fairview House (Gibsons)	• Part-time care and independent living	5 beds

VCH also provide approximately 20 Supported Independent Living (SIL) subsidies for housing. SIL subsidies are split between designated SIL apartments and subsidies provided to individuals that offset rent in market units.

Adult Community Mental Health employs two case managers (1.75 FTE) and two outreach workers (2.0 FTE) and a Vocational Rehab Coordinator to provide long-term, ongoing support to clients. Additionally, staff members on the unit have started informally accessing Home Care Teams to visit discharged clients to ensure they are taking their medications.

Community Service and Housing Providers

As a small, rural region, the Sunshine Coast has relatively few housing and service options for individuals with mental illnesses. Eight units of mental health housing (Legacy Housing in Sechelt) were recently developed (units became available in early 2011), on the same property as the Arrowhead Centre, a clubhouse society that provides services to its members in a structured clubhouse setting 4 days a week. It should be noted that turnover of residents in these units is low.

The Yew Transition Home in Sechelt is a resource for women leaving situations of violence, operated by Sunshine Coast Community Services Society. This Society also provides general community services. In some cases, Adult Community Mental Health staff may liaise with employment service organizations on behalf of particular clients.

4.4 Characteristics of a Successful Discharge

Clients who show **clear, positive change** are more likely to be successfully discharged. Showing insight into their illness, and a willingness to continue with treatment and medication are central to positive long-term housing outcomes.

Strong support networks including a concerned family that is supportive of a client represents another key factor in successful discharge. Staff noted that long-term dependency on support networks can 'burn out' family and friends, but that these support networks remain vital to recovery.

Patients with a **long-term treatment plan** that includes a stable housing component (either returning to an established housing situation or identifying new, appropriate and affordable housing), follow-up with Adult Community Mental Health, and in some cases access to community services, such as the Arrowhead Clubhouse are the most likely to succeed.

4.5 Barriers to Successful Discharge - Hospital Perspective

Affordable housing gaps represent a major barrier to long-term stability for clients discharged from the unit. Other than the 11 units of VCH housing and 8 units of Legacy Housing, there are no supportive housing options on the Sunshine Coast for individuals with a mental illness. There are also no low-income housing options for individuals, and no low-barrier housing options available for individuals with complex diagnoses.

Concurrent disorders, particularly an addiction in combination with an Axis 1 diagnosis, can be a major barrier to successful long-term housing outcomes. As noted above, there are no low-barrier housing options for individuals in this situation, and clients who are not certifiable are free to choose to live at risk.

A lack of family or other support network is another barrier to successful discharge. Without supports in recovery, clients are more likely to face risk of homelessness.

Clients who are **unwilling to commit to treatment** (including adhering to medication and regularly working with outreach workers or case managers) are less likely to see positive long-term housing outcomes. While there are a variety of reasons why clients may refuse treatments, one interviewee noted that First Nations clients may not engage with a treatment plan because of the **historical legacy of residential schools**, and a lack of culturally relevant or appropriate services within the mental health system.

Being a small, rural hospital, St. Mary's also sometimes experiences high pressure on **limited mental health and addictions resources**. While this is being addressed through the expansion of the PIPU, currently unit staff may be working specific tasks 'off the side of their desks'(e.g., identifying income and housing supports). This role would traditionally fall to a social worker, a staff position not available to the PIPU at the time of interviews.

Finally, staff noted that a number of other stressors, including **negative peer influences**, **the stress of being out of hospital, involvement with the justice system** and often **living in poverty** can all place additional burdens on clients that negatively impact long-term housing outcomes.

4.6 Community Housing/Service Providers

Three community service and/or housing agencies who work with mental health clients and/or the homeless population on the Sunshine Coast were interviewed.

Arrowhead Centre
Mandate: Arrowhead's mandate is to serve anyone living on the Sunshine Coast with a history of mental illness

Housing/Services: Arrowhead works under the International Center for Clubhouse Development's clubhouse model. Arrowhead provides a range of opportunities for members to participate in clubhouse operations, including a lunch program, prepared by members, a garden tended by members, and clubhouse administration program. Members also provide peer support for each other. The Legacy Housing is also on the same property, and supported by ACMH outreach workers. Residents are not required to become Arrowhead members, but are encouraged to do so. Arrowhead is currently funded by BC Housing and operated through Sunshine Coast Community Services Society.

Sunshine Coast Extreme Weather Emergency Shelter
Mandate: The Sunshine Coast Extreme Weather Emergency Shelter (EWES) is an emergency shelter for all residents of the Sunshine Coast.

Housing/Services: EWES is currently hosted by St. Hilda's Anglican church and operated by the Salvation Army. The shelter operates between November and March each winter. The shelter is open on nights of extreme weather, and has an associated meal program prior to opening.

Child and Youth Mental Health and Wellness Liaison
for Aboriginal Youth
Mandate: This position, staffed by one person and funded by MCFD and managed by the Sechelt Indian Band, provides a point of contact for all Aboriginal youth on the Sunshine Coast.

Housing/Services: The Liaison provides support to Aboriginal children and youth by organizing cultural groups, liaising with VCH Mental Health Services and working with mental health clinicians to make them aware of cultural concerns and cultural activities in the community. The liaison provides support to children, youth and families who may have undiagnosed mental health issues in an effort to refer them to appropriate clinicians. The Liaison has worked with at least one client admitted to St. Mary's PIPU and provided support during hospitalization of that client to both the client and the client's family.

4.7 Role in Discharge Planning

Arrowhead

Arrowhead has an informal relationship with Adult Community Mental Health. If an outreach worker determines that Arrowhead may be a good fit when a client is discharged they will introduce that client to the staff at Arrowhead. There is also strong overlap in staff between Arrowhead and Chapman House, with staff working part-time positions at each facility. The facilities are not formally linked, but do share this informal connection.

Arrowhead staff monitors members, and there are informal peer supports in place. Staff may make a referral to the crisis line, which is answered by the hospital social worker at St. Mary's. If a client is admitted the social worker will usually do some form of follow up with Arrowhead.

EWES

The Extreme Weather Emergency Shelter does not have a role in discharge planning, and is not notified by St. Mary's or Adult Community Mental Health if a patient is discharged who may need emergency shelter.

Child and Youth Mental Health and Wellness Liaison for Aboriginal Youth

The Child and Youth Liaison is called in on a specific case-to-case basis. Where appropriate, the Liaison will pay a role in planning discharge, including liaising with the family, community and other relevant parts of the government system (e.g. MCFD). This is not a formal role, but when it occurs includes high levels of engagement.

4.8 Barriers to Successful Discharge: Community Perspectives

Lack of Appropriate Housing

In general, affordable housing is hard to find and in high demand on the Sunshine Coast. There is no low-barrier housing on the Sunshine Coast and support programs for homeless outreach (which operated from 2010 to 2011) have had funding discontinued. The cost of rental for even small units is generally significantly higher than the shelter component of Income Assistance. Arrowhead Clubhouse regularly has members who are looking for affordable housing options.

There are a very limited number of supported units on the Sunshine Coast. While the Legacy Housing development in 2011 represents an important step forward, it does not fully address the housing need for the population that has mental health problems.

Discharge Timeframe and Bottlenecks

The limited capacity of the St. Mary's PIPU (6 beds) can mean that clients may be released before they are fully stabilized, according to some community services providers. In particular, the pressure to admit new patients from the emergency department may mean that patients who are stable may be discharged before they are fully prepared. While key informants are aware that the unit is small and faces significant pressure due to volume of patients moving through all parts of the health system, this was still cited a concern for local service agencies that may not be prepared to meet all a client's needs. This issue will likely be (at least partly) addressed through the addition of 4 or more new beds (for a total of at least 10) with the expansion of the PIPU, slated for completion in 2015. However, additional community resources (particularly housing) may be required to ensure that patients are not discharged without appropriate planning to address housing and other concerns.

Lack of Community Services

The Sunshine Coast has a limited number of organizations that provide support for the homeless and individuals with mental health problems. Mainstream service organizations (e.g. Sunshine Coast Community Services Society) are not equipped to address the needs of the severely mentally ill.

Those services that do exist for individuals with mental health problems usually operate on a limited budget and with restricted hours (e.g., Arrowhead Clubhouse is open approximately 25 hours a week). There are currently no service organizations on the Sunshine Coast that work primarily with individuals with concurrent disorders, though some of their needs may be met through the EWES and associated food program. There currently exists no form of rapid response or assertive community treatment (ACT) for mental health issues.

Communication and Inclusion in Discharge Planning

While the Aboriginal Youth Liaison is contacted when appropriate, Arrowhead Clubhouse is rarely notified that a client may be discharged back into the community. While this would not be feasible or appropriate for all discharges from the PIPU, if there is a known and established relationship between a client and Arrowhead, providing some notification to the Clubhouse staff would be useful in addressing the client's community needs.

Transportation

The dispersed, rural nature of most Sunshine Coast communities makes transportation a major issue for individuals and families who do not have a vehicle. The lack of transportation options[14] means that individuals living outside the Gibsons-Sechelt

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[14] The Sunshine Coast is serviced by 4 bus routes. The primary bus route travels between the ferry at Langdale and Sechelt. It runs approximately once per hour in each direction. Transit at less frequent intervals extends as far north as Halfmoon Bay, and does not service the Pender Harbour/Egmont

corridor may have difficulty making appointments at St. Mary's for services. The additional cost of public transportation can also place a burden on low-income individuals, though sometimes bus tickets are available through service organizations (e.g., Arrowhead and Sunshine Coast Community Services Society).

4.9 Opportunities for Change

There are a number of opportunities for change in the discharge planning process to address homelessness and risk of homelessness.

The primary issue identified by both health care and community service providers is the lack of appropriate and affordable housing. There are a number of groups on the Sunshine Coast currently working on this issue; however, there is a role for Vancouver Coastal Health and the provincial government to play in providing supportive housing for individuals leaving the PIPU. Adopting a model similar (though at a smaller scale) to the one utilized by Lions Gate Hospital (with contracted housing providers) may be an appropriate approach. St. Mary's will be adding new beds to the psychiatric unit in 2015. This will ease pressure on staff to discharge clients in order to free up beds. However, there will still be a need for long-term housing solutions for individuals with mental health problems.

Additional community supports could also significantly improve long-term outcomes for clients. Additional outreach workers and case managers through ACMH would provide additional support. Increasing the capacity of organizations like Arrowhead to expand their hours would also provide a community-based support system for monitoring the well-being of clients.

Developing some form of more formalized information-sharing between Arrowhead and St. Mary's/ACMH could also increase the ability of community service providers to respond to the needs of clients once they are discharged. . If Arrowhead and other community-based service and housing providers were more fully included in discharge planning processes (where appropriate) they could more fully participate to ensure that all community-based supports are in place for discharged clients.

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communities on the north end of the peninsula, or the area beyond Langdale toward Port Mellon on the east side of the peninsula.

5. Burnaby Centre for Mental Health and Addictions Residential Treatment Program

5.1 Description of Burnaby Centre for Mental Health and Addictions

Program Description

The Burnaby Centre for Mental Health and Addictions, or Burnaby Centre (BC), is located in Burnaby, BC. Opened in 2008, it is a 100-bed residential treatment program for adults age 19 and over affected by both substance use and mental health issues. The Program is six to nine months duration, with an initial assessment/stabilization period of four to six weeks. Clients can have complex medical and/or behavioural issues, but they must be independent with activities of daily living. The Burnaby Centre accepts clients on probation, as well as those using methadone. Referrals are required from the screening committee of the Health Authority where the client resides. It is wheelchair accessible. Its programme is offered in partnership with Vancouver Coastal Health and PHSA. There is one stabilization unit and 4 treatment units.

Burnaby Centre is a community-based resource meant to fill identified gaps in service for this specific clientele, and with multiple points of access: primary health, hospital, community, and criminal justice. The BCMHA services are accessible to clients from all over the province, through an Access Protocol defining referral processes as well as distribution of beds per health authority.

The main characteristics of the BCMHA program are as follows:

- A voluntary-based program, focusing on assertive engagement by clients, in order to increase treatment retention;
- A strength-based treatment philosophy, to build clients ability to manage and control most aspects of their lives;
- A three-phase program: stabilization (including engagement and persuasion), active treatment, and transition to community;
- An integrated approach to clients' needs, concomitantly treating all four health domains: mental health, addiction, physical health and behavioural issues;
- Service offerings which encompass an array of inpatient professional supports including medical services, nursing and psychiatric care, as well as addiction care, counselling and trauma support, in a combination of individual and group interventions;

- Integration with the community-based services for this clientele and assistance to clients in transitioning to community once their health conditions have stabilized.

Staffing

The centre has 100 full time and part time employees plus 50-70 casual staff. Full time staff are comprised of 40 registered nurses, 20 mental health and addictions support workers (5 each unit), a driver and intake person, 4 social workers, 4 occupational therapists, 3 recreation therapists, 4 patient care coordinators (1 each unit), 5 part-time psychiatrists, 2 part-time general practitioners, 1.6 nurse practitioners, 2 full-time psychologists plus part-time music therapists, art therapists, physiotherapists, dietitian, practise leader, nurse educator, spiritual care practitioner and administration.

Client Characteristics

Clients are generally 30% First Nations and 70% Caucasian. Most patients are in the 30 to 40 year old age range, but clients in their 20s or 50s to 60s are not uncommon. Males represent 60 to 70% of clients (women have access to another facility, Hartwood). The mental heath diagnosis is generally psychosis, bipolarism, schizophrenia, schizo affective disorder, personality disorder, or PTSD – all with addictions. 70% are voluntary clients and 30% are certified. A high percentage of clients are hidden homeless or simply homeless, including those from shelters.

Length of Stay

The maximum limit of stay for clients is meant to be nine months, though in some circumstances this may be stretched if a housing solution or transfer of care takes slightly longer. The length of client stay varies widely depending on a number of factors, including diagnosis and options for discharge.

Access

Beds are allocated proportionally among five provincial health authorities. Vancouver Coastal Health has 27 beds (including five Downtown Community Court beds). Fraser Health has access to the most beds, being the largest health authority in the province. The current waiting list is short, taking no longer than one month to access a bed. (It used to be 6 months). Each HA has its own waitlist and manages its own waitlist. Approximately 50% of clients come from community and 50% from acute hospitals.

5.2 The Discharge Process

Discharge Planning Team

Each of the four units at Burnaby Centre does its own discharge and transition planning, using a team approach. Depending on a client's needs a number of staff may be involved in discharge planning including the social worker, occupational therapist, and patient care coordinator. The team also includes a representative from a referral source such as the Health Authority case manager, addiction worker, or general practitioner - a

designated person at the referral source who knows the client. The client is also involved in decision-making. The team makes a recommendation to the housing coordinator (if there is one) or case-worker based on this comprehensive assessment. (Not all locations have a housing case manager. In most Health Authorities the designated contact is the case manager. Vancouver Coastal Health has a housing case manager who acts as the liaison for Burnaby Centre, and has done so since it opened. This position attends at Burnaby Centre once per month, to complete housing assessments for those ready for discharge.

The Burnaby Centre social worker for the case has responsibility for the discharge plan and for collaborating with the client. The team recommends their preferred option for housing, for example, but if the client does not agree, the client can still choose his or her preference.

An MSW is required for the social worker position, unless the employee was grandfathered prior to that requirement being established. Social workers at Burnaby Centre receive no specialized training in homelessness, but they do shadow shifts at the outset. A social worker does not need to know resources available in each Health Authority, as it is up to each Health Authority to deter exact resource suitable for each discharging patient. However, the social workers do, of course, learn over time.

Burnaby Centre works with the referring Health Authority and, in some cases, community agencies. For example, if the Burnaby Centre team recommends that a client live in market housing with support, a community agency (Progressive for example) may provide support. The Health Authority case manager would refer the client to Progressive, and the Team would meet with Progressive.

There is currently no peer support available at Burnaby Centre. Mental Health Team Strathcona has some peer support workers but they have no particular role in discharge and transition planning.

Discharge Planning Approach

A review of Burnaby Centre after about a year of operation resulted in some changes to the discharge process, the most important of which was the shifting of responsibility for discharge and transition planning from Burnaby Centre to the referring and ultimately receiving Health Authority. However, according to Burnaby Centre, discharge planning is still considered a team approach—Burnaby Centre engages with the receiving Health Authority and provides input to the discharge planning process.

The discharge planning process begins at admission with an early exit plan in case the patient leaves while still in the Assessment and Stabilization Unit. The original referral from the Health Authority has a discharge plan (for housing and other services). The social worker will check that plan and consult with the client. However, sometimes the emergency discharge plan provides no option for housing or it could specify a shelter.

For early or emergency discharge, Burnaby Centre has a standard decision making process, allowing the client (if not certified) to choose where to go. (The client can go to a shelter if there are no other options). The social worker will call the family and the MENTAL HEALTH team, notify them of the time client is leaving, and the staff recommendations. If the client changes his or her mind and wants to return, they must go through the referral process again. Staff follows up with the Team, general practitioner, and nurse practitioners.

At month three of treatment, a comprehensive assessment is done. Staff members have a checklist of steps to go through for discharge and transition planning. This is required to get clients on the housing waitlist, so that by month 8 a space in housing is available. The occupational therapist does a functional assessment and the social worker meets with the client to discuss options and client preferences. The team might prepare two plans, for example, Plan A and B.

The social worker will start the housing placement process early if possible, being mindful of potential stress for the client. Some clients may perceive that Burnaby Centre is trying to kick them out. In those cases staff find it is better to get to know the client better, emphasizing that Burnaby Centre is not trying to kick them out. It is usually hard to find suitable housing, as housing availability and affordability is a widespread problem in the province, even more so for patients at Burnaby Centre. Other clients are different and want to talk about their housing options right away.

The Housing Case Manager uses the Mental Health and Addiction Housing Services Assessment V3 Tool (a tool used by to assess a client's needs). It covers basic demographic information, languages, housing type client referred for, housing history including moves/evictions, history of homelessness, personal history, contacts, relationships with external agencies, risk factors, hospital stays, allergies, medical and psychiatric profile, support needs/resources used, life skills, housing goals and recommendations for housing type. The typical housing trajectory for a Burnaby Centre patient is from Burnaby Centre to Berman House then to Fraser Apts.

Ultimately, the patient can choose their housing placement, no matter what the Burnaby Centre Team recommends. The team may recommend a stepped approach: "Try A for two weeks and see, then you could move to B" (which client wants). Another option is gradual transition; for example, the client goes to their placement for a day, then returns to Burnaby Centre, goes for a weekend, returns, then total discharge.

Burnaby Centre patients in the discharge process are referred to Central Intake for assignment to a mental health team. In the past, mental health staff were reluctant to take Burnaby Centre clients with their complex needs. There was a stigma attached to mental health issues combined with addiction. This has improved with Central Intake.

In addition to housing, the team identifies the type of community support that will be needed and ensures that the patient has a general practitioner on discharge. The occupational therapist and social worker provide referrals to community services, for example Daytox, Echo, YMCA. They complete the forms and letters required, and take care of financial aspects. Some Vancouver community service staff will come to Burnaby Centre to meet the client, to determine if a particular client is a good fit. However, for clients from outside the lower mainland, this is not possible. The Burnaby Centre team provides a general recommendation on the type of community services each client needs (e.g., “client needs to be able to go swimming”) and the local Health Authority team refers the client to specific resources.

The Referral partner provides client information to Burnaby Centre upon intake. While the client is at Burnaby Centre, staff updates the referral partner with new information. Burnaby Centre provides the housing case manager or case manager with client notes and collateral information a week ahead of meeting with patients being discharged. The HCM or CM reviews this information, then interviews the client to determine which housing option would be a good fit.

Some patients are difficult to place in the community for a variety of reasons and this may mean a longer stay at Burnaby Centre while staff tries to find an appropriate placement. Burnaby Centre instituted Alternative Level of Care (ALC) monthly meetings to review all ALC clients, and get assistance with special cases from senior Health Authority staff. After too long at Burnaby Centre, if the patient has completed the program, it ceases to be therapeutic. The client may relapse because they are bored and frustrated.

The original Burnaby Centre discharge and transition planning approach requiring Burnaby Centre to do discharge and transition planning for all their discharging clients was unsatisfactory, resulting in high Alternative Level of Care rates. The current approach requiring the referring Health Authority to assume the lead role was developed to address concerns. Initially there was push back from Health Authorities for this expanded role, but the revised approach has reduced the ALC rate at Burnaby Centre from 30% to 11%. At a recent provincial stakeholder meeting, there were no complaints about the Burnaby Centre discharge planning process.

Ongoing Client Monitoring/Outcomes

Once the client is discharged, Burnaby Centre does post-discharge follow-up. The Burnaby Centre psychiatrist phones the Health Authority at 3 months to track the HONOs score15. They also ensure that the patient is connected to a general

[15] Health of the Nation Outcome Scales. They are 12 simple scales on which service users with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated – say after a course of treatment or some other intervention – and then compared. If the ratings show a difference, then that might mean that the service user's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures.

practitioner. Information is obtained from the Health Authority Case Manager in the community but it can be challenging getting these forms returned. Long-term monitoring of client outcomes is the responsibility of the Case Manager at Adult Community Mental Health.

Table 1: Burnaby Centre Client Outcomes

Burnaby Center outcomes, percentage of patients	Percent
With discharge plan on file	100%
Connected at discharge with a community provider	93.1%
With a general practitioner at 3 months post discharge	90.5%
With addiction counselor, mental health team, ad team connections at 3 months	97.9%
Alternative Level of Care16 (ALC) rate	10.3%

Source: Burnaby Centre. Stats for Qtr 1 and 2, 2013

[16] Means patient could be accommodated outside Burnaby Centre but has nowhere to go.

5.3 Community Resources Used in Discharge Planning

Vancouver Coastal Health, Mental Health Teams and Mental Health Housing
Burnaby Centre works with the mental health team at the referring Health Authority. In some Health Authorities and health areas, mental health housing staff members are available to assist in the housing placement of clients exiting Burnaby Centre. Housing case workers manage access to Vancouver Coastal Health mental health housing resources, as well as contracted services.

In Vancouver Coastal Health, mental health supported housing includes group homes, dedicated apartment buildings, and scattered apartments which provide affordable housing with onsite or outreach support, provided by Coast, MPA, Kettle, PHS, Triage and Katherine Sanford Society. Addiction-supported housing includes group homes, scattered apartments and supported hotels with some alcohol and drug free units to support individuals in recovery (examples PHS, BCH, Chrysalis, Coast).

Community Service Provider
Cultural needs may be met by the Burnaby Centre Team contacting Aboriginal groups in the community, but some clients don't want to be connected with them. These cultural needs are largely for Aboriginal persons; however, Aboriginal resources seem to be overloaded. The Burnaby Centre Team starts with the Health Authority team, who may know culturally appropriate resources in the community.

There are many informal connections between mental health teams and community agencies, for example, in the Downtown Eastside there is the Lookout Living Room drop in centre, and Carnegie Centre Outreach. Lots of non-profits and agencies provide services in Downtown Eastside, also faith-based groups. For example, the mental health teams partner with CMHA to provide employment counselling services at all locations.

5.4 Characteristics of a Successful Discharge

Burnaby Centre staff and mental health teams suggest the Burnaby Centre discharge and transition planning system /process functions reasonably well.

The easiest, most successful discharge (but relatively rare), occurs if the patient has a **place to go upon discharge**, be it with family or elsewhere. Patients in this situation experience less anxiety and can focus on treatment. If homelessness is a concern, it is harder for them to focus on treatment. Patients with Axis 1 mental illness and no difficult behaviours tend to have more successful discharges.

Burnaby Centre has successfully discharged formerly homeless persons if they **engage in the treatment program**. The mental health assessor might look for appropriate housing and allow client to stay longer than 9 months in the Alternate Level of Care if needed. This will allow time to find appropriate housing.

Regular Long Length of Stay meetings were instituted a couple of years ago and are held monthly. Each ALC client at Burnaby Centre is reviewed on the phone with directors and managers of Vancouver Coastal Health Mental Health and Addictions. Number of days in Burnaby Centre, number of days ALC, discharge and transition planning barriers/challenges, and options are considered. Managers get involved and make calls to people in high places to address barriers and blockages. These meetings are considered a best practice.

Staff has also learned not to judge a patient or to make discharge plans based solely on the client's history. Rather, if they have now completed treatment, it is important to look at client strengths and learned skills.

5.5 Barriers to Successful Discharge

The essential challenge of Burnaby Centre is to take 100 people with the most complex needs and house them in a system that was not designed for them. While the health system is moving slowly towards dealing with concurrent disorders, **housing resources don't necessarily match people coming from Burnaby Centre with concurrent disorders**.

There are several primary concerns around discharge planning from Burnaby Centre. The illness itself represents a challenge. **Difficulties associated with mental illness and addiction** (i.e. people are not 100% compliant with medications or still using while in Burnaby Centre), resulting in unsuccessful treatment and/or behaviours that make housing difficult.

The **volume of clients** is another major barrier to successful discharge. New supportive housing can't keep up with the demand for it, making it difficult to discharge individuals to appropriate housing after treatment.

Finally, in the Downtown Eastside the **prevalence of drugs** represents a major barrier to successful discharge. If individuals have been successfully treated but return to the Downtown Eastside they will likely be exposed to substance abuse and may begin using again.

If the patient is engaging in **illegal or violent behaviours** such as selling drugs or sexually inappropriate behaviour placing staff and patients at risk, staff will employ the Clinical Safety Initiative. This involves educating the client about risk and next steps. Burnaby Centre can handle some violence but if they are unsuccessful in modifying the behaviour, then the client is discharged, using the original emergency discharge plan. This is usually to a shelter. Also, some clients make the decision on their own to leave, without adequate time to find housing. The social worker will inform the receiving Health Authority team, call the family, call shelter, identify which pharmacy the

prescription will go to, and organize the client to pick up medication from the pharmacy. The client can return, but must go through the referral process with a case manager.

Patients discharged 'home' with anxiety about whether they will be able to continue to stay in that "home" environment include patients with Axis 2 mental illnesses with behavioural concerns, who might be blacklisted from housing resources. This demonstrates a need for male-only housing. Staff members also have anxiety about discharge for those patients with a lack of life skills. This includes everything from knowing what to do when a smoke alarm goes off to more significant behavioural issues like hoarding or aggression. Other issues include ongoing drug use and predation by drug dealers, involvement in the sex trade, illiteracy, and innumeracy. Individuals with delusions may take apart the apartment, thinking there is someone in the walls, and fire setters and careless smokers are challenging as well.

One of the barriers to successful discharge is **physical accessibility** for the typical client age 30-70 years. The client, who has had a hard life, might have a damaged liver, be HIV positive, an amputee, or have some form of degenerative illness, such as MS or Parkinsons (perhaps diagnosed at Burnaby Centre).

In some cases **financial incentives** discourage clients choosing a housing resource than recommended by staff. In a facility, a client gets $95 comfort allowance (monthly) for Persons With a Disability Income Assistance (PWD IA). In enhanced housing or market housing, they get $400+ comfort money (monthly), a financial incentive. So, people don’t want to go to licensed care, even if their life skills suggest it would be most appropriate. This incentivizes sharing housing, but if the other person doesn’t pay rent, then both are evicted.

Immigrants may have **immigration and legal issues** that can affect discharge options. For example, if a deportation order is in process, the Health Authority must still find housing, so it is business as usual until the order is finalized. Interpreter services are available at Burnaby Centre, at no cost to the client, so that language has not been a barrier in finding housing to date.

5.6 Community Service and Housing Agency Perspectives

Three community service and/or housing agencies who work with discharged Burnaby Centre clients were interviewed for this study.

Mental Health Unit

Mandate: The Mental Health team provides assessment, rehabilitation, and specialized services to adults and seniors who have serious mental illness, and to children and youth with serious behavioural/emotional disorders living in the catchment area. Staff at one health unit includes 20.5 case managers, responsible for housing and discharge planning. Each has 60 clients on their caseload.

Housing/Services: The mental health and addiction system has a number of designated resources, but the typical route out of Burnaby Centre is Berman House or Fraser Apartments. Berman House is a 6-bed purpose built licensed care facility, run by the MPA Society. It provides 24/7 meals and medications, and is located in a residential area. It offers an adventure therapy program for those that are psychiatrically stable. It involves trips to Manning Park, bungee jumping and other physical education activities. It is ideal for young men, who can stay up to one year.

Raincity Fraser Apts
Mandate: RainCity Housing and Support Society is a non-profit organization delivering progressive housing and support solutions for people living with mental illness, addictions and other challenges. It provides emergency shelter, supportive housing, long term housing, outreach and an ACT team.

Housing/Services: Raincity Fraser Apartments is a 30 unit freestanding building operated by RainCity with self -contained bachelor units, 24/7 staffing, medication administration, no meals, community kitchen, and programming offered in the building. Residents meet with a key worker to review goals and liaise about resources. It is a transitional housing facility, with an expected residency of 18 to 24 months.

Raincity Fraser Apts provides transitional supported housing in an alcohol and drug-free environment located outside of the Downtown Eastside. Tenants are provided with a full range of support services, including social and recreational opportunities, life skills assistance, support in achieving their treatment goals, and support in finding and maintaining employment. The building is staffed 24 hours per day 7 days a week. Vancouver Coastal Health provides program funding and refers potential residents, and RainCity Housing provides the program and delivers the services. The tenants are supported by the staff within the Fraser Apartments as well as by community agencies and services, and the larger community.

Lookout Emergency Aid Society
Mandate: Lookout Emergency Aid Society is a charitable organization and social safety net that provides housing and a range of support services to adults with low or no income who have few, if any, housing or support options. The people served have challenges meeting basic needs and goals, so that Lookout places minimal barriers between them and their services.

Housing/Services: Lookout provides a range of services including outreach services, a drop in centre, community kitchen, four emergency shelters, extreme weather shelter capacity, 166 units of transitional housing in six buildings and 454 units of permanent and supportive housing. Lookout operates in several communities around the Lower Mainland. Lookout is funded to operate shelters that primarily serve individuals with mental health issues in downtown Vancouver, Mount Pleasant, the North Shore and

New Westminster. VCH is the primary source of funding for the downtown shelter (with some BC Housing funding); BC Housing funds the shelters on the North Shore and in Mount Pleasant; and Fraser Health funds the New Westminster shelter.

5.7 Role in Discharge Planning

Mental Health Unit - Case worker and HCW

Mental health teams/units are viewed as a "community agency" in relation to Burnaby Centre. They perform a gatekeeper role, providing the key to link from the community to Burnaby Centre and back to the community, including mental health care, housing and support services upon discharge. Health Authority staff often know the clients discharging from Burnaby Centre, unless it's an unplanned discharge, ie someone from Kelowna with nowhere to go. Typically if the client has successfully completed Burnaby Centre, they don't return to Downtown Eastside. Patients are encouraged to get housing elsewhere. However, if they do return to Downtown Eastside, they might start out in a shelter, found either by Burnaby Centre or the mental health team.

RainCity Fraser Apartments

As a contracted housing provider for Vancouver Coastal Health, Fraser Apartments accepts clients being discharged directly from Burnaby Centre. This referral occurs through the Housing Coordinator when a Fraser unit becomes available. Fraser Apartments does not have the right to refuse referrals and indeed they sometimes find that they have difficulty housing particular clients who are not a good fit for the building.

Because of the contractual nature of the relationship between Fraser Apartments and Vancouver Coastal Health, Fraser Apartments has access to a client's basic diagnosis, additional medical information (e.g. diabetes diagnosis or nutritional requirements) and medication information as well as basic housing history information. Fraser staff meets with the patient for about an hour and conduct a tour, discuss requirements of residency and complete necessary forms. Often Fraser doesn't speak to staff from Burnaby Centre at all in the process. Instead communication occurs between Fraser Apt staff and the patient regarding when they will move, etc. If there is a problem with a resident, Fraser staff have found it difficult to get in contact with the right person at Burnaby Centre.

Lookout

Lookout has contact with Burnaby Centre patients in several ways: as a provider of transitional housing for patients discharging directly from Burnaby Centre, and in their Yukon shelter where Lookout provides holding space for clients waiting to access Burnaby Centre. This latter is based upon an informal arrangement. They also see former Burnaby Centre patients indirectly, in the shelters and their drop-in centre.

Turnover at Lookout permanent housing is low, so there is little opportunity for Burnaby Centre patients to discharge there. Their transitional housing has 25% turnover per year.

When units come up, Lookout does take Burnaby Centre patients. There is no formal contract or Memorandum Of Understanding (MOU) with the Health Authority. Lookout controls tenant mix in their buildings to ensure there are not too many high needs residents in one building. Lookout will determine if the client is a good fit for the particular building or community. They can refuse a Burnaby Centre client. Lookout has also accommodated people in transitional housing who are awaiting access to Burnaby Centre but can't get in.

Lookout generally wants to know Burnaby Centre staff perspective on the discharging patient, even if unofficially. Prospective residents must submit a letter stating why they are a good fit for Lookout housing. Lookout generally finds they get the information they need from Burnaby Centre.

5.8 Barriers to Successful Discharge: Community Perspectives

Housing to serve a range of specific client needs

There is a lack of appropriate housing to meet the specific, unique and sometimes very challenging behaviours of some Burnaby Centre clients. For example:

- There is no long-term tertiary care that is available for two to three years for clients who cannot return to independent living.
- More supported housing is needed for people continuing to use, ensuring there are not too many high needs residents in one place.
- Appropriate housing for the geriatric population with mental health supports and physical accessibility features. Care facilities are reluctant to take a client with mental illness or addictions. And most supportive housing for people with mental health issues and addictions would not take individuals who need assistance with Activities of Daily Living. Wheelchairs are a barrier and smoking is a barrier. For older seniors, some resources require people to sign a "do not resuscitate" order, because the facility does not have the medical care to offer.
- Also how to deal with people with cognitive challenges.
- Gender specific housing is needed for male only, female only.
- There is the big question of housing for people with the most challenging behaviours, for example, fire setting - how do you house these people safely?
- BC Housing is full and appears to offer no priority for clients from Burnaby Centre.

Community services

Getting people to services is a problem; there is a need to embed more services in the community. Better services are generally available in Downtown Eastside.
More services for women, particularly for those not ready to 'come inside,' (i.e. access support services): some kind of drop in, female only, safe, secure, no or low barrier supports are needed.

Outreach workers are important and they do not need to be ACT type teams with psychiatric experience, but rather to help residents with additional supports, access community resources, link to peer groups, and help to rebuild relationships.

Relapse response

The question arose: Why make it so difficult to return to Burnaby Centre when the diseases Burnaby Centre is treating have high relapse rates, in fact are recidivistic? Burnaby Centre patients have long-term addictions and behaviours. It takes a long time to break those habits.

Communication and Information sharing

Adult Community Mental Health is the main point of contact that community agencies have with the mental health system, including Burnaby Centre. This seems to be a problem for some agencies, but not for others. There is a general view that more information could be shared with community agencies, and that in some cases, agencies have little access to Burnaby Centre staff for specific questions/concerns. The intermediary approach, using the Health Authority, may not be clear or timely enough.

Burnaby Centre has patients for six to nine months. Community agencies only get to meet them for an hour or so. Burnaby Centre could collect more information, such as hospital record and criminal record. Sometimes the community agency case worker doesn't have complete information, or even a firm diagnosis. For example, one patient has had 11 falls but there has been no investigation of this. If the patient attends medical drop-in clinics, staff might not know what the past health history is.

5.9 Opportunities for Change

A central concern is the lack of housing resources for 'hard to house' individuals. Relevant senior government agencies should review housing resources to ensure housing options exist to meet the needs of all discharging clients.

More community integration would improve long-term housing outcomes, including more Burnaby Centre follow-up and connection with former clients. Better connections between the health system and community agencies, would allow them more time to prepare to receive clients. When a former Burnaby Centre client destabilizes or deteriorates, allowing them to re-access Burnaby Centre, or allowing community agency to access Burnaby Centre resources would be valuable. Community service agencies suggested a "flying squad" from Burnaby Centre who are familiar with client issues, could come out and do interventions in the community for people deteriorating. This would only work in the Lower Mainland (where there are arguably the largest number of clients). The skills of Burnaby Centre staff are different from those of community resources. Burnaby Centre could follow up in the community and thereby prevent readmission; e.g., change meds, intensify support.

Interview participants also noted that it would be helpful if each Health Authority or housing area had a system for prioritizing housing based on client needs not where they come from (e.g., hospital or Burnaby Centre). Hospitals and tertiary facilities (Burnaby Centre) currently get priority for housing, but the types of clients who get priority appears to have changed, and it remains unclear which types of clients from which facilities get top priority.

Key informants also stressed the importance of developing a strategy and resources to deal with difficult to place older clients who need assistance with ADL or who are not mobile.

Further facilities like the Burnaby Centre could also provide geographically distributed opportunities for treatment of individuals with concurrent disorders. This would distribute care across the province and allow for greater community integration with local service providers.

Community service providers also said that mental health service providers should consider more use of the scattered site model tested by Chez Soi, using private market rental with incentives for landlords. That was successful and has the advantage of allowing clients to integrate in the community. Could offer incentives for owners of basement suites to rent to clients, as some do like to rent to Burnaby Centre clients because of the guaranteed income. However, evictions can be a problem if drugs are involved.

Community service providers also noted that receiving more information on clients (e.g. diagnosis, background, etc.) would better help organizations meet client needs.

Appendix 1: List of Interview Participants

Lions Gate Hospital and North Shore Vancouver

Health Care Providers:

Jeb Dykema: Temporary Housing Coordinator, Adult Community Mental Health, North Vancouver
Zoe Krickan: Patient Care Coordinator, Acute Psychiatric Inpatient Unit, Lions Gate Hospital
Catherine Pigeon James: Social Worker, Acute Psychiatric Inpatient Unit, Lions Gate Hospital

Community Service Agencies:

Andrea Kiesser: Seniors Outreach Worker, Hollyburn Family Services Society
Sandra Severs: Executive Director, Canadian Mental Health Association, North Shore Chapter
Ross Stewart: Executive Director, Marineview Housing Society

St. Mary's and the Sunshine Coast

Health Care Providers:

Dr. Anthony Barale: Attending Psychiatrist, Psychiatric Inpatient Unit, St. Mary's Hospital, Sechelt
Penny Brown: Patient Care Coordinator, Psychiatric Inpatient Unit, St. Mary's Hospital, Sechelt
Cristie Dugal: Case Manager, Adult Community Mental Health, Sunshine Coast

Community Service Agencies:

Reverend Clarence Li: Rector, St. Hilda's Anglican Church, Sechelt
Janet Mulligan: Child and Youth Mental Health and Wellness Liaison for Aboriginal Youth, Sechelt Indian Band
Carey Rumba: Manager, Arrowhead Centre, Sechelt

Kootenay Boundary Regional Hospital and Trail

Health Care Providers:

Wendy Smandych: Social Worker, Acute Psychiatry Short Stay Unit, Kootenay Boundary Regional Hospital, Trail
Joann Auger: Manager, Harbour House Tertiary Residential, Trail
Kristin Lockhart: Patient Care Coordinator, Acute Psychiatry Short Stay Unit, Kootenay Boundary Regional Hospital, Trail

Community Service Agencies:

Sheila Adcock: Program Coordinator, Career Development Services, Trail
Laura Bruckner: Family Counsellor, Trail FAIR Society, Trail

Sue Flagel: Trail Programs Administrator, Canadian Mental Health Association, Kootenays Chapter

Burnaby Centre and Vancouver

Health Care Providers:
K. Embacher: Patient Care Coordinator, Burnaby Centre for Mental Health and Addiction
S.W. Ayesha: Social Worker, Burnaby Centre for Mental Health and Addiction
Marg Scott, Mental Health and Addiction Housing Case Manager for North Health Unit, Vancouver

Community Service Agencies:
Karen O'Shannacery: Executive Director, Lookout Emergency Aid Society
Darlene Fiddler: Fraser Street Program Manager, Raincity Housing and Support Services
Gerry Bradley: Team Director, Adult Mental Health Strathcona Health Team, Vancouver