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Preventing Homelessness through Mental Health Discharge Planning

Best Practices and Community Partnerships in British Columbia

Volume 1: Overview and Cross Case Analysis

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Acknowledgments

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1. Overview

1.1 Background and Key Findings

Individuals with mentally illness are currently over-represented among the homeless, and mental-health care providers are not always able to connect clients leaving care with appropriate housing and support services. Developing effective practices to prevent homelessness among the mentally ill has been recognized by organizations like the City of Vancouver, Streetohome Foundation and the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University as important in addressing the issue of homelessness. Literature suggests that a key component in preventing homelessness is the integration of community service organizations into discharge planning, in order to ensure that clients are successfully transitioned from medical treatment back into the community.[1]

However, while the literature also suggests a range of best practices, little research has been done in British Columbia to identify appropriate approaches to ensuring that appropriate long-term community supports are in place in order to prevent homelessness. The purpose of this study is to identify effective policies, practices and resource requirements for discharging residents and patients from mental health facilities (particularly hospitals and community residential institutions), in partnership with community service organizations, in order to prevent homelessness.

The research resulted in the following key findings:

- The case study facilities in general use many of the best practices identified in the literature (see Volume 3) when discharging clients from acute or tertiary/long-term facilities;
- However, the ‘hard to house’ population is the most challenging population to develop appropriate discharge plans for: behavioural issues and/or concurrent disorders can significantly and adversely impact long-term housing outcomes for these types of clients when leaving a mental health unit;
- There is a lack of appropriate housing resources in British Columbia to adequately meet the needs of clients being discharged: this is a combination of a general lack of affordable housing and low shelter rates for Income Assistance in BC communities, and a lack of low-barrier options to serve challenging populations;
- Community services in British Columbia are generally under-resourced and working at (or over) capacity, and community service organizations are some of the primary organizations that work on the front line with the homeless;

[1] Patterson, Michael, et al. 2008. (Sources listed in full in Volume 3).

- Community service organizations may have formal or informal links with the mental health system, but often have little involvement in discharge planning, despite having ongoing relationships with many clients in mental health units;
- Peer support networks are not used during discharge planning in any of the case study facilities.

By using best practices in discharge planning for individuals with mental illness, there is an opportunity to both improve long-term housing outcomes for clients, while potentially reducing some burdens on the mental health system.

1.2 Methods

This research was conducted using a community-based qualitative approach, with limited quantitative analysis. A research advisory committee has guided the project since the beginning. This committee consists of:

- Dave MacIntyre (MPA Society)
- Dave Brown (Lookout Society)
- Sue Flagel (CMHA Kootenays)
- Elizabeth Stanger (VCH)
- Michael Goldberg (Community Researcher)
- Judy Graves (Homeless Advocate)

The first step in the project was the development of a literature review (Vol. 3), consisting of a scan of relevant literature on discharge planning from across Canada, the United States, Europe and Australia. This literature review was intended to identify common best practices in discharging planning to prevent homelessness as well as barriers to success (please note that the literature review contains all citations).

Four case study facilities were selected to provide a mix of urban and rural communities with a range of different mental health care facilities. The following facilities were selected:

- **St. Mary's Hospital:** Psychiatric In-Patient Unit (Sunshine Coast)
- **Kootenay Boundary Regional Hospital:** Psychiatric In-Patient Unit and Tertiary Residential Care (Trail and area)
- **Lions Gate Hospital:** Acute Psychiatric Inpatient Unit (North Shore of Vancouver)
- **Burnaby Centre for Mental Health and Addiction:** Provincial facility for individuals with both substance use and mental health issues (BC wide, with this report providing a case study in Vancouver)

Because the Burnaby Centre is a provincial facility, patients are generally discharged to their 'home' community mental health unit. The research therefore focuses on discharge planning practices from the Burnaby Centre, with one health unit in Vancouver providing a community perspective.

While Kootenay Boundary Regional Hospital serves a large geographic basis, due to budget and scope limitations the focus of the research was the City of Trail and immediately surrounding areas.

Six interviews were conducted in each case study. Three interviews were conducted with health care providers. These included unit staff, such as social workers, psychiatrists and patient care coordinators, and staff from associated community mental health units, such as case managers and outreach workers. Three interviews were conducted with community services organizations, including housing providers, community service workers and staff of organizations who work with the homeless. Vancouver Coastal Health discharge and readmission statistics were requested from the Health Authorities and information was provided by for Lions Gate and St. Mary's Hospitals. Burnaby Centre for Mental Health and Addiction also provided data on discharge resources, but this facility does not collect the same type of readmission statistics, due to the nature of long-term stays.

The original intent of this research was to also conduct interviews with clients of these service organizations who had been admitted to one of the case study facilities; however, clients were consistently unwilling to participate. Staff from community service organizations attributed this to a sense of trauma associated with being admitted to the facilities. As such, follow up vignettes describing composite individuals with concurrent disorders were sent to health care staff to identify how someone who is 'hard to house' would move from hospital to community. Staff at Lions Gate Hospital and St. Mary's Hospital responded. Responses to these questions can be found in Volume 2, Sections 1.2 and 3.2.

A cross-case analysis was conducted to find similarities and differences in the following areas:

- Effective discharge planning practices and their replicability;
- Relationships between residential mental health care facilities and other community service organizations in discharging clients;
- Local conditions, particularly housing costs, that affect success;
- Availability of support services (both mental health-focused and broader community services); and
- Analysis of where case study agencies stand in relation to the best practices identified through the literature review.

The purpose of the cross case analysis is to understand if there are common approaches, successes and challenges in how local partnerships and services contribute to the long-term stabilization of mental health clients in the community.

1.3 Important Terms

Assertive Community Treatment (ACT) teams: ACT teams are "a client-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, pschyosocial rehabilitation, and recovery for persons who have the most serious mental illnesses, have severe symptoms and impairments, and have not benefited from traditional out-patient programs." The teams are multidisciplinary, composed of health staff and serve the needs of the hardest to house, developing long-term relationships and individual treatment plans.[2]

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, defines psychiatric disagnosis sing a multiaxis approach. Axis I and II are the most relevant to this research and are defined below.

Axis I diagnosis: An Axis I diagnosis indicates clinical mental health disorders including (but not limited to) cognitive disorders, substance-related disorders, schizophrenia and other psychotic disorders, mood disorders and anxiety disorders.

Axis II diagnosis: An Axis II diagnosis relates to personality disorders and developmental disabilities. These include disorders typically first evident in childhood and diagnoses such as antisocial and borderline personality disorders.

Behavioral issues: In this report, the term 'behavioral issues' generally refers to emotional or physical outbursts from clients. These behaviours generally represent a barrier to finding housing as market rental or social housing units will generally not have supports in place to address these outbursts.

Concurrent disorders: The Centre for Addiction and Mental Health states that 'Concurrent disorders is a term for any combination of mental health and substance use problems. There is no one symptom or group of symptoms that is common to all combinations."[3] Concurrent disorders may sometimes be called dual disorders or dual diagnosis. However, dual diagnosis can also refer to a person with a developmental disability and a mental health problem.

Culturally Appropriate Healthcare: Culturally appropriate healthcare systems provide cultural and linguistic services to patients in order to reduce racial and ethnic disparities.[4] In the context of this research, two different types of culturally appropriate approaches were identified: those that serve Aboriginal clients and those that serve immigrant clients. The types of services required by these populations may differ significantly, but both are types of culturally appropriate services.

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[2] van der Leer *et al* 2008.
[3] CAMH 2012a.
[4] Anderson *et al.* 2003.

Damp Housing: Damp housing is defined as housing “where tenants do not need to be "clean" when entering the program but are expected to be actively working on recovery from substance use problems.”[5]

FTE: The abbreviation FTE refers to ‘full-time equivalent.’ A staff position of 1.0 FTE works 40 hours per week.

Involuntary Treatment, Certified Patients and Extended Leave: The BC Mental Health Act allows authorized physicians to ‘certify’ a client in order to treat them involuntarily, if they are incapable of giving consent. When a patient is under license, the patient may be released home for periods longer than 14 days on ‘extended leave.’[6]

Low-Barrier Housing: Low-barrier housing is defined as housing “where a minimum number of expectations are placed on people who wish to live there. The aim is to have as few barriers as possible to allow more people access to services. In housing this often means that tenants are not expected to abstain from using alcohol or other drugs, or from carrying on with street activities while living on-site, so long as they do not engage in these activities in common areas of the house and are respectful of other tenants and staff. Low-barrier facilities follow a harm reduction philosophy.”[7]

PWD: The abbreviation PWD refers to ‘persons with disabilities’ and is often used as shorthand for disability assistance provided by the Ministry of Social Development.

Tertiary Care: Vancouver Coastal Health defines tertiary care as “24-hour specialized in-depth wellness and recovery-based rehabilitation services for people with serious mental illness. Services help clients increase their independence and quality of life. The treatment team has specialized training in psychosocial rehabilitation. The goal is to help clients gain the skills and abilities they need to return to their home community with supports in place. Clients can expect to receive the support required to work toward their wellness goals.”[8]

Trauma-Informed Practice: Trauma-Informed Practice (TIP) is a clinical approach to working with individuals who have experienced trauma (including many individuals with mental illness) that recognizes and responds to a range of traumas (from personal to historical) in a client’s background. TIP incorporates this understanding of trauma and its symptoms into all clinical practices.[9]

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[5] Here to Help 2014.
[6] BC Ministry of Health, 2005.
[7] Here to Help 2014.
[8] VCH 2014a.
[9] Arthur *et al.* 2013.

Wet Housing: Wet housing is defined as housing "Housing where tenants are not expected to abstain from using alcohol and other drugs, and where entering a rehabilitation program is not a requirement. Tenants have access to recovery services and get to decide if and when they use these services. Wet housing programs follow a harm reduction philosophy."[10]

[10] Here to Help, 2014.

2. Cross-Case Analysis

2.1 Community Context

The following facilities were selected for the research, one in each participating community. These facilities represent a mix of sizes, geographic areas that they serve and types of communities (rural vs. urban).

- **St. Mary's Hospital:** St. Mary's Hospital is a small community hospital serving the Sunshine Coast. St. Mary's has a 6-bed Psychiatric In-Patient Unit.
- **Kootenay Boundary Regional Hospital:** KBRH is a regional hospital located in Trail serving communities in the West Kootenays. Its has a 12-bed Acute Psychiatric In-Patient Unit and Tertiary Residential Care.
- **Lions Gate Hospital:** Lions Gate Hospital serves the North Shore of Vancouver, but also acts as a regional hospital for Sea-to Sky and Sunshine Coast communities. It has a 26-bed Acute Psychiatric In-patient Unit.
- **Burnaby Centre for Mental Health and Addiction:** Burnaby Centre is a 100-bed provincial facility for individuals with both substance use and mental health issues.

Table 1 provides some statistical context for the size and housing conditions in each of the communities. The North Shore has a population of approximately 175,000 residents. This population is spread across three municipalities: the City of North Vancouver, the District of North Vancouver and the District of West Vancouver. The City of Trail is a small community in the West Kootenays with a population of 7,681. It is the service centre for the Lower Columbia Region, which includes communities such as Rossland, Warfield and Fruitvale. KBRH serves a much larger region, including other urban areas such as Castlegar and Nelson. The Sunshine Coast is a regional district accessible only by ferry with a population of 28,619. It is spread out along a peninsula and includes two municipalities (Sechelt and Gibsons) and rural communities including Roberts Creek, Halfmoon Bay, Pender Harbour and Egmont. Vancouver is BC's largest urban centre, with a population of 603,502.

Core housing need is highest in Vancouver, with 20.6% of households paying more than 30% of their gross income toward shelter costs. The Regional District of Kootenay Boundary has a core housing need of 12.2%.[11] The Sunshine Coast and Metro Vancouver have a comparable proportion of households in core housing need: 16.5% and 17.0% respectively.[12]

[11] It should be noted that core housing need data is unavailable for Trail and the North Shore Communities. Core housing need statistics for the Regional District of Kootenay Boundary are lower than core housing need in Trail, due to Trail's role as a regional service centre.
[12] Metro Vancouver is a Regional District composed of 22 municipalities, with 2,476,000 people.

Table 1: Selected Community Statistics

	North Shore	Trail	Sunshine Coast	Vancouver
Population (2011)[13]	175,302	7,681	28,619	603,502
Proportion of Households in Core Housing Need (2006)[14]	17.0% (Metro Vancouver)	12.2% (Regional District of Kootenay Boundary)	16.5% (Sunshine Coast Regional District)	20.6% (City of Vancouver)
Average monthly shelter costs for renters[15]	$1,126 (North Van. CY) $1,271 (North Van. District) $1,558 (West Van.)	$646	$986	$1,089

Average monthly shelter costs vary significantly across case study communities. The two rural communities have generally lower average monthly shelter costs: $646 (Trail) and $986 (Sunshine Coast). The urban communities of the North Shore and Vancouver have average shelter costs of upwards of $1000 per month in these communities.

Homeless counts have been conducted in most of the case study communities. Vancouver has the highest number of homeless residents, with 1,600 (in 2013). In 2011 122 homeless residents were counted on the North Shore, while in 2009 the Sunshine Coast counted 54 homeless residents.

In general, interview participants saw housing costs as an issue in all case study communities, and a lack of appropriate (i.e. well-maintained) and affordable housing was seen by community service agencies as a significant barrier to the long-term housing outcomes of clients being discharged.

While the four case study communities do not have a consistent metric for counting homeless individuals, both the North Shore and the City of Vancouver participate in the region-wide Metro Vancouver Homeless Count. Both the Sunshine Coast and Trail track homeless statistics through shelter usage rates, though a homeless count on the Sunshine Coast was conducted in 2009.

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[13] Statistics Canada 2012
[14] Canada Mortgage and Housing Corporation, 2014
[15] Statistics Canada 2013

Table 2 shows the preliminary results of the 2014 Metro Vancouver Homeless Count for the North Shore. On the North Shore about 50% of the homeless population was counted as unsheltered, while the other half was either sheltered on the night of the count or had no fixed address. In Vancouver, about 30% of the homeless population was counted as unsheltered, while about 63% were sheltered and 7% had no fixed address.[16] Generally, interview participants noted that resources are available to serve the homeless in these communities; however, they may be overburdened with staff working beyond their capacity.

Table 2: Results of 2014 Metro Vancouver Homeless Count, North Shore and Vancouver

		Sheltered		
	Unsheltered	**Emergency Facilities/Shelters**	**No Fixed Address**	**Total**
North Shore	60	54	5	119
Vancouver	538	1,136	124	1,798

The Sunshine Coast currently operates a shelter during winter months (November to March). For the first time during the winter of 2013-2014, a community-funded cold weather shelter was run concurrently with the Extreme Weather Emergency Shelter (EWES) in order to fill gaps in service, when weather criteria for the EWES is not met. The location and staff remained the same, but the community shelter was resourced through community fundraising. A meal program was operated in conjunction with the shelter program. However, interview participants reported relatively few other resources are available for the homeless population on the Sunshine Coast.

Table 3 shows shelter usage rates for the winter of 2013-2014. The two shelters operated for 126 between mid-November and mid-March. A total 758 client stays were recorded, with an average of six clients per night. [17]

Table 3: Shelter Usage Rates for Sunshine Coast, Winter 2013-14

	Nights open	**Number of stays**
Cold weather shelter	83	501
EWES	43	257
Total	126	758

Trail also operated an extreme weather shelter funded through BC Housing's Extreme Weather Response program. The shelter was open from November 1 to mid-March. During this period there were 25 individual intakes, 17 male and 8 female. The average

[16] Metro Vancouver, 2014
[17] Thomson, 2014

length of stay for clients was approximately 3 to 5 days. However, some individuals stayed the full 30 days allowed by the shelter.[18]

2.2 Discharge Planning and Preventing Homelessness

A major BC study of three communities in 2009 confirmed a strong relationship between mental health and homelessness. Krausz[19] found that 93% of participants in the study experienced a mental disorder or a substance use disorder at one time in their life. Nearly two-thirds (65%) had a non-substance related mental disorder.

The literature shows that clients with complex mental health needs have their needs best met when they receive high support housing and community-based mental health services and supports. The availability of a full-spectrum of housing from long-stay, high-support to more independent forms of housing for a range of diagnoses represents the best approach to ensuring positive long-term housing outcomes for individuals with mental illness or concurrent disorders.[20]

Discharge planning represents an important intervention point in preventing homelessness and appropriate discharge planning practices and resources can play a significant role in preventing homelessness.[21] By identifying services that a client can access upon leaving a mental health facility, discharge planning can help ensure that client vulnerabilities are addressed where previously they may not have been. Successful discharge planning is contingent upon a number of best practices, outlined more fully in Volume 3. These include:

- Appropriate housing resources
- Appropriate community support services
- Partnerships across health care providers, community service agencies and peers
- Information sharing agreements between hospitals and community service agencies
- Early identification of 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

When implemented, these best practices can:

[18] Adcock, 2014
[19] Krausz, 2011
[20] Butterill *et al.,* 2009
[21] Backer *et al.*, 2007

- Prevent and reduce homelessness amongst clients being discharged from mental health care units or hospitals[22]
- Allow hospitals to identify clients at risk of readmission and reduce readmission rates[23]

2.3 Common Characteristics of Successful Discharge

Interview participants identified some key characteristics of successful discharge planning in each case study. The characteristics common to all case studies follow. There were no significant differences between rural and urban communities studied.

An integral part of a client's positive long-term housing outcomes is that the client shows a **clear, positive change** over the course of their treatment. Clients who show insight into their mental illness and a willingness to address it are, according to health care providers, much more likely to be successfully housed.

A **long-term treatment plan** is another key component to successful discharge planning. This includes a willingness to adhere to medication and work with outreach workers and/or case managers through their local mental health teams. Part of a long-term treatment plan is the identification and use of appropriate community service supports.

Clients who are successfully housed will usually have a **strong support network**. Family or close friends can provide stability and support to the client both during treatment and after discharge. This support network may also include community service organizations who have a history of working with the client. Clients with a strong support network may be able to rely on family/friends for interim or long-term housing, if appropriate.

2.4 Common Barriers to Successful Discharge

There are also a number of common barriers to successful discharge planning identified by interview participants. Currently, there is no formal involvement of non-health care providers (i.e. community service agencies and peer support networks) in discharge planning. Additionally, rural communities were more likely to lack appropriate resources for mental health clients. Finally, clients who show little or no positive change during treatment, avoid long-term planning and have no support network are the most likely to have poor long-term housing outcomes.

The four case study facilities currently implement a number of best practices. However, **the do not currently integrate non-health care providers** (i.e. community service agencies and peer support networks) into the discharge planning process. This is identified in the literature as a key best practice in ensuring long-term integration of clients back into communities, as it allows a transition of care, and monitoring of patient

[22] Housing LIN, 2009
[23] Moss *et al.*, 2002

outcomes beyond the health system. Generally, clients are monitored by case managers and outreach workers through community mental health units.

While there are relatively few major differences between the case study communities in discharge planning, rural communities generally have fewer community-based resources for individuals with mental illness. In all communities, these resources were considered 'stretched thin.' However, **the rural communities generally experienced a greater lack of resources**, both in housing (e.g. a spectrum of mental health housing) and services (e.g. fewer outreach workers and case managers). 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.

Clients with a **concurrent disorder** (usually an Axis-1 diagnosis and an addiction issue) are challenging during discharge planning because of the significant gap of housing able to appropriately support them. Very few facilities in British Columbia are 'wet' or 'damp' (i.e. allow drug or alcohol use) and clients may choose to return to the street or a shelter rather than commit to abstinence-based housing.

Clients with **behavioural problems** are also a challenge to appropriately house. These clients may cause significant property damage and require significantly more supports than staff at many supported facilities are able to provide. In some cases behavioural problems can lead to **forensic involvement** which further impacts treatment options and can lead to clients becoming incarcerated instead of receiving ongoing mental health support. In other cases immigration or other legal issues may affect discharger planning. Clients with behavioral challenges were seen as more common in urban areas, though rural areas definitely noted that these types of clients were also an issue.

Negative peer influence was cited as another major issue, one that can contribute both to ongoing addictions issues and behavioural problems. Peers may represent a support system for clients, but negative peer influence can impact treatment and long-term planning done during the discharge process.

The sheer **volume of clients** who move through the health care system means that the needs of all patients are not always met. New supportive housing cannot keep up with the demand for beds/units. The volume of clients can also mean that there **is not enough time to plan appropriately for the discharge of hard-to-house clients**. The **significant gaps in appropriate affordable housing** across the housing spectrum (from supported to independent) across British Columbia are a major factor in poor long-term housing outcomes.

The cost of housing and the low amount provided to individuals on income assistance or disability assistance means that many clients admitted to psychiatric units may be **living in poverty**. Clients who are living in poverty may be less likely to follow up with

treatments and medication and therefore more likely to be at risk or become homeless. In general, **affordable housing** remains a significant issue in all the case study communities, and appropriate housing, when it is available, is often at capacity.

In addition to a lack of affordable housing, **community services may be lacking** (in rural areas) **or over-burdened** (in urban areas). Funding cuts to these services have increased the burden that these organizations currently manage. These include cuts in both federal (e.g. Aboriginal Friendship Centre funding) and provincial funding (e.g. cuts to community resources, legal aid, family programming, etc.). Community service organizations note a lack of capacity in dealing with the volume of clients who access many of their resources, and in some cases are only able to provide a limited support to clients they see. There are generally **no formal mechanisms** for involving community service organizations in the discharge process, despite the fact that they may play a significant role in a client's extended support network. The lack of community services and other supports (e.g. drug and alcohol treatment) is particularly pronounced in the rural case studies.

Other issues that can affect discharge planning include **financial incentives** leading clients to choose a housing resource that may not fully service their needs. Physical accessibility of available housing can also pose a challenge for many clients being discharged, as affordable accessible housing is not always available. The rural case studies also noted that transportation can be a major barrier for clients in accessing services or working with their Case Manager, as there is limited public transportation in the Trail region and the Sunshine Coast.

2.5 Discharge and Readmission

Discharge and readmission statistics were received from Vancouver Coastal Health for Lions Gate Hospital and St. Mary's Hospital. In 2010/11, Lions Gate Hospital admitted 525 clients to the inpatient psychiatric unit; in 2011/12 634 clients were admitted and in 2012/13 574 clients were admitted. The large majority was discharged home (between 82% in 2010/11 to 88% in 2012/2013). The proportion of clients receiving home-based care rose from 1% in 2010/11 to 5% in 2012/13, likely due to a new program (Acute Home-Based Treatment) described in the case study. A small proportion of clients (5% in 2010/11, 3% in following years) signed out of the unit against medical advice. Remaining patients were transferred to other levels of care.

In 2010/11, St. Mary's Hospital admitted 296 clients to the inpatient psychiatric unit; in 2011/12 305 clients were admitted and in 2012/13 281 clients were admitted. The large majority was discharged home (between 81% in 2010/11 to 84% in 2012/2013). A small proportion of clients (8% in 2010/11 and 2011/12, 4% in 2012/2013) signed out of the unit against medical advice. Remaining patients were transferred to other levels of care.

Based on input from key informant interview, individuals who signed themselves out against medical advice are most likely to be homeless or at-risk of homelessness. Unless

these clients are certified, hospital staff cannot require them to stay and follow through with appropriate discharge planning. Staff also noted that individuals with concurrent disorders were most likely to sign themselves out against medical advice.

Both hospitals showed relatively stable unplanned readmission rates within a 28-day period over a three-year time period. At Lions Gate Hospital, readmission rates ranged from 10% (2010/11) to 7% (2011/12 and 2012/13). At St. Mary's hospital readmission rates were 12% in 2010/2011, 13% in 2011/12 and 11% in 2012/2013. Hospital staff noted that high-risk clients (e.g. concurrent disorders or signing out against medical advice) were more likely to be readmitted.

2.6 Commonly Used Best Practices

Interview participants identified **few overall differences between discharge planning approaches at urban and rural facilities**, both in the literature and the case studies in this report. The main difference between these communities was the availability of housing and/or community service resources for clients being discharged (see Section 2.4). The following best practices were common to all case studies.

Begin Discharge Treatment Plan (DTP) at Admission

Beginning the plans for discharge at admission and during treatment allow staff to identify client needs and the resources to address these needs. All facilities studied in this research began discharge and transition planning as soon as clients were admitted to a mental health unit. This generally allowed staff to identify client needs and vulnerabilities, and identify community resources to support clients upon discharge.

Housing Resources Available

Having appropriate housing resources for DTP means having staff to plan for discharge, and the services and housing to support clients once they are in the community. All case study hospitals had some form of housing to provide supports for clients who need long-term or ongoing support. However, none of the case study communities felt that the number of housing units was adequate, particularly for the hardest to house.

Long-Term Focus

Providing services and maintaining relationships over the long-term helps support the success of clients in the community. Discharge planning is generally conducted with an eye on long-term goals and successes for clients. The Adult Community Mental Health teams, which are part of the mental health care system, provide this long-term support for clients leaving an inpatient unit or the Burnaby Centre.

Culturally Sensitive

All Health Authorities in British Columbia have staff positions for Aboriginal Patient Navigators. These navigators assist patients with understanding the hospital care system, provide support in discharge planning and connect clients with community resources. They also assist staff in the health authorities to understand the history and

context of aboriginal peoples. However, there are no formalized supports for new immigrants, even in the urban areas studied.

Adapted to Patient's Needs

A discharge plan that meets the needs of clients is a prerequisite for success. As much as possible hospital and Burnaby Centre staff members develop plans that are tailored to individual client needs. This is done through a team approach to discharge planning, the development of a relationship with clients and focused meetings that orient all discharge team members to the specific needs of each client. The central limitation to this best practice is when resources are at capacity or do not exist, a significant problem for clients termed 'hard to house.'

2.7 Summary of Gaps in Discharge Planning and Community Integration

Interview participants indicated that addressing the following gaps would strengthen discharge planning at the case study facilities in order to prevent homelessness.

No Existing Formal Partnerships with Community Service Organizations

Community service organizations represent an important resource for clients in each of the case studies. However, with the exception of housing contracts between non-profits (e.g. Marineview on the North Shore and Fraserview Apartments in Vancouver), these non-profits have no formal connection to the mental health system and no role in discharge planning.

No Formal Involvement Peer Support Resources

While peer support is a component of community mental health treatment (formally or informally), in all the case studies, peer support currently has no formal role in discharge planning in any of the facilities studied. The literature suggests that peer support can provide an integral component of discharge planning (Forchuk *et al.* 2007) while also representing a relatively cost-effective program to implement.

The development of formalized partnerships between community service organizations and the mental health care could include:

- Regular roundtable discussions of clients in care or leaving care, to determine suitable housing and service resources for them
- Information-sharing agreements between agencies to ensure that client privacy is respected

No Staff Training on Concurrent Disorders and the 'Hard to House'

Staff at inpatient psychiatric units will come into contact with clients who have concurrent disorders; however, they have not necessarily been provided training to help understand the challenges and stigma associated with concurrent disorders. The Centre

for Mental Health and Addiction (CAMH) provides online training on concurrent disorders.[24]

Not Enough Housing Resources

The two rural case studies in this report identified a general need for affordable, appropriate housing. These two communities (Sunshine Coast and Trail) generally have little in the way of low-income housing, and both currently lack permanent shelters. In the urban communities (North Shore and Vancouver), there was more housing available generally; however, both health care providers and community service providers noted that these were generally inadequate for high-needs clients, as there are few low-barrier housing options available in these communities. Additionally, the current $375 maximum monthly allowance for the shelter portion of Income Assistance is inadequate for allowing individuals on IA to access appropriate and safe housing.

Community Services are 'Stretched Thin'

Community services, particularly in rural areas, are often limited or operating at (or over) capacity. Increased funding to supports such as outreach workers, meal programs and gathering places (e.g. friendship houses and clubhouses) would provide the basis for long-term client integration into the communities into which they are discharged.

[24] CAMH 2012(a)