HOMELESS PEOPLE WITH ‘CONCURRENT DISORDERS’ ARE MORE VULNERABLE THAN OTHER HOMELESS PEOPLE AND FACE EVEN GREATER BARRIERS TO HEALTH CARE & COMMUNITY SERVICES

In a survey by Street Health of 368 homeless adults in Toronto, one quarter (26%) reported both mental health issues and regular drug or alcohol use, a condition often referred to as a ‘concurrent disorder’. Our study compared this group with other homeless people and found that homeless people with concurrent disorders were more socially isolated and more likely to be physically assaulted. Homeless people with concurrent disorders also had worse health status, as well as worse shelter and health care access, than other homeless people.

Kevin’s Story

Kevin has struggled with mental health and substance use issues for most of his life. Diagnosed with schizophrenia in his twenties, the medication he was prescribed didn’t work for him and eventually he began to use street drugs. For over twenty years, he lived on the streets, in shelters, and in prison. Kevin’s life finally began to turn around when, almost by accident, he was referred through the justice system to a residential treatment centre designed to address all of his needs in an integrated and holistic way. His discharge plan included finding him his own apartment with supports attached. Throughout all these transitions, Kevin received ongoing support and encouragement from a community worker who has worked with him for over 18 years. All of these supports helped Kevin to improve his mental health and stabilize his substance use, and have helped him continue to stay housed. Today, Kevin’s involvement in various community-based activities and groups is vital to his current state of well-being and his motivation to keep doing well.

“Without counselling, how do you know what’s out there? What helps is having a partnership with your worker … and support. Giving me encouragement … it makes it easier to endure it out there. [My worker] helps me to figure out the system, she opens doors.”

– Kevin, Street Health Survey Peer Researcher with lived experience of a concurrent disorder
ABOUT SURVEY RESPONDENTS

Of the 368 adults surveyed:

- 14% (51) had only a mental health issue
- 43% (157) had only a substance use issue
- 17% (65) had both a mental health issue and a substance use issue
- 26% (95) had neither

In total, we surveyed 95 people who could be classified as having both mental health and substance use issues. Of these:

- The average length of time homeless was 5.4 years
- The average age was 41 years
- 35% identified as female; 65% as male
- 48% had a high school diploma or a higher level of education
- 91% were born in Canada

Defining a ‘concurrent disorder’

The term ‘concurrent disorder’ is used to describe when someone experiences a combination of mental health and substance use issues.

Within the general population, other studies estimate that approximately 30% of people diagnosed with a mental health issue will also have a substance use issue at some point in their lives. The Toronto Central Local Health Integration Network (TC LHIN) reports that “37% of TC LHIN residents who abuse alcohol also have a mental illness, and 53% [of people] who abuse drugs also have a mental illness”.

For the purpose of this study, a mental health issue was defined as having received a mental health diagnosis and/or having been hospitalized for a mental health reason in one’s lifetime. A substance use issue was defined as heavy alcohol use (5 or more drinks on one occasion at least 3 times a month) and/or regular illicit drug use (3 or more times a week, excluding marijuana and over-the-counter or prescription drugs not taken as prescribed) in the past year. Health Canada defines ‘heavy alcohol use’ as drinking 5 or more drinks on one occasion at least 12 times per year. For this study, we used a higher cut-off of at least 36 times per year to better reflect popular attitudes about alcohol use and its risks to health and well-being.

Although a clinical diagnosis of substance dependence would not be made solely on the basis of how often substances are consumed, the levels of substance use reported by people we defined as having a concurrent disorder would be concerning to most health care providers. However, it is possible that our definition includes some individuals whose substance use does not result in significant problems or interference with life activities; these individuals would therefore not be clinically classified as having a concurrent disorder.

Not reflected in our definition of concurrent disorder is the reality that many people with mental health issues never receive a mental health diagnosis or are never hospitalized for their mental health issues. If we take this into account and expand our mental health criteria to also include those survey participants who reported experiencing mental health symptoms such as serious depression, anxiety or hallucinations in the past year (but do not necessarily have a formal diagnosis of a mental health condition or lifetime hospitalization for a mental health reason), the number of people in our survey who could be considered to have a concurrent disorder jumps to 55% (203) of those interviewed. The findings in this bulletin are based on our conservative estimate which only includes those 95 respondents with a mental health diagnosis or who had been hospitalized for a mental health issue.

Regardless of whether the people we defined as having a concurrent disorder are actually experiencing what would be clinically diagnosed as a concurrent disorder, the findings below reflect the experience of homeless people with mental health issues who also use substances regularly.

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1 Centre for Addiction and Mental Health. 2006. What are concurrent disorders? Available at: www.camh.net.
2 Toronto Central Local Health Integration Network. 2007-2010 Integrated Health Service Plan: Appendix H. Available at: www.torontocentrallhin.on.ca.
3 We used a standard definition which defines ‘drink’ as: one bottle or can of beer or a glass of draft; one glass of wine or a wine cooler; or one drink or cocktail with 1 ½ ounces of liquor.
THE DAILY LIVES OF HOMELESS PEOPLE WITH CONCURRENT DISORDERS

Homeless people with concurrent disorders have worse health and face greater social isolation, stress, experiences of suicide and physical violence than other homeless people.

Homeless people with concurrent disorders have worse general health and well-being and report higher levels of stress and social isolation.

- 55% of people with a concurrent disorder rated their general health\(^4\) as fair or poor, compared with 35% of other homeless people who reported the same.
- 66% of people with a concurrent disorder reported high levels of stress on a daily basis, compared with 37% of other homeless people.
- 52% of people with a concurrent disorder reported that they often feel lonely or remote from other people, compared with 34% of other homeless people.

Homeless people with concurrent disorders are more likely to have a serious physical health condition.

- 85% of people with a concurrent disorder had at least one serious chronic physical health condition\(^5\), compared with 70% of other homeless people.

Homeless people with concurrent disorders are more likely to consider and attempt suicide.

- 40% of people with a concurrent disorder had seriously considered suicide in the past year, compared with 18% of other homeless people.
- 20% of people with a concurrent disorder had attempted suicide in the past year, compared with 6% of other homeless people.

Homeless people with concurrent disorders experience more physical assaults.

- 45% of people with a concurrent disorder had been physically assaulted at least once in the past year, compared with 32% of other homeless people.

Homeless people with concurrent disorders are more likely to use substances to self-medicate.

- 87% of people with a concurrent disorder had used drugs or alcohol in the past year to relieve stress, pain or to feel better about their lives, compared with 69% of other homeless people.

Our findings are consistent with other reports which have also documented the extraordinarily stressful conditions experienced by homeless people. Many of the factors that compromise mental health and contribute to substance use, such as social isolation and violence, are part of the daily reality of homelessness. It is not surprising, then, that many homeless people find themselves facing both mental health and substance use issues. Many people experience mental health and substance use issues, or have existing issues become worse, only after they become homeless.

Drugs and alcohol are often used to help people cope with illness, trauma, stress or pain. Since many homeless people with concurrent disorders cannot access the support or resources they need, mental and physical pain is often accompanied by what is recognized as ‘self medication’. In the past, substance use was predominately restricted to alcohol. More recently, the easy accessibility and relatively low cost of other options such as crack cocaine have meant that these illicit substances have become the “medications of choice”. The high rates of self-medication found in our study are a likely reflection of the difficult daily lives and poor health of homeless people with concurrent disorders.

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\(^4\) Health was defined as not only the absence of disease or injury but also in terms of physical, mental and social well-being.

\(^5\) A “serious physical health condition” was defined as any of 22 serious conditions, including: cardiovascular and respiratory diseases, hepatitis and other liver diseases, gastrointestinal ulcers, diabetes, anemia, epilepsy, cancer and HIV/AIDS.
BARRIERS TO HEALTH CARE & SOCIAL SERVICES

Worse Access to Housing, Shelter and Food

Homeless people with concurrent disorders experience worse living conditions, as well as worse access to shelter and food than other homeless people. They are also more likely to use emergency health care services and to experience poor treatment in the process of seeking health care.

Homeless people with concurrent disorders listed economic factors as the most common reasons for remaining homeless.

- 68% cited the cost of rent or inadequate income as one of two main reasons that were keeping them from finding and maintaining housing
- 30% cited lack of suitable housing or bad landlords
- 30% cited their addiction
- 14% cited their mental health condition

Homeless people with concurrent disorders are more likely to cite poor living conditions as a reason for becoming homeless.

- 35% of people with a concurrent disorder cited poor living conditions (i.e. bad landlord, substandard housing, safety concerns) as one of the primary reasons they lost their last housing, compared with 23% of other homeless people

Homeless people with concurrent disorders have worse access to shelter beds.

- 64% of people with a concurrent disorder could not get a shelter bed at least once in the past year, compared with 49% of other homeless people

Homeless people with concurrent disorders experience higher levels of hunger.

- 39% of people with a concurrent disorder reported that they had often gone hungry in the past three months, compared with 25% of other homeless people

Homeless people with concurrent disorders were more likely to cite poor living conditions as the reason they lost their last housing. This is likely due to discrimination by landlords. Homeless people are often denied housing on the basis of their mental health or substance use issues. People with concurrent disorders must face both of these barriers and as a result are even more likely to be forced to live in substandard housing.

Poor shelter access and high rates of hunger reflect both a lack of capacity among homeless service providers to accommodate the needs of people with mental health and substance use issues and a lack of willingness to provide services to this group. Despite the best efforts of many agencies, limited budgets and inadequate funding create structural inadequacies and an inflexible one-size-fits-all approach that does not meet the needs of people experiencing multiple challenges. Many services for homeless people in Toronto operate from an abstinence-based model and deny access to people who use drugs or alcohol. Discrimination by service providers adds another barrier for a group of people who are already at a disadvantage.

Inadequate and Discriminatory Health Care

In addition to having both mental health and substance use issues and higher rates of physical illness than other homeless people, our study found that homeless people with concurrent disorders report unmet treatment needs and have poor access to the health care system.

Homeless people with concurrent disorders report high levels of unmet mental health care and addiction treatment needs.

- 26% needed mental health care in the past year but had been unable to get help
- 27% had tried, but were unable to access a substance use treatment program in the past year

Homeless people with concurrent disorders experience higher rates of hospitalization and emergency department use.

- 41% of people with a concurrent disorder had stayed in a hospital at least one night in the past year, compared with 18% of other homeless people
- 67% of people with a concurrent disorder had visited an emergency department at least once in the past year, an average of 7 times, compared with 49% of other homeless people who reported the same, an average of 3.4 times
Homeless people with concurrent disorders are more likely to leave a hospital emergency department before being seen.

- 43% of people with a concurrent disorder who had used an emergency department in the past year had left before being seen, compared with 28% of other homeless people.

Homeless people with concurrent disorders are more likely to report discrimination by a health care provider.

- 43% of people with a concurrent disorder felt they had been judged unfairly or treated with disrespect by a health care provider in the past year because they were homeless, compared with 25% of other homeless people.

Homeless people with concurrent disorders have more difficulty following their health care providers’ advice.

- 53% of people with a concurrent disorder said they had been unable to follow their health care provider’s advice or treatment plan at least once in the past year, compared with 26% of other homeless people.

- The main reasons that people with a concurrent disorder gave for not being able to follow their treatment plan were because: their living situation wouldn’t allow it (51%), they disagreed with the treatment plan (45%), it cost too much (29%), or they had no one to help them (29%).

High rates of emergency department use and hospitalization reflect the lack of preventive resources and community-based supports available to homeless people. Our findings on access to shelter and food confirm that homeless people with concurrent disorders are often faced with nowhere to go for basic survival and support needs. As a result, many are forced to use emergency departments for basic needs such as food and warmth. These same findings also indicate that homeless people with concurrent disorders are not receiving adequate primary health care. Emergency departments are not designed to meet primary health care or survival needs yet they are an important point of access to health care for homeless people without any other options. It is disturbing that so many people with concurrent disorders reported leaving the emergency department before receiving any care.

Homeless people with a concurrent disorder are less likely to be able to follow health advice, highlighting their increased difficulty in taking care of health needs while living in the shelter system or on the street. Many shelters do not allow residents to stay in bed during the day or have restricted periods when residents can access medications. As well, many health care supplies and services, such as some prescription drugs and counselling, are not covered by government health insurance and many homeless people simply can’t afford to follow recommended health care advice. In addition, some health advice is difficult to carry out on your own, such as taking care of wounds or broken bones. The inability of many people with concurrent disorders to follow treatment plans because they had no one to help them points to their high levels of social isolation and lack of support.
People with ‘concurrent disorders’ often get blamed for being unable to navigate and fit into our inflexible and uncoordinated social service and health care system. Structural inadequacies and discriminatory practices make it very difficult for people with both mental health and substance use issues to access any type of social service or resource such as housing, shelters or health care. There is a lack of integration and coordination between mental health and addiction services. Many mental health services will refuse treatment to a person with active drug or alcohol use, while many addiction services will not treat people for substance use issues while they are taking mental health medications or if they exhibit symptoms of mental illness. There is a strong need for integrated mental health and substance use treatment and for social services in general that will serve people who experience both mental health and substance use issues.

The least tangible aspects of service provision are perhaps the most critical in working with people who experience mental health and substance use issues. Many programs that, in principle, appear to meet the needs of homeless people with concurrent disorders do not deliver in practice because they lack a genuine underpinning of respect, trust, flexibility, and client autonomy. Health policies and programs must be based within a human rights framework, one which recognizes the inherent right of all people to housing, health care, and equal participation, regardless of their mental health status or whether or not they use substances. Requiring people to abstain from substance use before allowing them to access health and social services is unrealistic and discriminatory. Health and social service providers must work from a non-judgmental harm reduction philosophy which does not require abstinence.

The recommendations below reflect only the most immediate and glaring gaps in service provision facing homeless and low-income people with concurrent disorders. The root solutions to the vulnerability and barriers faced by homeless people, regardless of their mental health issues or substance use, lie in addressing poverty through increased social assistance and minimum wage rates and in increasing the overall availability of affordable and appropriate housing.

At the same time, all levels of government must provide adequate resources toward specific services that meet the immediate needs of people with mental health and substance use issues.

1. The City of Toronto and the Toronto Central Local Health Integration Network (LHIN), with adequate funding from the Governments of Canada and Ontario, should **create supportive housing options for people with mental health issues who use substances**. This should include the building of new, and conversion of existing buildings into, subsidized housing units with highly supportive, flexible, non-coercive, multidisciplinary support programs attached to the housing. For people requiring less intensive support, rent supplements and case management services that are attached to the person receiving services (and not the housing unit) should be provided.

2. The Ontario Ministry of Health and Long-Term Care and Toronto Central LHIN should **expand and strengthen community-based intensive case management services** specifically for homeless people with mental health and substance use issues. Community-based agencies should be funded to support these positions 24 hours a day, 7 days a week. Services should include long-term support, advocacy and service coordination. Case managers should work with people in crisis but also provide help with basic needs and personal goals. These positions should operate from a social determinants of health framework which recognizes and works to address the impact of issues like poverty, social isolation, access to health care and nutrition on mental health and well-being.

3. The Ontario Ministry of Health and Long-Term Care and Toronto Central LHIN should **create, expand and strengthen community-based mental health and addictions programs**. These should include peer support and capacity building programs, drop-ins and survivor-run services.
4. The Public Health Agency of Canada, Ontario Ministry of Health & Long-Term Care and Toronto Central LHIN should ensure mandatory education and sensitivity training on mental health issues, substance use and harm reduction for health care and other service providers. This includes not only physicians but also nurses, people working in addictions and mental health, corrections staff, and health care and social service providers at community-based organizations.

5. The Ontario Ministry of Health and Long-Term Care and Toronto Central LHIN should create a 24-hour non-medical crisis support centre for people with mental health and substance use issues. The centre should include a support phone line, a drop-in centre, safe beds for people in crisis with nowhere to sleep, outreach services and peer support.

6. The Toronto Central LHIN should fund and require all downtown hospitals to create a Community Support Worker position within emergency departments, 24 hours a day, 7 days a week, who can provide support to homeless people with mental health and substance use issues and connect them with community-based services when they are accessing the emergency department.

7. The Ontario Ministry of Health and Long-Term Care and Toronto Central LHIN should increase the number of drug and alcohol detox beds and residential treatment options in Toronto and ensure that these services are willing and equipped to work with people with substance use and mental health issues.

Promising practices from community-based programs that address the needs of homeless people with concurrent disorders

The Centre for Research on Inner City Health at St. Michael’s Hospital in Toronto conducted a study to explore best practices and promising models in community-based programs addressing concurrent disorders among homeless people. Because little research has been done on this topic in Canada, this study focused on programs in the United States. The research found that programs that were successful in achieving positive mental health outcomes incorporated all, or some, of the following program components:

- An emphasis on autonomy and client choice in decision-making
- Positive interpersonal relationships between clients and service providers based on mutual trust, respect, dignity and caring
- Providing outreach-focused, multidisciplinary teams of health care providers which were highly flexible to client needs and choices, and were highly accessible and available 24 hours a day, 7 days a week
- Providing housing, particularly client-chosen, independent housing
- Providing comprehensive supports to address the full range of clients’ needs including help with income, education, employment and advocacy support as well as access to meals, showers and recreational activities
- Flexible and non-restrictive program policies and approaches, such as a harm reduction philosophy which does not require abstinence from substance use as a condition for program participation

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6 Detailed findings of the study can be found in: Centre for Research on Inner City Health. Community-based Services for Homeless Adults with Concurrent Disorders: What Works for Whom, Where, Why, and How?: Summary of a Realist Systematic Review. February 2009. Available at: www.crich.ca.
Who Is Street Health?

Street Health is an innovative, community-based health care organization providing services to address a wide range of physical, mental, and emotional needs in those who are homeless, poor and socially marginalized in Toronto.


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Copies of this bulletin and related documents can be downloaded from our website.