CAMH Schizophrenia Program High Support Housing Initiative

-Evaluation of Year 1 of the 90 Shuter St. Partnership–

October 26th, 2010

Evaluation Coordinators: Sean Kidd, Ph.D. and Sandra Cushing, MSW
Assistance provided by: George Mihalakakos, Peer Support Worker and Jessica Meisner (MSW Candidate).

Table of Contents

Executive Summary

The Centre for Addiction and Mental Health has partnered with Homes First and Pilot Place to offer high support housing services to long stay Alternative Level of Care clients in the CAMH Schizophrenia Program. To date, services have been offered to 18 clients through this partnership in an apartment building located at 90 Shuter St. This evaluation was conducted to examine the process and outcomes of the first year of operation (August, 2009 – July, 2010) in which the first 9 clients moved into 90 Shuter.

The first year of operation would appear to have been highly successful. The initial 9 residents have successfully transitioned out of hospital and have made substantial gains in their sense of wellness and community engagement. No client was readmitted to hospital in this period (a trend that continues up to the time of this report) and the services offered at 90 Shuter St. cost a fraction of what is needed to maintain an inpatient level of support.

While all stakeholders consider the 90 Shuter St. service to be a resounding success, there is room for further improvement. Recommended improvements include a greater emphasis upon client autonomy and community participation in programming, a better integration of direct service staff, greater attention to physical health in programming, and a need to determine if there are opportunities to create efficiencies in the interface between services.

The present in depth evaluation will be followed up by ongoing evaluation of key functional, quality of life, and satisfaction variables which will be complemented by periodic repetition of the in depth evaluation process documented here.

Evaluation Overview

This report provides an overview of an initial evaluation of the CAMH, Homes First, and Pilot Place high support housing partnership located at 90 Shuter St. The time period covered by this evaluation is August, 2009 to July, 2010. In that period a total of 9 CAMH clients were discharged to 90 Shuter St. (5 in August, 2009 and 4 in January, 2010). These clients were all discharged from our Integrated Rehabilitation Unit and had an average length of stay of approximately 9 years, ranging from 3 years to over 20 years. All of these clients might be regarded as Alternative Level of Care (ALC) clients who did not require the intensity of treatment offered in an inpatient facility but remained in that setting due to a lack of feasible options for necessary support in the community.

Purposes of the Evaluation

This evaluation had several purposes:

1. Provision of an initial indication of client recovery at the 90 Shuter St. setting.
2. Provision of an indication of the strengths and weaknesses of the partnership and supported housing model as it has been developed to date.
3. Provision of information that might guide further development of this and other partnerships.
4. Provision of information to inform a method for ongoing tracking of client progress in high support housing settings.

Methods of Evaluation

This evaluation was comprised of both quantitative and qualitative methods of inquiry. Sources of information included the following:

Staff and Management

All relevant staff and managers from CAMH, Homes First, and Pilot place took part in this evaluation. Inquiry included individual and focus group semi-structured interviews regarding the 90 Shuter St. service and partnership. Staff and management also completed two self-report measures. One was the Wilder Collaboration Factors Inventory (Mattessich, 2004). This structured inventory assesses the various components of partnerships (e.g., "People in this collaboration communicate openly with one another"; strongly disagree – strongly agree). They also completed the Recovery Self-Assessment (RSA) to evaluate the *recovery-orientation* of the service (RSA; O'Connell et al., 2005). The RSA assesses domains of recovery-oriented practice in mental health care settings with specific questionnaires for consumers, service providers and administrators. Five subscales are embedded in the tool: pursuance of individually defined life goals, involvement of consumers in service provision, diversity of treatment options, respect for rights and choice, and provision of individually

tailored services with items rated on a 5 point scale (strongly disagree – strongly agree). The tool has demonstrated good validity and reliability (O'Connell et al., 2005; Salyers, Tsai & Stultz, 2007).

Residents

A total of 7/9 residents took part in the evaluation (2 residents declined the offer to participate). In a manner complimentary to staff and management, residents took part in individual semi-structured interviews regarding their experiences at 90 Shuter St. They also completed the client version of the Recovery Self-Assessment (see above for a description). Finally, clients completed the brief 26-item version of the World Health Organization Quality of Life Scale (WHOQOL-BREF). This measure has shown good validity and reliability in psychiatric populations (Skevington et al., 2004).

Family Members/Key Supports

While an effort was made to contact family members and key supports of residents to complete semi-structured interviews, we had little success with only one family member interviewed. This was due to a combination of some instances of minimal contact with family, limitations around consent to contact some family members, and a lack of family member/support follow up on invitations to participate.

Service Use and Level of Functioning

We have also obtained 6 month follow up Resident Assessment Instrument (RAI) findings for residents. While the use of the tool in outpatient contexts and reliability questions do not make using this tool ideally reliable, it provided an approximate indicator of change in key functional domains. Re-hospitalization data was also gathered.

Evaluation Findings

Self-Report Survey Findings – Recovery Self-Assessment

A table outlining the Recovery Self-Assessment ratings of each of the stakeholder groups is provided below. All scores are mean scores out of 5, with 5 being the highest possible congruence with the practice domain and 1 being the lowest. Along with overall mean RSA scores, domain scores include the following:

Life goals vs. symptom management (extent to which staff help consumers pursue individually defined life goals such as employment and education).

Diversity of treatment options (extent to which there are linkages to peer mentors and support, a variety of treatment options, and assistance with getting involved in non-mental health related activities).

Rights and Respect (extent to which staff refrain from coercion, listen to and respect the choices and preferences of consumers).

Individually-tailored services (extent to which services are tailored to meet individual needs, cultures and interests, provided in the person's natural environment, with a focus on community connections).

Consumer Involvement in Care (extent to which clients are actively involved in decision making about care, in developing programming, and in evaluating the quality of programming).

In general, ratings with respect to the recovery orientation of the care provided at 90 Shuter fall in what might be considered a moderate range with a trend towards higher scores in the domain of consumer rights and respect. Lower scores were obtained from some groups in areas of consumer involvement and diversity of treatment options with, from the client perspective, the area in which the most improvement might occur being individually-tailored services.

Mean Recovery Self-Assessment Findings (all ratings are /5 – high ratings in bold, lower ratings underlined)

Domain	Clients	IRU Staff	IRU Manager	Central Link Staff	Pilot Place Staff	Pilot Place Manager	Homes First Staff	Homes First Manager
RSA Mean	3.71/5	3.36	3.53	3.43	**4.04**	**4.25**	3.63	3.89
Individually Tailored Services	3.17	3.40	3.40	3.50	**4.06**	**4.20**	3.60	3.60
Consumer Involvement	3.42	3.42	2.88	2.13	3.71	3.63	2.69	2.63
Rights and Respect	**4.00**	3.28	3.83	**4.00**	**4.29**	**4.83**	**4.33**	**4.67**
Diversity of Treatment Options	3.83	3.56	**4.00**	2.92	3.93	**4.67**	3.33	3.83
Life Goals vs. Symptom Management	3.89	3.32	3.64	3.84	**4.16**	**4.18**	**4.09**	**4.55**

Self-Report Survey Findings – Wilder Collaboration Inventory

Service managers and direct service staff completed the Wilder Collaboration Inventory with the goal of identifying strength and areas of improvement regarding the Homes First-Pilot Place-CAMH partnership. This tool measures multiple domains of partnership with items completed on a 5-point likert scale with 5 being the highest/best endorsement of a given area of partnership. Across the 18 domains of partnership measured, both staff and management regarded the partnership as being strong across multiple dimensions with scores ranging from 3.2-5.5/5 with the mean manager score being 4.18/5 and the direct service staff score being 3.85/5.

Overall, most perceived as strengths in the partnership the presence of the right cross-section of partners, partners holding a shared vision, and the partners feeling motivated by a common purpose. Relative weaknesses that emerged with some consistency in ratings were the quality of informal relationships and communication, particularly in the area of means and opportunities for open and frequent communication. Across subgroups, areas in which there were divergent perspectives included the degree to which partners were perceived as compromising and some differences of opinion regarding pace with which the partnership was moving forward and the resources available (with the latter points arising more in direct service provider ratings).

Self-Report Survey Findings – WHO Quality of Life Inventory

The WHO brief quality of life measure was used with residents as it is a reliable and valid tool that assesses perceived quality of life in major domains of normal life in the community. Scores on this quality of life scale fall within 4 major domains: quality of social relationships, environment factors (financial, physical environment, transportation), psychological and physical health. For the residents at 90 Shuter St., scores across these domains fell in a range between 62-67/100 (standardized scores). As a point of comparison, scores from a non-psychiatric population are provided in parentheses next to the resident scores in the table below. While resident scores were consistently lower than normative population scores, this trend tended to be more marked in areas of social relationships and environment factors. It is of note that psychological health ratings were quite similar to those of a normative population.

WHO QOL Findings

Domain	Score / 100 *(normative comparator)*
Social Relationships	62 (range 44-81) *(70.1)*
Environment (financial; physical environment; transport)	67 (56-81) *(75.1)*
Psychological	67 (56-81) *(70.6)*
Physical Health	67 (50-88) *(73.5)*

Qualitative Interviews with Residents

A total of 7/9 clients also completed individual semi-structured interviews. In these interviews clients were asked about their experience at 90 Shuter St. across a number of dimensions such as the quality of the physical space, the neighbourhood, relationships with other residents and staff, quality of the services provided, and their sense of their recovery in that setting (i.e., general sense of wellness, engagement in meaningful activities such as employment, and participation in the community). Interviews were audiorecorded and analyzed to pull key themes from the narratives of residents regarding their experiences.

All of the residents interviewed were very happy with the quality of the physical space in the apartment and the food, in several instances drawing sharp contrasts with other settings in which they had resided in the past. All of the residents also described their new neighbourhood as being good with respect to quality and nature of the amenities available. Two residents commented that they found the neighbourhood somewhat unsafe, though this

description was in general terms and they clarified that they themselves did not feel unsafe and had not had any instances in which they had been threatened or assaulted. There was a general agreement among residents that they were getting along well with one another and had formed friendships and a cohesive group. They were also very happy with the Pilot Place staff, stating that they liked them and valued their relationships at a personal level.

While residents were very happy with most aspects of the services received at 90 Shuter St., the one area in which there was critical commentary revolved around the degree of autonomy afforded in the programming. Residents expressed a desire to be able to come and go as they pleased and to otherwise have removed restrictions placed around their activities. Some residents also expressed a desire to retain control over their own finances.

"I can't really get involved [in community groups] because we have to be in by 9:00"

"I want to go to restaurants in the morning for coffee, but I can't. I've got to stay here. It's kind of depressing, because you can see more people in the morning."

When asked about their goals, most clients described wanting to gradually increase their level of activity in the community and to increase their level of autonomy. For many this involved employment and volunteering, while for others this involved wanting to work towards having their own apartment in a less supported setting.

"It's very nice living here, very beautiful. I've got my own room. I want to get a job now. I'm just so comfortable that I want to get a job."

"I want to make my own meals. I want to go to work."

Residents were also asked about any changes that they have noted in themselves since they moved to 90 Shuter St. All of the residents described making progress in their recoveries with no resident reporting a decline in any area and only one resident stating that no changes had taken place. Areas of improvement included (i) being more socially involved and having improved relationships with peers, community members, and family, (ii) a sense of participating to a greater extent in normal community settings and feeling more comfortable in the community, (iii) greater levels of physical activity, and (iv) a general increase in their level of psychological wellness.

"I'm talking more…I haven't done much of that in my life."

"I try to go to church every day. It makes me feel better. I make lots of friends at church."

"I'm doing a little bit better. I get to go out and walk around."

"I feel better here. You get your marbles back. You get a bit loony over at Queen St."

Qualitative Interviews with Staff and Management

Direct service staff and management from Homes First, Pilot Place, and CAMH were interviewed regarding the programming offered, resident progress at 90 Shuter St., and the quality of the partnership. Key themes are outlined below.

Resident Gains

Staff and manager descriptions of the gains that residents made were largely congruent with those of the residents themselves. One manager noted that the core gain sought for residents, that of being housed, had been achieved: "Well I think it is working well in that the people are still housed. Ultimately, that's the best measure." Staff across all of the services involved also described a marked increase in both social skills and involvement among residents. This included both casual contacts with others and the formation of friendships with other residents.

"It was really amazing. We [saw] two of the clients who were very isolated on the IRU and I was totally blown away…they created a bond with one another and talked about that bond."

Other areas in which gains had been made were, as was the case in resident narratives, involved improvements in levels of autonomy and community participation. Staff also described what they thought was underlying this increase in observed autonomy. Most felt that residents' levels of anxiety had decreased as they experienced improved self-esteem and confidence. Overall, they felt that residents were "less dependent" than they had previously been in the hospital setting. CAMH staff described many hospital staff as being "surprised" at how well the residents had done at 90 Shuter given the levels of symptomatology observed at the IRU.

"They were very unmotivated and didn't bother to go out [while on the unit], but there they go to church, go out to dinner, and they really had activities that they were involved in….someone else is going swimming on a regular basis."

"I see them more confident…more comfortable and open…just seeing the increase in self-esteem and confidence was great."

Services Provided

An effort was also made in these interviews to obtain a detailed overview of the nature of the services provided at 90 Shuter along with shelter and basic amenities. The services provided fell within the following categories:

- Bridging from the inpatient unit: A bridging process is in place in which CAMH inpatient staff tour the site with prospective residents and, following discharge, maintain daily contact by phone or in person for 3 weeks with contacts gradually tapering down over three months. Clients and staff described this bridging component as being crucial to reduce fears regarding the move to a new setting and to promote better continuity in services. *"Clients like it because they didn't know us that well, or at all. They were so happy when [IRU staff] would come and visit."*
- Facilitating engagement in treatment: Pilot Place staff highlighted, as a key component of the services offered, the facilitation of residents maintaining treatment adherence in terms of both medication and appointments. *"We don't allow people to miss treatments. As much as possible, nobody misses appointments."*
- Independence skills: The most central aspect of services, along with maintenance in treatment, was described as promoting the independence/autonomy of residents. This included encouragement of residents to take part in chores in the apartment and encouragement to become more active in the community. In general, the main strategies used were breaking down activities and tasks into component parts and a gradual increase in task/activity complexity or intensity.
    - *"We break it [e.g., washing dishes] into steps, so it's clear."*
    - *"We always try to engage them in terms of taking them out into the community…we encourage who we can."*
    - *"Right from the beginning we have taken them to safe spots that we know of downtown…eventually they know certain spots in the neighbourhood and feel confident to go on their own."*
- Family involvement: Staff described making an effort to involve family and key supports, with most noting that there had been considerable successes in this area with many residents having far more regular contact with family at 90 Shuter. *"We celebrate Christmas, Mother's Day, Family Day, and we usually call family. For one individual, 9 family members came to an event….it makes a big difference."*
- Peer Support – recovery groups: Finally, a Peer Support worker offered group programming at 90 Shuter to address general recovery issues in a supportive manner.

Autonomy vs. Safety: A Divergence of Perspective

While themes and perspectives around support strategies and resident gains were largely congruent, the one area in which perspectives on care differed was with respect to the balance between (i) the importance of cultivating autonomy and measured risk taking in respecting client rights and clients making gains in their recovery and (ii) the importance of providing a degree of support that prevents clients from entering situations in which they might be exposed to risks that could compromise their safety and mental health. Staff and management from CAMH and Homes First held the impression that, while the 90 Shuter model was working well, there needed to be a greater emphasis upon resident autonomy and Pilot Place staff and management communicated an impression that the current, more preventative/protective approach, was necessary.

Autonomy:

"Not having that accessibility to go and come as they feel…that in a sense is taking them a couple of steps back."

"There needs to be more integration, openness to community, and utilizing the resources available in the community."

"It's still a semi-hospital setting."

"I want to encourage clients to be on their own a little bit more."

Safety:

"We've had to defend them a lot of times. Some of them are quite innocent. Some of them are just targets to be taken advantage of and we are not going to let that happen…there is a lot of criminal activity."

"I interviewed all of the residents when we first got them and even though the workers thought they should have metro passes, so they could travel about the city, when you actually talk to them they don't want to go anywhere."

"I primarily believe in safety."

Additional Comments

A number of additional points were raised as areas to consider in further developing the services offered through this partnership. These included:

- The need for more programming around physical health/fitness
- The removal of a staff presence during Peer Support group sessions
- Some concerns regarding the potential duplication of services and room for efficiency (e.g., around obtaining medications)
- The need to address scheduling challenges (distance to GPs; outpatient clinic)
- The need for better integration of stakeholders (staff-staff; resident-other tenants in the building; resident-community service; resident-other camh clients for programming)

Family/Key Support Interview

Unfortunately, of the supports and family members that we had consent to contact only one family member responded to the request for an interview regarding 90 Shuter St. This person indicated that they were extremely happy with the quality of the apartment and the

services provided there. He noted that at 90 Shuter that his family member had his medications monitored more consistently and was doing better with respect to physical health and psychotic symptoms. He thought his family member was kept well "occupied" with activities and events and, overall, stated that he thought the service at 90 Shuter was "great". He did, however, note that his family member felt restricted in what he "could and couldn't do" and indicated being unsure as to whether or not such restrictiveness was warranted.

Service Use and Level of Functioning

The final two domains encompassed in this evaluation are hospital service use and functional indicators. With respect to hospital service use (aside from standard outpatient care provided by CAMH through the Central Link service), it is of note that there has been no readmission to hospital for any of the 9 residents living at 90 Shuter in its first year of operation.

Functional indicators were gathered from the Resident Assessment Instrument (RAI) as they were completed by clinician raters. Ratings are available at discharge and 6 month follow up for the first 5 residents and at 6 month follow up for the remaining 4 (discharge RAI ratings for the second group are pending). Due to the limitations associated with using the Resident Assessment Instrument (RAI) in this context, RAI findings were examined primarily for scores that appeared markedly problematic or changed markedly over time. Per the clinician ratings, mood and anxiety symptoms were either absent or minimally present for all 9 residents, with no marked discharge-6 month follow up change for the first 5 admitted to 90 Shuter. It is also of note that behavioural concerns such as suicidality and difficulties with anger and aggression were indicated as being absent or minimal for all residents. Psychotic symptomatology ranged considerably across residents from minimally present to evident on a daily basis, with no marked change in this area noted for the 5 original residents over their first 6 months at 90 Shuter. While functional indicators are very circumscribed with the RAI, it is of note that for most residents significant problems with behaviour and functioning were not observed in most areas. Two areas of change in functioning were noted for the first 5 residents admitted. These were a modest increase in the need for assistance with meal preparation and indication that medication and treatment adherence had improved.

Economic Analysis

An economic analysis has been completed to provide a comparison between the costs of providing services at 90 Shuter St. as compared with services provided at CAMH. We estimate the basic costs of maintaining a resident including amenities, rent, and clinical/support services at 90 Shuter to be approximately $76/day. This per diem cost can be compared with the mean per diem cost for a tertiary bed at CAMH which is $698/day. It is of note that the per diem cost at 90 Shuter is substantially less than the provincial mean cost of high support housing which is estimated at approximately $100/day. Overall, even allowing for some variability in

estimates, the comparison is striking with inpatient treatment being over $250,000/year per client as compared with just under $30,000/per year at 90 Shuter.

Conclusions and Recommendations

Overall, there are several indicators that the high support housing service provided at 90 Shuter St. has been highly successful. The partnership is comprised of three organizations that are very committed to the shared vision of providing high quality supported housing services. They are providing a service that has effectively created a bridge into the community for ALC clients who have been in hospital at CAMH for an average of 8-9 years. The service providers are viewed as very caring and invested by clients and providers have sought to support clients in staying engaged in their treatment and in making functional gains. The clients, in turn, have done very well at 90 Shuter St. No client has been rehospitalized in the first year of operation, there have been no reports of increased symptomatology or risk behaviours, and there are indications of increased functioning with respect to general activity levels and social engagement. As one staff member commented:

> *"I see them more confident…more comfortable and open…just seeing the increase in self-esteem and confidence was great."*

The consensus, across stakeholders and method of inquiry, is that 90 Shuter St. is providing an effective alternative to inpatient care in which clients experience an improved quality of life. Furthermore, a comparison of costs is striking with the annual cost of a year of inpatient care at CAMH being over $250,000 as compared with costs of just under $30,000 per year at 90 Shuter. As such, this evaluation supports the plan to expand upon this and other similar partnerships in that they provide an clinically and cost effective means through which we can assist our clients in attaining greater autonomy and quality of life outside of the hospital.

While it was agreed that there are many strengths to the model of care offered through this partnership, there were some themes that emerged across stakeholder perspective that suggested some domains in which improvements could be made. Based upon the comments and ratings gathered in this evaluation, the following recommendations are made:

1. The most pervasive line of commentary with respect to both need for further development of the services offered and differing opinion was with respect to the degree to which resident autonomy and community participation were supported. As is typically the case, both perspectives hold some merit. For individuals who have been in hospital for many years, a careful and graduated approach to providing support is necessary to ensure that they have an opportunity to explore goals and aspirations in a manner that won't be overwhelming and ill-informed. There is also, however, extensive evidence that unless individuals with severe mental illness are provided with active support in extending their community participation and levels of functioning the result

is typically a truncation of potential gains and the cultivation of dependence upon service providers. There is a need to support clients in carefully considered and measured 'risk taking' if gains are to be made, even if there are mistakes made and some anxiety occurs in the process.

It is, therefore, recommended that clear and individualized plans be made to identifying and supporting client goals for attaining greater independence. This should be done in a graduated approach with appropriate supports. An example might be using peer support workers to work one on one with clients, shadowing them as they learn to use transit independently and navigate their way around the community. Similar planning might also be done around areas such as promoting greater freedom of movement, greater involvement in activities such as meal preparation, and promoting greater independence with respect to control over their own finances. Additionally, in line with this theme, it is recommended that Pilot Place staff do not remain present in the room during the group programming offered by the CAMH Peer Support Worker. It is important for clients to have the opportunity to explore their experiences with a Peer Support Worker without their being observed by other direct service staff.

2. Consistent with the above theme of integration, staff commentary and ratings on the partnership scale would suggest the need to cultivate more opportunities for informal contact between the direct service staff of the three organizations. This might include periodic meetings, invitations to attend social events and programming for the other residents at 90 Shuter St. and, possibly, the integration of programming offered to other CAMH clients outside of 90 Shuter (e.g., recreation therapy through Central Link or programming based out of the 1001 Queen West site). This should also include for direct service staff clarification of specific contacts, roles, and means of contacting one another. This effort will require oversight and planning by the steering committee that, at present, meets on a monthly basis.

3. With respect to specific programming needs, several staff persons noted the need for increased attention to physical health. Suggestions included access to smoking cessation supports, planning around group and individual exercise activities, and a greater involvement of Recreation Therapy.

4. The final area of recommendation regarding the services offered, and one stemming from comments about scheduling challenges, lies in the need to examining how the current profile of services might become more efficient. Specifically, the following areas might be examined or explored further: (i) Ongoing work to determine the feasibility of finding GPs in the immediate vicinity that are more readily accessed and who have the capacity to effectively interface with psychiatric service providers. (ii) Consideration given to Central Link case managers and Psychiatrist providing services onsite at 90 Shuter rather than requiring residents to go to Central Link in what has been described as a dispersed array of individual appointments. (iii) Some dialogue taking

place around which provider holds and is responsible for medications to reduce instances of Pilot Place staff needing to travel to the Queen St. site pharmacy after hours.

5. The final recommendation is for there to be put in place an ongoing mechanism for the efficient and effective evaluation of services offered at 90 Shuter St. This would ideally include case manager completion of a brief functioning scale, Peer Support assistance in evaluating quality of life and satisfaction with services, tracking of inpatient service use, and annual completion of the partnership inventory by service managers. This ongoing evaluation would be complemented by periodic (e.g., every 18 months – 2 years) in depth evaluations.