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BY OLIVIER FARMER, MD*

MENTAL HEALTH

MAPPING A NEW ROUTE

The successive deaths (under police fire) of several homeless people (Mario Hamel in 2011, Farshad Mohammadi in 2012, and Alain Magloire in 2014) exposed important flaws, indeed, the dismal failure of the healthcare system in the case of homeless people.

An inadequate understanding of the phenomenon; the lack of institutional and political will; the absence of coordination between police actions, those of healthcare workers and those of community organizations have all contributed to this paltry track record. And yet, homeless people cost taxpayers a lot in police interventions and ambulance transportation, in prison or hospital stays. The problem is that the system's faults make these actions ineffective and futile, a real waste of public funds.

A DIFFICULT CONTEXT

We, in the healthcare network, are currently living through a storm of transformations linked to budgetary cut-backs, Bills 10 and 20, and soon activity-based financing. In the circumstances, it is difficult to imagine doing anything other than keeping our heads above water! It's quite a challenge to keep on facing the future, to continue developing innovative practices and to improve access to our services. And yet, if we want to avoid stagnation and a decline in services, to do so is a constant obligation.

Increasing access and a better integration of services are avowed aims of current reforms. Better services for vulnerable individuals are regularly demanded by the population via the media. The government has just equipped itself with a policy to fight homelessness that calls upon all workers in healthcare, social services, the municipal sector, housing, and others, to unite forces in order to reduce the phenomenon. We expect the network to become quicker and more efficient, less complicated to negotiate, and finally, better adapted to the specific needs of patients and their families.

ANSWERING THE CALL

I am a psychiatrist practising in downtown Montreal, where more than half of the homeless in the city live. They come in increasing numbers to the emergency room. A lack of understanding of the phenomenon of homelessness in the healthcare network has long been a hindrance to quality care for people living in such a state. Caregivers are often powerless and frustrated when faced with such complex problems, which results in therapeutic distance and stigmatization. Having just completed a Public Psychiatry Fellowship, I was attracted by this field which is neglected, mysterious, and asking only to be explored. On the psychiatric side, everything needed to be done. With a strong desire to help and to mobilize the network to better support our fellow citizens who are having a hard time, I decided to work towards obtaining financing and developing services that are adapted to the needs of the homeless with mental health issues living in downtown Montreal.

THE REALITY FOR HOMELESS PEOPLE DOWNTOWN

One of the realities of the downtown sector is the concentrated presence of people in great difficulty, homeless, isolated and most often ill, and among whom more than 50% have psychiatric disorders. These people, generally cut off from all family ties or support networks, are often reticent to interact with public services, whether it's through fear of stigmatization, because of bad experiences in the past, or even because of paranoid ideas. They represent an important clinical challenge for the typical structure of healthcare services and, moreover, are generally considered undesirable in medical and psychiatric emergency rooms: they often have neglected personal hygiene; they seem to repeatedly present themselves for the same problems; linking with ambulatory services almost never works; they don't have a RAMQ card and, therefore, can't buy medication; etc.

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That's probably why the network chose to "spread the misery" by creating a weekly on-duty schedule,

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according to which paramedics and police officers, in 2011-2012, were directed to bring sick individuals who were homeless to a specific hospital centre that changed every week. Thus, if a patient in crisis was taken in charge close to a refuge in downtown Montreal, he or she could be transported to a hospital in the north end of the city. A simple visit to the emergency room does not create an association with the hospital and therefore, the temptation is great to release the patient rapidly on the assumption that the responsibility will fall to another centre the following week. It's not surprising that police officers and community organizations complain that these patients are subjected to swinging doors in the healthcare system, often brought into emergency rooms, but never really taken in charge.

WHAT ELSE CAN BE DONE?

By thinking about possible solutions that would lead to a better result, our team tried to analyze the needs of homeless people. In what way are they different from regular patients? Why can't we manage to link them solidly to services?

Often, they have lost all proof of their identity (including their health insurance card); as a result, they can't open a bank account, apply for social or housing assistance, or buy medication. Without revenues and without a fixed address, and thus without a safe place to store their medication, they are often unable to rest adequately and there is no way for caregivers to reach them. Psychiatric disorders are exacerbated by the necessity of sleeping in the street or in crammed shelters; by the reality of always being in public places; and by the immediate possibility of purchasing and consuming alcohol or drugs. When these persons arrive in the emergency room, it's generally due to a crisis, during which a police or *Urgences-Santé* intervention, often with strong-arm tactics, may have taken place. Once they arrive at the hospital, they are often angry and rarely receptive to an offer of help.

It seemed clear that a global solution would have to respond to all these issues within the framework of a single intervention and with a single team, because it is not reasonable to ask people, living such a disorganized life and under constant stress, to undertake approaches all over the city to obtain their identification papers, their benefits, their medication, etc. In addition, an immediate offer of housing seemed to be the wisest and most productive avenue to reduce stress, provide space to rest and reflect, as well as allow follow-up actions without having to institute a manhunt for the patient. Finally, rather than try to attract patients to a hospital, which is a strange and stressful place for them, where they have previously experienced stigmatization and indifference, or which they associate with coercive actions by police, it seemed more pertinent to attempt to reach patients in their normal environment, before a crisis develops.

It's by following these principles that an agreement was established in October 2014 between the CHUM and the Old Brewery Mission to create services aimed specifically at helping homeless people who are struggling with mental disorders to come in from the street, to settle into a stable apartment or housing, and to undertake a follow-up within the health and social services network. This is how appeared the PRISM Project (*Projet de réaffiliation en itinérance et santé mentale*) that delegates a full-time social worker employed by the hospital and a psychiatrist, to spend two to three half-days per week managing about 10 beds dedicated to this end within the shelter itself. The shelter's management rapidly chose to add a psychosocial counsellor (one of its full-time employees) to the team.

HOSPITALIZED AT THE SHELTER?

PRISM offers a stay of about six weeks to men (the shelter being strictly for male clients) who present with the profile of a mental health problem associated or not with the consumption of drugs or alcohol. Candidates come from the shelter, from *Café Mission* (a drop-in centre open to everyone during the day, providing coffee and lunch as well as computer and Internet access), or are referred either by the ER of a hospital centre or directly by police officers or community organizations canvassing out in the street. The person sees someone the same day (sometimes within minutes of being identified) and is asked if he wants help to come in from the street.

Housing, offered free of charge within the framework of PRISM, is a clear improvement over what is generally available in shelters: a single bed is provided instead of a bunk; there are partitions providing privacy from other residents; a personal locker with a key is made available to each participant; they can stay for the entire day and benefit from the day's three meals, rather than having to leave with all their belongings early in the morning, spend the day outdoors, then come back and line up for a bed

A SUBSTANTIAL NUMBER OF HOMELESS PEOPLE DO NOT GO TO SHELTERS AND SLEEP IN THE DOORWAYS OF STORES, IN TEMPORARY SHELTERS OR IN RESTAURANTS OPEN 24 HOURS A DAY WHEN IT'S TOLERATED. THEY ARE PRESENT IN THE STREET, THE METRO, MONTREAL'S UNDERGROUND OR IN THE PARKS.

late in the afternoon. It's a tempting attraction for people who have lived with almost constant suffering and discomfort, at times for many years! On the other hand, they have to commit themselves to meet with the team on a regular basis; to participate in and collaborate, as well as they can, with the project that aims for them to leave homelessness; and to accept to put a portion of their money away, in trust, in order to eventually live in an apartment.

Thanks to a special agreement with the RAMQ, the social worker is authorized to issue a valid RAMQ card as soon as the patient arrives. This allows the person who has lost everything to have a first piece of ID, giving him the possibility of opening a bank account, of applying for social assistance (also on the first day), and of obtaining his medication free of charge. Incidentally, this also allows the psychiatrist to be paid for his clinical follow-up from the very start of the process. Within the 72 hours that follow his admission, the person meets the psychiatrist, who undertakes the psychiatric evaluation, develops a diagnosis and offers treatment. A weekly psychiatric follow-up is done until the end of the stay. The psychiatrist can order blood tests if needed or even prescribe medication by injection, where indicated, thanks to the presence of a male nurse at the shelter. Treatment is suggested, but not mandatory as long as the person is still available to work on the project of coming in from the street in spite of active symptoms. Quite rapidly, the social worker analyses the housing and support requirements of the person and refers or even accompanies the person directly in search of housing. Special agreements with owners, non-profit housing organizations or even people in charge of the public housing network, make it possible in most cases to find permanent housing adapted to the needs of the person within a few weeks at most. Everyone who passes through the program is then redirected to the health and social services network, whether it's to an outpatient clinic, a follow-up team within the community or even direct community follow-up.

The program began modestly with 6 beds, then progressively expanded to reach 18 beds today. Another PRISM, this one for women, opened in March 2015 at the Old Brewery Mission's Patricia Mackenzie Pavilion, adding another 10 beds. With average stays of 60 days and a 67% success rate, some 160 persons benefit from a stay per year, among whom some 100 will move on to a permanent apartment or housing, associated with a medical and psychosocial follow-up. In several cases the persons were homeless for years (more than 20 years for some of them). When the cost of the program is analyzed, each person who successfully leaves homelessness costs some $2,500 to $3,000. This is a bargain when we know, based on studies performed in several Canadian cities, that the annual costs generated by one homeless person (stays in shelters, prison or hospital; police and ambulance interventions, etc.) exceed $50,000.

PSYCHIATRY IN THE STREET

After receiving significant funding from the Ministry of Health, in line with its new policy to fight homelessness, a new side was added to our offer of services in March 2014, that of an intensive follow-up team within the community specific to the homeless and the mentally ill (*Suivi Intensif Itinérance* or SII). This team, also based at the Old Brewery Mission and made up of social workers, nurses, a criminologist as well as a counsellor from the Mission, has allowed us to go outside the walls of the shelter itself to intervene in the street.

A substantial number of homeless people do not go to shelters and sleep in the doorways of businesses, in temporary shelters or in restaurants open 24 hours a day when they're tolerated. They are present in the street, the Metro, Montreal's Underground or in the parks. With the help of community organizations and nurses who initiate contact, as well as with allies in the police force, the team goes out to meet people in the community, sometimes with the psychiatrist, to evaluate cases directly in the street. We thus follow some fifty people at a time in the community, the majority of whom are quickly housed following the intervention. Sometimes legal means, such as a court order to treat and house, are

used to break the impasse in certain cases and give a chance to people who have been sick for years to experience a psychiatric treatment, to come in from the street and to re-join society. In the majority of cases, the people treated this way recover their lucidity, become aware of the devastating impact of the illness on their lives and are grateful for the intervention, even if coercive methods had to be used.

BALANCE SHEET AND OUTLOOK

Up to now, the CHUM's teams as a whole who offer services to homeless adults have followed and treated more than 300 persons since November 2013, among which more than 180 have left the street and are now in apartments or adapted housing. We are in discussions with several partners to open other PRISM sites.

We have seen people barely 18 years of age, others on the far side of 70, men and women who had worked at trades or even practised professions in their lives, and finally some whose families had been searching for them for years thus reuniting them. Most of these people lived in fear or in a fog induced by psychosis, but thanks to more favourable circumstances and an adapted treatment, which

WELCOME TO *CHEZ DORIS*

BY PASCALE DES ROSIERS, MD*

Imagine that, one day, for no particular reason you find yourself close to Atwater Avenue sauntering eastwards on St-Catherine Street, heading towards downtown Montreal. You come to the intersection with Chomedey Street which looks small and quiet. Without knowing exactly why, you turn into it...

Your attention is drawn to a nice-looking Victorian brownstone with a turret flanking its left side. If it wasn't for the curious forged-metal grating that wraps around the porch, you would probably not notice it among similar buildings in this neighbourhood.

Intrigued, you come closer and enter. That's it, you're sure you're going to fall in love with this place.

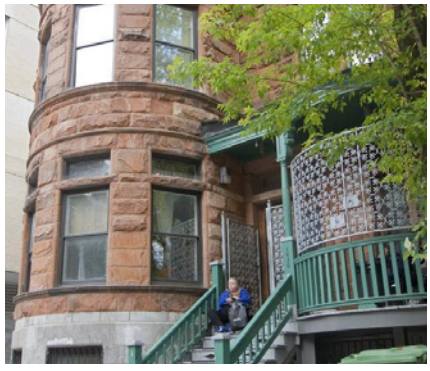
This sounds like what happened to me, some fifteen years ago (all right, I'm obviously romanticizing somewhat! But, it is true that I arrived there a bit by chance). A colleague had been working at *Chez Doris*, but she was overloaded and couldn't carry on. I was curious and I wanted to see! The building housing *Chez Doris* seduced me. I was grabbed by this magical place and, since then, I've been going back, always as impressed by the extraordinary women who work there and always attached to those who come there seeking help.

When you first enter *Chez Doris*, you realize that this is not a house like any other. There are women sitting on the porch, sometimes on the steps. They talk. They laugh. You know, just by looking at their worn-out clothing and their marked faces, that life has been hard for them. They speak loudly, they laugh loudly, they smoke a lot; sometimes they're hard, vulgar or even brutal. Life has forced them to grow a shell. They have learned to defend themselves. You may even have the reflex to withdraw (that little fear that grabs us sometimes, those of us who are neat and well-off, when faced with those who aren't). But, if you pay attention, you will notice that in this house that isn't like any other, these women can relax for a few rare moments of their existence. Here, they know they are safe.

Some of them look at you as you enter; some say hello; others don't care a jot that you're there, and that's all right. This is their place. It's not a clinic that operates around a doctor's schedule; it's not a rehabilitation or treatment centre; it's not a CLSC. This is the house where they can lay down their armour. This is their home.

Chez Doris is a day shelter, created some forty years ago following the murder of a homeless woman, Doris, found dead in the street. Shortly before her death, she had voiced the desire to find a "place to go without prying eyes and too many questions." She was never able to find her sanctuary, but this house honours her memory and offers the kind of place she would have wanted for other women in difficulty.

You continue your visit. In the vestibule, there's often a happy crowd. OK... it's not always completely happy! We're on earth here, not in heaven!



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dispersed some or all of the fog, they were able to recover the capabilities they used to have and thus resume a more normal life, at times with astonishing speed.

Although the success of such a project is never guaranteed, we won our wager. We obtained stable financing by demonstrating that it's possible to get significant results for each dollar invested in PRISM. We can feel the enthusiasm of future healthcare practitioners (externs, residents, fellows and others) who are already knocking on our doors. If we could create positions, they would rapidly be filled!

Our conclusions are clear: mental illness and homelessness are not inescapable ills that we have to accept philosophically and, especially, without power, such as cancer used to be. They are instead treatable conditions, sometimes showing modest results, sometimes astonishing success. These ills deserve to be fought with the same ambition and the same energy as the other great diseases we know.