Quick Takes
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HOSTED BY DR. DAVID GRATZER

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Episode 32: Chronic homelessness with Dr. Vicky Stergiopoulos

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[Musical intro]

David Gratzer: He explained to me that he'd slept in the train station for the previous four nights. The shelters were all full. "Where else could I go?" he asked. We hear these stories often. Too often. Across North America there seem to be more people who are chronically homeless than at any previous time. Who are they? What are their psychiatric problems? How can we help them?

Welcome to *Quick Takes*. My name is Doctor David Gratzer, I'm a psychiatrist here at CAMH. On this episode we look at chronic homelessness and perhaps some solutions. Joining us, Doctor Vicky Stergiopoulos, who is an international expert on the topic. She's also the first author of perhaps the biggest RCT ever on Housing First published in *JAMA* a few years ago. She, of course, has had leadership positions, including here as a former physician in chief and was, of course, the psychiatrist in chief at St. Michael's Hospital. Welcome, doctor Stergiopoulos.

Vicky Stergiopoulos: Thank you for having me.

David Gratzer: Now, doctor, this is a population you're well familiar with. Indeed, you were visiting some people who had been precariously housed just a few hours ago. How did you get interested in working with these individuals?

Vicky Stergiopoulos: I think I was a resident. I was rotating through St. Michael's, and the Wellesley Hospital back in the days, and I was just intrigued by the challenges and also compelled to do something about them. So, after I finished my residency, I landed at St. Mike's, where again, I had the opportunity to work more closely with this population. Gradually, through my experience in the inpatient unit and community mental health teams at St. Mike's, I was exposed more to shelters and the streets, and I started working there and taking my practice there because I thought at the time that's where the need was, and gradually building research around my clinical work, and that's how it came to be.

David Gratzer: And your career has stretched for some years, and you've had different positions over time, including major leadership positions, and yet you've maintained clinical work with this population pretty much throughout.

Vicky Stergiopoulos: Well, this is what keeps me going. That's what, paradoxically, this is what gives me hope. I learn a lot from the population. It's an opportunity to hear heartwarming stories of compassion, of camaraderie. I work currently in the shelter hotels, the Bond Hotel and the Toronto Plaza and some of the individuals that I meet are just remarkable. Both in terms of the patient that I see, but also the staff that work in these settings.

David Gratzer: Some of our colleagues might consider this, frankly, a tough population to work with. But I know that you've been very focused on this group. In fact, at your professorial round some years ago, you had talked about a particularly challenging patient in the connection you developed over time. Can you share the story?

Vicky Stergiopoulos: Well, I have had several stories, but I'll talk about "John" or the name that I used for my rounds, which was an individual I met at an abandoned garage maybe 15, 16 years ago And I would go week after week and he would hide when he saw me and I would leave my card, so he would know that I was there. And one week it was away, and I was at a conference and low and behold, when I came back, there was a message in my phone and say, "What happened to you? Why didn't you come this week?" So, I knew that I had managed to engage him. And from then on, it was easier. We started going to the supermarket, to coffee shops and I bought him a bicycle with program funds because that's what he needed. And three months later, he was housed and followed by an ACT team. And when I checked several years later, he was still housed and followed by an ACT team. Long history of schizophrenia. Prior admission to CAMH but lots to follow up.

David Gratzer: Amazing.

Vicky Stergiopoulos: These are the kinds of stories that keep you going, like one at a time. But you can succeed.

David Gratzer: On a slight pivot. This is also a population that that's changed with time. So of course, we're talking about the chronically homeless. Some people go through short periods of homelessness. But if we talk about the chronically homeless, how have these individuals changed in your view, over time?

Vicky Stergiopoulos: I'll speak from my clinical experience because the literature on that is not robust. Again, we have some, you know, systematic reviews on the topic, and we know what's happening at the international level from that perspective. But I'll speak from what I see on the ground.

When I started like 22 years ago or so, I would see a lot of people with psychosis at the shelter. These days, what I see in the shelters is a lot of addictions and trauma. I do see some people with psychosis, but by far the majority are people with severe addictions these days. If we look at the international literature, we still know that up to 75% of individuals that are homeless meet criteria for a current mental disorder. And we know that the rates of psychotic disorders have stayed stable over time, but we've seen increases in rates of depression, high rates of personality disorders, trauma, and addictions. But this is the population we have. Still people with schizophrenia are overrepresented in the population but by far they're not the biggest group.

David Gratzer: And the substance itself has changed. I work here in the emergency department at CAMH. Substances like crystal methamphetamine were relatively rare, maybe 1% of presentations tied to amphetamine misuse seven, eight years ago. Whereas today it's closer to 10%.

Vicky Stergiopoulos: Yeah. When I started again 22 years ago, it was a lot of alcohol. And a few years later it's a lot of crack, and now it's fentanyl and crystal meth primarily. This is what over 90% of the people that I see misuse these substances.

David Gratzer: Substances grew cheap, they grew more potent with time. How has that influenced presentations you've seen?

Vicky Stergiopoulos: They are harder to engage. They are harder to engage in treatment and developing personalised care plans. They are less likely to accept psychiatric medications. Some are keen to get psychiatric treatment. Others tell me they like their drugs better than mine. And they prefer to forego psychiatric care. And some are too ill to come to care. A person with schizophrenia, it's easier for me as a psychiatrist to take care of. I have my tools, both in terms of medications, in terms of psychosocial interventions. But even

the Mental Health Act forms, if I think somebody is at imminent risk of harming themselves or others, with addictions it's trickier. Even if somebody I can, you know, reasonably foresee that they might overdose in the next few days, I have very few tools to deal with it in the community. So overall a much more difficult population to engage and treat. And we have we're not as good at treating addictions as we are treating psychosis or other mental health conditions.

David Gratzer: And yet that seems to be far more prevalent in this population. What advice might you give to our clinician colleagues in terms of working with those who are precariously housed?

Vicky Stergiopoulos: It's good to go back to the literature and see what we've heard from this population about what they want in services and in relationship with providers. What they've told us in prior research is that they want low barrier access to services. That means not just geographical accessibility, but also interpersonal accessibility. They want timely services. They want comprehensive services. They want one stop shopping. And they want providers that understand the realities of homelessness. And they work from a trauma informed perspective. They want providers that can they can see as a friend. And I know it's hard to keep the boundaries clear that they're professional. And at the same time, they want somebody they can trust as a friend and who relates to them at that level. And it's not an easy thing to do, but certainly those that I work with in the homeless sector have a lot of these qualities. And this is what's so interesting, so rewarding to work with these providers.

David Gratzer: We seem to be talking more about those who are chronically homeless than in the past, and politicians have weighed in, sometimes spectacularly and bombastically. So why is that?

Vicky Stergiopoulos: Because it's in front of us. I think we've seen rising rates of homelessness internationally, with few exceptions. It's visible. It's in our streetcars and buses our subways our streets, and it's hard to ignore. I think, important that we do talk about it. And it's also even more important to do something about it. We have solutions, although, as you know, they're being contested and there are doubters out there, but what the solutions could be or should be. But definitely we've learned from both jurisdictions and other systems about what works and what can be used to decrease rates of homelessness.

David Gratzer: And obviously you've been involved in that research, including Housing First. Some time has passed and there have been more experiments, including at the national level. What's your read on the literature these days?

Vicky Stergiopoulos: We get replications of studies that have been done before, and we get replication of findings. Housing First works. It works as a program. We see reduced rates of homelessness, and we see in many cases improve other outcomes, including health service use. We see people using more community-based services, less emergency- and hospital-based services. We've seen some improvements in some aspects of quality of life, not as much improvement in other health domains. But again, these are people that have chronic health conditions and that remain profoundly poor. So, we need to be realistic about what we can expect.

But I think I need to talk about Housing First, not just at the program level, but at the system level, because where we've seen success in decreasing rates of homelessness, it's when Housing First has been adopted, not just a program but as a policy. And I'll cite two examples. One is Finland, that adopted Housing First as a policy ten years ago and has seen significant reductions in the rates of homelessness, and they hope to end homelessness in the next several years. And the other one is just south of the border in the US. If you look at the veteran sector and when they adopted the Housing First as a policy. That includes homeless prevention and coordination of services and measurement to ensure that they're on the right track. They cut homelessness by half. And again, I wanted to highlight that Housing First is not just housing only, it's housing and services. And if it's implemented right and on scale, I think it has a great chance of securing and ending homelessness.

David Gratzer: I mean, there are two stories south of the border. Since you bring it up with Housing First. There's the story of jurisdictions like Denver, which, yes, combined Housing First with services. They actually picked a harder subpopulation. They picked chronically homeless individuals who have been in and out of the jail system and could show not only were they stably housed, but they actually show that they access psychiatric care, were appropriate, more often, used EDs less frequently. But the other story south of the border is increased hostility to Housing First. In fact, a backlash in some states. How do you reconcile the growing evidence with the growing dismissal?

Vicky Stergiopoulos: I think you're dealing with philosophical and ideological differences. The critique comes from the conservative think tanks that believe in turning the clock back and moving to a treatment first approach. They feel the rising rates of homelessness in the US are the result of failures of Housing First, as opposed to failure of other structural barriers like lack of affordable housing or minimal wages that are not adequate or the lack of a safety net. So, it's easier to point their fingers to Housing First, as opposed to recognising that even when Housing First was funded in the US, in many cases it wasn't funded with good fidelity to the model. So, it wasn't implemented properly or to scale to see the changes that we've seen, either in Finland or within the veteran sector. And you know, unfortunately, the treatment first approach is what we had before Housing First. Housing First didn't come out of the vacuum. It came because treatment first, you know, seeking people to engage in psychiatric care to stay, become abstinent from services, to start working. It wasn't working. That's how Housing First came to be.

David Gratzer: We've talked about some of the political backlash, and some of this also is some institutional backlash. People who have been involved in the old ways even have worked in the system, have jobs in the system. Was that frustrating to you to deal with that backlash and to hear about it?

Vicky Stergiopoulos: Absolutely. When we did the At Home/Chez Soi study, we were constantly confronted by providers that worked from the more traditional treatment first models, and they felt very uncomfortable about our work, and they felt threatened, frankly, about our work. And they were, of course, as you might expect, lobbying the government against Housing First. And to that, add organisations that eventually did lose opportunities for funding because of the shift of policy to Housing First, then you have a mix of interests and ideology fighting against the evidence based. So, you get the perfect mix for this.

David Gratzer: And is that becoming, in your view, a perfect storm?

Vicky Stergiopoulos: I mean, I don't know that I would call it a storm, but it's certainly brewing. I think eventually we need to come to a consensus that Housing First is not a panacea. Definitely it needs to be a cornerstone of any effort to end homelessness. But there is room for additional models, based on client needs and preferences. and let's work together to figure out what this might look like so that everybody feels that they can be included while at the same time respecting the evidence and building the evidence for what else we need. Part of what we said after we finished the Housing First trial. What? So now what else? So, let's continue researching "what else?"

David Gratzer: You've spoken previously about your hands-on work and some of the challenges working with very difficult individuals. What was that like?

Vicky Stergiopoulos: I mean, these were the most interesting years of my career. At some point, I spent 80% of my time on Housing First and trying to make sure that people stay housed and stay out of out of jail and out of hospital, and it was rewarding because I wasn't working alone. I was working with phenomenal teams in the community. But the teams required support. The teams required frequent case conferences about challenging behaviours, figuring out how to solve problems. Like, you know, what do you do with the fire setter? Or what do you do with somebody who has a history of sexual violence and how do you house them safely and keep the community safe? And that involved a lot of reading, a lot of learning, a lot of consulting and a lot of collaboration across sectors and levels of care as well. Sometimes there were times that I would call a forensic psychiatrist for advice to do a risk assessment, because I wasn't feeling comfortable doing it

myself. And yeah, that's what it takes, a village.

David Gratzer: And of course, there's the original research that you've published out of the Canadian Housing First, At Home. But there've been follow up studies. In fact, I think the last study you guys published was at the seven-year mark.

Vicky Stergiopoulos: Correct. And to me, that was even more remarkable than the two-year outcomes. Keep in mind that we were only able to do seven years follow up in Toronto because we were funded by CIHR to do the follow up here for that long. But to see for people with high needs, people that required ACT level of support even seven years later, 40% difference in housing stability between Housing First and treatment as usual. Like it's undisputable. Housing first works so much better than usual services. One could have argued that in two years, yes, you give them housing and support, you'd expect them to do well. But if this difference, although attenuated, persists seven years later, I think that says a lot about the model and about what happens in usual services.

David Gratzer: You are, of course, familiar with the literature you've helped create and shape the literature. What's the biggest surprise you think in terms of these Housing First experiments?

Vicky Stergiopoulos: I wouldn't say surprised. I think I've been inspired by how studies have tried to enhance the model, recognising that in some areas we weren't able to achieve what we initially thought we'd achieve based on the program theory. We thought, you know, we would eventually be able to get people to enjoy better quality of life, to have better community integration, to succeed in employment. And now I see studies, and I'm really heartened to see, you know, where they integrate supported employment and Housing First teams, or cognitive remediation or other psychosocial intervention that need to be available to this population as well, in addition to the case management and the rent supplements to access housing. So, I think these were the pleasant surprises where I see people still trying to improve the model. The non-surprise was also that the replication of findings in different contexts. And in Canada we did it in five different cities of different size and resource availability and we saw the same things in France. The findings were even more remarkable in some areas because usual care is even less organised there than here. And, everywhere it's been tried, whether it's Denver or New York, it works.

David Gratzer: You've mentioned Finland and the possibility of ending homelessness. Clearly that's going to involve Housing First and mental health services. But how do we think in terms of prevention in the first place?

Vicky Stergiopoulos: I think that's the key. Like Housing First as a policy that's not just a program would involve also, for example, homelessness prevention. And that's intervening early looking at kids that are at risk of homelessness, whether because they experience, you know, homelessness through their family or because they've had adverse childhood experiences or experienced school failure and developmental difficulties. Making sure that we also address the structural barriers like adequate wages, affordable housing. I think these are key ingredients that need to be there to prevent homelessness. Otherwise, we're chasing our tails. So, we need to be working concurrently at preventing homelessness as well as ending homelessness where it's already there.

David Gratzer: The debate in North America increasingly touches on coercion, forcing people into psychiatric care or substance care, or both. What are your thoughts?

Vicky Stergiopoulos: We've published our thoughts on this. And it's a coercion as long as there's procedural justice could have a role as long there were resources to offer at the end of it. I think to bring somebody to hospital if there is no ACT level if you like, support and no housing immediately available, it's not going to be productive. The biggest barrier that I found in working with the population is engagement. It takes a lot of skill to engage them. And I think using coercion without a solution at the end, it's only going to serve to disengage them.

David Gratzer: Doctor Stergiopoulos it is a *Quick Takes* tradition to close out with a rapid-fire minute. Are you ready?

Vicky Stergiopoulos: I'll do my best.

David Gratzer: Your enthusiasm is contagious. Let's put a minute on the clock. Doctor, do you think Finland will end homelessness?

Vicky Stergiopoulos: I think they'll come pretty close.

David Gratzer: What's the most exciting revision to the Housing First model that you've seen?

Vicky Stergiopoulos: I think I would say without hesitation, the integration of physical health monitoring, so that the ACT teams can also provide physical health care for this population.

David Gratzer: Do you think there's going to be a petering down of the debate over Housing First over time, or will it grow more controversial?

Vicky Stergiopoulos: I think it depends on who gets elected next in the US.

David Gratzer: What makes you hopeful about the future?

Vicky Stergiopoulos: I would say the populations themselves and their resilience. And also the people that work in the sector They come from a value set, an idealism that's inspiring.

David Gratzer: You've worked with this population for decades now. Are you going to continue to work with them?

Vicky Stergiopoulos: I hope so. As long as I can.

David Gratzer: We very much appreciate you taking the time to join us. And, again, it's been inspiring to hear you talk about not only this population, but your commitment to working with this population.

Vicky Stergiopoulos: Well, thanks for having me.

[Outro:] *Quick Takes* is a production of the Center for Addiction and Mental Health. You can find links to the relevant content mentioned in the show and accessible transcripts of all the episodes we produce online at CAMH.ca/professionals/podcasts.

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