Canadian Mental Health Association Middlesex
Mental health for all

Community Homes for Opportunity (CHO) Program Description

Purpose:
CHO is a supportive housing program for people with serious mental illness. The program is intended to assist Residents by providing appropriate housing and support services to achieve and maintain stability in a home that is safe and affordable. The Program offers opportunities for Residents to enhance the quality of their daily living, their personal growth and development and improve life skills through participation in a variety of activities and programs. CHO provides housing, meals and support services in a home setting for people with serious mental illness who require 24 hour supportive care. Homes that are now part of the CHO program were once a part of the Homes for Special Care (HSC) program.

CHO sites:
London – 5 homes
Strathroy – 2 homes, (1 rural)
Exeter – 1 home
Parkhill – 1 home

Philosophy/Vision Statement:
"Every person has the right to quality, safe and affordable housing and support services to enable them to live as independently as possible and flourish in a community setting. We believe a supportive environment in our homes will enhance individual quality of life, skills, dignity and sense of worth. We value the uniqueness of each resident and adhere to the principles of Psychosocial Rehabilitation."

Goals:
1. To improve/stabilize residents' physical and mental health
2. To support residents housing stability and ensure housing is safe and affordable
3. To support residents to have greater independence and control of their housing and supports
4. To facilitate participation and integration into the community
5. To support residents improvement in life skills

The goal is to support resident's recovery potential by encouraging increased responsibility for themselves with the objective of moving on to a more independent living setting.

Partnerships:
Working alongside independent Homeowners, CMHA Middlesex CHO staff provide community support to residents of the program. 24 HR/DAY Support is offered by the Homeowner and their staff, providing board and lodging. Fire drills and maintenance are provided by the partners, and some persons served programming support responsibilities are shared.

Target Population:
The target population is adults, age 16 and up with serious mental illness who require 24/7 care. The homes are not fully accessible. Pre-admission risk assessment (during the intake interview) is critical in determining suitability.

Fees:
Rent is paid by the residents, based on their income. Meals, snacks and boarding are provided by the home owner. Medications and most health care costs are provided by the program. Transportation to medical appointments and regular scheduled recreational activities are also provided by the program.

Length of Stay:
Length of stay is dependent on the resident's readiness and goals. The homes may be permanent however the goal for some residents will be to move on to a community setting with greater independence.

Psychosocial Rehabilitation Approach and the Recovery Model:
The CHO program takes a recovery-based approach and provides access to support services both in the CHO home and in the community, which will aim to improve and/or stabilize peoples' physical and mental health, foster independence, and enhance participation and integration into the community.

Access and Referral: Completed Referral Forms can be found on the CMHA Middlesex website and received during business hours (8:30am – 4:30pm) via fax. The CHO Manager or Team Lead will contact the referral source to arrange a tour with the resident. Further visits and collection of information will determine suitability for the home.

Admissions: Admissions take place between the hours of 8am and 6pm, 7 (seven) days per week.

Ontario Common Assessment of Need: (OCAN)
Completed within the first few months of admission, the OCAN is a tool that assists with mental health recovery and identifies individual needs; it matches these needs to existing services, and highlights any service gaps. A self-assessment can be completed along with a staff supported assessment to determine mutually agreed upon person centered goals. The OCAN is utilized on an individual level to reduce repetitive information gathering, it is reviewed annually, and adapted as needed.

Individual Rehabilitation Plan (IRP)/ Wellness Plan: With the information for the OCAN an IRP is completed. The CHO staff, home staff and when available, the community support staff will be involved in creating the IRP as directed and guided by the resident. The IRP is resident driven and based on Best Practices strengths model of goal setting. The SMART method is used when creating an IRP. IRP's are reviewed by all parties involved every 6 months initially and at least annually thereafter.

Plans and Actions Group: Monthly Plans and Actions Groups may be held where residents set their individual goals for the month. The group process encourages peer support and understanding. Residents IRP's are used to give direction to each resident.

Medications: Medications are managed by the Home Staff, and independence with medication is encouraged.

Clinical Support:
Nursing staff are available through a partnership with Parkwood Hospital. Access to the nursing staff will be planned in advance as needed.

Support:
This program may be offered in the home environment where Residents can develop new skills, for example, daily living skills, according to the wishes of the Residents. More structured programs can be available through community-based agencies, which offer activities designed to build a variety of skills and increase opportunity for social connection.

Additional Groups:
CHO Staff will regularly implement new groups based on the individuals served, stake holder input and new community trends. Calendars are available at each location describing the groups provided on a month to month basis.