



Preventing Discharge to No Fixed Address-Youth (NFA-Y)

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Sponsors

- ▶ Thank you to our funders for sponsoring this important work:
 - ▶ The Networks of Centres of Excellence (NCE)
 - ▶ Making the Shift (MtS) Youth Social Innovation Lab
 - ▶ Canada Mortgage and Housing Corporation (CMHC)'s National Housing Strategy.



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MAKING
THE SHIFT^{INC}



Community Partners



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SOCIAUX ET COMMUNAUTAIRES

No Fixed Address – Youth (NFA – Y)



The NFA-Y evaluation tests the effectiveness of a potential best practice intervention for preventing discharge into homelessness for youths aged 16-25



Purpose: help inpatient youth who are at-risk of being discharged to homelessness find stable housing upon hospital discharge



Clients across two hospitals access the program referral from health care provider

NFA-Y Program Overview

Find stable housing

Access financial support

Transition to Community post-discharge

Why a youth version of NFA?

- ▶ 20% of the homeless population in Canada is comprised of youth between the ages of 13-24. (<https://www.homelesshub.ca/about-homelessness/population-specific/youth>)
- ▶ In a given year, there are at least 35,000-40,000 youth experiencing homelessness. (<https://www.homelesshub.ca/about-homelessness/population-specific/youth>)
- ▶ The needs of youth differ from the needs of adults



Unique needs of youth

Education
Supports

Children's Aid
Society

Youth-Sector
Employment

Ontario Works vs
ODSP

Sex Trafficking

Housing

- Lack of tenancy history
- Need for co-signer

No Fixed Address – Youth (NFA – Y)



Staff from Youth Opportunities Unlimited (YOU) assists youth to access:

- shelter
- long term housing
- supportive housing
- private market rentals
- and other housing supports



Staff also assists youth with:

- navigating community resources
- case management
- referrals to other community partners for additional supports and dual case management.

No Fixed Address – Youth (NFA – Y)



Helps youth obtain financial assistance through

- Ontario works (OW)
- Ontario Disability Support Program (ODSP)
- employment supports.



Works in partnership with the Housing stability bank (HSB) to help youth obtain grants for first and last months' rent

Research Methods

Administrative data from hospitals, and community agencies will be assessed to determine changes in the rates of discharge from hospital to homelessness

Interviews conducted prior to discharge, and at 6- and 12-months post-discharge:

Focus groups examine perceptions of the intervention, strengths of the implementation strategy, and suggestions for improving the program

There are several key factors that will help ensure patients receive the proper support upon discharge:

1. Create a seamless transition between hospital and the housing stability system using the common assessment tool, VI-SPCAT.
2. Record homelessness and a risk of homelessness as early as possible, allowing individuals to receive the support needed to become stably housed.
3. Patients at risk of homelessness are provided with homeless prevention and preventative eviction supports as soon as possible.
4. Patients who are paper-ready with ID and income source are added to the housing priority Lists and are matched to housing finding, housing allowances and housing stability supports based on eligibility.
5. Homeless patients who are at a heightened risk of medical complications following discharge are flagged and supported appropriately.

Onsite Drop-In Hours

**London Health Science Centre
Victoria Campus B7**
Tuesday 9:00 a.m. to 5:00 p.m.

**St. Joseph's Health Care -
Parkwood Institute Mental
Health**
Thursday 9:00 a.m. to 5:00 p.m.



Coordinated Access to Housing and Services

A collaboration with CMHA Elgin Middlesex, City of London Youth Opportunities Unlimited and Housing Stability Bank



The City of London Homeless Prevention and Housing team wants to ensure every individual and family experiencing or at risk of experiencing homelessness has the opportunity to get the right support at the right time. The goal of a coordinated access approach, in conjunction with CMHA and YOU, is to ensure patients are not discharged without appropriate housing supports.

Referral Process

The referrals from B7 at LHSC Victoria Campus

Short Stay Patient: If a patient is on a short stay unit (24) and inpatient less than a week, staff will reach out to the Homeless Prevention Coordinated Access at 519-661-4663 or 1-833-932-2291. The team can also be reached at homelessprevention@london.ca

Long Term Patient: If an inpatient is at risk of experiencing homelessness and over the age of 24 on B7 for more than one week please contact Housingsupports@cmhamiddlesex.ca

If an inpatient is at risk of experiencing homelessness and under the age of 24 on B7 for more than one week please contact NFAV@you.ca

Referrals from St. Joseph's Health Care - Parkwood Institute Mental Health

Short Stay Patient: If experiencing homelessness and inpatient less than 30 days, staff will contact Homeless Prevention Coordinated Access at 519-661-4663 or 1-833-932-2291. The team can also be reached at homelessprevention@london.ca

Long Term Patient: If an inpatient is at risk of experiencing homelessness, is over the age of 24 at Parkwood for more than 30 days please contact Housingsupports@cmhamiddlesex.ca

If an inpatient is at risk of experiencing homelessness, is under the age of 24 at Parkwood for more than 30 days please contact NFAV@you.ca

Once a referral is submitted, the Coordinated Access staff will reach out and arrange either an in-person or over-the-phone intake meeting. During the intake meeting, staff will work through diversion and prevention tactics, complete the VI-SPCAT form and input data into the HPS system, along with access to additional housing supports and services.



Coordinated Access to Housing and Services

The goal of a coordinated access approach is to ensure patients are not discharged from the hospital without the appropriate housing supports.

This program supports both **YOUTH** and **ADULTS** who are admitted to London Health Sciences - Victoria Site or St. Joseph's Health Care.

For information on how to get assistance with housing finding, allowances and stability supports, speak to the Social Worker on your unit

If you would like to contact a Coordinated Access Worker yourself:

✉ And are **over the age of 24:**
contact housingsupports@cmhamiddlesex.ca

✉ And are **under the age of 24:**
contact NFAV@you.ca



A collaboration with CMHA Elgin Middlesex, City of London, Youth Opportunities Unlimited and Housing Stability Bank.

Hospital Poster & Brochure

Housing for youth (September 2023)

Out of the 48 unique individuals met this year, 45 have been diverted from homelessness

10 Live in Private Market Rentals

2 have been matched and are living in YOU Corner Stone Transitional Housing

4 Living in YOU Shelter

12 have returned to live with family

1 Youth in St. Leonard's Transitional Housing

12 Youth matched to housing programs through the City of London

4 Youth Living in CMHA Transitional Housing

Results: Participant demographics

INTERVIEW 1

Inclusion

- Ages 16-24*
- Homeless or at-risk of homelessness
- Psychiatric inpatient

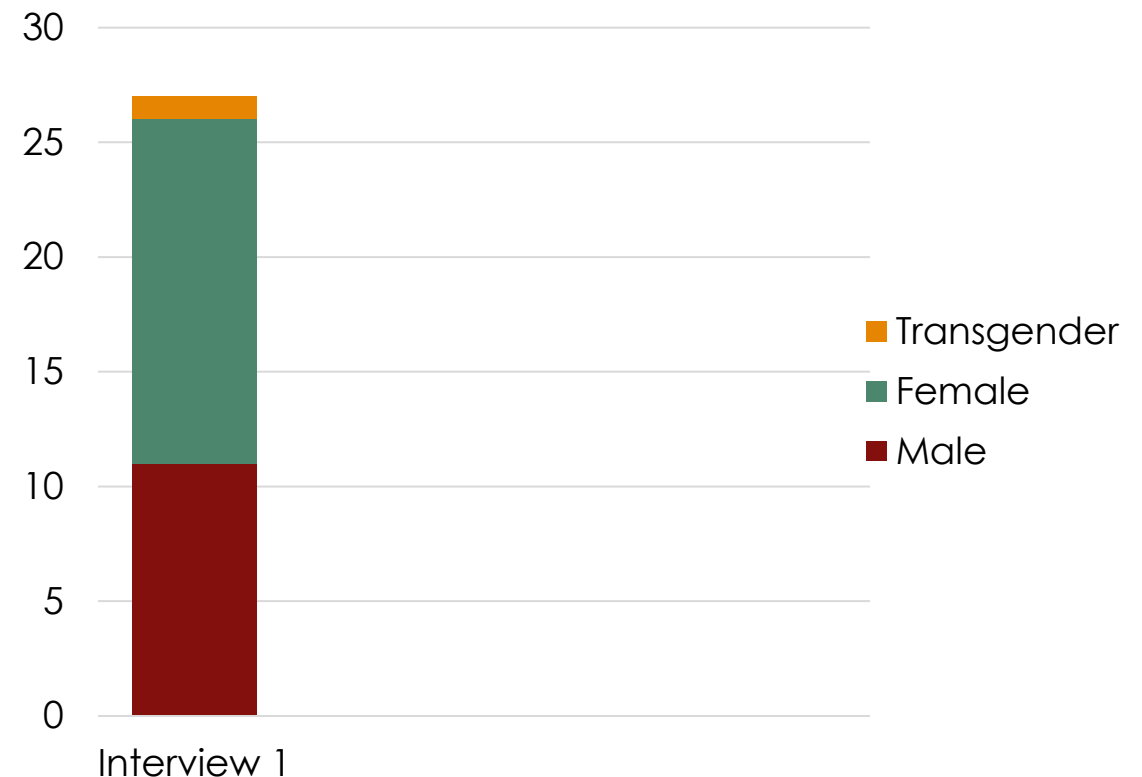
Program Utilization

- (As of September 2023)
- N=48

Interview Sample

- N=27
- 11 Male (40.7%); 15 Females (55.6%); 1 Transgender (3.7%)
- Age: $M=20.3$, $SD=2.9$
- Ethnic/Racial/Cultural group (Missing: $n=1$)
 - European origins (Caucasian): $n=17$
 - Indigenous: $n=3$
 - Visible minority: $n=6$

Participant Gender at Baseline



Results: Participant Psychiatric Diagnosis

Psychiatric Diagnosis(es)	Interview 1 N(%)
Yes	27 (100.0%)
Single Diagnosis	8 (29.6%)
Multiple Diagnosis	19 (70.4%)

Psychiatric Diagnosis(es) Type	Interview 1 N(%)
Developmental Disorders (e.g., autism, learning disability)	5 (18.5%)
Anxiety Disorder	12 (44.4%)
Disorder of Childhood/Adolescence (e.g., ADHD)	5 (18.5%)
Schizophrenia	9 (33.3%)
Mood Disorder	18 (66.7%)
PTSD	4 (14.8%)
Other	2 (7.4%)

Results: Participant Physical Diagnosis

Physical Health Diagnosis(es)	Interview 1 N(%)
Yes	13 (48.1%)
Single Diagnosis	12 (44.4%)
Multiple Diagnosis	1 (3.7%)

Physical Health Diagnosis(es) Type	Interview 1 N(%)
Heart Condition	2 (7.4%)
Arthritis	1 (3.7%)
Respiratory Illnesses	2 (7.4%)
Epilepsy	1 (3.7%)
Other	8 (29.6%)

Results: Participant Homelessness

Homelessness	Interview 1: Yes N(%)	Interview 2: Yes N(%)	Interview 3: Yes (N%)
Absolute Homeless (current)	20 (74.1%)	6 (31.6%)	2 (14.3%)
Risk of Homeless (current)	7 (25.9%)	5 (26.3%)	2 (14.3%)
Absolutely Homeless (past year)	18 (66.0%)	16 (84.2%)	12 (85.7%)

* CASES ARE EVALUATED ON AN INDIVIDUAL BASIS.

Results

From focus groups for NFA Y and H²I (adult) programs



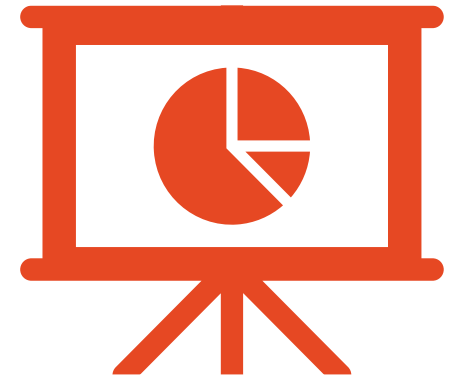
Communication



Collaboration



Coordination



Outcomes

Communication

- ▶ The collaborative approach allows for improved communications between agencies to provide improved care for clients
- ▶ The use of focus groups to identify issues and address them allows for continuous improvement of the program



Collaboration

- ▶ This program has many different agencies with diverse perspectives and experiences
- ▶ This program involves engaging community partners, using the services they have to offer
- ▶ Having youth with lived experience on the advisory committee provides for an invaluable perspective in the implementation of the program



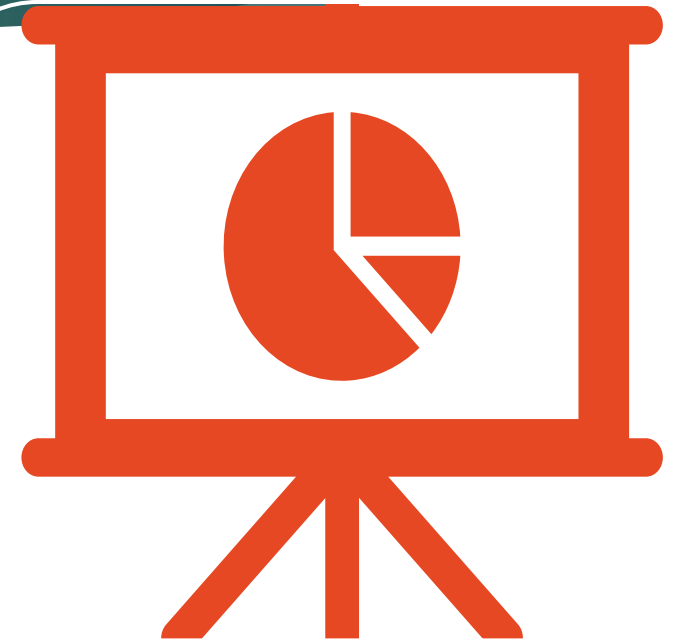
Coordination

- ▶ Having a single, internal contact to network between the participating agencies to streamline access to housing
- ▶ The use of a centralized database (HIFIS) means that different agencies can continue being involved in patient care beyond a single encounter



Outcomes

- ▶ *“What’s gone well is actually the amount of people that have been supported into housing through our diversion and prevention efforts”*
- ▶ *The NFA Y program has been so successful that it has been sustained by LHSC as a permanent program beyond the research funding period*



Conclusions: Tips for implementation



Communication

- Recognize discharge to homelessness could be a problem in your community.
- collect administrative data on how frequently patients are discharged into homelessness.

Collaboration

- Work with agencies within your community as partners to address the issue of discharge to homelessness.
- Establish relationships with landlords

Coordination

- Establish a primary point of contact who can oversee admissions and referrals.
- Produce a brochure that contains the contact information of the primary point of contact.

Questions?

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