



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.

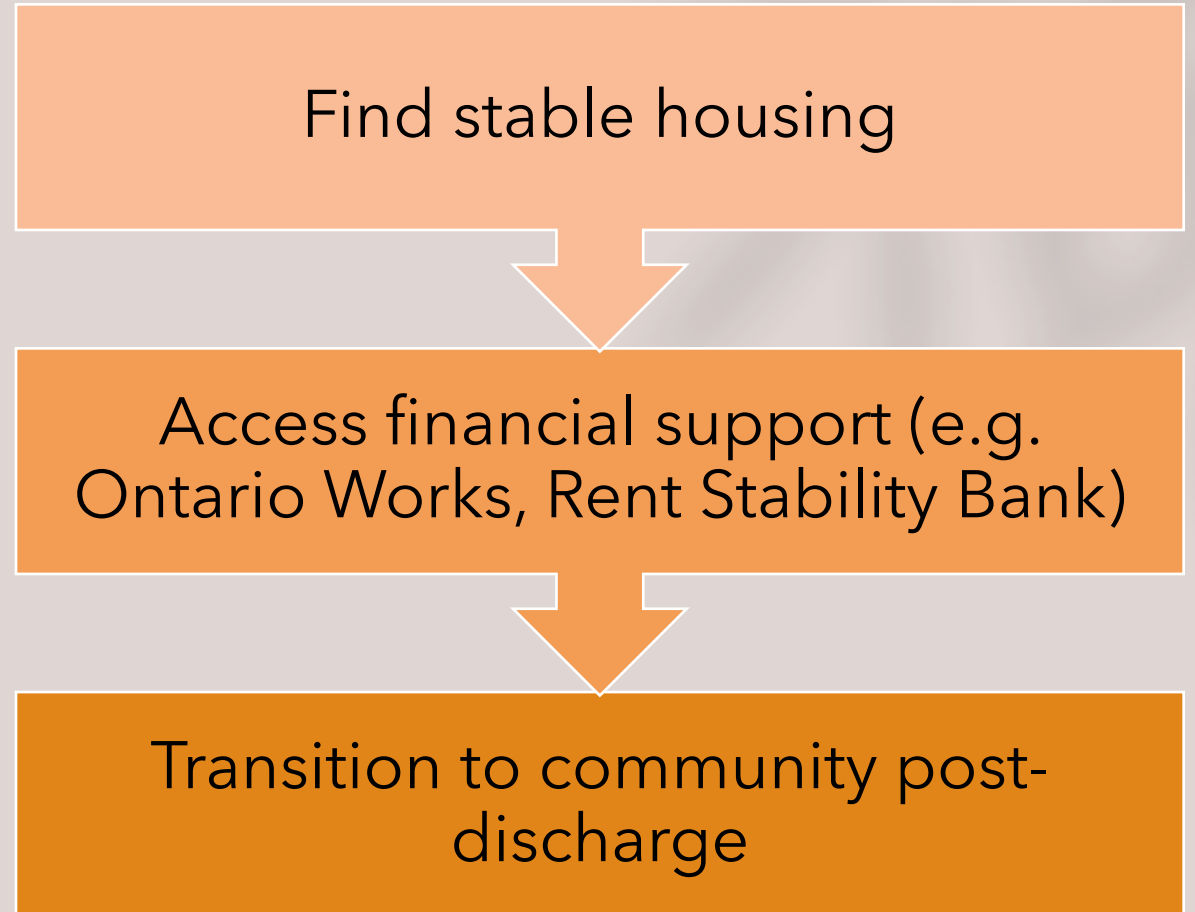


Partners



Introduction

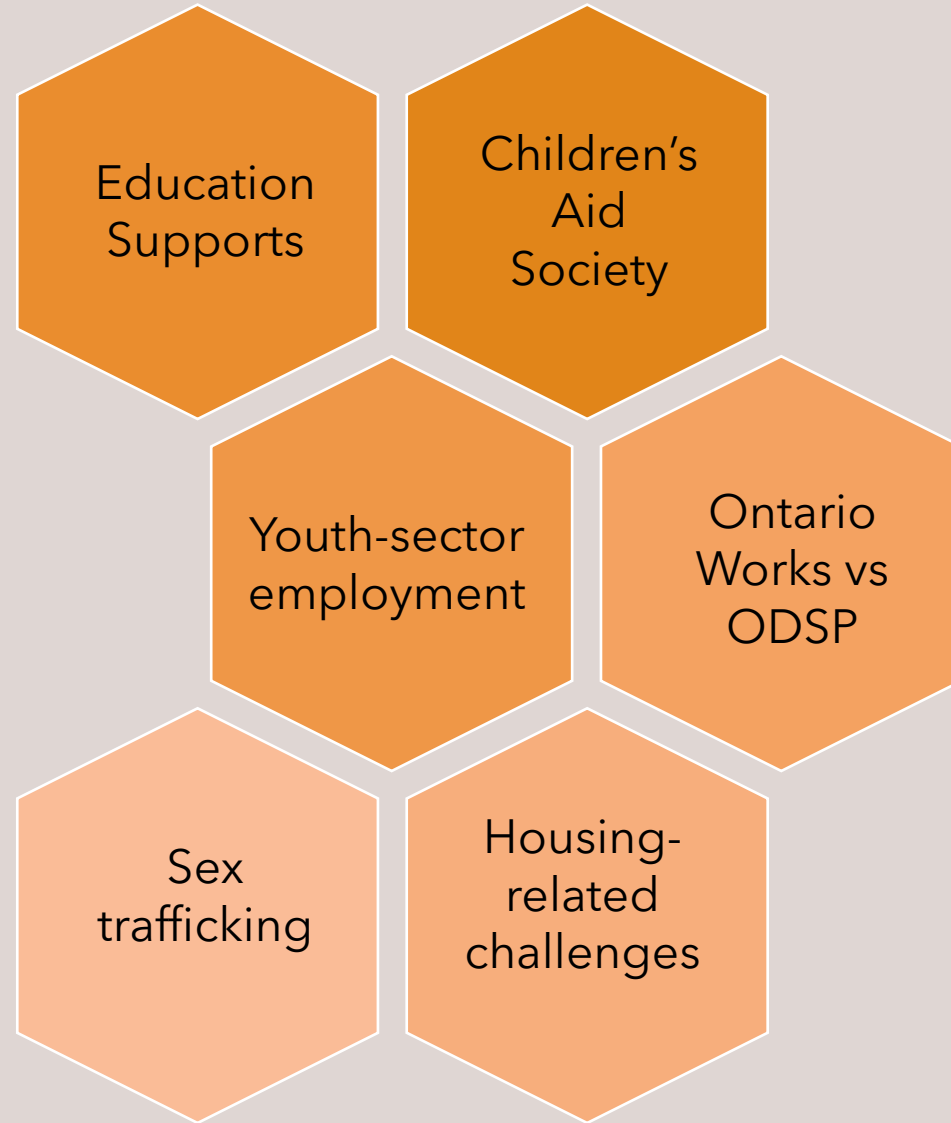
- The NFA Y program tests the effectiveness of a potential best practice intervention for preventing discharge into homelessness for youths aged 16-25
- **Purpose:** help hospitalized youth who are at-risk of being discharged to homelessness find stable housing
- People across two hospitals access the program



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



Methods

- Administrative data from partner groups is 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
 - Demographics
 - Housing History
 - Housing Preference/Needs
 - Quality of Life
 - Service Utilization
 - Youth SPDAT
 - Program Feedback Form
- Focus groups examine perceptions of the intervention, strengths of the implementation strategy, and suggestions for improving the program

Hospital Poster

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 Brochure

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-SPDAT.
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.


 Canadian Mental Health Association
Mental health for all


 The Elmhurst
Living Hope Today


 Canadian Mental Health Association
Mental health for all


 The Elmhurst
Living Hope Today









Coordinated Access to Housing and Services

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 London

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 (D4) 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-SPAT form and input data into the HHS system, along with access to additional housing supports and services.

Participant Demographics

Inclusion

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

Program Utilization

- (As of October 2022)
- **N=26**
- **4 identified as LGBTQ2+, 8 identified as BIPOC**

Interview Sample

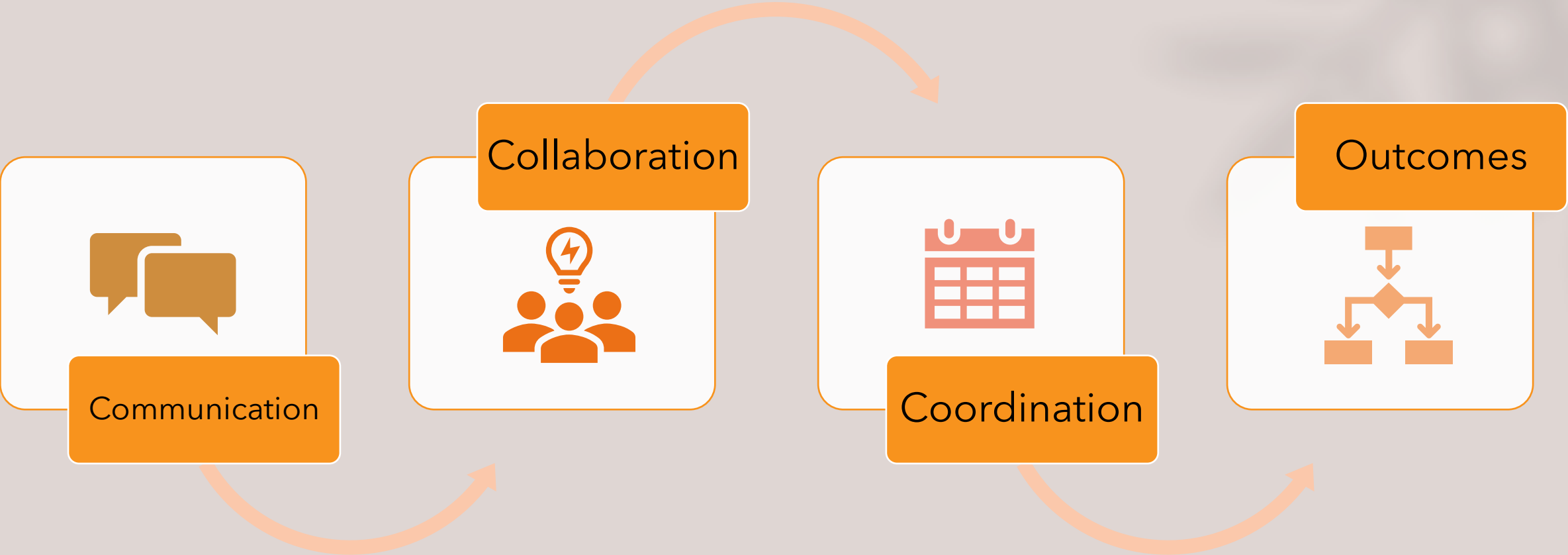
- **N=17**
- **9 male (52.9%); 8 females (47.1%)**
- **Age: $M=20.2$, $SD=2.9$**
- **Ethnic/Racial/Cultural group (Missing: $n=1$)**
 - **European origins (Caucasian): $n=8$**
 - **Indigenous: $n=4$**
 - **Visible minority: $n=4$**

* Cases are evaluated on an individual basis.

Mental health diagnosis(es)	N(%)
Developmental Disorders (e.g., autism, learning disability)	3(17.6%)
Anxiety Disorder	9(52.9%)
Disorder of Childhood/Adolescence (e.g., ADHD)	2(11.8%)
Schizophrenia	6(35.3%)
Mood Disorder	10(58.8%)
PTSD	3(17.6%)
Current substance/addiction issues?	N(%)
Yes	13(76.5%)
No	4(23.5%)

Results

From Focus Groups for NFA-Y and H2I (Adult) Programs



Results

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

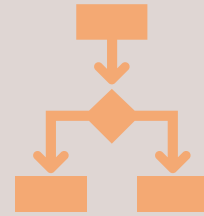
- This program has many different agencies with diverse perspectives and experiences
- This program involves engaging community partners, using the services they have to offer
- Having youth with lived experience on the advisory committee provides for an invaluable perspective in the implementation of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

Results



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”*

Conclusions: Tips for Implementation

Communication

- Recognize that discharge to homelessness could be a problem in your community.
- Homeless shelters and hospitals 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.
- With the diverse perspectives and experiences of different agencies, identify key needs within your community and develop a program to address these needs.
- Establish relationships with private landlords by agreeing to take on the burden of financial risk for housing.

Coordination

- Establish a primary point of contact who can oversee admissions and referrals. This staff member should be present on-site to build trusting relationships
- Produce a brochure that contains the contact information of the primary point of contact.

Questions?

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