CRD Community Health Network Housing and Health Forum

Summary Report

November 27th, 2024

Downtown Community Centre

Background

Throughout the late summer and fall of 2024, members of the Downtown Service Providers' Network and the Capital Regional District's Community Health Network (CRD CHN) came together to plan a 2024 Housing and Health Forum. The goal of the forum was to highlight the impact adequate housing has on individuals' health and identify ways to address challenges at the intersection between housing and health.

This year's forum, held on November 27, 2024, focused on discharge into homelessness. Specifically, forum participants discussed situations where individuals are being discharged from acute care settings, such as hospitals, into homelessness. These individuals may have entered acute care without housing or have lost housing during their stay.

The day was opened by Elder Sky who is an Elder at the Victoria Native Friendship Centre. Elder Sky shared her insights on the topic and provided a welcome to set the stage for the forum.

The event began with a presentation from Dr. Cheryl Forchuk from the Arthur Labatt Family School of Nursing at Western University. Dr. Fochuk shared information about her current projects focussed on prevention of discharge into homelessness in London, ON.

Dr. Forchuk's presentation was followed by a local perspectives panel where representatives from local organizations, as well as a panelist with lived experience of discharge into homelessness shared information on programs to prevent discharge into homelessness that currently exist in our region, as well as changes that could be made to move this work forward. The four panelists were:

- **Tracy Dansereau** is a person with lived experience of homelessness, substance use and mental health challenges. Tracy accessed acute care services for 4 months before she was discharged into homelessness. At the event, she put a face to those being discharged into homelessness. Her goal is to use her knowledge to inform change.
- **Kay Martin** is a Transitional Discharge Model (TDM) Peer support worker for Mental Health Recovery Partners South Island. Kay is also a person with lived experience of mental health and substance use challenges and has experienced homelessness. Currently Kay uses her expertise to support her peers in Royal Jubilee Hospital.
- **James Charles-Roberts** is a Community Integration Specialist with the Ministry of Social Development and Poverty Reduction. He has been in this role since the program was introduced in 2019.
- **Kellie Guarasci** has been a nurse for almost 30 years and has worked at Cool Aid for 8 years. Her previous nursing experience includes palliative care, infectious disease, teaching and community case management.

Following the panel discussion, attendees broke into small groups to reflect on what they heard and identify potential next steps for preventing discharge into homelessness.

Next Steps

Following the small group discussion, each group was asked what one next step should be taken to move this work forward.

Create a centralized list of available shelter beds to inform discharge plan	Increase communication among service providers and awareness of different services	Have ID clinics in hospital and ensure hospital staff are aware of them
Gather and report data about the numbers and stories of discharge into homelessness	Have conversations with policymakers to create policy and funding change	Build closer connections between community services and hospital social workers

Group Discussion

Forum participants divided into groups and were asked to respond to the following five questions:

1. What 2 ideas did you find most interesting from the panel or Dr. Forchuk that could be applied in our region to prevent discharge into homelessness?
2. What steps could we take now to prevent discharge into homelessness?
3. What steps could we take in the longer-term to prevent discharge into homelessness?
4. What barriers stop us from doing these things now?
5. Who needs to be involved?

Most groups were only able to respond to the first two or three questions. However, answers to other questions were captured in their notes.

The following key themes from the small group discussion notes were identified.

Key Steps to Prevent Discharge into Homelessness

Community Services in Hospital: Every group identified the need for more community services to be in the hospital. This would allow patients to more easily identify what they need and could build awareness of existing programs amongst the hospital social workers. This could take many different forms such as a centralized “hub” within each hospital where information about community services is shared or the introduction of a wraparound community service provider who works with the hospital social worker to create a discharge plan. Participants agreed that people should not be discharged from hospital until housing is secured.

Research and Data: Another common need identified by many groups was the need for more data about discharge into homelessness. Some suggested that information on an exit survey could used to identify where patients would be sleeping and who they will be with upon discharge. Forum participants indicated that it is important to gather stories of the experience of discharge into homelessness and that this information must be shared with community so that we are able to use it to make policy and programming decisions that prevent discharge into homelessness. It was also recommended that hospital staff be given access and be required to enter data into the Homelessness Management Information System used in BC (Homeless Individuals and Families Information System (HIFIS)).

Harm Reduction: Harm reduction should be offered in hospitals so that individuals do not leave early to access the drugs that they need.

Contact after Discharge: It was recommended that a key contact be established for individuals prior to discharge to allow hospital staff to maintain contact and help them access services after discharge. It was noted that once individuals have left the hospital, it becomes more difficult for these individuals to access the supports they need.

Interim Housing Options: There should be more interim housing options created for people leaving hospital. One specific recommendation suggested a 'tiny town', similar to the 'tiny town' that was located at 940 Caledonia in Victoria, be created to support people while they wait for longer-term housing.

Early Intervention: It was recommended that discharge plans are developed as soon as people enter the hospital so that applications and forms for housing and other supports are started while people are receiving care.

Barriers that Allow Discharge into Homelessness

Silos: Silos between and within organizations was the main barrier that every group identified. This creates barriers in communication between in-hospital social workers and available community supports, inhibiting successful wrap-around-supports. Further, working in silos often impacts policy and funding decisions.

Stigma: Stigma was also identified as a barrier by almost all groups. Stigmatization of homeless patients by hospital staff affects service both in and outside of the hospital, impacting those experiencing homelessness. This may also inhibit the full development of a discharge plan. In addition to stigma targeting patients, stigma around community services/staff working in the homelessness serving sector may inhibit partnerships between those working in the sector and hospital employees. Stigma is an especially significant barrier in supporting people who use substances.

Privacy: Privacy policies, as they exist now, are often barriers as they often keep hospital staff from working with community service providers in the most effective way.

Staff Turnover: Community service provider organizations and hospitals are seeing increases in staff turnover. When staff leave, clients can fall through the cracks as replacement staff may not have full information and/or may not be in place immediately. This issue adds emphasis to the importance of team-based care and good working conditions for staff.

Lack of Housing: The housing market in the Capital Region in BC is very tight. Lack of accessible and appropriate housing is a barrier to getting people into housing once they are discharged from the hospital if they require housing.

Landlord Awareness: Landlords are often unaware of programs that could maintain rental payments during an individual's acute care stay. This leads to unnecessary evictions and people losing housing while accessing acute care.

Who is Missing from the Conversation

- BC Housing needs to be included as they may be able to identify housing spaces and create mechanisms to prevent loss of housing during acute care stays
- Different levels of Government need to be part of the discussion in order to create partnerships and effect needed change policy
- The health sector must be involved in order to allow services delivery into hospitals and break down stigmatization of patients who are experiencing homelessness or may be tenuously housed
- Landlords need to be included so they are aware of ways to prevent eviction leading to an individual's loss of housing during acute care stays

Call to Action

At the end of the event, participants were asked to identify next steps their organization will take to prevent discharge into homelessness. Commitments were written on the "Call to Action" board at the event. The following commitments were made:

- Umbrella Society will meet regularly with other peer support organizations in the hospital
- The Community Social Planning Council will expand ID clinics in hospitals and will raise awareness amongst hospital social workers about the service
- Others will work towards breaking down stigma