LAWSON
HEALTH RESEARCH INSTITUTE

# *Collaboration to Address Homelessness: Health, Housing, and Income ($H^2I$)*

## *Implementation Guide*

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*"Homelessness is a crisis, but it's further exacerbated when it's in a medical setting. I'm very happy that these supports are available to Londoners"*

*"What's gone well is actually the amount of people that have been supported into housing through our diversion and prevention efforts."*

## Discharge to Homelessness – A Canada-wide Problem

Homelessness is a growing problem affecting nations around the globe and Canada is no exception. Current estimates have up to 235 000 individuals in Canada per year experiencing homelessness for a period of time and approximately 35 000 on any given night (Gaetz et al., 2016). The impact homelessness has on personal health, and consequently on the healthcare system, is significant. Individuals facing homelessness experience disproportionate burdens of illness (Mikkonen & Raphael, 2010). They also have a higher incidence of premature death, mental illness, and traumatic injury (Public Health Ontario & Berenbaum, 2019). They often rely on hospitals as their primary source of care (Tadros et al., 2016; Buccieri et al., 2019), and therefore spend more time in the hospital than the non-homeless population.

Highly & Proffitt (2008) reported that individuals experiencing homelessness spend approximately 4 more days in hospital per year. In addition, the 30-day readmission rate is almost four times higher in the homeless population due to being discharged to situations not conducive to recovery (Laliberte et al., 2019; Saab et al., 2016). This result is expensive; homeless patient admissions cost on average $2559 more than house patient admissions.

In order to effectively address the issue of homelessness in Canada, there must be a validated and coordinated service model to address the cycle from hospital to homelessness, an all-too-frequent occurrence (Forchuk et al, 2006).

The "Collaboration to Address Homelessness: Health, Housing, and Income" ($H^2I$) strategy is an innovative intervention that streamlines housing and income supports to break the "revolving-door" cycle from hospital to homelessness.

Hospitals spend an additional $2559 caring for individuals experiencing homelessness compared to housed individuals (Hwang et al, 2011).

A previous study found that bringing a housing worker and income support staff directly into the hospital reduced discharge to “no fixed address” (Forchuk et al., 2008, 2013). In a more recent evaluation of discharge from medical and psychiatric units (2017-2020), focus groups with participants and providers identified that some individuals returned to hospital due to an inability to maintain housing obtained through the intervention. A transitional worker who may assist participants post-discharge, through conflict management between participants and landlords for example, was recommended.

The results of the evaluation indicated that the intervention was effective at reducing the number of individuals discharged from hospital into homelessness. However, 50% of the sample continued to be discharged without housing given the short length of stay and high acuity of patients in medical wards. Individuals discharged from tertiary care psychiatric units fared better, with 80% of the study participants being housed. Focus groups recommended community follow-up to improve health and housing outcomes for participants whose needs cannot be met in-hospital.

## Health, Housing, and Income: A Collaboration to Address Homelessness

The Health, Housing, and Income ($H^2I$) program sought to improve the health, housing, and income status of individuals experiencing homelessness, or who were at-risk of homelessness, accessing healthcare. This program improves upon a previously successful program (Forchuk et al, 2008, 2013) and works towards establishing a best-practices model that addresses homelessness from the healthcare setting that could be instituted across the country.

The $H^2I$ program was implemented at multiple sites to assess its effectiveness for different subpopulations: those from tertiary psychiatric care units (St. Joseph's Health Care – Parkwood Institute Mental Health Care), individuals from acute psychiatric care units (London Health Sciences Centre – Victoria Hospital Adult Inpatient Psychiatry), and those from acute medical care units, also at Victoria Hospital.

The overall aims of this project were to answer the following questions:

What are the effects of offering income and housing supports to individuals at-risk of homelessness in different healthcare facilities?

How does transitional support post-discharge impact outcomes in the various groups?

What are the costs and other implementation issues related to the intervention strategy within hospital, and within each subpopulation?

What are the costs and other implementation issues related to the transitional support for each subpopulation?

What are service-user and staff perceptions of the intervention within different healthcare facilities and in the community, for each subpopulation?

# How does the program work?

### 1. A patient admitted to hospital is at risk of discharge into homelessness

Sometimes patients are homeless before admission into the hospital, and sometimes admitted patients lose their housing while they are in the hospital. For patients who are at risk of being discharged into homelessness, a social worker refers the patient to the Coordinated Access to Housing Services program.

Patients may sometimes feel the stigma of being at risk of homelessness and may be hesitant to disclose this information to hospital staff. Posters and brochures advertising the program can be found inside the hospital, and patients can reach the program independently by accessing services in a program office on site. The advertisements used in this project are found at the end of this document.

### 2. The patient connects with Coordinated Access to Housing Services

Coordinated Access staff have office space within the hospital and arrange an intake meeting for these patients. Staff work with the patients to complete the Vulnerability Index -Service Prioritization Decision Assistance Tool (VI-SPAT) and input data in the Homeless Individuals and Families Information System (HIFIS). *Due to the ongoing COVID-19 pandemic, some intake meetings occurred through a telephone interview.*

The patients are provided with homeless prevention and preventative eviction supports as soon as possible, including assistance finding employment and access to income supports.

### 3. Eligible patients receive access to housing and community supports

Patients who are paper-ready with ID and an income source are added to housing priority lists and matched to find housing, housing allowances, and housing stability supports based on eligibility.

Sometimes housing cannot be secured before discharge. In these cases, the transitional case worker provides continued community support until a time where both the transitional case worker and the patient mutually agree that the patient is capable to manage on their own.

# Implementing this program in other communities

***Prior to implementation***:

- ✓ Recognize that discharge from hospital into homelessness could be problem in your community.
  - Homeless shelters and hospitals collect administrative data on how frequently patients are discharged into homelessness. This is a good starting point to identify the severity of the problem of discharge to homelessness in your community

- ✓ Identify different agencies within your community addressing the problem of homelessness. Collaborate with these agencies to identify core needs within your community, and work to develop a program that addresses these specific needs (e.g., housing, healthcare, and income).
  - Every community agency brings a unique perspective and expertise to addressing homelessness. The collaboration of these agencies produces a robust program that benefits the community more than any one agency can alone.

- ✓ Work with your municipality or community agency and establish a primary point of contact who can oversee admissions and referrals. Ideally, this person should be present in-hospital to build trusting relationships with patients, and could be involved with:
  - Conducting patient intake meetings (VI-SPDAT)
  - Helping patients become paper-ready (e.g., obtain ID, proof of income)
  - Liaising between participating community agencies
  - Liaising between community partners and hospital staff

- ✓ Create a brochure containing the program information and the means to reach the primary point of contact. This brochure should be made available to patients while in hospital.
  - For reference, a copy of the brochure used in the $H^2I$ collaboration is included as an appendix within this implementation guide.

# Implementing this program in other Communities

***After implementation:***

- ✓ Have regular, ongoing meetings with representatives from each community agency to share status updates and identify any key areas for improvement.
  - Regular meetings with community partners bring the different community agencies together, and by addressing areas for improvement, the program is allowed to grow and continually improve to meet the various needs of the community.

- ✓ Continually work within your community to expand the breadth of the program, recruiting new organizations or services.
  - In the $H^2I$ project, focus groups with health care staff and community agency service providers revealed that the overall success of the program could be improved with more collaboration with, for example, Service Ontario to expedite access to ID, or with Ontario Works to expedite access to financial supports.

- ✓ Encourage relationship-building with private landlords to increase the amount of housing available to patients at risk of discharge to homelessness.
  - Unfortunately, the demand of housing supports is often greater than the supply and providing housing supports is only possible when housing supports are available. By seeking out partnerships with supportive, private landlords, more individuals can receive housing supports through this program.

- ✓ Work to improve integration of the program within the hospital, and improve collaboration between hospital staff and community partners
  - Addressing the inherent disconnect between hospital care providers and community partners bolsters the strength of the program. Community care partners can refer clients to hospital and receive necessary follow-up, and hospital care providers can refer patients to the program with the confidence that efforts will be made to find affordable and appropriate housing.

## What are the Strengths of this Program?

During the H$^2$I project, a research team conducted a total of five focus groups with hospital staff and community partner representatives to learn more about the perceived strengths the program. Some common themes emerged:

**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 that they have to offer
- This collaboration allows community partners to come together, have discussions, identify issues, and problem-solve solutions when patients are in need"

**Coordination**

- Having a single, primary point of contact to network between the participating agencies and streamline access to housing
- "It was easy to get access to them, and they brought a lot of different options. We were able to do things individually for the patient that a lot of places might not."

**Outcomes**

- 138 unique individuals accessed the program supports and services
- Almost all individuals were connected to long-term community supports and obtained housing

*"What's gone well is actually the amount of people that have been supported into housing through our diversion and prevention efforts."*

## How Could this Program be Improved?

Focus groups also highlighted several areas in which this program could be improved. Common themes are described below:

- Ideally, supports for clients should in-person. Provincial guidelines in response to the COVID-19 pandemic have reduced the ability for assisting clients face-to-face, which has made it more challenging to develop trusting relationships with clients.

> "Being on-site, being physically present: for me, that human connection piece is so crucial."

- The housing-first program in London requires participants to have valid identification. Improved collaboration with community partners for stream-lined access to IDs would be beneficial in this program. Ideally, there should be an on-site ID clinic in hospitals

> "We were waiting just for the ID because the housing-first program would not accept them without the ID. So that wasted like at least two months and extended their stay at hospital that long."

- While the collaboration between community agencies benefits clients, it was noted that collaboration between hospital and community partners could be more integrated.

> "I just feel like [they] go into hospital, and then we don't know what happens. We don't know when they're being discharged, so I think it's that continuation of service that's really valuable."

- Housing supports can be provided only when housing is available. This program could benefit from the ongoing establishment of positive relationships with private landlords so that more individuals can benefit from this program.

> "I have some people that could function on their own in an apartment, but the rooms don't exist, or there's a massive degree of discrimination with landlords."

## Recommendations for other communities

The following recommendations came from Focus Group participants when asked, "What tips would you give to others thinking of implementing a similar program in their communities?"

Coordinated Access being in-hospital is crucial for success.

- Face-to-face conversations with patients builds trust and engagement
- Face-to-face intake meetings make the process of obtaining VI-SPDAT data more smooth
- When hospital staff know the face and name of Coordinated Access workers, it becomes easier to call for support for a patient
- Being on-site allows for clients to drop-in to receive supports. Scheduling appointments is more challenging, for example, if these clients do not have access to a telephone.

Different subsections of the community population may have different needs and having separate streams for these subsections is beneficial. *In the H²I program, there was a separate stream for adults and youth.*

The use of HIFIS was encouraged. HIFIS allows the conversation with a client to continue beyond a single encounter, and is particularly helpful in tracking down more transient individuals.

Healthcare providers can be the champions in the hospital wanting to see this program be successful. Considering staff turnover within hospitals and community agencies, it is also important to have appropriate information easily accessible to staff to allow continual growth over time.

Each community agency comes to the table with difference experiences and perspectives, and this diversity bolsters the strength of the program. Additionally, there is value in having persons with lived experience on advisory committees, to offer insight into their experiences and how to help support other people in similar situations while they're in-hospuital.

## Advisory Committee Terms of Reference

**Purpose:** To provide ongoing collaborative input into decision-making for $H^2I$-project related activities. The objective of this committee is to: a) ensure the project remains on track; b) help the project team overcome obstacles that may arise; and c) help align the technology with present and future opportunities for scaling. The Advisory Committee advises and contributes to the ongoing work of the implementation committee.

**The Advisory Committee contributes to:**

1) Planning, developing, and monitoring of all project-related activities and ensuring open channels of communication among all Advisory Committee members;
2) Facilitating active involvement of key stakeholders in all aspects of the research process over the course of the project. Key stakeholders include researchers, representatives from the health programs of London Health Sciences Centre and St. Joseph's Health Care, and community partners, such as members from the City of London's Housing Coordinated Access team, Ontario Works (OW) and Ontario Disability Support Program (ODSP); Children's Aid Society of London Middlesex, The Salvation Army's Housing Stability Bank, and Youth Opportunities Unlimited (YOU).
3) Ensuring principles of participatory action research are honoured and adhered to over the course of the project;
4) Reviewing and advising on reports prepared for the funder and partners in this project as agreed to in the project plan;
5) Assist in identifying strategies for the dissemination and application of the project's findings at program and policy levels.

**Committee Structure:**

The Advisory Committee consists of the principal investigator, the project coordinator, and representatives from key stakeholders including patient advocates as well as members of the co-investigative research team.

**Subcommittees:**

1. Research and Evaluation Subcommittee – overseeing focus groups and data collection
2. Media subcommittee – Knowledge translation
3. Knowledge and Dissemination Committee

**Meetings**:

The Advisory Committee normally meets once every two months by teleconference throughout the duration of the project. Summaries of all meeting discussions and decisions are recorded as minutes and submitted to all Advisory Committee members.

**Committee Membership:**

| Organization | Name | Role |
|---|---|---|
| Canadian Mental Health Association Elgin Middlesex | Nedrita Shemshedini, *N.Shemshedini@cmhamiddlesex.ca* | Supportive Independent Living Manager |
| City of London | Carolina Dale *cdale@london.ca* | Operational Manager, Ontario Works |
| City of London | Craig Cooper *ccooper@london.ca* | Director, Housing Stability Services |
| City of London | Laura Cornish *lcornish@london.ca* | Manager of Homeless prevention |
| City of London | Elle Lane *elane@london.ca* | Coordinated Access Manager, Housing Stability Services |
| London Abused Women's Centre (LAWC) | Elizabeth Tellier *elizabeth@lawc.on.ca* | Advocate/Counsellor |
| London and Middlesex Children's Aid Society | Carrie Thomas *Carrie.Thomas@caslondon.on.ca* | Service Director |
| London Health Sciences Centre | Robin Ward *robin.ward@lhsc.on.ca* | Manager, Adult Inpatient Mental Health |
| London Health Sciences Centre | Michelle Murray *Michelle.murray@lhsc.on.ca* | Manager, Adult Inpatient Mental Health |
| London Health Sciences Centre | Dr. Laura Powe *Laura.Powe@lhsc.on.ca* | Psychiatrist, Victoria Hospital |
| London Health Sciences Centre | Tim Rice, *Tim.Rice@lhsc.on.ca* | Medicine Director, Victoria Hospital |
| London Health Sciences Centre | Dr. Julie Richard, *Julie.Richard@lhsc.on.ca* | Psychiatrist, Victoria Hospital |
| London Health Sciences Centre | Dr. Priya Subramanian *Priya.Subramanian@lhsc.on.ca* | Psychiatrist, Victoria Hospital |
| Lawson Health Research Institute | Dr. Cheryl Forchuk *cforchuk@uwo.ca* | Beryl & Richard Ivey Research Chair; Assistant Director & Scientist |
| Lawson Health Research Institute | Anne Peters *Anne.Peters@lhsc.on.ca* | Research Project Coordinator |
| The Salvation Army | Melissa Jeffrey *melissa_jeffrey@hotmail.com* | Program Manager, Housing Stability Bank |
| St. Joseph's Health Care London | Dr. Sandra Fisman *Sandra.Fisman@lhsc.on.ca* | Psychiatrist, Parkwood Institute – Mental Health Care Building |
| St. Joseph's Health Care London | Deb Gibson, *Deb.gibson@sjhc.london.on.ca* | Director, Mental Health |
| Western Area Youth Services (WAYS) | Leanne Pringle-Cole *Lpringle-cole@ways.on.ca* | Program Supervisor |
| Western University | Dr. Richard Booth *rbooth6@uwo.ca* | Associate Professor – Faculty of Health Sciences – Nursing and Epidemiology |
| Youth Opportunities Unlimited | Steve Cordes *stevec@you.ca* | Chief Executive Officer |
| Youth Opportunities Unlimited | Katherine Krakowski *katherinek@you.ca* | Housing and Employment manager |
| Youth Opportunities Unlimited | Jason Galindo *JasonM@you.ca* | Housing Team Leader |

| | | |
|---|---|---|
| Youth Opportunities Unlimited | Matthew Forget<br>*MattF@you.ca* | Youth Development Coordinator |
| Youth Opportunities Unlimited | Josi Chalmers<br>*josiah.c.chalmers@gmail.com* | Youth with Lived Experience |

## Implementation Committee Terms of Reference

**Purpose:** To provide ongoing collaborative input into decision-making for H2I-project related activities across the lifespan of the project. The Implementation Committee discusses and strategizes around practical matters relating to program implementation, including monitoring of phase planning, implementation of interventions, and collaboration with key stakeholders to create a permanent, sustainable system for inter-agency collaboration.

**The Implementation Committee contributes to:**

1) the planning, development, implementation, and evaluation of the $H^2I$ project
2) fostering creation of a permanent, sustainable structure to promote and facilitate active involvement of key stakeholders in all aspects of the research process over the course of the project. Key stakeholders include researchers, representatives from the health programs of London Health Sciences Centre and St. Joseph's Health Care, and community partners, such as members from the Canadian Mental Health Association, City of London Coordinated Access, the Salvation Army Housing Stability Bank, and Youth Opportunities Unlimited (YOU).

**Committee Structure:**

The Implementation Committee consists of the principal investigator, the project coordinator, and representatives from key stakeholders including patient advocates as well as members of the co-investigative research team.

**Meetings**:

The Implementation Committee normally meets twice per month by teleconference throughout the duration of the project. Summaries of all meeting discussions and decisions are recorded as minutes and submitted to all Implementation Committee members.

**Committee Membership:**

| **Organization** | **Name** | **Role** |
|---|---|---|
| Canadian Mental Health Association Elgin Middlesex | Nedrita Shemshedini<br>*N.Shemshedini@cmhamiddlesex.ca* | Supportive Independent Living Manager |
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| London Health Sciences Centre | Robin Ward<br>robin.ward@lhsc.on.ca | Director, Adult Inpatient Mental Health |
| London Health Sciences Centre | Michelle Murray<br>*Michelle.Murray@lhsc.on.ca* | Director, Adult Inpatient Mental Health |
| London Health Sciences Centre | Tim Rice<br>*Tim.Rice@lhsc.on.ca* | Medicine Director, Victoria Hospital |
| Parkwood Research Institute, Lawson Health Research Institute | Dr. Cheryl Forchuk<br>*cforchuk@uwo.ca* | Beryl & Richard Ivey Research Chair; Assistant Director & Scientist |
| Lawson Health Research Institute | Anne Peters<br>*Anne.Peters@lhsc.on.ca* | Research Coordinator |
| The Salvation Army | Melissa Jeffrey<br>*melissa_jeffrey@hotmail.com* | Program Manager, Housing Stability Bank |
| St. Joseph's Health Care London | Deb Gibson<br>*Deb.gibson@sjhc.london.on.ca* | Director, Mental Health |
| Youth Opportunities Unlimited | Katherine Krakowski<br>*katherinek@you.ca* | Housing and Employment manager |
| Youth Opportunities Unlimited | Jason Galindo<br>*JasonM@you.ca* | Housing Team Leader |
| Youth Opportunities Unlimited | Matthew Forget<br>*MattF@you.ca* | Youth Development Coordinator |

## Key Stakeholders

*The City of London*

The City of London has provided one transitional case worker (TCW), who provides support to maintain or obtain housing for participants who would otherwise be discharged to no-fixed-address. The TCW also provides support to participants for whom housing cannot be secured before discharge, as well as continued community support for individuals who present with multiple risk factors which may indicate difficulty at maintaining their housing (as determined by the Service Prioritization Decision Assistance Tool (SPDAT).

Additionally, the TCW develops and maintains effective relationships and working partnerships with landlords, property owners, and property management. They secure housing units from varied locations within the City of London, and help participants access resources for housing-related assistance as well.

*Ontario Works*

Ontario Works provides income and employment supports for people in financial need, including the provision of funds to cover costs associated with housing. Ontario Works staff support the implementation of the $H^2I$ by providing services on location in hospital sites, and with the provision of data regarding expenses and other issues related to implementation.

*The Salvation Army's Housing Stability Bank*

The Salvation Army offers a Housing Stability Bank that is utilized to access needed financial resources to secure or maintain housing. The Housing Stability Bank provides interest-free loans to people experiencing financial barriers to stable housing. Low-income Londoners are eligible for financial assistance and for first and/or last month rent or rental arrears, and utilities, depending on their situation.

## Research Project Investigators

*Cheryl Forchuk, RN PhD, Lawson Health Research Institute (Principal Investigator)*

Dr. Cheryl Forchuk is the Beryl and Richard Ivey Research Chair in Aging, Mental Health Rehabilitation and Recovery, Parkwood Institute Research, St. Joseph's Health Care London, as well as Assistant Director and Scientist at Lawson Health Research Institute. Dr. Forchuk is a doctorally prepared psychiatric nurse and a leading researcher in mental health and housing. She is a fellow of the Canadian Academy of Health Sciences and has been awarded the Order of Ontario. Her work has brought together psychiatric consumer/survivors, community agencies and researchers to improve systems of care and promote community integration among health and social service users. Dr. Forchuk's research leverages numerous provincial and national funding sources. As the Principal Investigator, Dr. Forchuk oversees this program of research to ensure that milestones and deliverables are met efficiently. Her role includes directing research staff recruitment, leading research committee meetings, obtaining research approvals, guiding implementation and evaluation, and monitoring financial spending and reporting. She also leads the analyses and focus groups.

*Sandra Northcott, MD FRCPC, St. Joseph's Healthcare London (Co-Investigator)*

Dr. Sandra Northcott is the Site Chief of Parkwood Institute - Mental Health and Southwest Centre for Forensic Mental Health Care, both part of St. Joseph's Healthcare London. Dr. Northcott collaborated with Dr. Forchuk as a Co-Investigator on previous versions of the "Preventing Discharge to No Fixed Address" studies (versions 1, 2, and 2-expansion project). As a co-Investigator in this project, Dr. Northcott participates on project advisory meetings, assists with the implementation of the research program at Parkwood Institute – Mental Health, and participates on publications.

*Rebecca Vann, BSW, MSW, RSW, St. Joseph's Healthcare London (Co-Investigator)*

Ms. Vann is a Registered Social Worker at St. Joseph's Healthcare London, Parkwood Institute - Mental Health. Ms. Vann collaborated with Dr. Forchuk as a co-Investigator on previous versions of the "Preventing Discharge to No Fixed Address" studies (versions 1, 2, and 2X-Expansion project). As a Co-Investigator on this project, Ms. Vann participates on project advisory meetings, assists with the implementation of the research program at Parkwood Institute - Mental Health, and participates on publications and knowledge translation activities.

*Timothy Rice, RN BScN, London Health Sciences Centre (Co-Investigator)*

Mr. Tim Rice is the Director of Family Medicine at the London Health Sciences Centre (LHSC). Mr. Rice has collaborated with Dr. Forchuk as a Co-Investigator on expansion of the "Preventing Discharge to No Fixed Address version 2X" project to the medical units at Victoria Hospital,

LHSC. As a Co-Investigator on this project, Dr. Rice participates on project advisory meetings, assists with the implementation of the research program at LHSC, and participates on publications.

*Richard Booth, RN PhD, Western University (Co-Investigator)*

Dr. Richard Booth is an Associate Professor at the Arthur Labatt Family School of Nursing, Western University. Dr. Booth has collaborated with Dr. Forchuk as a co-Investigator on version 2 of the "Preventing Discharge to No Fixed Address" project. As a Co-Investigator on this project, Dr. Booth participates on project advisory meetings, advises on research methodologies, participate on publications, and assists with quantitative analyses.

# Brochure Found Within Participating Hospitals

**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 an income source are added to housing priority lists and become eligible to be matched to housing stability supports.
5. Homeless patients who are at a heightened risk of medical complications following discharge are flagged and supported appropriately.

## How to Connect

**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.

OR contact Coordinated Access at 519-661-4663

YOUTH OPPORTUNITIES UNLIMITED

THE SALVATION ARMY
Giving Hope Today

## Coordinated Access to Housing and Services

A collaboration with City of London Youth Opportunities Unlimited and Housing Stability Bank

YOUTH OPPORTUNITIES UNLIMITED

THE SALVATION ARMY
Giving Hope Today

London CANADA

London CANADA

London
CANADA

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

# Referral Process

**The referrals from B7 at LHSC Victoria Campus**

If a patient is 24 years old or over and is experiencing homelessness, staff will reach out to the Housing Stability Services Coordinated Access at **519-661-4663** or **1-833-932-2291**. The team can also be reached at **homelessprevention@london.ca**

If a patient is experiencing homelessness and under the age of 24, please contact **NFAY@you.ca**

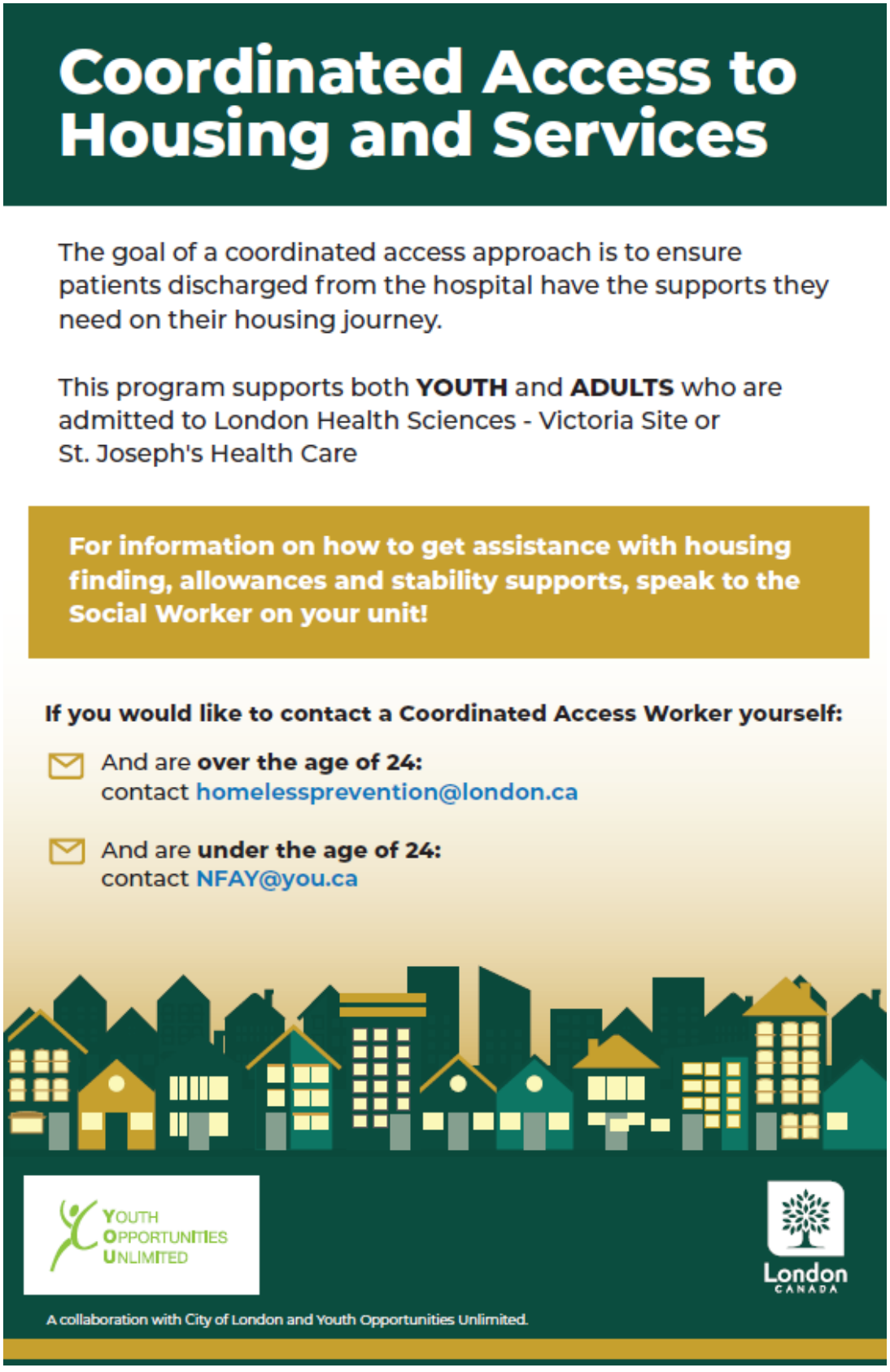
**Referrals from St. Joseph's Health Care – Parkwood Institute Mental Health**

If a patient is 24 years old or over and is experiencing homelessness, staff will contact Housing Stability Services, Coordinated Access at **519-661-4663** or **1-833-932-2297.** The team can also be reached at **homelessprevention@london.ca**

If a patient is at risk of experiencing homelessness, is under the age of 24 at Parkwood please contact **NFAY@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-SPDAT form and input data into the HIFIS system, along with access to additional housing supports and services.

## Poster Found Within Participating Hospitals



## References


Buccieri, K.; Oudshoorn, A.; Frederick, T.J.; Schiff, R.; Abramovick, A.; Gaetz, S.; Forchuk, C. (2019). Hospital discharge planning for Canadians experiencing homelessness, *Housing, Care, and Support 22* (1), 4-14.

Forchuk, C.; Russell, G.; Kingston-Macclure, K.; Turner, K.; Dill, S. (2006). From psychiatric ward to the streets and shelters. *Journal of Psychiatric and Mental Health Nursing 13* (3), 301-308.

Forchuk, C.; Kingston-MacClure, S.; Van Beers, M.; Smith, C.; Csiernik, R.; Hoch, J.; Jensen, E. (2008). Development and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'No Fixed Address'. *Journal of Psychiatric and Mental Health Nursing 15* (7), 569-575.

Forchuk, C.; Godin, M.; Hoch, J.S.; Kingston-Macclure, S.; Jeng, M.S.; Puddy, L.; Vann, R.; Jensen, E. (2013). Preventing homelessness after discharge from psychiatric wards: perspectives of consumers and staff. *Journal of Psychosocial Nursing and Mental Health Services 51* (3), 24-31.

Frankish, C.J.; Hwang, S.W.; Quartz, D. (2005). Homeless and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health 96* (2), 23-29.

Gaetz, S., Dej, E., Richter, T., Redman, M. (2016). *The State of Homelessness in Canada 2016*. Canadian Observatory on Homelessness Press.

Highley, J.L. & Proffitt, B. (2016). Traumatic brain injury among homeless persons: Etiology, prevalence, and severity. *Health Care for the Homeless Clinician's Network*, 1-18.

Hwang, S.W.; Weaver, J.; Aubry, T.; Hoch, J.S. (2011). Hospital costs and length of stay among homeless patients admitted to medical, surgical, and psychiatric services. *Medical Care 49* (4), 350-354.

Laliberté, V., Stergiopoulos, V., Jacob, B., Kurdyak, P. (2019). Homelessness at discharge and its impact on psychiatric readmission and physician follow-up: a population-based cohort study. *Epidemiology and Psychiatric Sciences 29*, e21.

Mikkonen, J. & Raphael, D. 2010. Social Determinants of Health: The Canadian Facts.

Ontario Agency for Health Protection and Promotion (Public Health Ontario), & Berenbaum, E. (2019). *Evidence Brief: homelessness and health outcomes: what are the associations?* Queen's Printer for Ontario.

Saab, D.; Nisenbaum, R.; Dhalla, I.; Hwang, S.W. (2016). Hospital readmissions in a community-based sample of homeless adults: a matched-cohort study. *Journal of General Internal Medicine 31* (9), 1011-1018.

Tadros, A.; Layman, S.M.; Brewer, M.P.; Davis, S.M. (2016). A 5-year comparison of ED visits by homeless and nonhomeless patients. *Americal Journal of Emergency Medicine 34* (5), 805-808.


Canadian Mental Health Association
Middlesex
*Mental health for all*



London Health Sciences Centre


London
CANADA

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

MINISTÈRE DES SERVICES SOCIAUX ET COMMUNAUTAURES