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Preventing Homelessness through Mental Health Discharge Planning

Best Practices and Community Partnerships in British
Columbia

Volume 3: Literature Review

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Table of Contents

1. Introduction	1
1.1 Background	1
1.2 Purpose	2
1.3 Scope and method	2
1.4 Limitations	3
1.5 Organization of the Report	3
2. Discharge and Transition Planning	4
2.1 Defining Discharge and Transitional Planning.....	4
2.2 Discharge and Transition Planning and Homelessness	4
2.3 Purpose of discharge planning.....	6
3. Approaches to Discharge and Transition Planning	7
4. Barriers to Successful Discharge and Transition Planning.....	18
5. Best Practices for Successful Discharge and Transition Planning	20
5.1 Principles of Discharge and Transition Planning	20
5.2 Best Practices and Tools	21
6. Citations.....	24

1. Introduction

1.1 Background

People who are mentally ill are currently over-represented among the homeless, and mental-health care providers are not always able to connect clients leaving care with appropriate housing and support services in the community. Developing effective practices to prevent homelessness among the mentally ill has been advocated by organizations like the City of Vancouver, Streethome Foundation and the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University as important in addressing and preventing homelessness. Literature suggests that a key component of homeless prevention is integration of discharge planning with community service providers, to ensure long-term care for clients (Patterson, 2008).

However, while the literature suggests a range of best practices for effective discharge planning, it is important to understand the context of BC health care and housing environment. Little research has been identified with a BC focus to identify appropriate approaches to ensuring that appropriate long-term community supports are in place in order to prevent homelessness. The purpose of this study is to identify effective policies, practices and resource requirements for discharging residents and patients from mental health facilities (particularly hospitals and community residential institutions), in partnership with community service providers, in order to prevent homelessness, and in particular to look at how community size and context plays a role.

While discharge plans exist for mental health patients from all facilities run by provincial health authorities, resources are not always available to ensure that a client has somewhere “to be discharged to when their illness is stabilized” (Fraser Health, 2006). This has led to a situation where mental health patients are over-represented among the homeless. In the 2011 Vancouver Homeless Count 35% of the homeless population was found to have some form of mental illness (Metro Vancouver, 2011). A 2011 study of hidden homelessness in BC communities found through interviews with homeless individuals that about 50% reported a mental health challenge (SPARC, 2011). A survey conducted by the Canadian Mental Health Association’s BC branch indicated that front-line workers estimated between 60% and 100% of the absolutely homeless and 30% of the at-risk population in rural areas were affected by mental health issues (Patterson, 2008).

While efforts to reduce homelessness among the mentally ill in BC have included emergency responses such as shelters, outreach, drop-in centres, and permanent housing, including scattered site and purpose built supportive housing, it is becoming clear that in order to address the wider problem of homelessness, a focus on preventing new homelessness from occurring must be a priority. A 2008 study identified the crisis-oriented nature of services for individuals with severe addictions and/or mental illness (SAMI), and noted that “Despite general agreement that inadequate attention is

devoted to preventing homelessness among the SAMI population, little funding has been directed to addressing underlying causes. Thus, managers and service providers understandably focus on stop-gap solutions to immediate crises” (Patterson, 2008). Streetohome Foundation’s 10-year plan identifies the need to invest in housing projects for individuals leaving public institutions, such as hospitals as one of key priorities (Streetohome, 2010), and the City of Vancouver is turning its attention to mental health issues in order to prevent homelessness (City of Vancouver, 2012).

1.2 Purpose

The purpose of this literature review is to identify what is known about best practices, strengths and challenges in mental health discharge planning in partnership with community service providers. By identifying best practices from other jurisdictions, we can determine, using case studies, whether these practices are being implemented, or have been adapted, here in British Columbia. The literature review will also identify factors that contribute to success and create challenges, and the role of community size, if any.

The focus of this review is on prevention of homelessness in mental health clients and particular emphasis is on research that examines integrated community approaches to mental health discharge and transition planning.

1.3 Scope and method

The literature review synthesizes national and international best practices in discharging mental health clients. A strong body of research has been developed the United States and the UK , with some research located in Australia. The bulk of Canadian research into mental health discharge and transition planning has taken place in Ontario, particularly those of Cheryl Forchuk at Western. CAMH Health Systems and Consulting Unit’s “From Hospital to Home: The Transitioning of Alternate Level of Care and Long-stay Mental Health Clients” in 2009, a comprehensive examination of the housing and community service supports necessary to transition a specific group of mental health clients to the community, was particularly helpful.

This review has used resource websites such as Homeless Hub, the European Federation of National Organisations Working with the Homeless and the Australian Housing and Urban Research Institute. The researchers also used Google Scholar and EBSCO as a resource for searches. The following search terms were used:

- discharge planning
- transition planning
- mental health discharge
- discharge homelessness

The time period for this literature review is approximately the last 15 years; in the late 1990s two models of discharge (Transitional Discharge Model and Critical Time Intervention) were developed and studied. The review only considered English language publications, and although focused on discharge planning for patients with mental health issues, the literature review incorporated some studies applicable to other groups of vulnerable patients as well.

1.4 Limitations

This project focuses on the links between the health system and community agencies when discharging mental health patients from acute and tertiary care. The research therefore is intended to examine both the workings of the health system and the workings of community support agencies. In the literature search however, it appears that the bulk of research comes from the health care sector. While many of the articles and reports discussed below provide community perspectives, approaching discharge planning from a health-care perspective means that researchers are often concerned with the consequences of discharge planning on the health system (e.g. length of stay and readmission rates are both indicators commonly used to measure success of a program). In many cases, this means fewer details are provided describing the impacts of discharge planning for the individual involved, from the community service perspective or the community at large. This may be a limitation of the literature itself, or an artifact of the literature search (ie we may have missed some relevant work). For example, while housing outcomes are tracked across many of the studies, few details are available regarding the impact of these efforts on community agency workloads, visible homelessness, etc. In addition, it means that fewer articles describe the transition planning process from a community perspective, focusing rather on the institutional protocols and processes.

1.5 Organization of the Report

This report is structured with four main sections exploring discharge and transition planning (DTP). Section 2 defines DTP in the context of the literature and discusses the link between DTP and homelessness. Section 3 summarizes a range of approaches to discharge planning, ranging from institutionally-based approaches to those that rely heavily on hospital-community partnerships. Section 4 identifies barrier and challenges to effective DTP. Section 5 lists the best practices from the literature.

2. Discharge and Transition Planning

2.1 *Defining Discharge and Transition Planning*

In its broadest sense, discharge planning is about planning appropriate transitions from hospital to home involving a patient, their family, health care provider and community service providers (VCH, 2010). In the context of mental health care, the US Substance Abuse and Mental Health Services Administration (1997) defines it as “the process to prepare a person for return or reentry to the community, and the linkage of the individual to essential community treatment, housing, and human services.” An important aspect of discharge planning for individuals with mental illness is its use as “a structurally based intervention to prevent homelessness” (Moran *et al.*, 2005). Comprehensive discharge planning ensures that patients will be referred to appropriate housing and community services (Moran *et al.*, 2005), and as such indicates a collaborative effort across fields and organizations.

Mental health organizations such as the American Association of Community Psychiatrists (AACCP) has proposed the use of the term ‘transition planning’ in place of discharge planning, to indicate ongoing collaborative care with service providers (2001). The AACCP report notes that discharge implies a termination of care that in the context of mental health and homelessness can be problematic, as ongoing care may be required.

Both Interior Health¹ and Vancouver Coastal Health² use the term discharge planning to refer to patients leaving hospital, but there appear to be few resources that examine the process as it relates to mental health patients.

While the literature uses both discharge and transitional planning, this literature review will use the term “discharge and transition planning” or DTP to indicate the full spectrum of planning processes in place, from the admission of mental health patients, to care, to their reintegration back into the community. However, Volumes 1 and 2 of this report focus primarily on discharge planning and less on transitioning between levels of care.

2.2 *Discharge and Transition Planning and Homelessness*

A major study of the health of the homeless population in three BC communities in 2009 confirmed the relationship between homelessness and mental illness. According to Krausz (2011), “Almost all participants (93%) experienced a mental disorder or a substance use disorder at one time in their life. Eighty-three percent met the criteria for

¹ <http://www.interiorhealth.ca/YourStay/Discharge/Pages/default.aspx>

² http://www.vch.ca/your_stay/in_hospital/discharge/

substance use disorder, and almost two thirds (65%) of participants met the criteria for a non-substance related mental disorder. “

Krausz points out that “One of the main challenges homeless individuals pose to the current health care system is the complexity of health related issues that they experience. Multiple severe morbidities are the norm, and concurrent disorders (the presence of a mental disorder and substance disorder) are highly prevalent and present specific barriers to recovery and adequate care.” Thus finding and ensuring adequate post discharge circumstances for this population is challenging.

In their examination Schutt *et al.* (2009) note that “enhancing case management services [for mental health clients] by itself is not consistently associated with lessened risk of homelessness” and that housing is a primary requirement for reducing homelessness. However, they also note that while housing is a necessary component in reducing risk of homelessness, “it is often insufficient to prevent homelessness among impoverished persons with mental illness who abuse substances. . . . [and that] Programs that seek to reduce the risk of homelessness among individuals with severe mental illness should thus offer different residential and service options for different subgroups” (Schutt *et al.*, 2009). Backer *et al.* (2007) note that the Housing First approach fits well with discharge planning for mental health patients.

Butterill *et al.* (2009) also note that “Good outcomes can be achieved for individuals with high complex mental health needs in the community when they receive the appropriate high support housing and community mental health services and supports” when being discharged from hospital care (both acute and tertiary). Their study of Ontario’s discharge and transition processes notes the importance of a full continuum of housing, including “long-stay and transitional high support housing, housing with less intensive supervision and monitoring, group homes, individual apartments, emergency or crisis housing, and specialized housing for people with concurrent disorders, dual diagnosis, or geriatric mental health issues” (Butterill *et al.*, 2009). However, they also note the importance of ongoing services, highlighting the transitional discharge model (discussed in section 3) as a model of partnerships between community and health care services.

A particular challenge in discharging mental health patients from hospitals stems from the strong link between mental health and addictions, and the complexities of meeting their needs in the community successfully. Butterill *et al.* (2009) note that

Due to the nature of their conditions, individuals with concurrent disorders have increased risk of homelessness and repeated hospitalizations, as well as experiencing specific barriers to stable housing . . . Supportive housing models need to be flexible, with options for individualizing supports and services for clients as needed, and with minimal barriers to access.

As part of a spectrum of health care and social services, discharge and transition planning can play a significant role in preventing homelessness (Backer *et al.*, 2007). “Discharge Planning identifies and organizes services a person with mental illness, substance abuse, and other vulnerabilities needs when leaving an institutional or custodial setting and returning to the community.” Backer *et al.* (2007) note that some quantitative studies have showed mixed results in discharge planning, they point out that other research suggests that when proper discharge planning for homelessness occurs, then “success in consumers’ efforts to find stable housing can result” (Backer *et al.*, 2007). They note that success in discharge planning requires a strong integration of services that provide stable, permanent housing and integrate with both health and community services.

Steffen *et al.* (2009) also conducted a meta-analysis of discharge and transition planning as a strategy for preventing homelessness. Their analysis included twelve studies on discharge planning from around the world: these included six American studies, three from the UK, one each from Israel, Japan and Canada. This analysis concluded that discharge planning in the mental health system contributed to “reducing hospital stays and to improving patients’ adherence to aftercare as well as symptomatic impairment.” Their analysis also showed a significant reduction in readmission rates where some form of discharge or transition intervention occurred (Steffen *et al.*, 2009).

Published Canadian research on discharge and transition planning has largely been conducted in Ontario. In London, Ontario, a small pilot project that “provided [the intervention group] with immediate assistance in accessing housing and assistance in paying their first and last month’s rent” (Forchuk *et al.* 2008). All recipients of the intervention remained housed after six months, while 6 of 7 who received usual care remained homeless.

2.3 Purpose of discharge planning

The purpose of discharge and transition planning, and the definition of success, varies across approaches discussed in section 3. Moss *et al.* (2002) define success of the Care Coordination Team (CCT) approach according to four factors:

- “Successful identification of patients at risk of readmission
- Increased utilisation of Home Care Support Services
- Utilisation of Home Care Support Services reduces the rate of functional decline
- Reduction in repeat presentation of patients to hospital” (Moss *et al.*, 2002)

In a review of several discharge planning initiatives in the UK, success is measured qualitatively, as the ability of hospital discharge staff to link patients to housing resources and community services (Housing LIN, 2009). The critical time intervention (CTI) approach was developed expressly to prevent homelessness upon hospital discharge, and success is measured by:

- Long-term housing outcomes of participants
- Long-term relationships with and access to community resources and services (Herman *et al.* 2011).

Both the Transitional Discharge Model (TDM) and the community-based discharge planning model (CBDM) take the same view of success as defined by the CTI approach, with additional measures of success. Both consider readmission rates to hospital in their definition of a successful discharge approach, and TDM also considers the cost-saving component of successful discharge (Forchuk *et al.*, 2007; Jensen, 2009).

3. Approaches to Discharge and Transition Planning

Backer *et al.* (2007) identify a three-part structure to many discharge and transition planning interventions, intended to provide a continuum of care:

1. Institutional assessment and treatment
2. Discharge planning
3. Service coordination and integration

They might be referred to as the needs assessment phase, the planning phase, and implementation phase, and roughly moves from actions that take place within the hospital or mental health resource to those that take place with or in the community. The literature suggests that all discharge planning should start at admission, in order to identify possible risks and vulnerabilities, help identify discharge needs (e.g. housing, services, etc.) and ensure that enough time is available to discharge a patient safely (Moss *et al.*, 2002; Backer *et al.* 2007)

These components of discharge and transition planning connect institutional and community services based on a service user's needs. The authors also note that successful discharge and transition interventions can range from an informal process to a comprehensive, standardized process.

We have identified a number of models or approaches that span the full spectrum of discharge and transition planning described by Backer *et al.*, ranging from those focused on institutional assessment and treatment to more community-based approaches. These are:

- Coordinated Care Teams (CCT)
- Integrating in-hospital protocols and positions to specifically prevent discharging patients to homelessness (3 case studies from the UK)
- Critical Time Intervention (CTI)
- Transitional Discharge Model (TDM)
- Community-based discharge planning (CBDP)

These approaches are discussed below, and presented in an order that reflects the most institutional-based (with less community supports and networks) to the most community-based form of discharge planning. Those with the most community supports are most relevant to this research.

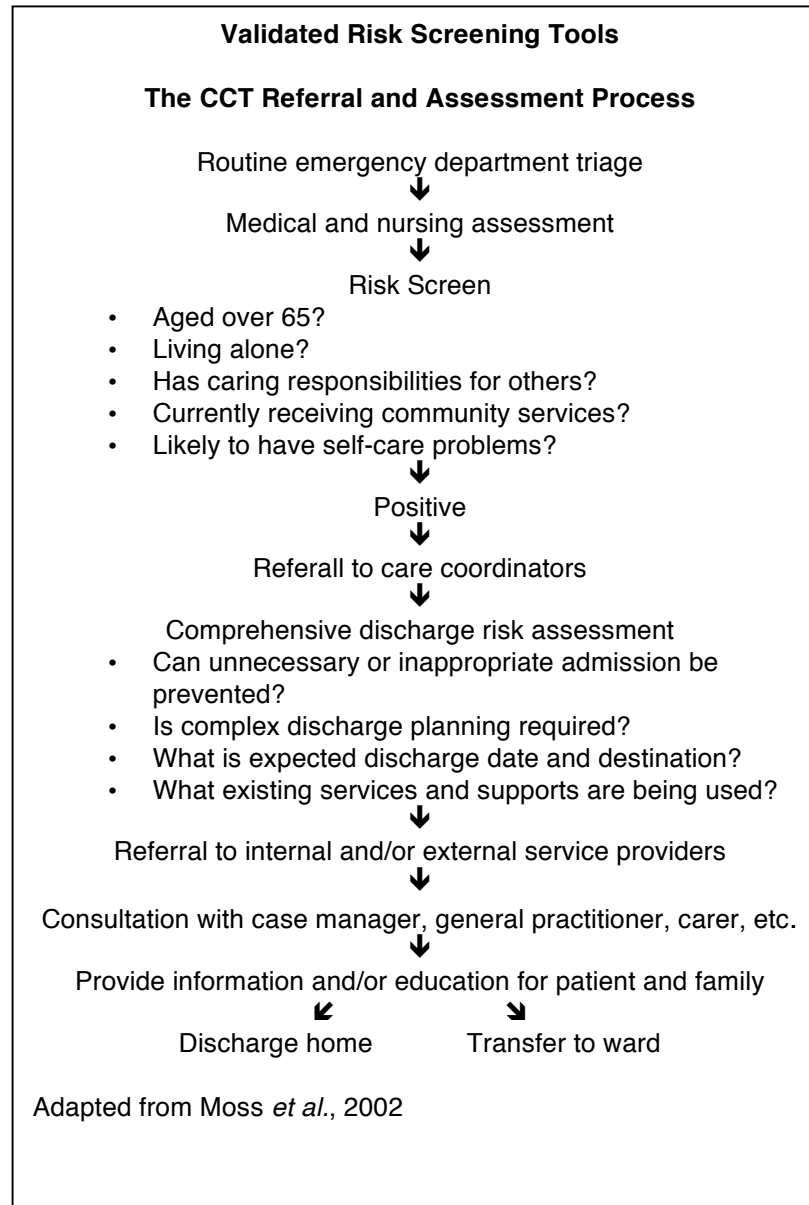
Coordinated Care Teams

Coordinated Care Teams represent an integrated approach to discharge planning, focusing on those patients who may be vulnerable upon discharge (Moss *et al.*, 2002). In April 2000, the Royal Melbourne Hospital developed a multidisciplinary Care Coordination Team (CCT) to facilitate reintegration of patients into the community from their emergency department.

A committee consisting of “hospital staff and community service providers, including post-acute-care facilitation and hospital-in-the-home services” was struck to identify patient needs and coordinate the CCT. The CCT was comprised of four nursing and allied health personnel, who were the CCT care coordinators in its first year.

The CCT approach was designed to address the needs of a wide range of patients, including “the frail elderly; those who frequently attend the Royal Melbourne Hospital emergency department; those requiring assistance with activities of daily living or having complex medical problems; those not eligible for hospital in the home; those requiring complex discharge planning; the homeless; and those with drug and alcohol problems.” Their goal was to:

- “[prevent] unnecessary and/or inappropriate hospital admissions;
- [minimize] repeat presentations of patients; and
- [provide] safe and effective discharge from the ED” (Moss *et al.*, 2002).



The primary focus of this approach is to improve discharge within the health system, and is not necessarily focused specifically on mental health clients. The study therefore does not examine long-term housing outcomes, nor is the purpose of the approach to ensure successful long-term housing outcomes.

A validated risk screening tool (see sidebar) was used by staff to identify vulnerable patients, who were then referred to the CCT. This allowed the CCT to redirect patients to existing resources and services to avoid admitting those not in need of emergency services, as well as ensuring that patients who are admitted had access of appropriate services to ensure a safe discharge. Additionally, the CCT included 24 a day access to home services, and implements “an early effective discharge to the homeless persons nursing program.” This program, provided through the Royal District Nursing Service, provides “holistic healthcare to people experiencing homelessness and to improve their access to general community services. [The program works] with other services to arrange healthcare that is accessible and relevant to the needs of the homeless, and at an equal level to that received by the general community” (RDNS, 2013).

The success of the CCT approach is its ability to identify early on in a treatment process which patients are vulnerable, including those who may be homeless or at risk. The approach also builds in appropriate referral and follow-up to emergency care, and therefore able to provide appropriate support to homeless patients. The program was successful from staff, patient, community service provider perspectives, with high rates of satisfaction from all three groups. Low readmission rates represented another measure of success for the program overall (Moss *et al.*, 2002). While the CCT approach is not designed specifically to prevent homelessness, the results of this study reflect that even a broad approach to identifying risk and vulnerability may have positive impacts on homeless patients.

In 2008, a CCT Demonstration Project was implemented at the Toronto East General Hospital. Teams consisted of Registered Nurses, Registered Practical Nurses and Patient Care Assistants, with each team customized according to patient unit (TEGH, 2009). The evaluation of this project indicates increased patient safety, patient satisfaction, resource use and staff and physician satisfaction. However, the report does not review housing outcomes for patients who are homeless or at risk.

Local Discharge Planning in the UK

The following three case studies were commissioned by the UK’s Department of Health. They highlight the ways in which housing authorities and hospital trusts approach discharging homeless individuals from hospitals at a local level. Each of these case studies represents a different approach to the issue, “demonstrating that the approach and the level of investment of time and resources needs to be oriented to the local circumstances” (Housing LIN, 2009).

Newcastle: Municipal Discharge Planning Protocol

The need for discharge planning as a tool to prevent homelessness was recognized in Newcastle's 2003 homeless strategy. The process of developing a comprehensive discharge program was developed through workshops with health and social care professionals, and driven by a partnership of these organizations.

Health service providers in Newcastle developed a cross-service protocol for discharge planning encompassing acute care, mental health services and accident and emergency departments (Housing LIN, 2009). The protocol provides a framework for a number of partners, including local governments, health service providers and community service and housing providers, to collaborate in order to prevent discharging patients to homelessness ((NCSHS, 2007).

The protocol is a set of tools and policies for health staff and partner organizations to use in order to ensure appropriate discharge planning for homeless patients. Specifically, the protocol outlines:

- Actions that staff can take to prevent homelessness at all phases of treatment, from admission to discharge
- Appropriate partner agencies to contact regarding housing/accommodation and other community supports
- Information for display regarding homeless and discharge for patients and staff
- Monitoring and evaluation of the program and partnership agreements
- Processes for information sharing between partner agencies, including confidentiality and privacy policies

In the development of the protocol, a Housing Pack, containing "the role each agency involved in working with homeless people in Newcastle will take in relation to preventing homelessness for people leaving hospital. The Pack also contains information about the homelessness legislation and system, and contact details for other local authorities in the North East, and for agencies signed up to the Protocol" (Housing LIN, 2009). The protocol has two main strengths in preventing homelessness through discharge planning:

- It provides staff a clear set of processes for staff to follow that allows them to identify homelessness and risk, even when they may not be experienced or particularly informed regarding housing and homelessness
- It establishes clear partnerships and responsibilities amongst its signatories to provide resources for homeless patients upon discharge

The protocol has led to significant improvement in the discharge process, providing a standard set of procedures and resources for discharging homeless individuals. The protocol has also led to greater cooperation between sectors, greater awareness by health care providers of services for homeless individuals and the development of additional support protocol for preventing homelessness. The report does not identify

or track specific housing outcomes for patients, and simply identifies the wider benefits noted by interview participants of having the protocol in place (Housing LIN, 2009).

Research also identified some challenges in implementing the protocol which differed according to the type of health care provider:

- *Acute services*: the links between advice/support worker in charge of discharge planning and supported housing options and networks are limited, representing a serious flaw
- *Emergency departments*: lack of time to usefully link individuals into services through Emergency departments; no 'wraparound care' (i.e. integrated care across disciplines and sectors, including both health and community housing and service providers)
- *Mental Health (i.e. tertiary care)*: In mental health beds (longer-term) there is more lead time, and mental health wards access dedicated Community Psychiatric Nurses and a mental health advisory from *Your Homes Newcastle*; discharge protocol has been successful in clearly identifying housing and preventing homelessness

West Sussex: Co-ordinator for Housing, Health and Social Care

The Worthing and Southlands Hospital identified the need to address the significant time spent in acute care beds by those with complex health, social care and housing needs (e.g. elders who could not return home, young people with substance use issues). In the community, homelessness and outreach teams were not getting warning of discharge, which led to the need for costly and unsuitable emergency accommodation to be accessed by these teams. This led to the appointment of a Housing, Health and Social Care Co-ordinator, responsible (among other things) for discharging homeless individuals.

The Co-ordinator provided training to all wards on homelessness and the services and resources available, and discharge folders for homeless patients are available on every ward with information about local housing and homelessness services. The Co-ordinator also developed a discharge policy around homeless patients, built relationships with housing and community service agencies, and assists directly with patients' housing applications.

The development of the position responsible for preventing homelessness through discharge planning has led to a number of tangible benefits:

- Greater cooperation between agencies
- Greater awareness of services
- Ongoing outreach and training to hospital staff and physician

- Saving money: Discharge accommodation resource developed an interim housing pilot project (one flat), which saved 251 hospital bed stays; prevents bed-blocking
- In 2006, 32% of patients delayed leaving care due to housing issues, while this number dropped to only 7% in 2008
- Identified need for post-detox safe accommodation
- This approach to discharge planning has also impacted health care policy

Some challenges remain, particularly in the Accident and Emergency department, where stays are short, and patients who are not admitted may not be referred to services. However, the program is seen as successful overall (Housing LIN, 2009).

London Guys and St. Thomas' Hospital: Specialist Post

In the London Guys and St. Thomas' hospital, nurses and discharge coordinators with no specific training in housing issues had been conducting discharge planning. There were no specific protocols around discharging homeless individuals, which resulted in problematic discharges, including discharge to inappropriate accommodation and a lack of referral to appropriate services.

The hospital identified the need for a specialist post, with a background in housing and homelessness through the social work department. This co-ordinator is responsible for discharge and transition planning for all patients identified as homelessness. The Co-ordinator has access to a short-term hotel associated with the hospital that provides bed, board and minimal personal care. Additionally, the co-ordinator has access to the London Combined Homelessness and Information System (CHAIN) to assess the history of a client's engagement with community services and assist in planning supports. This information is immediately available to the Co-ordinator.

The Co-ordinator has specialist knowledge of the housing and community support system, and helps in navigating London's complex services for homeless individuals. The creation of the position has

- Improved relationship with homeless agencies who are now contacted immediately
- Hospital interventions represent an important opportunity to address chronic homelessness
- Hospital staff have improved understanding of homelessness
- Decrease in re-admissions -
- Better able to address patient needs and situation
- Development of evidence base and understanding of gaps (Housing LIN, 2009)
- The Co-ordinator provides monitoring information regarding discharge quarterly, but does not track long-term housing outcomes of discharged clients; between July and September, 2008, there were 75 homeless referred to the Homeless

- Person Unit (providing assessment on the need for housing) and street outreach services
- Hospital staff indicated that re-admission rates of homeless persons were lower due to the Co-ordinator's work on discharge planning, but did not provide monitoring information

Critical Time Intervention

Critical time intervention (CTI) represents another approach to discharge and transition planning, designed specifically to prevent homelessness by researchers at Columbia University and the New York Psychiatric Institute. The approach has been tested in New York state, and is currently being applied and researched in the US and internationally (CTI, 2013). CTI represents a nine-month intervention, that "aims to gradually pass responsibility to community sources for providing ongoing support after the intervention ends, thereby leading to a durable reduction in risk of future homelessness" (Herman *et al.*, 2011).

CTI aims to prevent homelessness by strengthening long-term ties to services, family and friends, and by providing emotional and practical support during transition period. The approach shares much with assertive community treatment,³ with an additional emphasis on maintaining continuity of care during transition into the community (Herman *et al.*, 2011).

In a CTI research study (Herman *et al.*, 2011), all participants (control and CTI groups) received basic discharge planning and 'usual' community services (e.g. case management, clinical treatment). CTI participants: received significant housing support (community residences, supported apartments, independent housing), and the following supports, delivered in three stages, each three months long:

- Transition to community involving intensive support and assessing resources that exist
- Testing and adjusting systems: community service providers have assumed primary responsibility for services, and "the CTI worker can assess the degree to which this support system is functioning as planned"
- Transfer of care: This phase involves the termination of CTI with a support network in place

In addition, participants' housing status was assessed every 6 weeks for an 18-month follow up period after the CTI, via self-reports collected by interviewers.

³ Assertive Community Treatment (ACT) is "a client-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most serious mental illnesses, have severe symptoms and impairments and have not benefited from traditional out-patient programs." This approach is currently utilized across British Columbia (BCMH, 2008).

Previous studies have shown the enduring positive results of CTI in housing outcomes (Susser *et al.*, 1997), that this study confirmed. A review of three CTI studies conducted in 2006, including Susser *et al.* (1997), found that CTI participants averaged only 30 nights homeless during the follow-up period, compared with 91 nights for clients receiving only usual services. This study also noted that (as of 2006) CTI had been implemented in 25 service sites in the US, with a total of 500 participants. There were also two sites in the UK and one in the Netherlands (SAMHSA, 2006).

In Herman *et al.*'s study, participants assigned to the CTI group had significantly lower likelihood of being homeless at the end of the follow-up period, compared with the control group. Seventy-nine percent of participants had reported two or more previous homeless episodes. Forty percent said their longer duration of homelessness period was 1 year or more. Only 5% of the CTI group experienced homelessness during study, while 19% of the control group experienced homelessness. This is associated with a statistically significant five-fold reduction in the odds of homelessness (Herman *et al.*, 2011).

Transitional Discharge Model

The Transitional Discharge Model consists of two essential components: “Peer support, consisting of the assistance and friendship of a former consumer of mental health services who is now living successfully in the community [and] . . . Bridging staff, who facilitate an overlap of hospital and community care such that the hospital staff do not terminate their therapeutic relationship with the discharged client until a therapeutic relationship has been established with the community care provider” (Forchuk *et al.* 2007). A comparative analysis has been conducted of TDM in Canada and Scotland, both with positive results in stabilizing clients in their communities.

TDM in Canada was created and established in Hamilton, Ontario in the late 1990s. The pilot project developed out of a need to address very low discharge rates at an Ontario mental health facility. The pilot, called Bridge to Discharge, developed a model of peer and staff support for transitioning patients into the community. The project developed a formal relationship between a psychiatric hospital, a public health team, and a consumer group. These three groups were involved through the project, from planning to evaluation. A participatory model of discharge and transition planning involved clients in the design of the program in order to develop and maintain therapeutic relationships after discharge.

The intervention involved an overlap of services between inpatient and community programs, where a public health nurse from the community started working with clients for 6 months before discharge, or “the hospital nurse continued to see the client for as long as necessary after inpatient discharge” (Forchuk *et al.*, 1998). This period of overlap generally took between one and two years. The project also ensured that contact with the hospital, including readmission, was made more accessible to clients. For example, clients could contact the inpatient unit without formal admission “or be

admitted at their own request.” Clients discharged to the community could also visit informally for celebrations (e.g. Christmas). Additionally, a downtown apartment was used as a community space for those discharged into the community. Independent living skills and drop-in support services were available, provided in partnership by consumer and public health partners (Forchuk *et al.*, 1998).

The initial project at the pilot hospital was successful. The Canadian study of TDM then expanded to four hospitals and 26 tertiary care psychiatric wards (13 intervention, 13 control) (Forchuk *et al.* 2007). This study confirmed the positive results of the earlier pilot, including:

- Clients’ quality of life improved, including:
 - “Expressing and maintaining hope for a future outside of the hospital” was a significant result, from a hospital with minimal discharges in the previous 5-year period
 - “Talking and visits with staff and staff support” was seen as helpful and therapeutic, in terms of being able to rely on established relationships
 - Development of a “planning process that evolved over time to an action taken,” including financial planning, planning for housing and basic life and independent living skills (e.g. cooking, social interaction, etc.) (Forchuk *et al.*, 1998)
- More clients left the hospital (Forchuk *et al.* 2007)
- The costs of care were reduced (in the larger study resulting in a savings of \$12 million) (Forchuk *et al.* 2007)
- Shorter length of stay (Forchuk *et al.* 2007)

The researchers identified a number of factors in the successful implementation of the project, as well as challenges. Factors for success include:

- Pre-existing infrastructure for consumer-survivor groups, embedded in existing mental health services
- Support from hospital administration who championed the model

The challenges to the success of TDM identified in the study included:

- Sustainability of the model: consumer-survivor groups received funds from government, but only had part-time staff and identified this as an issue for peer support coordination and activities; funds for the model were only available for 3 years
- Staff understanding of TDM and commitment to the model varied across locations; in a number of wards staff “lacked experience in including consumer-survivor groups in the process of transitioning from hospital to community care.”
- Ongoing change and reform of health care system, with psychiatric hospitals going through period of divestment; need for numerous orientation sessions for new admin, and funding cutbacks and bed closures (Forchuk *et al.*, 2007)

TDM in Scotland arose from concern around rehospitalization of patients and lack of appropriate community integration and adjustment. In their review of best practices, Scottish researchers looked to the Canadian model of TDM. The project was piloted in a rural area of Scotland, in three acute psychiatric wards. The findings of the Scottish study reflected the findings of the Canadian study, indicating that TDM is an effective model of transitional planning for integrating mental health patients back into a community. They found that those “in the usual treatment group [control group] were at more than double risk of being rehospitalized during a 5-month period.”

The Scottish pilot shared some of the same factors in success as the Canadian study. These factors included:

- Theory into practice approach⁴ advocated by mental health nurses was supportive of TDM; local service users shared concerns around re-hospitalization
- Support from hospital administrators and senior nursing staff
- Willingness of nursing staff and peer supporters to be flexible, given small size of study and resource limitation

The Scottish study also faced some challenges, which were somewhat different from the Canadian study:

- Small size of the study meant limited funds; both geographically limited study and availability of TDM was uneven across clients in intervention group
- Difficulty establishing and maintaining peer support infrastructure, with local service user group unable to commit to managing the scheme (nonetheless peer support volunteers emerged)
- Large number of women as peer support volunteers, making it difficult to match male clients with male peer support

Forchuk *et al.* (2007) conclude, in comparing the two studies, that the Canadian and Scottish TDM programs differ in their funding models and the degree of autonomy available to peer support. However, in both studies organizational support was key to successful implementation of TDM. Administrators particularly supported the acceptance and integration of research activity within mental health services.

The authors also note that a mental health system that is committed to continuing education for all involved, that values consumer and staff participation and that implements evidence-informed practices is key to “sustainable development of discharge planning, which clearly benefits consumers of mental health care and, ultimately the health of the community” (Forchuk *et al.*, 2007).

⁴ This theory of interpersonal relationships (Peplau, 1989) provides the basis for the development of the transitional discharge model in Canada (particularly the peer support component and the development of therapeutic relationships with bridging staff) and was of strong interest to the nurse practitioners involved in the Scottish program.

Community Based Discharge Planning

In focus groups with care providers, policy-makers and other stakeholders in the Ontario mental health system, Butterill *et al.* (2009) found that “Participants placed strong emphasis on collaborative discharge planning processes that involve hospital and community providers.” In addition to TDM, another example of discharge planning that has been applied in Ontario is community-based discharge planning (CBDP).

CBDP is a coordinated case management service provided by the Canadian Mental Health Association (CMHA) in partnership with Bluewater Health in Sarnia, Ontario, a hospital with 27 acute care beds. A multidisciplinary team involving these partners develops a discharge plan for individuals at the Mental Health Unit (Jensen *et al.* 2009). The community-based discharge planning program provides the following services:

- “Meet with referred patient
- Provide a needs assessment
- Help the referred patient develop a plan for discharge
- Provide seamless support when transitioning back into the community
- Complete appropriate referrals to community agencies that meet patient identified needs
- Advocate with community agencies for support” (Jensen *et al.*, 2009).

Any member of the multidisciplinary team can refer patients to the program, which is managed by a Community Case Manager (CCM). At the outset of a case, a patient is contacted and a session involving the patient (and usually a support network) will take place explaining the role of the CCM and the services available. A case conference involving the patient’s psychiatrist, social worker, CCM and others is organized for information sharing. The CCM meets regularly with the patient to identify needs, and has access to hospital records for the purposes of the needs assessment. Upon discharge the CCM can assist the patient with immediate needs such as shelter, finances and nutrition. The CCM also refers the patient to services available in the community for long-term support.

This study uses both administrative data and interviews with patients over a six-month period after discharge to evaluate the approach, though they are limited in their scope as this evaluation did not include a control group. During the CBDP the average length of stay and number of admissions did not change, but there were corresponding reductions in readmission and increased housing stability. The readmission rate in the first year of the CBDP showed a 40% reduction in readmission of patients compared with the hospital-based discharge planning. At one month post discharge, “67.7% of the participants were receiving at least monthly mental health services” and at six months 66.2% were still receiving mental health care (Jensen, 2009). All participants were housed six months after discharge from the program.

4. Barriers to Successful Discharge and Transition Planning

Researchers have identified a number of barriers to successful discharge and transition planning in order to prevent homelessness in the various approaches documented in the literature. While there are many challenges, depending on the context and health care system being discussed, the following barriers to successful discharge and transition planning were identified and are presented here in order of the number of times they appear in the literature. Where relevant we have flagged challenges that may apply to communities of a particular size or type.

Table 1: Challenges in Discharge and Transition Planning

Challenge	Description	Studies
Lack of Community Supports	A community, particularly smaller or rural communities, may not have appropriate supports or infrastructure to ensure long-term success. These may include a lack of resources to prevent relapse and ongoing community support services.	Backer <i>et al.</i> , 2007 Forchuk <i>et al.</i> , 2007 Baron <i>et al.</i> , 2008 Butterill <i>et al.</i> , 2009 Schutt <i>et al.</i> , 2009 Housing LIN, 2009
Lack of Appropriate Housing	Lack of long-term housing supports can be a major barrier to successful DTP. Housing in particular plays an important role in long-term success. In some cases it may be because client needs are more than existing services can handle, while in other cases there may simply not be appropriate housing. In one Ontario study, the authors noted that “Access to high support housing and community mental health services and supports continue to be a serious problem due to long wait-lists and shortage of resources” (Butterill <i>et al.</i> , 2009).	Backer <i>et al.</i> , 2007 Forchuk <i>et al.</i> , 2007 Baron <i>et al.</i> , 2008 Butterill <i>et al.</i> , 2009 Schutt <i>et al.</i> , 2009 Housing LIN, 2009
Individual Response /Diversity of Needs from Community to Community and Client to Client	Discharge planning requires developing an approach that factors in differing community characteristics; there is no template for discharge planning that works across all communities, and some lack of consensus on effective discharge and transition planning. In particular, attention should be paid to the diverse needs of clients and their support networks, with tailored placements (in both housing and services) that reflect a	Backer <i>et al.</i> , 2007 Butterill <i>et al.</i> , 2009 Schutt <i>et al.</i> , 2009

	good fit for a client are important. Urban areas may experience a higher prevalence of 'hard-to-house' individuals who need greater follow up supports	
No Ownership of Discharge Planning for Homeless	There may be no dedicated 'home' for discharge and transition planning for homeless and at-risk individuals	Moran <i>et al.</i> , 2005 Backer <i>et al.</i> , 2007 Butterill <i>et al.</i> , 2009
Stigma	Patients may experience stigma and discrimination when accessing services, which can adversely affect long-term outcomes, including their ability or desire to access other services.	Baron <i>et al.</i> 2007 Backer <i>et al.</i> , 2008 Butterill <i>et al.</i> , 2009
Lack of Cultural Sensitivity	Care may not be available to patients in their preferred language, or may not be culturally appropriate	Backer <i>et al.</i> , 2007 Baron <i>et al.</i> , 2008 Schutt <i>et al.</i> , 2009
Lack of Partnerships Between Health Care and Community Service Providers	Some systems may lack an appropriate 'bridge' between the hospital and the community, allowing an appropriate transition of client from in-patient to community care. When discharge occurs quickly it can further challenge the client's long-term success	Backer <i>et al.</i> , 2007 Butterill <i>et al.</i> , 2009
No Staff Knowledge of Homelessness	Staff may lack familiarity with community housing and services options	Baron <i>et al.</i> , 2008 Housing LIN, 2009
Lack of Funding for Discharge and Transition Planning	There are few formal 'homes' for the funding discharge and transition planning in many health care systems, and as such there may not always be appropriate resources to develop and maintain discharge and transition planning programs to address homelessness	Backer <i>et al.</i> , 2007 Butterill <i>et al.</i> , 2009
Not Enough Time to Plan Appropriately	In some contexts, particularly emergency department settings, staff may lack time to appropriately assess and plan for patients.	Backer <i>et al.</i> , 2007 Housing LIN, 2009

5. Best Practices for Successful Discharge and Transition Planning

5.1 Principles of Discharge and Transition Planning

A number of research and advocacy organizations have identified principles and characteristics for successful discharge and transition planning. The American Association of Community Psychiatrists (2001) has identified 14 principles for transition of care between levels of service (i.e. from hospital to community):

- **Prioritization:** Identification of transition needs at outset of care
- **Comprehensiveness:** Transition plans consider all care needs
- **Coordination:** Coordination occurs between all levels of service and care
- **Continuity:** Transition planning should consider the full context of an illness or disability
- **Service user participation:** The service user should participate significantly in the formulation of transition planning
- **Support system involvement:** Client and family involvement throughout transition planning
- **Service user choice:** Transition planning should address a service user's needs in the way that is as inclusive of their wishes as possible
- **Cultural Sensitivity:** Transitions should be managed in a culturally sensitive manner
- **Prevention:** Transition planning should be designed with the intention of avoiding relapses, particularly in shifts from more to less structured settings
- **Resource utilization:** Plans should maximize resources available to the service user.
- **Timing:** Transitions should take place gradually, working with a client's ability to adapt to change.
- **Designation of responsibility:** Clear responsibility of all partners in each phase of transition planning is necessary to ensure success
- **Accountability:** Mechanisms for monitoring and improving transition plans should be in place
- **Special needs:** Recognition that special populations may require specific sets of guidelines around transition planning

5.2 Best Practices and Tools

Health care providers and community service agencies currently utilize a range of best practices and tools, identified in the literature above. In addition, the CAMH study by Butterill *et al.* (2009) presented a list of best practices in transitioning ALC/Long stay mental health and addictions clients, identified through their literature scan, focus groups and key informant interviews. Table 2 presents the or system-level best practices in DTP as identified in this literature review.

Table 2 ; Best Practices in DTP

Practice	Description	Studies
Housing and other Support Service Resources	Having appropriate resources for DTP means having staff to plan for discharge, and particularly the housing and services to support clients once they are in the community. Some literature suggests that social workers are the main discharge planners (Butterill <i>et al.</i> 2009). Butterill <i>et al.</i> note that “a mechanism is needed for the administration of flexible funds that follow the client for the purpose of purchasing needed services and supports to facilitate discharge planning”	Backer <i>et al.</i> , 2007 Forchuk <i>et al.</i> 2007 Baron <i>et al.</i> , 2008 Butterill <i>et al.</i> , 2009 Housing LIN, 2009 Schutt <i>et al.</i> , 2009
Partnerships consist of health care team, community service provider and peers	Any approach to discharge and transition planning needs to successfully bridge the transition from hospitals to community care; a team approach to DTP has been identified as successful when it consists of a patient’s health care team, community service providers and peer support	Forchuk <i>et al.</i> 2007 Backer <i>et al.</i> , 2007 Baron <i>et al.</i> , 2008 Butterill <i>et al.</i> , 2009 Housing LIN, 2009 Schutt <i>et al.</i> , 2009
Hospital and community service providers share information about client	Hospitals and community service providers will share records of a client who accesses health or community services with each other to ensure all the patient’s needs are identified and addressed	Housing LIN, 2007 Forchuk <i>et al.</i> 2007 Backer <i>et al.</i> , 2007 Baron <i>et al.</i> , 2008 Butterill, 2009 Housing LIN, 2009
Begin DTP at admission	Beginning the plans for discharge at admission and during treatment allow staff to identify client needs and the	Backer <i>et al.</i> , 2007 Baron <i>et al.</i> , 2008 Butterill <i>et al.</i> , 2009

	resources to address these needs	Housing LIN, 2009
Discharge and transition planning has a home	Programs should have a 'home,' either in the hospital or in the community, with a dedicated position to address the needs of mental health patients being discharged	Backer <i>et al.</i> , 2007 Baron <i>et al.</i> , 2008 Butterill <i>et al.</i> , 2009 Housing LIN, 2009
Adapted to the Patient's Needs	A discharge plan that meets the needs of clients is a prerequisite for success. Butterill <i>et al.</i> (2009) note that "Discharge planning and transitioning processes are more successful when tailored to the needs of the individual, carefully planned, inclusive of family, appropriately timed, and collaborative in nature."	Backer <i>et al.</i> , 2007 Forchuk <i>et al.</i> 2007 Butterill <i>et al.</i> , 2009 Schutt <i>et al.</i> , 2009
All partners "buy in" to DTP	Support from hospital staff and administrators, as well as community partners is a necessary component of successful DTP	Forchuk <i>et al.</i> 2007 Butterill <i>et al.</i> , 2009 Housing LIN, 2009
Long-term Focus	Providing services and maintaining relationships over the long term helps support the success of clients in their community	Forchuk <i>et al.</i> 2007 Baron <i>et al.</i> , 2008 Butterill <i>et al.</i> , 2009
Culturally Sensitive	Discharge planning needs to be culturally sensitive in its approach, understanding that intercultural differences can create significantly different short and long-term need in patients.	Backer <i>et al.</i> , 2007 Baron <i>et al.</i> , 2008 Schutt <i>et al.</i> , 2009

A number of specific tools and approaches for DTP were identified in the literature. These are presented according to the three phases of discharge planning identified by Backer *et al.* (2007).

Institutional assessment and treatment

- Admission protocol, usually involving a needs assessment and/or risk screening tool for patients in emergency departments, to identify homelessness or risk thereof; this allows the staff to identify the most vulnerable patients
- A standard set of procedures and policies for discharging mental health patients of which all staff are aware

- Training in hospital wards for staff re homelessness, services, supports available
- Step down beds that allow a staged reduction of care

Discharge planning

- Access to 24-hour housing support
- Ability of discharge planner to provide client with appropriate referrals to community services, and links to these organizations
- Access for individual doing discharge planning to all available client records, both hospital records (if a community service provider) or community service records (if a member of hospital staff)
- Bridging staff who are capable of transitioning patients from hospital to community and maintaining a 'therapeutic relationships'
- Use of discharge check lists
- Specialized multi-disciplinary teams consisting of a range of hospital staff (e.g. social workers, psychiatrists, nursing teams, etc.)

Service coordination and integration

- Access to short-term hostel or crisis housing affiliated with the hospital
- Peer support is available to patients throughout the discharge process, from in-patient care to community, as it helps to ameliorate client concerns and provide a bridge to community.
- Pre-existing communities of care for mental health clients (i.e. existing services for a range of needs are in place in the community)
- Collaborative approach, with in reach and outreach components to DTP
- Community service provider involvement is facilitated by placement of community service staff in hospital, their attendance at hospital rounds, pre-discharge meetings, etc.....
- Hospital back up is available post discharge to support the placement, including fast tracks to readmission, and ongoing therapeutic relationships between hospital staff and clients
- Monitoring of client outcomes, including housing stability and client access to mental health services
- Crisis support plans developed in partnership with community service providers

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