Evidence In Action

March 22, 2013

Profiling knowledge generation, exchange, & implementation activities

Reconnecting Disconnections: Research Helps Prevent Homelessness in London

What is the initiative?

When a person with “no fixed address” is being released from hospital, unit staff typically do their best to find the person a place to go. Since it can take weeks to locate housing and receive rent money from Ontario Works (OW) or the Ontario Disability Support Program (ODSP), many of these individuals end up having to go to a shelter when they leave the hospital.

But Dr. Cheryl Forchuk and her team are trying to do things differently. They recently designed an intervention to reduce the number of people who are discharged from psychiatric units to a shelter or the streets in London, Ontario.

The initiative includes all individuals who have no home to go to after they leave an acute psychiatric unit or a specialized psychiatric hospital in London. It changes normal policies related to housing and start-up fees for individuals who receive income support from OW or disability support from ODSP.

More specifically, it offers the individual the option of meeting with a housing advocate from the Canadian Mental Health Association (CMHA), who has access from the unit to a database of all available rental housing and group homes in London. Also, an OW worker is available to the psychiatric unit three days a week, with direct computer access to the OW database.

Because these services are offered while clients are still in the hospital, many of them can find a home, avoid being evicted, and/or receive a check for first and last months’ rent before they leave the hospital.

Dr. Cheryl Forchuk

How did the initiative come about?

Cheryl is a member of a London community–university research alliance, and during one of its meetings, representatives from local shelters mentioned a growing problem: people were going directly from the hospital psychiatric ward to the shelters. The alliance decided to act and began to look at available options.

Unfortunately, when Cheryl's team searched the research literature, they didn't find any studies that looked at discharges to homelessness or interventions aimed at fixing the problem.

"There was nothing," she remembers. "You would assume it was a myth."

To find out the extent of the problem in London, the team conducted a study. They found that 194 people had been discharged from psychiatric wards to a shelter or the streets in 2002.

Addressing the problem

The team designed a pilot project with a two-pronged approach that would give clients access to:

1. A CMHA housing advocate who would help them find a new home while they were still in the hospital, and
2. Community start-up funds from OW or ODSP. If they were in the intervention group, the team called a senior manager at one of these agencies and the process was speeded up so clients received the funds in no more than 24 hours.

The team enrolled 14 inpatients who were about to be discharged from one of the psychiatric wards. These individuals had lost their housing within a month of going into hospital but had never been homeless before.

Of the overall group, the researchers selected seven at random who would have access to income and housing support right in the psychiatric unit. The remainder would receive "usual care," which meant a psychiatric unit staff did their best to find them housing before their release but didn't have access to the fast support from OW/ODSP and the CMHA representative in the unit.

Pilot results

The results of the pilot project showed that six months after their release, all the people in the intervention group were still housed, while six of the people in the "usual care" group were homeless (the only one who was not homeless had entered the sex trade to avoid being homeless).

Based on these results, Cheryl and her team decided to stop randomizing individuals to "usual care." For phase 2 of their project, they offered the intervention to everyone in the acute psychiatric ward of a general hospital in London. Phase 3 followed, and included individuals in a specialized tertiary care psychiatric hospital in London.

Phase 1 had included phoning supervisors at the income support agencies (OW/ODSP), but this was not feasible as an ongoing intervention. So for phases 2 and 3, there was a direct electronic link to the OW database available at the hospitals, which the OW staff, who were available three times a week, could access directly from the ward. This made it possible to get immediate approvals for community start-up funds and/or first and last month's rent, or to prevent evictions by paying rent or utilitities that were late.

What is the initiative contributing to our knowledge?

When the research team looked at the outcome of phase 2 and phase 3, they found that 15 individuals were referred to a shelter from a psychiatric unit in the city of London in 2008 (after the intervention was started) compared with 194 in 2002 (before the intervention).

A total of 243 people accessed the service in 2008-2009. Of these, 92.5% were in imminent danger of being discharged with no home to go to (that is, they had a near discharge date and no home). All but three found affordable, permanent or temporary housing and received personal support services through the intervention.

What is the perspective of clients?

"People in our focus groups from an earlier study were saying that things were ripped away from them," explained Cheryl. "They were losing control. When we were going through the data, the descriptions reminded us of a tornado.

"When you look at the studies and the problem of being discharged to homelessness, you see issues that are systems-related and person-related," she added.

"The assumption in practice is often that the problem is person-related. But we randomized these people, and we got a black and white response. The only thing we changed is the system. The tornado is the system—the response by society," she added.

Those clients who participated in the intervention said more money is needed for start-up costs, clothing allowance, and school supplies, and there needs to be more benefits for individuals receiving government assistance. Many clients also said the wait times for subsidized housing were too long.

Some issues raised about implementation are that the space for the office where this intervention is provided needs to be more accessible and visible, and that brochures and posters should advertise the service and be placed in elevators at the tertiary hospital and on wards at both sites. Also, the housing advocate, income support staff, and ward staff need to communicate more regularly.

What is the impact on the mental health and addiction system?

The cost to have CMHA staff on the wards for three days a week is about $42,000 per year and about $5,300 to set up the service unit. This cost

doesn't include the hospital's in-kind contributions, such as office space, computer set-up and access, telephone, parking, and security clearance to access the hospital network.

The cost to run the program is $3,917 each month, which is less that the $5,040 monthly cost of one family of four that becomes homeless.

According to an earlier study that Cheryl and her team conducted, if these individuals had become homeless, they would have been on the street for at least six months, at a cost to the shelter system of at least $283,500. And this figure doesn't include the extra cost of any dependents that also would have become homeless.

There were 36 children and one pregnant woman who were at imminent risk of homelessness during the study period. All of these families remained housed thanks to the program.

What is the impact on clinical practice?

Those who run the shelters are happy that fewer people are being sent to them from psychiatric units, Cheryl said. But they've noted that, while psychiatric discharges decreased, they continue to see clients coming from hospitals. During the study period, there were 10 referrals to shelters from emergency departments and 96 from medical wards.

What are the next steps?

The two hospitals involved in the studies continue to use these interventions but at a more basic level and without designated funds. The psychiatric units still have the direct line to the OW database that the OW workers can access.

"This is an unusual partnership in that healthcare providers and income providers are often not used to working together to find solutions," Cheryl explained.

Also, the CMHA housing advocate is available three days a week, but split between the two hospitals. So access to the database of available housing in the city and surrounding area is only available when this individual is on the ward.

This project shows the benefit of linking housing support and income support in a hospital setting to reduce homelessness.

"We have to have a broader understanding of who our partners are," Cheryl noted. "Our consumers are our partners, and [workers in the] housing system and income support system are our partners. We're all in this together. And we need to make sure we'll address the solution and reconnect the disconnections."

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If you would like to share evidence with her or to receive additional information about the intervention, please contact her at cforchuk@uwo.ca or 519-685-8500 ext. 77034.

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