Canadian Homelessness Research Network

the homeless hub

NFA Project

London, Ontario

PROGRAM TYPE: Intervention to Prevent Psychiatric Discharge to Homelessness

Mental health problems affect approximately one in five Canadians (Wilton, 2004). Traumatic life events, lack of social support and lack of coping strategies mean that many people will suffer from depression, anxiety, personality disorders and psychotic disorders in their lifetime. These issues can further compromise peoples' ability to deal with life's challenges, and a lack of housing can worsen the problem. The same life circumstances that contribute to homelessness (job loss, family conflict and other traumas) can also contribute to mental health problems. For those who have mental health problems and who are also homeless, it would understandably be difficult to enjoy life and deal with challenges when you do not know where you are going to sleep at night or when you do not know where your next meal is going to come from.

Although there is a lack of standardized measures used in the homeless sector to accurately identify the number of homeless people who also have mental health problems, a number of studies suggest that people with mental illness and/or addictions are over-represented among the homeless. Among the research is a 1997 Toronto study of 300 shelter users that found that two-thirds of respondents reported a lifetime diagnosis of mental illness (Goering et al., 2002) In Ottawa, 33 per cent of a sample of the adult street population self-reported mental health difficulties. Of these, 20 per cent reported depression (Farrell et al., 2001). Toronto's Pathways into Homelessness Project also found that 29 per cent of shelter users met criteria for anti-social personality disorder, often in addition to another diagnosis such as depression, post-traumatic stress disorder (PTSD) or psychotic disorder (Mental Health Policy Research Group, 1997).

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KEY MESSAGES

- SERVICE INTEGRATION - RECONNECT HOUSING, INCOME AND HEALTH SERVICES
- UNDERSTANDING DIFFERENT CLIENTS' NEEDS
- USE OF TECHNOLOGY
- ADDRESS THE CORE ISSUE: HOUSING
- ACCESSIBILITY

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In addition to the personal circumstances that can lead to poverty, many people find themselves homeless after being in the care of public institutions and systems, including corrections, foster care and health facilities. Beginning in the 1970s with federal policy reforms that saw a shift in mental health care from hospitals to the community, and a gradual decline in supports for people with mental health or addiction problems, systems have played a significant role in contributing to the problem. A lack of integration between sectors like housing, corrections, health and child protection services means that housing is outside of the mandate of these systems, and the lack of a national policy on housing and mental health further contributes to this risk. Canada has no national housing strategy, and until a recent Mental Health Commission document entitled *Changing Directions, Changing Lives: The First Mental Health Strategy for Canada* (2012), we also lacked a national mental health strategy. Availability of affordable housing also decreased during the 1980s and 1990s and responsibility for social housing shifted from federal to provincial and/or municipal governments. Over the past decade rates of income support have also been reduced.

In some cases, people are discharged from hospitals, prisons, and children's aid services, without a support network and/or with no fixed address (NFA). They then enter the homeless system and can become chronically homeless, often returning to the system from which they were recently discharged.

People who are housed can risk losing housing as a result of receiving inpatient psychiatric care. Some patients are already homeless when they enter hospital, and systems are not currently in place to ensure that they are being discharged to housing, let alone housing that addresses their needs and can help them permanently avoid homelessness. Even for those who have homes to go back to, the initial period after leaving hospital can be a time when maintaining their wellbeing is challenging.

In order to prevent homelessness among the population that is also struggling with mental health issues, it is critical to address the systemic issues that have contributed to the growing problem. There was growing concern among the local shelters about the numbers of people coming directly from hospital in 2002. According to baseline shelter data, in London, Ontario, discharge from psychiatric wards to shelters or NFA occurred at least 194 times in 2002, and discharge from hospital psychiatric wards to shelters or NFA occurred at least 167 times according to hospital data. As a result, a pilot project was created to provide immediate support to find housing, as well as secure income supports in order to maintain housing for people facing mental health challenges. The pilot intervention was designed to prevent first-time homelessness among individuals who were psychiatrically stable but about to be discharged from hospital without housing. This was then expanded to provide support to anyone at risk of discharge to homelessness, regardless of prior history of homelessness.

"Preventing homelessness is crucial in the fight to end homelessness. Without a focus on prevention, our success in moving people out of homelessness will be compromised by those falling in. We would simply be 'bailing the leaking boat' of homelessness."

(Philip F. Mangano, Executive Director of the United States Interagency Council on Homelessness)

PROGRAM DESCRIPTION

The project took place in two hospitals in London, Ontario. At one hospital, clients could access the project staff three times per week between 9am-12pm. Clients at the second hospital could access the project staff three times per week between 1-4pm. Appointments could be made or individuals could drop in during those hours to access two types of support: housing and income. The intervention was implemented in three phases:

Phase 1: Intervention in two hospitals with psychiatric wards

Phase 1 consisted of modifying existing policies related to housing and start-up fees for a select group of income support recipients from both Ontario Works (OW) and Ontario Disability Support Program (ODSP). This included providing a random group of seven clients rapid access to community start-up funds (i.e., for first and last months' rent), and fast-tracking them through a direct connection to income support including OW/ODSP, and immediate access to a housing advocate to help find housing. Another group of seven random people received care as usual. As mentioned, these 14 people had no history of homelessness prior to losing housing with the current admission. They also had stable income (Ontario Works or Ontario Disability Support), and were psychiatrically stable upon discharge.

The seven participants who received this additional assistance were still housed six months later, whereas six of the seven of those who received usual care were still homeless six months post-discharge. The only person to avoid homelessness was recruited into the sex trade on the way into the shelter. The pilot team concluded that if even very stable clients with no prior history of homelessness could not avoid homelessness without the intervention, other more vulnerable clients would certainly be unable to do so (Forchuk et al., 2007). The phase one pilot was concluded and researchers soon began phase two, which included all London psychiatric clients at risk of being discharged to no fixed address.

Phase 2: Intervention for all acute psychiatric patients within a general hospital

For Phase 2, Ontario Works (OW) linked a staff person directly to an acute care psychiatric ward within a general hospital in London, Ontario. This person provided assistance to any OW applicants and recipients on the ward in need of income and housing support. There was a direct computer link from the ward to the OW database, which meant appropriate action (e.g. community start up funds or paying rent that was in arrears to prevent eviction) could occur immediately. Ontario Disability Support Program (ODSP) participated by identifying a key contact for the project. A Canadian Mental Health Association (CMHA) housing advocate assisted clients in finding housing. The CMHA worker had access to community housing resources, referral applications for individual support including group homes and a computer database listing current available rental housing in London.

Phase 3: Intervention for all patients within a specialized tertiary care psychiatric hospital

Phase 3 took place in a tertiary care psychiatric hospital in London, Ontario and implemented the same services as Phase 2. The Ontario Works (OW) staff person provided assistance to OW applicants and recipients on the ward in need of income and housing support. A direct computer link to the OW database was provided at the hospital so fund transfers could occur immediately. Ontario Disability Support Program (ODSP) identified a key contact for the project. A Canadian Mental Health Association (CMHA) housing advocate had access to community housing resources, referral applications, and a computer database of current available rental housing in London, and assisted clients in finding housing. Phase 3 was unique in that tertiary care patients required more extensive support from the housing advocate. The housing advocate contacted housing options on behalf of some clients and visited some apartments with them as well. The housing advocate also checked where clients were on subsidized housing waiting lists and, for those not yet on the list, helped them fill out necessary forms.

EVIDENCE OF EFFECTIVENESS

The research team (researchers from the University of Western Ontario, community members, and community agencies) collected data to compare the effects of offering the income and housing supports to psychiatric clients at risk of homelessness. The design for phases 2 and 3 was a program evaluation design rather than a randomized control. Since the control subjects had fared so poorly in phase 1 it was considered unethical to continue to withhold the intervention. They also conducted a cost-benefit analysis.

Findings

14 people were enrolled in the Phase 1 pilot project. Six months after discharge from hospital:

- The 7 who were randomly assigned the intervention (rapid access to income and housing support) were still housed while 6 of the 7 who received usual care were still homeless (Forchuk, MacClure et al., 2008).

Forchuk et al., (in press) expanded on these results by testing the intervention in a larger sample of 251 individuals. According to shelter data:

- The intervention reduced the number of individuals discharged to homelessness or NFA from 194 in 2002 (the baseline for the study) to 15 in 2008 according to the shelter data (the year the intervention was implemented).
- The number of clients discharged from tertiary and acute care to homelessness or NFA also dropped from 167 in 2002 to 132 in 2008 according the hospital data. However, the tracking improved by 2008 and the detoxification centre was moved to one of the shelters, so the actual drop is likely larger.
- The results show that of those accessing the intervention, 92.5% of individuals were at imminent risk of homelessness, and all but 3 of 251were attached to affordable permanent or temporary accommodation.

Cost-Benefit Analysis

The costs of implementing and maintaining the intervention were less than the increased medical costs associated with homelessness and the cost of housing individuals in shelters. Specifically, the total cost to implement the intervention on a hospital ward for 3 days/week ($3,917 per month) was less than the monthly cost of keeping 4 individuals homeless ($5,200) (London Ontario Community and Protective Services Committee Meeting, 2008).

USER PERSPECTIVE

Sixty-six clients completed in-depth interviews at the time of their discharge, and again one and three months post-discharge. The interviews included quantitative instruments and open-ended questions.

Additionally, a total of 31 focus groups were held with 75 individuals and staff (i.e. hospital staff, income support staff, housing advocacy staff). The focus groups were held at each site a month after implementation of the intervention and again six months post-implementation. Clients reported that:

- They were very happy with the service they received. They were happy to be able to find housing that was safe and affordable. Clients liked the promptness of the service and how quickly appointments were set up with welfare workers to address OW issues.
- They were very pleased with the housing advocate staff member and described her as helpful, friendly, fast, efficient, tolerant, courteous, understanding, resourceful, positive, knowledgeable, compassionate, and willing to listen and help. After their visits, clients felt hopeful and optimistic about their housing prospects.
- The service has given them motivation to start looking for housing, and to pursue financial support options. The housing advocate has relieved clients' stress and has helped those who need to find somewhere to live after being discharged from hospital. Clients also reported that they have seen how the service has helped others on the ward.
- One client expressed that without the housing advocate she "wouldn't have known where to go."

Staff Perceptions of the Intervention

Hospital staff reported that the intervention:

- Was a positive influence for their clients
- Influenced other aspects of clients' lives, as housing was central to their well-being and peace of mind
- Increased clients' ability to participate and actively engage in their care
- Increased clients' level of responsibility and independence
- Increased efficiency of the transition into the community, which for this population is most important. Discharge planning is initiated upon admission and a plan can be laid out based on these services to ensure prevention of discharge to no fixed address
- Had a positive influence on the clients' treatment while in hospital (Forchuk et al., 2008)

RESOURCES & ORGANIZATIONAL MODEL

Staffing

At each hospital there was one Community Support Coordinator from the CMHA Housing Advocacy Program, and one OW Case Worker who provided services to both hospitals.

Housing Advocate

The CMHA Community Support Coordinator utilized the CMHA housing database to assist in accessing available housing listings and assisted individuals in contacting landlords, arranging viewings, and completing applications. The Coordinator then worked with hospital staff in order to prepare clients' discharge plans, provide updates, and also to identify potential transitional challenges, for example securing finances, waiting for applications to be approved, or waiting lists and availability of units.

Income Support Staff

The Ontario Works Case Manager attended each hospital to complete or review clients' applications. The laptop was set up to accommodate access to the OW online system, as well as to print required documentation. The OW worker was able to arrange approval for financial support as part of the discharge planning.

CMHA provided follow up for transition from hospital to the community, including obtaining basic needs, referrals for required support through other CMHA programs or additional community service providers.

Partnerships

Partnerships were critical in ensuring the success of the intervention. The partnership between the community agencies and staff (CMHA, OW, ODSP, shelter staff, community staff) and hospital staff (nurses, social workers) was key to the implementation of the project and became stronger during the process.

Hospital Referral Sources

London Health Science Centre & Regional Mental Health Care London

The hospitals provided baseline data as to the rate of discharge to homelessness prior to the intervention. They were also the site of recruitment and data collection for clients, as clients were residing in the hospitals prior to discharge. The cooperation of hospital administration and staff was very important to ensure data was collected, clients were identified for participation, and feedback as to the success of the intervention was provided.

Income Support Providers

Ontario Works and Ontario Disability Support Program

The current intervention would not have been successful if not for partnership with OW and ODSP. Housing support and available payment was necessary for clients to secure housing and avoid being discharged to homelessness. The cooperation and support of OW and ODSP was required in order to secure these supports for clients.

Community Mental Health

The local branch of the Canadian Mental Health Association was key as a partner. They had experience with housing support and provided this to the participants. They also had developed a large database of all available housing within the city, which was an important resource.

The City of London

Staff from the City of London were key. This was not only the administration of Ontario Works local office but also the Social Services Department as a whole. The City provided the initial funding to pilot the intervention, which was instrumental to the larger full scale study. The City has staff directly working with a homelessness portfolio and the priority within the city facilitated collaboration on this project.

The Shelters

The homeless shelter staff first identified the problem, and the homeless shelters provided information from their administrative data to assess the baseline situation, as well as the situation after the new intervention was in place.

Research and the Community

Staff initially worked on the identification and early intervention strategies through a Community University Research Alliance (CURA) funded by SSHRC (Social Sciences and Humanities Research Council of Canada). This was a partnership from the identification and validation of the problem, through to developing and testing implementation strategies.

Cost

The City of London provided financial support for the delivery of the intervention at both sites. The participating agencies reported that it costs approximately $42,000 per year to have staff on the ward for 3 days a week. It also costs an additional $5,300 (approximately) to set up the service unit on the hospital ward. This cost does not account for the in-kind contributions of the hospital, which include office space, computer set-up and access, telephone, parking, and security clearance to access the hospital network.

Funding to evaluate Phase 2 was received from the Canadian Institutes of Health Research and funding to evaluate Phase 3 was received from the Homelessness Partnering Secretariat.

KEY MESSAGES

SERVICE INTEGRATION - RECONNECT HOUSING, INCOME AND HEALTH SERVICES

Nationally there is a lack of affordable housing. For people living on low incomes who also have mental health problems, the situation is even worse. Everyone's health and wellbeing can be strongly influenced by a variety of social factors including housing and income, however at both the provincial and federal levels, housing and employment services operate independently, making collaboration and funding between sectors difficult. Disconnect among the services leads to disconnect of care, which means that peoples' basic needs are not met and they become at risk of homelessness. This project has demonstrated that homelessness can be reduced by connecting housing support, income support and psychiatric care services in order to adequately meet the needs of clients with mental health problems who are at risk of becoming homeless.

The level of income supports available through public assistance makes it difficult for anyone relying on them to acquire and keep appropriate housing. This new intervention is restricted by these larger system problems. However, despite these problems, this intervention can help at the local level. The results of this pilot project support the notion that systemic issues contribute to and maintain homelessness for some people and that system solutions are needed as urgently as individual ones.

UNDERSTANDING DIFFERENT CLIENTS' NEEDS

Clients' ability to access services and follow up on housing can depend on the extent of their psychiatric condition. Clients in acute care were more likely general welfare recipients, while clients in tertiary care were more likely on disability support. Therefore different systems needed to be accessed at the different sites.

Clients in acute care were more self-directed, came without a referral and easily followed up on suggestions for potential housing. Shorter lengths of stay for clients in acute care meant that the drop-in service was important. More hours of service are needed in order to be accessible if all clients are to have the ability to access the service prior to discharge. Not all acute care clients could be seen with only three half days per week due to the short length of stay. In particular, some clients who had been discharged before they could be seen came in on weekends.

Clients in tertiary care needed more direction from the housing advocate and follow-up from ward staff.
Less time was available for "drop-ins" since staff spent more time off site assisting clients. In tertiary care, the wards are widely dispersed throughout the entire hospital and since clients are also less well and less independent, it was important for the service to connect directly with the wards for referrals each week.

USE OF TECHNOLOGY

Access to databases with housing and income support data and information was key to making this service possible. To encourage similar projects that include rapid access to information through computer linkages, the province needs to develop flexible and secure means of accessing income support databases off-site.

ADDRESS THE CORE ISSUE: HOUSING

Homelessness brings with it many worries and fears; without the security of a home, life can be stressful. First and foremost is the lack of a safe place to sleep and live. The staff perceive that having this service has relieved the pressure and anxiety on clients because it gives them options, as well as hope that they will have some place to go upon discharge. With this major issue taken care of, the moods of clients have improved, and in turn, they are willing and able to focus on their treatment.

This service has also brought awareness to staff about the real reasons someone might be in hospital. A specific example mentioned by a focus group participant involved a patient who acted out in hopes to extend her hospital stay because she did not have housing. After the client accessed the housing advocate service, she had housing arranged in 24 hours. Her attitude completely changed towards treatment and discharge. In this instance the psychiatric issue was not necessarily the leading problem, but rather it was a financial/housing problem that led to extended hospital stay.

ACCESSIBILITY

Rather than patients having to travel to another service to sort out their housing needs, the housing advocate was available for patients on the ward, in a safe and familiar environment. This increase in accessibility reduces one of the barriers to accessing housing. A client who is suicidal cannot leave the hospital to visit the welfare office, however this is often their only option to access housing or help with income. The office needed to be accessible and highly visible. Also, brochures and posters were needed to advertise the service and were in elevators at the tertiary hospital and on wards at both sites. The posters required frequent replacements. The accessibility of offering multiple services on-site was also expressed by staff as having a great influence on the clients' ability to participate and actively engage in their care.

CONCLUSION

Discharge from a psychiatric ward to homelessness is an example of one of the systemic issues that contributes to homelessness. Overall, the data revealed the positive effect the intervention had on preventing homelessness and achieving housing for individuals being discharged from psychiatric wards. The data also revealed the success of and need for service implementation that crosses multiple service sectors to achieve the prevention of homelessness from psychiatric wards.

Staff expressed the success of the intervention as it relates to efficient transition into the community, which for this population is most important. Discharge planning is initiated upon admission and a plan can be laid out based on these services to ensure prevention of discharge to no fixed address.

The intervention has the potential to decrease the costs associated with homelessness and is therefore of interest to policy makers and governments who are responsible for preventing homelessness and reducing public costs. Similar strategies could be implemented for other key transition points including people fleeing situations of domestic violence, leaving jail, visiting the emergency room, leaving children's aid custody, and non-psychiatric hospital discharges. Other key areas in the health sector must be explored. For example, ER and medical wards were found to also frequently discharge mental health clients to no fixed address.

This intervention may be a new model that can ensure that no one is discharged from an institution with no place to live and could potentially prevent homelessness for all persons discharged from psychiatric care, not just those in London, Ontario.

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