Preventing Psychiatric Discharge to Homelessness

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ABSTRACT

The present study assessed the effects of an intervention that was designed to provide on-site, pre-discharge housing assistance for psychiatric clients. Participants included clients from acute (n = 219) and tertiary (n = 32) care hospital sites. Data were collected from hospital and shelter databases. Results revealed that in the majority of cases, the intervention reduced the number of individuals discharged to homelessness or no fixed address. In addition, the costs of implementing and maintaining the intervention were less than the increased medical costs associated with homelessness and housing individuals in shelters.

Keywords: homelessness, prevention, housing intervention, collaborative approaches

RÉSUMÉ

La présente étude a évalué les effets d'une intervention qui a été conçu pour fournir aux clients et clientes psychiatriques de l'aide au logement sur-place avant le congé. Les participants et participantes comprenaient des clients et clientes des sites hospitaliers de soins actifs (n = 219) et de soins tertiaires (n = 32). Les données ont été recueillies des bases de données des hôpitaux et des abris. Les résultats ont révélé que dans la majorité des cas, l'intervention a réduit le nombre d'individus rejetés dans le sans-abrisme ou sans domicile fixe. En outre, les coûts de la mise en œuvre et du maintien de l'intervention étaient moins que l'augmentation des coûts médicaux liés aux personnes sans-abri et au logement dans les abris.

Mots clés: sans-abrisme, prévention, intervention axée sur le logement, approches coopératives

It has been estimated that 20% of people in Canada will suffer from a mental illness at some point during their lives (Wilton, 2004). People with mental illness are consistently overrepresented among the homeless population, and psychiatric illness is a common risk factor for homelessness (Bonin, Fournier, & Blais, 2009; Eynan et al., 2002; Koegel, Burnam, & Baumhol, 1996; Kuno, Rothbard, Avery, & Culhane, 2000; Morrell-Bellai, Goering, & Boydell, 2000; Robertson, 1992; Steinhaus, Harley, & Rogers, 2004; Sullivan, Burnam, & Koegel, 2000). Indeed, in a Canadian sample of 300 adult users of homeless shelters, Goering, Tolomiczenko, Sheldon, Boydell, and Wasylenki (2002) found that 67% of their participants had received a diagnosis of mental illness at some point in their lives. Similarly, Mojtabai (2005) found that 56% of a national sample of 2,974 homeless individuals in the United States met the National Survey of Homeless Assistance Providers and Clients (NSHAPC) broad criteria for mental illness.

The difficulties involved with not having access to stable housing have many unfortunate consequences for people who have a psychiatric diagnosis. For example, in Canadian and U.S. studies, homelessness was found to be related to a large number of personal, physical, and psychological issues such as depression, aggressiveness, antisocial problems, criminal activity, legal problems, violence/danger to others, family problems and substance abuse (Fischer, Shinn, Shrout, & Tsemberis, 2008; Forchuk, Brown, Schofield, & Jensen, 2008; Lauber, Lay, & Rossler, 2006; Stein & Gelberg, 1997). Homelessness is also linked to physical health issues such as an increased risk for infection, musculoskeletal disorders, HIV, flu, diabetes, and asthma (Forchuk, Brown et al., 2008; O'Connell 2004; Stein & Gelberg, 1997). When appropriate supports are not in place, homeless individuals can also place an unnecessary burden on health care systems through their increased use of hospital and emergency room services (O'Toole, Gibbon, Hanusa, & Fine, 1999; Stein &

Gelberg, 1997; Weinreb, Goldberg, & Perloff, 1998). In their examination of 439 people in Montreal and Quebec City who met *DSM-IV* criteria for an affective or psychotic disorder, Bonin, Fournier, and Blais (2007) found that even in the absence of economic barriers to health care, individuals who live in poverty still experience significant barriers to obtaining proper mental health care. In fact, research suggests that for people who have had a psychiatric illness, getting, losing and keeping housing is as difficult to experience as it is for someone who has lost their home to a tornado, and must then attempt to put their lives back together (Forchuk, Ward-Griffin, Csiernik, & Turner, 2006).

The issue of homelessness among individuals with mental illness becomes especially disconcerting when the time comes for hospital discharge. Research consistently shows that effective discharge planning is crucial in preventing homelessness (Backer, Howard, & Moran, 2007). Following psychiatric treatment and discharge, however, individuals with mental illness often perceive their housing needs as being left unmet (Drury, 2008). Recent research also shows that the first days and weeks following discharge are particularly high-risk periods, with 43% of psychiatric client suicides occurring within the first month post-discharge (Hunt et al., 2009). In addition, it is now commonly believed that the obstacles to securing stable housing are most likely not due to the effects of psychiatric illness on the capacity for daily life, but rather the effects of prejudice, poverty, and a lack of available affordable housing upon discharge (Draine, Salzer, Culhane, & Hadley, 2002; Drake & Wallach, 1999; Forchuk, Joplin, et al., 2007; Forchuk, MacClure, et al., 2008; Koegel et al., 1996; McChesney, 1990).

In Canadian and U.S. studies, people who have been diagnosed with psychiatric illness consistently indicate that they prefer independent living (Forchuk, Nelson, et al., 2006; Piat et al., 2008; Tsai, Bond, Salyers, Godfrey, & Davis, 2010). For example, in their interviews with 12 individuals with a history of homelessness and mental illness from Hamilton, Ontario, Kirkpatrick and Byrne (2009) found that permanent housing allowed participants to move on from homelessness, reconnect with their social networks, and plan for the future. Indeed, providing stable housing for psychiatric clients post-discharge is consistently associated with beneficial results such as reduced instances of substance abuse, lower rates of hospital use, higher quality of life, and several other positive mental health outcomes (see Forchuk, MacClure, et al., 2008 for a review; see also Kertesz & Weiner, 2009; Kirkpatrick & Byrne, 2009; Kyle & Dunn, 2008; Nelson, Aubry, & LaFrance, 2007).

A variety of studies have also indicated that reliable housing support encourages stable housing and prevents homelessness and re-admission to psychiatric institutions (Shern et al., 1997; Goldfinger et al., 1999). For example, Lennon, McAllister, Kuang, & Herman (2005) found that an intervention consisting of strengthening people's ties to services, family and friends, and providing them with practical and emotional support, was effective in contributing to fewer periods of homelessness. In addition, Nelson, Clarke, Febbraro, and Hatzipantelis (2005) interviewed 20 formerly homeless individuals in Toronto and Hamilton, Ontario, who had experience with mental illness, and found that these individuals reported more stability in their lives and relationships after entering supportive housing.

Recent research also suggests that offering housing-first programs, which provide permanent housing upon discharge that is not dependent on treatment compliance, results in lower rates of substance abuse and higher rates of retention in mental health programs than treatment-first (i.e. standard care) programs (Padgett, Gulcur, & Tsemberis, 2006; Padgett, Stanhope, Henwood, & Stefancic, 2011; Pearson, Montgomery, & Locke,

2009). Despite the obvious benefits of providing housing to psychiatric clients, this population faces many obstacles when it comes to obtaining stable housing, particularly post-discharge (Carling, 1993; Tsemberis & Eisenberg, 2000).

In their recent review of supported housing for people with severe mental disorders, Chilvers, Macdonald, and Hayes (2006) suggested that the literature on the link between housing and mental health has many gaps and that more research needs to be done in this area using randomized trials. Similarly, in their review of the effects of housing on individuals with severe mental illness, Kyle and Dunn (2008) concluded that more research is needed on this topic using larger samples, more rigorous methodology and randomized control groups. In sum, prior research suggests that housing support is necessary to prevent homelessness among psychiatric clients. However there is a paucity of methodologically sound research in this area, a finding that led to the current project.

Pilot Project

Prior work by Forchuk, Russell, Kingston-MacClure, Turner, and Dill (2006) revealed that in London, Ontario, at least 194 people are discharged directly from psychiatric wards to shelters or the streets each year. Based on this data, Forchuk, MacClure, et al. (2008) designed a pilot study to address this issue. The pilot project consisted of an intervention that involved changing standard policies related to housing and start-up fees for a select group of income support recipients from both the general income support program, Ontario Works (OW), and the disability support program, Ontario Disability Support Program (ODSP). Individuals on the psychiatric ward who were psychiatrically stable, had lost their housing within the month of admission or during the hospitalization, and were about to be discharged without housing were eligible to participate in the study. Eligible participants were randomized into either an intervention group or a usual care group. In the intervention group, a manager at OW or ODSP (depending on the source of income) was contacted to fast track the community start-up so that first and last month's rent could be paid; this meant that a cheque was generally available within the day. In addition, a housing advocate would see the participant within the day to assist in finding housing.

This intervention was a resounding success with 100% of the seven participants who received the intervention still housed 3 and 6 months later, compared to six of the seven control participants who were still homeless 6 months later. The seventh escaped homelessness by being recruited into the sex trade. Despite the small sample, the differences between groups were statistically significant ($p < 0.01$). Forchuk, MacClure, et al. (2008) concluded that if psychologically stable clients could not avoid homelessness without the intervention, then more vulnerable clients would certainly be unable to do so.

Purpose of the Present Study

We believe that the intervention introduced by Forchuk, MacClure, et al. (2008) may be a new best-practice model that could potentially prevent homelessness for all persons discharged from psychiatric care, not just those in London, Ontario. Forchuk, MacClure, et al.'s (2008) results were promising; however, careful evaluation using a larger sample is required to encourage more widespread implementation. The present study addresses this gap by implementing Forchuk, MacClure, et al.'s (2008) intervention using a larger sample.

Hypotheses

Specific hypotheses included:

1. The intervention will reduce homelessness for individuals discharged from hospital, and clients accessing the service will acquire housing. (H1)
2. The costs of implementing and maintaining the intervention will be less than the increased medical costs associated with homelessness and housing individuals in shelters. (H2)

METHOD

Participants

All London, Ontario psychiatric clients at risk of being discharged to shelters or no fixed address (NFA) were eligible to participate. In total, 112 men and 107 women accessed the intervention from the acute care hospital, the majority of whom (76%) were between the ages of 25 and 54. Those accessing the intervention from the tertiary care hospital included 16 men and 16 women, the majority of whom (81%) were between the ages of 25 and 54. Participants were clients (in-patients or out-patients) at either hospital, and they could simply "drop in" to the service without a referral or appointment. A poster was available on the office door noting the times that staff was available. This information was also included on brochures that were available on the wards in several prominent locations including bulletin boards and common rooms. Some participants were also verbally encouraged by staff members to attend if housing was identified as an issue. Letters of information regarding the study were distributed to clients accessing the service.

Data Collection and Analysis

Administrative data. To determine whether the intervention was successful at reducing discharges, administrative data gathered from hospitals and shelters were used to compare the rate of discharge to shelters or NFA in 2008 to the 2002 baseline data collected by Forchuk, Russell, et al. (2006). For the hospitals, existing discharge data regarding addresses were used. For shelters, intake forms were used to determine how many clients came directly from hospital. Both of these methods likely underestimated the incidence of discharge to NFA but did provide a conservative estimate of the numbers of people coming directly from psychiatric wards into homelessness. Administrative data on the clients who accessed the intervention in 2008 were also used to understand who was utilizing the service as well as the cost of the intervention.

The Intervention

The intervention consisted of two sources of support: Assistance from an Ontario Works worker on site at the hospitals with direct computer access to the OW database, and assistance in finding housing from a housing advocate with access to all available housing in the city on a database.

Ontario Works support. A system was needed that could fast track the community start-up (i.e., money that can pay for the first and last months' rent required of landlords as well as other minor related expenses). With the usual system of support this could take a couple of weeks to process, but with the computer access

on the ward this could be provided almost instantly. OW provided a staff person who was present 3 days per week at the acute care psychiatric ward and tertiary care hospital. 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 or paying rent or utilities that were in arrears to prevent eviction) could occur immediately. In other words, rather than phoning the senior staff at the income supports office to speed up delivery of funds, this study employed an electronic means to accomplish fast service. The computer access was similar to having internet banking available at the hospital in that the OW staff could directly pay landlords or for utilities, and the transaction occurred immediately though the internet. The Ontario Disability Support Program participated by identifying a key contact person for the project who could be contacted by phone. People who were in-patients or community clients at the hospitals could drop in without prior appointment or referral during the 3 scheduled times at each hospital. If help was needed at other times, hospital staff could call the OW or ODSP staff.

Housing advocate support. A Canadian Mental Health Association (CMHA) housing advocate assisted clients in selecting and finalizing housing arrangements. The CMHA worker had access to community housing resources, referral applications for individual support including group homes, and a computer database listing and describing current available rental housing in London. Clients on the ward could see the properties on a map, see the surrounding areas, and sometimes even have internal views of the home. The housing advocate assisted clients with several types of tasks, including supporting clients to call the landlord, and at times visiting the potential housing with them. The housing advocate would also assist in setting up payments to landlords if the client wished this, reviewing lease arrangements, and helping to arrange utility payments if needed. Assistance in finding economical sources of furnishings and supplies was also sometimes required. The housing advocate support tended to be more office-based for the acute care clients and had more of an emphasis on accompanying clients to potential housing sites at the tertiary care sites.

This study was approved by the research ethics board at the University of Western Ontario and by the hospital research boards at the participating hospitals.

RESULTS

(H1): The intervention will reduce homelessness for individuals discharged from hospital, and clients accessing the service will require housing.

Table 1 summarizes the 2002 and 2008 discharge data from all sources in the present study.

Table 1
Number of Clients Discharged to Shelters or NFA in 2002 and 2008

Data Source	Year	
	2002	2008
Tertiary Care	74	9
Acute Care	93	123
Shelters	194	15

Data from Shelters

In 2002, the shelters reported 194 instances of referrals from psychiatric wards. This was not divided into acute care and tertiary care. Referrals from emergency and medical wards were not collected in 2002. In 2008, data from the shelters showed a total of 11 direct referrals to shelter from the acute care hospital and four instances of discharge from tertiary care psychiatric hospital to shelters. The instances of referrals to shelters from psychiatric wards significantly reduced from 194 to 15 according to shelter data.

Hospital Data

There were concerns that the 2002 hospital data only revealed 167 cases of discharge to homelessness while the shelters revealed 194 cases. Fortunately, the method for tracking these discharges was improved after 2002. In particular, the process of entering the admission address as the default address on the discharge form and thus underestimating the problem in the acute care site was corrected. Also, "risk of homelessness" was included on the standard assessment form (Resident Assessment Inventory, RAI) used for all clients in 2008.

However, one complication encountered in the present study was that a detoxification centre moved to one of the homeless shelters between the two data collection points. Consequently some discharges to a shelter address were not really to homelessness, but rather to an appropriate detoxification service. It was not possible to separate the detoxification clients from the shelter clients on the database. One must therefore be cautious in noting changes in trends, as the 2008 data were less likely to miss as many cases and includes some clients referred to detoxification. Accuracy is still dependent on the client identifying they have a housing problem and thus some examples are likely missing from both time periods.

Acute care. Data from the acute care ward showed that a total of 123 individuals were discharged from the acute care ward to shelters or NFA in 2008 out of a total of 1740 discharges. Of these, seven were discharged to the shelter that also housed the detoxification centre in 2008. This compares to the 2002 data with 93 discharges to homelessness out of a total of 1588 discharges. Based on the total number of discharges from the acute care hospital, there was a 1% increase in discharge from the hospital to the shelters (from approximately 6% to 7%) if both data sets were accurate. It appears that there was still a group of people at risk from the acute care site who were not reached by the service. There were only three individuals who accessed the intervention service who became homeless after discharge; these three people were homeless at the time of admission.

Tertiary care. Administrative data from the tertiary care hospital indicates that nine individuals were discharged from the hospital to NFA in 2008. This includes two individuals who were discharged against medical advice. These particular clients were documented as NFA since the address was unknown, but may not necessarily have been homeless. Only two of the individuals discharged to NFA were homeless at the time of admission. These numbers reflect a significant reduction in the instances of discharge to NFA from 74 instances in 2002 down to nine instances in 2008. Based on the total number of discharges from the psychiatric hospital, there was a significant reduction in discharge numbers from the hospital to the shelters from 7% of all discharges to 1%.

Housing Advocate Data

A total of 251 unique individuals accessed the service in 2008–9. Results show that 92.5% of individuals who were at imminent risk of homelessness were attached to affordable permanent or temporary accommodation. In addition, 100% of individuals at risk of homelessness who accessed the service were provided personal support services. In total, seven individuals relocated to another area and 17 individuals dropped out of the intervention from both hospital sites. Therefore, H1 was supported as those who accessed the service were attached to affordable, stable transitional or permanent accommodation. In looking at the housing advocate data beside the acute care data it appears that if clients accessed the service they avoided homelessness. However, not all individuals at risk accessed the service.

(H2): The costs of implementing and maintaining the intervention will be less than the increased medical costs associated with homelessness and housing individuals in shelters.

To address this hypothesis we used administrative data regarding the cost of the housing advocate and social service worker available to the wards. We then compared this to the cost of shelter support and to the increase in health service use reported in the literature for the homeless population. According to figures calculated for the present study based on costs from the local agencies involved in the intervention, it costs approximately $47,000 (CDN) per year to implement and run the intervention on a hospital ward for 3 days per week. This amount ($3,917 CDN per month) is less than the monthly cost associated with four people who become homeless ($5,200 CDN) (London Ontario Community and Protective Services Committee Meeting, 2008). In the present study, there were 225 people in imminent danger of homelessness who did not become homeless. According to our earlier study (Forchuk, MacClure, et al., 2008) these people would have been homeless for at least 6 months. Thus, it would have cost at least $292,500 CDN per month if these people had ended up in the shelter system (an individual cost of $1,300 per month, multiplied by the 225 people who did not become homeless). This figure does not even take into consideration the added cost of dependents who would have also been homeless. We also know that individuals who are homeless have increased health costs as reported by Forchuk, MacClure, et al. (2008). In addition, increased medical costs often occur in the form of maintaining clients in a psychiatric hospital beyond their period of recovery at a per diem rate of $681 in Canada when housing is unavailable (Institute of Health Economics, 2010). Thus, H2 was supported.

DISCUSSION

The hypotheses of this study were largely supported. According to shelter data, the intervention reduced the number of individuals discharged to homelessness or NFA from 194 to 15. The number of clients discharged from tertiary care to homelessness or NFA also dropped from 74 to nine. The only instance in which the rate of discharge to homelessness increased was for the acute care setting, where the number of clients increased from 93 to 123. It is important to note that this only represents a 1% increase based on the total number of clients discharged from acute care. As well, due to our ongoing work in this area, staff became more accurate when completing discharge data. In 2002, the default address was the same as the admission

address. In 2008, staff had to directly enter the address or lack of it. Future research should examine specific strategies for homelessness prevention that are effective in acute care settings.

The majority of clients accessing the intervention also acquired housing, with 92.5% of those who accessed the service and who were at imminent risk of homelessness being attached to affordable permanent or temporary accommodation. This high success rate is particularly relevant since those requesting the service were primarily individuals with a lower socio-economic status.

Most importantly, the costs of implementing and maintaining the intervention were less than the increased medical costs associated with homelessness and housing individuals in shelters. Specifically, the total cost to implement the intervention on a hospital ward for 3 days per week ($3,917 per month) was less than the monthly cost of four individuals who become homeless ($5,200).

In sum, the present study demonstrates the benefit of linking together housing support and income support within a hospital setting. Forchuk, Ward-Griffin, et al. (2006) argued that the large number of people with mental health problems who become homeless is related to the disconnection between housing policies, income support policies, and mental health policies. This disconnection is often invisible to the service workers who only see their own sector and may misinterpret the problem as being at the individual client level. The present study demonstrates that reconnecting these different service areas can reduce homelessness. The present findings are also consistent with prior work suggesting that one of the main obstacles to securing stable housing is the societal response to mental illness, not the psychiatric illness per se (Draine et al., 2002; Drake & Wallach, 1999; Forchuk, Ward-Griffin, et al., 2006; Koegel et al., 1996).

The current study also raises questions around the morality of discharging individuals with a psychiatric illness to shelters or no fixed address. Canada in particular stands alone in its lack of a national housing program. In fact, individuals with mental illness could be argued to experience a form of "societal abuse," in which societal structures prevent these individuals from reaching their full potential, or even their basic needs (Benbow, 2009; Forchuk, 2008). Future research should further examine the ethical issues surrounding mental illness, hospital discharge, and homelessness.

There were some limitations in this study, particularly concerning the administrative data. Because existing databases were used there were some potential inaccuracies in the data; this included the detoxification centre listed and categorized as a shelter. Many issues were corrected after the pilot project; however, some issues still remained that made complete accuracy difficult. A further limitation was that not all individuals at risk accessed the service. While there was great success for individuals who accessed the service, total numbers of those discharged to homelessness were still higher than hoped because some chose not to access the intervention. Finally, the current study is based on 2008 protocols and data. Thus, it is possible that system changes may have occurred between 2008 and the present day as well as between the baseline and final study that could have had an effect on the changes noted.

Recommendations

- It is necessary that other jurisdictions replicate the results using a strategy based on reconnecting housing, income, and health service.

- It is important that technologies such as internet access to databases to facilitate speedy service and inter-connectivity across sectors be utilized. This requires systems for secure access from multiple sites.
- Given the differences between the tertiary and acute care sites it is critical that additional community partners (i.e. ODSP) be incorporated dependent on the setting.
- 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 NFA.
- Exploring other key transition points like a departure from prison or from Children's Aid crown custody is also necessary.

CONCLUSION

The issue of discharge to homelessness for psychiatric clients is a common problem that occurs not only in London, Ontario, but also around the world (Chilvers et al., 2006; Kyle & Dunn, 2008; Padgett et al., 2006; Padgett et al., 2011; Pearson et al., 2009; Tsemberis & Eisenberg, 2000). This is not a simple matter of inadequate discharge planning but relates to the disconnection between mental health, housing, and income support policies (Forchuk, Nelson et al., 2006). Since the problems related to mental health and housing are linked to this disconnection, the solutions also need to cross sectors. This study has demonstrated that homelessness can be reduced by connecting housing support, income support, and psychiatric care. This project was aided by computer linkages and people making connections with one another to make the service possible. The results support the concept that it is a systems issue rather than an individual issue that puts clients with mental illness at risk of homelessness, thus supporting the idea that these systems issues need systems solutions.

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