January 2022

What Works Evidence Notes

07 Institutional Discharge

Evidence from across the world on solutions to homelessness
What Works Evidence Notes

This series draws together research evidence from across the world of what we know about how best to relieve and prevent homelessness. The notes are deliberately short to provide a summary for busy people of findings of research from different fields. They will be updated regularly as our knowledge of what works advances.

About the Centre for Homelessness Impact

The Centre for Homelessness Impact champions the creation and use of better evidence for a world without homelessness. Our mission is to improve the lives of those experiencing homelessness by ensuring that policy, practice and funding decisions are underpinned by reliable evidence.

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Evidence from across the world on solutions to homelessness
Purpose

This paper provides an overview of the evidence for interventions designed for individuals being discharged from institutional settings such as prison, hospital and care. In addition to looking at research on the links between homelessness and discharge, we also look at how policy and further research can help improve outcomes in these areas.

Overview

People discharged from institutional settings (prison, hospital and care) are at risk of homelessness and other negative outcomes including re-hospitalisations and recidivism. Among the three key groups discharged from institutions, people leaving prison and young people ageing out of local authority care are the most numerous, with people who have served time in prison particularly overrepresented among those who are street homeless. However, there is a substantial overlap between these groups. The numbers of people who are experiencing homelessness and were previously in local authority care or prison have been increasing over recent years, while numbers for hospital discharge remained fairly stable.

Existing evidence suggests that models which coordinate discharge with accommodation and a holistic offer of services – e.g. Critical Time Intervention and ‘Re-entry programmes’ – can be effective at reducing homelessness and improving other outcomes. There are also multiple evidence-based strategies to support people leaving prison, including support for drugs and alcohol use, and restorative justice approaches. We know a lot less about the best strategies to support people ageing out of care, showing an increase for both categories over the previous quarter. People leaving prison or care were also more likely to have long term experiences with street homelessness. In 2021 Q2, 33% of those living on the streets in London were prison leavers, compared to 15% of those who were new to the streets. For people leaving care, it was 11% of those living on the streets compared to 4% of those who were new.

Table 1: Street homelessness category breakdown, by prison, care or people leaving hospital

<table>
<thead>
<tr>
<th>Type of street homelessness</th>
<th>% who have previously been in prison</th>
<th>% who are have previously been in care</th>
<th>% who are leaving hospital*</th>
</tr>
</thead>
<tbody>
<tr>
<td>New to street homelessness</td>
<td>15%</td>
<td>4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Intermittent street homeless</td>
<td>36%</td>
<td>9%</td>
<td>n/a</td>
</tr>
<tr>
<td>Living on the streets</td>
<td>33%</td>
<td>11%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*the people leaving hospital figure from CHAIN is based on those whom outreach teams recorded as having been in hospital as their ‘last settled’ base. It does not represent the total number of people who sleep rough after leaving hospital.

The Challenge:

Key issues and recent trends

Households who are discharged from prison, hospital or local authority care are at a high risk of experiencing homelessness and, in particular, are at risk of street homelessness. This could be because their accommodation arrangements may break down or become unsuitable by the time they are discharged. They may also have existing challenges to their health and wellbeing which increases the risk of poor outcomes if discharged into homelessness, unstable housing or accommodation that is no longer suitable for their needs. About 5% of households assessed as homeless in Scotland and England were people who had left prison, care, or hospital, a figure which has remained relatively stable for the last several years. People leaving prison were the largest group: 8,630 in England and 1,574 in Scotland.

These groups are also more likely to be part of the population experiencing street homelessness. The Rough Sleeping Questionnaire shows that 12% of people surveyed had left a hospital or a prison. Of the people in London experiencing street homelessness, in the second quarter of 2021, 35% were people leaving prison and 9% were people leaving care, showing an increase for both categories over the previous quarter. People leaving prison or care were also more likely to have long term experiences with street homelessness. In 2021 Q2, 33% of those living on the streets in London were prison leavers, compared to 15% of those who were new to the streets. For people leaving care, it was 11% of those living on the streets compared to 4% of those who were new.

3 Compare to 2021 Q1, when 30% of those experiencing street homelessness were prison leavers and 8% were care leavers. Greater London Authority. (2021). Rough sleeping in London (CHAIN reports).
5 Requested from St Mungo’s CHAIN data.
6 Requested from St Mungo’s CHAIN data.
There is a lot of overlap between these different populations with people leaving care making up somewhere between 24% and 27% of the adult prison population.\(^7,8\)

People discharged from institutions tend to have long experiences of street homelessness and be part of the ‘stock’ rather than the ‘flow’: people who have spent time in prison make up one third of people who are living on the street and intermittent rough sleepers.\(^9\)

Some public bodies have a Duty to Refer people being discharged who are at risk of becoming homeless or are already homeless. However, the number referred by agencies is substantially lower than the number discharged from institutions who end up homeless. It seems likely that public bodies are missing vulnerable people who later approach local authorities for homelessness assessments.

As different groups might face different challenges we discuss them in turn.

1. **People leaving prison**

About 37% of people leaving prison indicate no fixed abode to enter once they have left custody\(^10\) and 83%\(^11\) of prisons had a rating of either “performance is a concern” or “serious concern” in ensuring those leaving custody have accommodation on their first night out.

From April 2020 - March 2021, 63,296 people were released from custody in England and Wales\(^12\) with 9% (5,954) released into homelessness and 3% (1,600) into street homelessness. While that is a 38% decrease in the number of households being released into homeless accommodation from the previous year, it nevertheless represents a high portion of prison leavers. In Scotland, 30% of those released from prison indicated they did not know where they would live after their release.\(^13\)

People leaving prison who become homeless are also more likely to have other negative outcomes. Firstly, they are significantly more likely to reoffend. Those experiencing street homelessness are the most likely (67%), followed by those in temporary accommodation (54%) and permanent housing (43%).\(^14\) Also, a large proportion of prison leavers remain unemployed upon release which may play a role in homelessness and other negative outcomes. From April 2020 to March 2021, 72% of those released from custody were unemployed after six weeks\(^15\) and 96% of prisons scored a “performance is a concern” or “a serious concern” regarding steps to support people into employment.

2. **People leaving care**

Young people who leave care are more likely to have poor outcomes than the general youth population in a variety of areas, including unemployment, need for public assistance, physical and mental health, and experience of homelessness.\(^16\) From 2018-2019, 30%\(^17\) of people leaving care aged 18 were not in education, employment or training compared to 13%\(^18\) of all 18 year olds in England. In Scotland, 75% of young people eligible for aftercare services, who are 16-26 years old, were not in education, training, or employment.\(^19\)

People leaving care are at higher risk for homelessness than the general youth population. Since young people in this situation leave home at a younger age than the typical youth population, they often have a harder time accessing permanent accommodation\(^20\) which may include difficulties paying rent in the private market\(^21\) or covering an upfront deposit. They may also lack support systems to fall back on for financial support.

3. **People leaving hospital**

About 1,000 households became homeless after leaving hospital in Scotland\(^22\) and England.\(^23\) People leaving hospital who are homeless have worse care outcomes compared to housed people leaving hospital which increases costs of care. They are more likely to be readmitted within 30 days (17% compared to 10% of the general population), and more likely to need an emergency department visit (27% compared to 12%), and over 50% less likely to get the post-discharge care they need.\(^24\)

People discharged to the streets may face greater risks if they have a continued medical vulnerability and potentially higher levels of mortality.\(^25\) There are also opportunities being missed to link people who are street homeless into services when they attend A&E for treatment but are not admitted as an inpatient.

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9. Requested from St Mungo’s CHAIN data.


What we know about what works

CHI’s systematic review of interventions for people discharged from institutions included 13 studies and concluded that these interventions were generally likely to improve housing stability and reduce the number of hospitalisations. There is also some suggestive evidence that they could reduce incarcerations. Unfortunately, there were insufficient studies to explore differences between institutional settings.

The most common interventions include: i) Critical Time Intervention (CTI), ii) short-term accommodation with additional services, iii) long-term accommodation following Housing First principles, and iv) more comprehensive offers of support including housing and a broader array of support services like education and training. There are also other models specifically designed for each of these cohorts.

We discuss each of them in turn.

1. Critical Time Intervention (CTI)

   CTI seeks to prevent recurrent homelessness in people leaving institutional settings. CTI is often delivered as a nine-month programme coordinated by a single caseworker supervised by a mental health professional. The program has three phases, each of which lasts approximately three months.

   Phase one (“transition to the community”) covers the period before and after discharge from the institution where the caseworker gets to know the client before discharge to assess needs and co-create a transition plan to link the person to services and the community. In phase two (“try-out”), the caseworker monitors and adjusts the systems of support that were developed during phase one and intervenes as needed. In phase three (“transfer of care”), the caseworker helps develop and implement a plan to achieve long-term goals (e.g., employment, family reunification) and finalizes the transfer of responsibilities to caregivers and community providers. Each CTI caseworker typically works with 10-15 clients at a time.

   CTI has been evaluated multiple times and in different contexts, including for people discharged from psychiatric hospitalisation and prison, as well as from shelters. The largest of these studies, discharging people from hospital, observed a substantial reduction in homelessness while all other studies found substantial reductions in other measured outcomes including enrollment with GPs, receiving medications, fewer symptoms of PTSD and reductions in unmet care needs. However, the longer-term impacts of CTI on other outcomes such as employment and recidivism have not been assessed.

2. ‘Re-entry programmes’ and other integrated models

   There are multiple integrated models for people transitioning out of institutional settings which include housing and additional elements of support and ongoing case management. These have been tested with multiple cohorts including prison leavers and young people aging out of care.

   ‘Re-entry programmes’ targeting people leaving prison include coordination across agencies like the police, correctional services, social services, employers and housing providers and found substantial improvements in recidivism rates. One of them also found improvements in contact with mental health services than those who received a shorter time TR support or only standard transition arrangements by the prison mental health team. Other studies albeit of lower methodological robustness, looked at similar models to support people ageing out of care finding improvements on housing stability and a reduction in STI rates, and people discharged from hospital also found large reductions in homelessness and hospitalisations.

3. Short term accommodation and respite care

   Multiple models of short-term housing exist depending on the institutional setting, which vary in effectiveness. Respite care is the most common model, understood as time-limited housing and supportive care, often embedded in the medical system. In most cases, offers are conditional on abstinence from substances and alcohol. Multiple studies have shown substantial reductions in hospitalisations with two studies, (Buchanan, 2006; Buchanan, 2008).

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27 Results show that the discharge programmes decreased the incidence of homelessness in the intervention group (SMD = -0.71, 95%CI [1.21, 0.12], p=0.02) compared to the comparison group.

28 Five studies from CHI’s review measure hospitalisation as an outcome. Results show that the discharge programmes decreased the incidence of hospitalisation in the intervention group (SMD = -0.52, 95%CI [0.38, 0.04], p=0.02).

29 Four studies from CHI’s review measured the impact of discharge programmes on reincarceration. Three of these studies examined discharge from prison while the fourth was discharge from hospital. The aggregated results showed a reduction in incarceration rates compared to the control group (ES=-0.41, 95% CI [0.86, 0.04]).


39 Green, B. et al. (2016). From Custody to Community: Outcomes of Community Based Support for Mentally Ill Prisoners. Psychiatry, Psychology and Law. 23(3).


Sadowski, 2009) showing reductions in emergency department visits. However, differences in terms of mental health were small and while the treatment group in Conrad (1998) reported fewer medical problems initially, the gap between treatment and control groups decreased over a two year period once the intervention period had been concluded. However, none of these studies compared short-term accommodation solutions with more supportive, long-term offers.

There is evidence that hostel-type accommodation tailored specifically for ex-offenders may facilitate the development of ‘criminal networks’, leading some researchers to conclude that it is more effective to house offenders in secure mainstream accommodation.  

4. Protocols

In many areas of the country local authority housing options services operate local protocols with hospitals and in some cases with prisons, to clarify responsibilities and prevent homelessness. CHI’s systematic review highlights the importance of written protocols that have been co-created with the person. When implemented well these can avoid poor practice, such as patients being sent to local authorities on discharge from hospital without prior warning or prisoners being discharged to the streets. However, even with protocols in place there can still be problems if a household is not in priority need under the homelessness legislation or if local connection to a particular area is disputed. Examples of such protocols include Southwark Council’s hospital discharge protocol and the Essex prisoner housing protocol, which covers all 14 Essex local housing authorities. The government published guidance on the development of local prison release protocols in 2019.  

5. Interventions for people leaving prison

In addition to the holistic interventions described above, there are also specific interventions for people leaving prison who have specific needs (e.g. substance misuse, employability).  

a. Drug and alcohol interventions

There is good evidence that a wide range of drug interventions have a positive impact on reducing reoffending. This includes methadone treatment, heroin treatment, therapeutic communities, psychosocial approaches, drug courts and probation and parole supervision. We summarise this evidence, with specific focus on people with experiences of homelessness in a separate evidence note.  

b. Drug courts

Drug courts are specially designed for offenders who are drug users, as an alternative to processing them through the normal court system. Using a system of supervision, reward and punishment, a judge and the drug court team support the participant throughout the process. Drug courts use a team approach in an effort to provide more consistent services to participants, with a number of individuals working together including the judge, drug court coordinator, supervision officers, case managers, treatment providers, prosecutors, lawyers, and law enforcement representatives. Drug courts can oversee an offender for as little as 3 months or for over a year, and successful participants, who do not offend over the course of the programme, graduate either with a dismissal of their original charges or a reduction of charges. Unsuccessful participants may continue through the traditional legal system or face additional sanctions. There is good evidence from the US that drug courts decrease recidivism, with access to and quality of treatment of services being determinants of successful interventions. However, the impacts on homelessness and other outcomes have not been assessed.  

c. Restorative justice

A Restorative Justice conference is planned face-to-face meeting between a victim, other people affected, and the offender. The conference is run by a trained facilitator to discuss the consequences of the offence and how to repair the harm they have caused (e.g. an apology or financial reparations). This has been studied extensively and evidence suggests it helps to reduce crime, with the 10 studies ranging from 7% to 45% fewer repeat convictions or arrests. However, the impacts on homelessness and other outcomes have not been assessed.  

d. Education, training and employment

Education and skills training programmes in correctional facilities aim to increase the education or skills levels of participants to improve their employment prospects on release. This may involve basic adult education, vocational training for specific fields of employment, or graduate education programmes. A meta-analysis of 50 studies found that participation in correctional education programmes is associated with a 13% reduction in the risk of reoffending. Two studies however found the opposite relationship, with participation in certain training programmes associated with increased risk of reoffending. This indicates that some programmes are far more effective than others at improving outcomes.

The effectiveness of work-skill programmes remains contested unless they are combined with more holistic motivational, social, health and educational support services to help address other needs that may act as barriers to finding employment (for example, learning difficulties, mental illness and substance abuse). It has also been concluded that vocational training activities without associated links to flexible employment prospects are unlikely to lead to reductions in reoffending.

Other holistic employment programmes such as Individual Placement and Support have had promising results for other populations with complex needs as discussed in our evidence note about Homelessness and Employment. Even if IPS has not been studied extensively among prison leavers, initial findings are promising and suggest better employment prospects.

45 See CHI’s Evidence Notes on substance use, mental health and employment for more detail on intervention in these areas.  
47 Centre for Homelessness Impact. (2021). What Works Evidence Notes: Drugs and Alcohol  
It’s important to note that the impact these interventions have on housing stability have not been assessed.

e. **Through the gate services**

The provision of accommodation services is a central element of Through the Gate activity, which saw increased funding from the Ministry of Justice of £22 million a year in resettlement prisons in 2019 and has now been expanded into the majority of non-resettlement prisons. The 2020 HMIP report notes that the extent to which this has improved accommodation outcomes is unclear, as performance against the relevant indicator has not yet improved. HMIP also found ‘very large unexplained variations in performance between different CRCs.’ Very few of the service users interviewed, with one or two exceptions, reported good experiences of Through the Gate services.

6. **Interventions for people leaving care**

There are also interventions specifically targeted at young people leaving care, but these seem to be ineffective with the exception of extending time under foster care.68

a. **Extending care**

There is limited but emerging evidence that extending care can improve outcomes across a number of domains, including homelessness. Washington state’s extended foster care policy enabled young people to remain in care beyond their 18th birthday and up to 21 years of age, aiming to improve the outcomes of foster youth into adulthood. They reported a large reduction in homelessness with the largest reduction for those between the ages of 18-21.69 They also reported better outcomes in terms of employment, earning, substance use, mental health, more likely to employed, have greater earnings, reduced substance use, mental health and

b. **Independent living programmes and other more intensive support**

Independent living programmes (ILPs) encompass a broad range of services which aim to help young people transitioning out of foster care into independent living. Service delivery varies among providers however emphasis is typically placed on improving education and employment outcomes. The review suggests that there is little evidence that standard individual independent living services achieve positive outcomes in terms of homelessness or housing stability and very small impacts on other domains like education and employment. They may be beneficial when combined with other services, however most appear insufficient on their own. For example, intensive support services (ISS) may or may not involve accommodation and can contain similar elements to ILPs. Where they differ is that ISS provides a greater intensity of support at an individual or small-group level that is tailored to the young people’s needs and wishes. Two studies examined the impact of ISS on a range of outcomes, one in Australia (PYI) and another in the United States (YVLifeSet). YVLifeSet reported some very small, positive effects for a range of outcomes: reduced homelessness, reduction in depression and anxiety, increase in high school completion, increase in earnings and reduced rate of being in a violent relationship.70

c. **Peer support**

Two studies examined the impact of coaching and peer support on high school graduation and found a combined positive effect (SMD = 0.50, 95% CI [0.01, 0.99]). The impact of coaching and peer support on employment outcomes found mixed results (g = 0.24, 95% CI [0.16, 0.64]). Other studies measuring the impact of other interventions for people leaving care on educational outcomes found small or very small effects.


64 Geenen, S. et al. (2015). Better futures: a randomized field test of a model for supporting young people in foster care with mental health challenges to participate in higher education. J Behav Health Serv Res. 42(2).


7. Interventions for hospital people leaving care

Research by King’s College London between 2015 and 2019 found evidence that specialist approaches to homeless hospital discharge are more effective and cost-effective than standard care, and more specifically that:

- Out-of-hospital care tailored to the needs of patients who are homeless is more effective and cost-effective than standard care.
- NHS Trusts with specialist homeless discharge schemes had fewer Delayed Transfers of Care compared to those that relied on standard care.
- Hospital based homeless healthcare teams increased access to elective follow-up care.
- HHD schemes with a ‘step-down’ service had a reduction in subsequent hospital use, with 18% fewer A&E visits compared to HHD schemes without ‘step-down’.
- This is also consistent with the evaluation of the DH Homeless Hospital Discharge Fund in 2015, which also highlights the importance of integrating housing and clinical staff into the discharge team, in a model that combines access to accommodation and other relevant workers. This continuous intensive support should be made available even after people have secured other accommodation.

The researchers produced a toolkit on transforming out of hospital care for people who are homeless. Recommendations include:

- Strengthen existing ‘HHD Protocols’ to ask housing authorities work to similar timescales as adult social care e.g. complete housing assessments within 72 hours.
- Integrate hospital-based specialist homeless health care teams (sometimes called ‘Pathway teams’) alongside existing multi-disciplinary discharge coordination services.
- Provide alternative ‘housing-led’ (step-down) pathways out-of-hospital for people who need time for recovery and reablement but who cannot go home (they are homeless) but whose needs would be over-catered for in a care home.
- Use trusted assessment and boundary spanning to bring the specialist clinical expertise of the homeless health care team into ‘housing-led’ intermediate care.

The government’s Shared Outcomes Fund has awarded £15.9m funding to DHSC, in partnership with MHCLG, to implement and learn from ‘out-of-hospital care models’ for people experiencing homelessness and at risk of rough sleeping (OOHHC) until the end of 2021/22. The OOHHC programme is designed to improve access to a pathway of step-down accommodation and support from hospitals for individuals who are homeless and is being delivered in 14 geographical areas.

The strong links and interrelationship between discharge from institutions and homelessness make it clear that an even more focused approach is likely to have an impact on reducing homelessness and vice versa.

Implications for policy, practice and research

The study also highlighted the need for better communication and engagement with patients by hospital staff at the point of discharge with clear referral processes tailored to the population group that projects are intended to work with (i.e. people experiencing street homelessness, those at risk of homelessness, groups with specific needs such as mental health or substance misuse issues, hostel residents).

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70 Cornes, M. et al. (2019). Transforming out-of-hospital care for people who are homeless. Support Tool & Briefing Notes: complementing the HImpact Change Model for transfers between hospital and home. The Policy Institute, King’s College London.
71 To facilitate early discharge planning and improved monitoring of system flow (including ID of housing related ‘pinch points’)
People leaving care

- There is emerging evidence that extending care (e.g. to 23 years of age) could improve outcomes across a number of domains, including homelessness.
- Greater experimentation is needed to identify the most effective mechanisms to support people aging out of care including a combination of housing, life skills, education, employment and financial support. Some of the principles of intensive support models such as CTI and ‘Re-entry Programmes’ used with other cohorts discharged from institutional settings could be adapted and tested for young people leaving care instead of more conventional independent living approaches that have a limited evidence base.
- There are several evidence-informed strategies\(^{75}\) to support young people while in care, such as placing them with family and friends and home visits, comprehensive parenting programmes to support lasting relationships, targeted educational and mental health support, among others. However, the impact of these interventions on outcomes later in life, such as homelessness, have not been assessed.

People leaving hospital

- Expand the provision of respite care facilities and ‘housing-led’ (step-down) pathways out-of-hospital for people who need time for recovery, preventing discharge into homelessness and other types of unstable accommodation as that may lead to poorer health outcomes, gaps in health provision, and greater costs to the public sector in terms of service utilisation in the future.
- Integrate hospital-based specialist homeless health care teams (sometimes called Pathway teams) alongside existing multi-disciplinary discharge coordination services. Out-of-hospital care must be integrated so people can move seamlessly between different services, depending on changing needs.
- Consider testing an approach in which hospitals in a local area are prohibited from discharging people from hospital without suitable accommodation. Especially if this is accompanied by funding, it could help to increase the priority given by Integrated Care System (ICS) areas to ending discharge to the streets.

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