Unhoused in Toronto: The delivery and experience of hospital healthcare services for homeless people

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It is well established within the research literature that a lack of adequate housing has health impacts. To be unhoused, homeless, is to experience a daily struggle for safe and secure shelter; this struggle poses a direct barrier to a person's ability to maintain their physical and mental health as well as their ability to take part in routine medical care and adhere to medical treatment regimes. People that are homeless experience disproportionately poorer health which is associated with frequent use of hospitals and longer hospital stays. Also, a person who is without housing faces circumstances which are atypical of the majority of people seeking healthcare at a hospital. The healthcare system, specifically care delivered by a hospital, must recognize that homeless people experience acute and chronic illnesses that are not necessarily the same for people who are adequately housed (Khandor et al., 2011).

The objective of this paper is to review what is known about the impact of homelessness on a person's health and in turn how healthcare delivered via an acute care hospital is experienced and utilized by a person that is homeless. This paper is focused on the homeless population in the city of Toronto. To reach an understanding of the health impact and hospital utilization of a person who is homeless a definition of homelessness as well as a brief overview of *Homelessness in Toronto* will be provided. Also, attention will be given to interventions that exist to support a homeless person in the days/weeks post hospitalization.

Defining homelessness

An attempt to define homelessness is fraught with difficulty and caution should be taken when doing so as to not 'define' in such a way that results in the minimizing of the diverse, complex and unique aspects of the individuals lived experience. A person who is homeless is one of the most disadvantaged and marginalized members within the larger community that they are

part of. The intersectionality of systemic and structural factors inclusive of poverty, a lack of affordable housing and inequality that reinforces the marginalization of individuals, demonstrates that homelessness is a societal issue not an individual issue. A person who is homeless typically experiences a lack of power (i.e. choices, self-determination), money and the supportive social conditions and health benefits they provide. The social situation of homelessness affects a person's ability to meet their basic needs, access health care, and comply with treatment which results in an increase in the complexity of the care they require (McNeil, Guirguis-Younger, Dilley, Turnbull, & Hwang, 2013).

Over a five year span it was estimated that 1.3 million individuals across Canada experienced extreme housing instability or homelessness (Gaetz et al., 2013). On average, 200,000 people access and utilize the shelter system and an additional 50,000 people experience 'hidden homelessness' (i.e. couch surfing, staying in a place that is not permanent or secure) (Canadian Observatory on Homelessness, 2015a). A lens applied to defining homelessness, when considering systems, is that of failures related to the discharge process utilized in hospitals, mental health facilities or correctional facilities which result in homelessness, and when considering the *individual* homelessness is defined by its linking with physical and emotional trauma, mental illness, addiction or family conflict (Frankish, Hwang, & Quantz, 2005; Gaetz, Donaldson, Richter, & Gulliver, 2013). The *Canadian Observatory on Homelessness* (2012) provides a definition which describes the situation that thousands of people across Canada experience on a daily basis:

> "Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and

> appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing." (Canadian Observatory on Homelessness, 2012, p.1)

Homelessness in Toronto

It is estimated that on any given night in Toronto there are 5,200 people that are homeless, of whom 450 people are living on the street and 3,970 are staying in city administered shelters (Canadian Observatory on Homelessness, 2015). The majority of the city's homeless population are male (65%), with women comprising one third (34%), and the remainder comprised of people identified as transgender or transsexual (1%). Of note, approximately 14% of the homeless population in Toronto are parents with dependent children (City of Toronto, 2013a).

In Toronto a significant number of individuals and families are currently experiencing homelessness, or are at risk of becoming homeless, and are awaiting access to subsidized or rent geared to income housing. Toronto, as of January 2015, has 90,731 names on its waitlist for affordable rental housing (Housing Connections, 2015); the average wait time in Toronto is over 8 years (CBC News, 2014). Though Toronto residents comprise 20.3% of Ontario's population, they represent 44.3% of the total active waiting list in Ontario (Ontario Non-Profit Housing Association, 2012). Information provided by the City of Toronto (2013) indicates that 38% of households in Toronto are spending in excess of 30% of their earnings on rent; this point demonstrates the likelihood of increasing numbers of people requiring placement in affordable housing.

Impact of homelessness on a person's health

A person who is homeless experiences a higher burden of acute and chronic illnesses when compared to a person that is housed (Khandor et al., 2011). A high number of people who are homeless have experienced physical and sexual assault, with sexually transmitted infections being a particularly pertinent issue among homeless youth (Hwang & Dunn, 2005). Higher than normal rates of tuberculosis, HIV and hepatitis B and C are found within the homeless population. Also, the prevalence of chronic health conditions such as diabetes, hypertension, pulmonary disease, seizures, and musculoskeletal disorders is much higher among people who are homeless (Hwang & Dunn, 2005). Foot problems (i.e. fungal infections, frost bite) are also commonly experienced by homeless persons (Hwang & Dunn, 2005). Among the homeless population of Toronto, there is a 67% lifetime prevalence of mental illness, and a 68% lifetime prevalence of substance abuse (Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002).

As indicated, physical abuse is a prevalent risk factor associated with homelessness (Herman, Susser, Struening, & Link 1997). A person who is homeless is more likely to experience higher rates of physical injuries and assault (Hwang et al., 2008). Also, there is evidence that a high number of adults who are homeless have encountered childhood physical abuse which is a contributing factor in the higher than normal rates of traumatic brain injury (TBI) of this population (Herman et al., 1997). TBI is common among persons that are homelessness, and is associated with overall poorer physical and mental health status (Hwang et al., 2008). A survey of 904 homeless adults in Toronto, undertaken by Hwang et al. (2008), found an incidence of 53% for TBI among the respondents.

When considering the numerous health challenges that homeless people experience, it is not entirely unexpected that there are significantly higher rates of mortality among this population when compared to persons that are housed. A study conducted by Hwang (2000) demonstrated that men living in homeless shelters in Toronto are between 2 and 8 times more likely to die compared to men of the same age in the general population; mortality rates were 8.3 % higher for the 18 to 24 year old group, 3.7 % higher in the 25 to 44 year olds, and 2.3 % among 45 to 65 year olds. In a review of mortality rates among homeless women within the age range of 18 to 44 years old mortality rates are 5 to 31 times higher compared to women in the general population of the same age range (Cheung & Hwang, 2004). Common causes of death among older persons who are homeless are cancer and heart disease, while overdose, suicide, homicide and HIV/AIDS are more common causes among homeless persons ages 45 and under (Cheung & Hwang, 2004; Hwang, 2000).

Environment, the living conditions and exposure to hazards experienced by the person, has a direct impact on the person's health. For example, a person who is homeless experiences overexposure to extreme temperatures, pollutants, constant mobility which impacts the sleep cycle, lack of food security, inadequate access to drinking water etc.; the few points provided begin to demonstrate how environment can exacerbate chronic illnesses. Also, homelessness can lead to mental health challenges such as loneliness, depression, low self-esteem, loss of social supports and connections with family and friends (Hulchanski, Campsie, Chau, Hwang, & Paradis, 2009); these points demonstrate the impact homelessness can have on a person's overall health and well-being. The circumstances provided throughout this section establish how a medical condition that is manageable in a safe home with rest and care from supports (i.e.

friends, family and community members) is transformed into a condition requiring hospitalization (Gaetz, 2004; Health Care for the Homeless Clinicians' Network, 2010).

Hospital use and homelessness

People that are homeless access emergency healthcare services, and require hospital admission, at a higher frequency then the general population (Khandor et al., 2011). Although rates of comorbidities amongst the homeless population are high, less than 45% of homeless persons have a primary care physician as compared with 94% of the general population who have similar chronic conditions (Khandor et al., 2011). Beyond a lack of primary care being provided the decision to seek hospital care is frequently related to a lack of social supports experienced by homeless persons (Raven et al., 2010). A study undertaken by Hwang and Henderson (2010) compared homeless men and women with men and women who are housed and who have comparable health issues; their findings indicate that homeless men were hospitalized 8.5 times more often and homeless women were hospitalized 4.6 times more often. Also, a person that is homeless is not only more likely to be admitted to hospital, their length of stay once admitted will exceed that of a person who is housed (Hwang, 2001). The longer length of hospitalization for a homeless person is often attributed to not having a safe and/or secure place to recuperate after a hospital stay.

The association of mental health challenges and substance use with homelessness is well documented in the literature and for many homeless people hospitals are often their only means of support during times of struggle. (Freund & Hawkins, 2004; Hwang, 2001; Raven et al., 2010). These issues complicate treatment in acute care settings where staff often lack training to manage these struggles. People within the homeless population that live with mental health

struggles and/or substance abuse are often inadequately treated in hospital which results in frequent admissions to mental health specific care beds (Hwang, 2001).

As is often the case, the utilization and allocation of resources is measured in dollar amounts. In a study undertaken by Hwang, Weaver, Aubry and Hoch (2011) it was demonstrated that hospital admissions of homeless people cost $2,559 more than admissions by comparable non-homeless people. For persons receiving medical and surgical services, the findings of the study attribute the variance in costs to the need for more frequent use of alternative level of care days among the homeless cohort. In regards to psychiatric services provided via hospital, care provided to a homeless persons cost $1,058 more on average per admission than housed persons, even after controlling for differences in length of stay between the two groups (Hwang et al., 2011).

Hospital admission/readmission

Hospital admission is based on acuity and complexity of medical needs; a ‘weighting’ system is used when considering case disposition for admission and again in assessing need for remaining in an acute care facility. An examination of the relationship between hospital discharge readiness and readmissions indicates that a person discharged without the necessary prescription is at greater risk of readmission, as are individuals who did not receive an appropriate referral(s) for post-hospitalization community supports and services (i.e. housing, primary care, pharmacy) (Craig & Bracken, 1995; Craig, Fennig, Tanenberg-Karant, & Bromet, 2000).

Doran et al (2013) makes clear that the risk, and likelihood, of hospital readmission for persons that are discharged to a shelter or to the street is far greater than that of persons

discharged to secure and stable housing. Kertesz et al (2009) compared 90-day readmission rates between homeless people who had been discharged to Boston's medical respite care program and those who had been discharged to shelter or to 'own care'. A person who was discharged to a respite care program was significantly less likely to be readmitted to hospital over the 90 day timeframe (Kertesz et al., 2009). Of note, homelessness is often not recognized or addressed as part of the hospital admission and discharge planning process which increases the likelihood, and risk, of being discharged to a shelter or to the street (Levy & O'Connell 2004).

Hospital discharge

A hospital discharge is only as successful as the planning that goes into it. Discharge plans must be somewhat flexible, and at times creative, and this is especially true when considering the unique, and complex, needs of homeless people. As stated by Backer, Howard and Moran (2007), discharge planning is a part of the continuum of care that is inclusive of assessment, treatment and the coordination of care in the community. During the admission assessment questions should be posed regarding housing which will then assist in identifying not only individuals who are homeless but those who are inadequately housed or in danger of losing housing (Greysen, Allen, Lucas, Wang, & Rosenthal, 2012). Early identification will allow for the inclusion of professionals and/or organizations that can contribute to effective discharge planning and ensure the person is not discharged to homelessness.

In a study focused on transition from hospital to a shelter, participants reported that communication between the hospitals and shelters, the providing of transportation and arranging for discharges to take place during hours when shelter beds can be accessed, were effective strategies to ensure that the person, at a minimum, was ensured a safe bed (Greysen et al., 2012).

It may not be possible to put in place housing during a single hospital admission but there is clear evidence that inadequate discharge planning is a major factor in contributing to people being discharged to homelessness (Backer, et al., 2007).

Interventions for support post hospitalization

Far too often during the transition following hospitalization people who are homeless are lacking the resources and social supports to adhere to treatment regimens and follow up appointments leading to adverse events and poor health outcomes (Daiski, 2007; Tsilimingras & Westfall Bates, 2008). Health issues and individual needs will vary between each person who is homeless yet there are two interventions which have clearly demonstrated efficacy in providing post hospitalization support and positive health gains; secure, stable and supportive housing specifically matched to the presenting needs of the person and/or respite care to support and provide the ongoing treatment needs of the person.

Notwithstanding the multitude of variations in housing interventions that cater to the specific needs of different subsets of the homeless population, there is mounting evidence in support of housing stability and health among the homeless population being directly linked to on-site supportive services (Fitzpatrick-Lewis, Ganann, Krishnaratne, Ciliska, Kouyoumdjian, Hwang, 2011). For example, among homeless persons with substance use challenges and/or mental health challenges, supportive housing was associated with improved housing tenure, reduction in negative health outcomes related to substance use and reduced need for hospital intervention (Fitzpatrick-Lewis et al., 2011). Larimer et al (2009) reported that homeless persons living with severe alcohol dependence demonstrated clear benefits when living in supported

housing with onsite case management in that alcohol consumption noticeably reduced as did the frequency of hospital visits/admissions.

Post hospitalization respite programs can serve to provide transitioning support for homeless persons that no longer require the acute care provided in a hospital environment but lack the supports necessary to continue treatment protocols to ensure positive health gains. Also, in some cases respite care would provide the person with the stability necessary in order to attain supportive housing where often staff have little, or no, medical training and are apprehensive of accepting a person with health needs. Respite programs have demonstrated evidence for improving housing outcomes, ensuring follow up appointments are attended, reducing the need for hospital readmission and completion of doctor recommended treatment regimens (Doran, Ragins, Gross & Zerger, 2013). A key element to the success of a respite program is its direct link to, and with, community supports. In Toronto, there are two established medical respite programs that offer service to the homeless; the Rotary Club of Toronto Infirmary at Seaton House (28 bed capacity) and the Sherbourne Infirmary (10 bed capacity) (City of Toronto, n.d.).

Conclusion

The ‘reasons’ that a person is unhoused, homeless, are multifaceted, and are linked to a variety of interrelated factors which are beyond that of the individual but instead often rest on the action and inaction of the community they are part of. The health and well-being of a person who is homeless is the responsibility of the community and, as made clear in the reviewed literature, a hospital is a central part of the person’s support system. A homeless person, a member of the community that is without adequate housing, experiences poorer health, utilizes more hospital

resources than the general population, and faces significant challenges to recuperating after an acute medical illness or injury.

An admission to hospital comes at a time when a person is experiencing a physical and/or a mental health crisis, however this is also an opportunity to address the psychological/social needs of the person as opposed to only the bio-medical needs. The inclusion of specialized supports during the admission such as housing workers, trauma informed counselling, primary healthcare providers in the community and outreach services would assist in the development of realistic planning that speaks to the unique needs of a homeless person. Also, hospital policies that address the continuity of care for a homeless person post hospitalization, as well as standardized discharge practices, should be developed and incorporated into the role of hospital discharge planners.

As indicated in *Interventions for support post hospitalization* partnerships between hospitals, community programs and community health care providers to establish and make available medical respite units provides a safe environment for healing and recovery as well as the social supports to ensure that a homeless person receives the post hospitalization care they require. Of note, Australia has in place a policy that no person is discharged from a hospital to homelessness and offers supported accommodations in order to continue, as well as maintain, the person's recovery and well-being (Moore, Gerdtz, Hepworth, & Manias, 2010).

Numerous studies reported that following the provision of adequate housing improvements in physical and mental health as well as reductions in utilization of acute care hospital resources occurred. One such study, undertaken by Sadowski, Kee, VanderWeele, and Buchanan (2009), found a 29% reduction in hospital admissions of homeless persons living with

a chronic illness who were offered transitional housing upon discharge compared to those who received standard discharge care from hospital (i.e. city shelter or street). The overall goal of reducing hospital admissions appeals to some as a cost saving measure but it is the hope of the writer that a reduction of hospital admissions becomes framed as an outcome that is directly related to the provision of equitable and adequate healthcare services to members of our community who are in need.

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