Commentary: Discharging the Homeless – A Daily Issue in Acute Care

Commentaire : Sortie d'hôpital des personnes sans-abri : un enjeu quotidien dans le secteur des soins de courte durée

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Abstract

There are complex issues surrounding hospital discharge planning for people experiencing homelessness. The issue involves the disconnection across policy areas of housing, income supports and mental health, and later health generally. Different models for different types of communities (large urban, mid-size, small and rural areas) likely need to be developed as well as for different types of conditions and different housing histories. The quality of data needs improvement including accuracy. Housing items need to be part of admission processes so that the need for post-discharge housing can be quickly flagged and more accurate data can be made available. System improvements need to include all levels of government, people with lived experience, and health as well as housing/homeless sectors. The income support sector also needs to be included. Discharge planning often assumes there is a fixed address after discharge. This clearly misses the needs of people who have lost their housing.

Résumé

La planification des sorties d'hôpital pour les personnes en situation d'itinérance apporte son lot d'enjeux complexes. La question touche au manque de connexion en matière de politiques entre divers secteurs, dont l'hébergement, le soutien du revenu et la santé mentale, puis éventuellement la santé en général. Il faudrait vraisemblablement mettre au point différents modèles pour les divers types de communautés (grands centres urbains, villes moyennes, petites régions éloignées) ainsi que pour divers types de situations et d'historiques d'hébergement. La qualité des données doit être améliorée, notamment pour ce qui est de leur précision. La question de l'hébergement doit faire partie du processus d'admission de sorte que les besoins en matière d'hébergement après la sortie soient rapidement signalés

et que des données plus précises soient disponibles. Les améliorations du système doivent impliquer tous les niveaux de gouvernement, les personnes qui ont l'expérience pertinente ainsi que les secteurs de l'hébergement et de l'itinérance. Le secteur du soutien du revenu doit aussi être impliqué. On tient souvent pour acquis, dans la planification des sorties, que le patient possède une adresse fixe. Les besoins des personnes qui ont perdu leur domicile sont clairement délaissés.

Introduction

Jenkinson and colleagues (2020) discuss many of the complex issues surrounding hospital discharge planning for people experiencing homelessness. They accurately describe the dearth of literature and proactive policy on this complex topic. Yet, people practising in acute care settings often experience the difficulties involving these complex situations daily.

Often, while speaking to younger healthcare providers, I have found that they are surprised to learn that the issue of discharge to homelessness is a relatively new phenomenon in Canada. When I worked as a clinical nurse specialist in the 1980s and 1990s, if someone was discharged homeless, we had to fill the same critical incident form as that used for a patient assault. In the early 1990s, I recall the alarm at the Hamilton hospital where I worked when this happened twice in a single year. A special leadership meeting was called to examine how such a terrible thing could happen. Yet, only a few years later, a study we conducted revealed that this happened at least 196 times in a single year in London, Ontario, from psychiatric programs alone (Forchuk et al. 2006).

The discussion that these types of discharges exemplify a broader systems failure is important. The disconnection between federal, provincial and municipal policies that is described certainly contributes to the increase in homelessness seen in recent years. However, it is important to understand that the issue also involves the disconnection across policy areas of housing, income supports and mental health, and later health in general. Together, these factors created the perfect storm for the marked increase in homelessness and the overrepresentation of people with mental illness among the homeless population.

Understanding the history of policy changes is important to understanding the current problems of discharge to homelessness. In Ontario, in the 1990s, the issues included the downloading of housing from the federal, to the provincial, to the municipal level, despite all other industrial nations having this responsibility at the federal level. With each passing of the housing responsibility to a different level of the government, the resources and the political will similarly lowered. New investment into public housing was reduced, and increasing waiting lists meant people could wait years for affordable housing. In Ontario, in the same period (1997), the *Ontario Works Act* replaced the General Welfare Assistance program, with a decrease in actual funds available to each individual or family. In 1999, the Health Services Restructuring Committee recommended that provincial psychiatric hospitals be transferred to community hospitals and that the number of psychiatric beds be reduced (policy disconnection summarized from Forchuk et al. 2007). Jenkinson and colleagues

(2020) point to the 2015 Ontario plan to reduce homelessness, the very recent national housing policy (https://www.placetocallhome.ca/) and reinvestment in Canada Mortgage and Housing Corporation after a long federal absence from housing policy and investment (Ontario Provincial Government 2015). These are both signs of policy progress.

Analysis of Key Points and Recommendations

Jenkinson et al. (2020) concisely summarize key points from the large body of literature that links homelessness to poor health outcomes and to higher hospital need. People who are homeless tend to have multiple mental and physical illnesses, and they remain in the hospital longer and are more likely to visit the emergency department and/or be readmitted after discharge (Hwang et al. 2011; Mikkonen and Raphael 2010; Munn-Rivard 2014). Managing one's health while homeless is not easy. Medication storage, food insecurity and exposure to the elements and violence are just a few of the challenges. One oversight that I noted is that there is an implicit assumption that the only people being discharged to homelessness were people who were already homeless upon admission. In our five-year Community–University Research Alliance program on homelessness, housing and mental health (Forchuk et al. 2011), we found that many people actually started their journey of homelessness with a discharge from the hospital. Housing can be lost following a hospitalization in many ways. Relationship breakups, loss of income (including income support programs) and an inability to pay rent or missing an eviction notice (and thus appeal) while in hospital are but a few examples.

Health practices and policies to shorten the length of stay (the push to discharge as soon as possible) contribute to inappropriate discharges to unsafe places. These practices and policies are in place owing to the limited number of hospital beds and the presumed efficiency of turning patients over quickly to accommodate more people. However, as in the commentary by Jenkinson and colleagues (2020), if discharging to homelessness means that the person will shortly return to the emergency department and be potentially readmitted even more ill, this is an illogical approach.

The commentary by Jenkinson and colleagues (2020) has four recommendations: evaluative and exploratory research, a policy priority, data generation and system improvements. I would agree with these recommendations. As noted in the literature review, there is a dearth of information outside the mental health field. Context matters. Different models for different types of communities (large urban, mid-sized, small and rural areas), conditions and housing histories likely need to be developed. We are nowhere near this level of evidence-informed interventions. The COVID-19 pandemic highlights some of the many gaps in healthcare for people experiencing homelessness and the need for homelessness to also be seen as a health-related priority issue. The quality of data, although improving with health records now containing more housing/homelessness fields, needs further improvement, including more accuracy. Often, admission data (such as address) become the discharge data, unless someone makes a point of recognizing and changing the field if housing was lost

during an admission. Housing status needs to be a part of the admission processes so that the need for post-discharge housing can be quickly flagged and addressed. System improvements are certainly needed. As noted, this needs to include all levels of the government, people with lived experience as well as the health, housing/homeless and income support sectors.

It is important to understand the context of the disconnection across policy areas that intersect with the issue of discharge to homelessness. Otherwise, the risk is to see such discharges as solely a health issue and something that could simply be addressed by better hospital discharge planning. The problems have evolved from this disconnection of changes in housing, income and health policies. The solutions must reconnect these policy areas. In our work that has successfully reduced discharge to homelessness from psychiatric programs, we have brought housing and income supports into the hospital (Forchuk et al. 2013). Although the program was very successful and integrated into usual care, we found that several program and policy changes required an expansion of the community partners involved. In our current (still in process) study, this includes having a housing support worker whose role is to help find housing, an Ontario Works (OW) staff with on-site access to the OW database and a Housing Stability Bank staff to provide short-term loans to assist with rent and/or utility bill arrears. Additional assistance also includes access to furniture, moving and cleaning services. These are all resources normally available in the community. However, by the time a person is healthy enough to access such resources in the community, they are discharged. It is therefore important to bring these services into the hospital and to have them work as a team with the hospital before discharge. We have only begun working with medical wards but find that the largest challenge is the far shorter length of stay compared to that in psychiatric units. In some cases, a person with a decade of homelessness has a one-night stay. The odds of finding and maintaining housing with such a small window are not good. Although studies are still ongoing, our preventing-discharge-to-no-fixed-address team has managed to find housing for half the referrals on acute medical wards (far less than the almost 80% on psychiatric programs). To address this issue in our next phase of the research, we are integrating our program with municipal Housing First programs and providing even more direct hospital access to these services with a revised program that will be implemented and tested once new non-COVID studies can begin.

Conclusion

In conclusion, Jenkinson et al. (2020) highlight that discharge planning often assumes that there is a fixed address after discharge. However, this commentary needs to also consider the needs of people who have lost their housing during hospital admission as well as before admission. We need policies that clearly recognize that a shelter address is still no fixed address, and this means that the discharge to a shelter, or to a friend or family member's house, is, nonetheless, a discharge to homelessness. The example I provided regarding our

work preventing discharge to homelessness supports the conclusion in the paper by Jenkinson et al. (2020), that "[g]reater coordination, communication and collaboration are required to rectify this policy gap and address health inequities for homeless populations" (2020: 19).

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