

**TAKING ACTION ON
HOMELESSNESS AND HEALTH:
Challenges, Barriers and Solutions**

**Report from 2006 Diversity & Wellbeing Conference:
Taking Action on Homelessness and Health**

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Taking Action on Homelessness and Health: Challenges, Barriers and Solutions

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Introduction

Background

Homelessness has emerged as a major social problem in urban areas around the world. The phenomenon of homelessness can be classified into two categories: “Absolute homelessness” which refers to those without physical shelter who sleep outdoors, in vehicles, abandoned buildings or other places not intended for human habitation, and “Relative homelessness” referring to those who have a physical shelter, but one that does not meet basic standards of health and safety; these include protection from the elements, access to safe water and sanitation, security of tenure, personal safety and affordability¹. Terms commonly associated with homeless include lazy, mentally ill, middle aged, and male². Homelessness is not limited to a particular age, gender, or ethnocultural group, or to individuals of any single intellectual ranking. Research in Canada has shown that the homeless population is diverse, including increasing numbers of young people, families, women, members of various ethnic communities, Aboriginals, and immigrants³. A 2008 count of the homeless population in Calgary found that 4060 individuals were absolutely homeless, representing a 18.2 % rise from 2006⁴. This dramatic increase in the number of homeless is troublesome given the well documented adverse effects that homelessness poses on individual’s health. Drug and alcohol dependence and mental illness are the most frequently expressed health problems of the homeless people⁵. In Canada, some of the health problems documented in homeless populations have included higher mortality in men⁶; higher rates of hepatitis B, hepatitis C, HIV infection, prevalence of pregnancy, higher prevalence of mental health problems among homeless street youth than in non-street youth⁷; and nutritional problems involving inadequate intake of vitamins⁸. Despite this available evidence on health issues of the homeless, research on interventions to reduce homelessness and improve health is still limited. This, according to Frankford⁹ appears to be a direct violation of the Canada Health Act.

A framework for tackling homelessness and improving health is shown in the work of Frankish et al¹⁰. They identified four categories of strategies for intervention including: biomedical and health care, educational & behavioural, environmental, Policy and Legislative. There are still significant gaps in knowledge of ways to effectively deliver services to homeless populations. Our environmental scan of approaches used elsewhere, revealed differing frameworks for providing services to homeless people. In the United Kingdom for example, service delivery to homeless people is being described as mainstream general practice that takes on an extended role (also known as ‘general practice with special interest’) and ‘specialised’ general practice that registers only homeless people⁵. However, there is little or no literature on how homeless people obtain care in each of this type of setting. Addressing health issues of homeless population can be a daunting task given that they are usually hidden and hard to reach. In an effort to draw awareness and inform policy the Calgary Health Region (CHR), in partnership with other institutions, organized a 2006 Conference on Diversity and Wellbeing: Taking Action on Homelessness and Health. This conference presented a unique opportunity to examine the

current practices and programs that serve homeless population in and around the Calgary Metropolitan area. Given the diversity of participants, we conducted this study with the purpose of generating practical information on issues and challenges, barriers and solutions to tackling homelessness and health related problems, from the view point of frontline workers, decision makers and service providers. Such knowledge is vital for planning service delivery models and enacting policy to improve the health of homeless populations.

Methods

Study design

This was a cross sectional survey of attendees at the 3rd Annual Conference on Diversity and Wellbeing: *Taking Action on Homelessness and Health*, in Calgary, Canada on November 17, 2006. Study participants included individuals working with the homeless, including decision makers, practitioners, front-line workers, students, as well as former homeless individuals. We started by developing a questionnaire for the study. The questionnaire consisted of close- and open-ended questions, as well as open-content, closed-questions. Questions assessed participants' gender, role, level of contact, and length of time working with homeless. A second series of questions required study participants to list five most important issues that relate directly in their opinion to the delivery of services to the homeless, five strategies that are used to deliver services to the homeless and rate according to a likert scale; and five suggestions that could be used to improve the delivery of services to the homeless, beginning with most important. Face validity was assessed with members of the conference steering committee. The questionnaire was revised based on comments and suggestions provided by the steering committee members.

Data collection

Our main source of data was from the standardized questionnaire, which was placed in the registration package and handed to all registrants at the registration desk. During the conference, announcements were made (up to eight times) to remind attendees to complete the questionnaire and return to a collection box. The questionnaires were completed anonymously without any personal identifiers. The second source of data was by means of facilitated group discussions. Participants were randomly assigned to 13 groups of 6 – 8 individuals each for the group session. Three questions were proposed to guide the discussion as follows:

1. What challenges do you face in providing health services to the homeless?
2. What are the issues/barriers to providing health services to the homeless?
3. What steps would you recommend to resolve the issues or meet the challenges?

Each group included one facilitator (conference volunteer) charged with keeping the discussion focused and within the allotted time. The facilitator wrote down the main points of the discussion on a flip-chart provided to each group. The flipcharts were collected at the end of the conference. Flipcharts were identified by group number. No individual names were recorded anywhere on the flipcharts.

Data Analysis

The data were entered into an Excel spreadsheet. Descriptives were computed for socio-demographic variables using STATA8. Qualitative data were analyzed using qualitative content analysis (QCA). QCA involved systematic picking out key words and phrases from the written content of the responses. The key words and phrases were then grouped into common themes or concepts. Two members of the project team conducted the QCA independently and then discussed the themes and concepts they formulated separately to assess the information further before arriving at the overall arching themes. These themes were then presented to other members of the project team for further discussion prior to making a decision on the final themes.

Results

Participant demographics

Of the 133 study participants, 87 (65.5 %) returned their questionnaires. Respondents included females (90.8 %) and males (9.2 %). More than half of participants (62.1%) reported to have direct contact with the homeless, 31 % indirect, and 6.9 % had no contact at all. Five categories of study participants were identified in relation to their occupation. This included: health care provider (41.0%), homeless services provider (13.8%), social worker (3.8%), administrator (8.9%) and others (23.0%). The mean length of time participants reported working with the homeless was 6.75 years [0–30]. Other characteristics of study participants are shown in Table 1.

A series of important issues related to the delivery of services to the homeless were reported. We classify them into four major themes (continuity of care, access, stigma, leadership & coordination) presented in more detail in Table 2. We identified two categories of service strategies used to deliver healthcare to the homeless: *Structural services* – whose aim is to improve health and reduce homelessness, for example, primary care or walk in clinics, provision of shelters, housing, and assertive outreach; and *People services* – whose aim is to improve health through the provision of dental care, counselling, mental health, case management, emergency response, food banks.

The ordering of these strategies in terms of importance was difficult to ascertain due to the variability in the number and type of responses. However, assertive outreach, affordable housing, walk in clinics, and to a lesser extent, shelters were often mentioned as current strategies used to deliver health services to the homeless. Table 3 presents a series of suggested action steps for improving healthcare delivery to the homeless. Housing, access to services, education, continuum of care, research, funding, amongst others were major themes generated from the group discussions for tackling homelessness and health related problems. This, together with accompanying aims and suggested actions are presented in table 4.

Discussion

This study looked into the challenges and issues hindering action on homelessness and health from the view point of conference participants. It was intended to highlight strategies that work, and those that do not, suggest action steps to reduce homelessness, and improve the delivery of services to this population. Generally, our study found that there is no single solution to tackling homelessness. A multi-disciplinary, multi-sector, well coordinated and integrated approach; addressing housing for the homeless, access barriers, stigma, poverty, funding, health insurance and drug benefits, mental health and addictions, continuum of care, collaboration and coordination is required to improve the health of this population.

We found that the lack of a continuum of care is a major issue in delivering health services to the homeless. This happens when a homeless patient is discharged from hospital with no follow-up. The lack of proper discharge protocol in hospitals may result in patients not taking medications correctly, and consequently developing serious complications and requiring further medical care. This leads to inconsistent and /or repeated diagnosis, misuse of medical resources. As a solution to this problem, study participants suggested a need to create and fund new positions (discharge planners) in hospitals to better coordinate discharge and follow up treatment. This would prevent homeless persons and inpatients at risk of being homeless from going to the streets. Discharge planning has been developed and documented as an effective strategy in tackling homelessness in Scotland, where in some situations, hospitals employ staff to improve discharge arrangements for homeless patients¹¹. In the United States, discharge planning, being part of a larger continuum of care has been shown to help people reach goals of stable housing, recovery, and increased quality of life in the community¹². While studying strategies to solve homelessness in the united states, Burt et al found that, in combination with supportive services, effective discharge planning involving housing was offered (in two out of five study communities) as part of secondary and tertiary prevention efforts¹³.

Access is another major issue limiting the delivery of services to the homeless. Here, access is explained in several dimensions including: access to providers and medication; access to health resources and social services, due to their location; access to information about resources; and long wait times. The issue of access is easily to understand because services offered to homeless people are not fully integrated. Addressing barriers to access requires training more staff, increasing facilities especially for mental health and alcohol addictions, involving the homeless in planning. Evidence has been made of the fact that homeless people tend to make less use of preventive health services and more use of emergency health services than the general population¹⁴. In Boston, efforts to improve access to health care services for the homeless have included sending multidisciplinary medical and mental health teams to the streets on a daily basis, working on outreach vans at night, and engaging people in familiar and unthreatening places¹⁵.

To solve the problem of limited supportive appropriate housing for low income families and the homeless, study participants suggested the need for Government to undertake measures to address increasing housing cost, and institute rent control, and revisit the use of shelters as temporary housing. Supportive housing, in combination with other strategies is an effective strategy to solving homelessness. This was the case in Massachusetts where declining rates of homelessness were found among admissions to state psychiatric hospitals over the 10 year period during which housing with supportive services expanded¹³. This study identified mediation in housing courts (in cases of threats of eviction) and cash assistance for rent or mortgage arrears to be primary prevention strategies that are effective. Supportive housing need not be 'mini-institutions' but should be aimed at promoting consumer autonomy and 'ownership of their housing. Such was the case in Maryland where, the mental Hygiene Administration decided not to fund any additional service-linked, programmatically based housing and has moved to funding the development of more supported and independent housing models¹⁶.

Stigma associated with homelessness is another issue that limits the delivery of services to this population. By stigma we mean "negative connotations associated with the word-homeless. " As a result of stigma, the homeless are often discriminated against when it comes to allocation and funding of services. Some homeless individuals do not come forward for help for fear of being associated with this population. Study participants suggested that addressing stigma would require targeting the factors fuelling stigma, including: a) lack of societal awareness and

education of the public, b) misunderstanding of the causes of homelessness, c) lack of understanding from service providers, and d) non acceptability of the homeless by society, a concept known as 'NIMBY-ism' (not in my backyard).

In general, participants identified poverty as one of main propagators of homelessness. Addressing poverty may improve cash flow to the homeless. They suggested the need to review eligibility requirements for social assistance, increase social assistance payments, and the minimum wage. Need for special programs to be developed to train and equip unskilled homeless persons with skills needed by local industries. This will also require facilitation of the process of employment by providing some incentives to potential employers. It has been documented that this strategy is often addressed later in the continuum by practitioners, who often give preference to providing people with safe and affordable housing and supportive services¹⁷.

Since the 2006 conference on homelessness, in January 2007 "the Calgary Committee to End Homelessness was established by 24 Calgary corporate, government and community leaders to develop a 10 year plan to end homelessness in the city. The committee will be building on a planning model promoted by the United States Interagency Council on Homelessness, which is being implemented in over 230 American cities and counties. The plan designed for Calgary was delivered in mid-2008" (City of Calgary, 2008). With the reported increase in the number of homeless in Canadian cities, Canadians must be looking forward to its implementation.

This study had a number of limitations. First, participants included a convenient sample of conference attendees, skewed towards females. This might have an effect on the way that study participants perceived the challenges and issues encountered in delivering care to the homeless. Secondly, the understanding and interpretation of challenges, issues and strategies by participants may have affected their responses. Thirdly, the limitation of the questionnaire may not have allowed a proper understanding of the topic of homelessness and health. Nevertheless, this study presents several strengths: 1) It provides an input from the frontline, something that has not been done before, 2) It utilizes both a survey and group discussion format to collect as much valuable information as possible, 3) The conference provided a thought environment where people reflected on the real issues around homelessness and health without being too distracted, 4) The findings include input from study participants at different levels of involvement with the issue of homelessness.

Conclusion

Our study identified five major action steps to tackling homelessness and health related problems as: 1) Continuum of care, 2) Improving access to services, 3) Supportive housing, 4) Addressing poverty, 5) Collaboration and coordination. The topics generated from the group discussion confirmed the findings from the individual surveys. Both the individual responses and group discussions emphasized the absence of a coordinated effort in addressing issues related to the homeless population and the need for strong leadership and funding. Also, there is a common acknowledgement of gaps in the medical health services for homeless persons especially related to early discharge from hospital with no-follow-up. Taking action on homelessness and health requires an integrated approach, involving the community, government, the private sector, service providers, and the homeless. The provision of shelter alone is unlikely to overcome the adverse effects of homelessness and health related problems.

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Table 1. Characteristics of study participants

Variable	% of 87
Frequency of respondents	
Females (n = 79)	90.8
Males (n = 8)	9.2
Type of contact with homeless	
Direct (n = 54)	62.1
Indirect (n = 27)	31.0
None (n = 6)	6.9
Type of (work) position of respondents	
Health care provider (n = 36)	41.1
Homeless services provider (n = 12)	13.8
Social worker (n = 12)	13.8
Administrator (n = 7)	8.0
^a Others (n = 20)	23.0
Length of time working with homeless (years)	
Mean	6.75
Standard Deviation	7.39
Median	3.5
Range	0 - 30

^a others were specified to include consultant, coordinator, instructor, counsellor, employment facilitator, health consultant, medical student, nursing student, planner/researcher, policy & program delivery, policy analyst, researcher, volunteer.

	<ul style="list-style-type: none"> • NIMBY-ism (i.e not in my backyard)
<p><i>Leadership / coordination</i></p>	<ul style="list-style-type: none"> • Need to develop partnership with agencies in the community with funding support* • Lack of political will • Policy barriers • Mistrust of the “system” [by homeless people] • [have to develop] appropriate programs specific to needs • Social assistance insufficient to pay for meds; e.g. AISH too low, too hard to get, especially for mental health patients • Need relevant research and funding for sustaining program; need accurate research to portray needs / views [of homeless people] • Need to establish community partnerships • Alternative (e.g. no cost / sliding scale) for healthcare • Lack government legislation • Lack social support system (financial) • Lack case management / outreach services • Lack system support / economic resources • Lack funding; e.g. CHR does not consider homelessness a priority • Need to engage stakeholders (e.g. CHR, city) • Lack of Calgary Health Region’s awareness

Table 3. Thematic outline of suggestions that could be used to improve the delivery of services to homeless people

Theme	Survey Content
<i>Coordination / collaboration / integrated care model / partnership</i>	<ul style="list-style-type: none"> • Multidisciplinary teams • Practitioners connected to shelters / agencies; e.g. in-house shelter services, include psychologist, eye care, dental care, foot care • Common data bank; e.g. electronic patient records – to avoid duplications, provide medical history • Mobile bus daily • Inner city clinics • Hospital – shelter – agencies → need more stable discharge plans • Increase linkage between CHR and community services; i.e. better communication, more partnerships
<i>Education / awareness / diversity training</i>	<ul style="list-style-type: none"> • Professional / practitioner education; Starting training with students • Abolish “us” versus “them” mentality • Put “face” to homelessness • Public education → increase public awareness of issues facing homeless; be aware of NIMBYism • Remove stigma / judgement • Change government / societal attitudes • Political understanding
<i>Accessible housing</i> -- came up in all three levels of inquiry, i.e. as an issue, as a strategy and as a suggested solution	<p>Need innovative strategies Affordable, supportive, transitional</p>

Table 4. Outline of recommendations for action on homelessness and health from group discussions.

Challenges/Issues	Aim	Suggested Actions
Housing & shelters	To prevent homelessness by providing affordable and appropriate housing. To provide shelters/beds as transitional housing.	Need to address cost of housing, institute rent control. Employers should provide housing for people relocating. Need to reduce time spent in shelters e.g An exit plan should be prepared for every individual during their first days in a shelter.
Access (primary care)	Provide health services to people where they are. E.g only two detox centres in Calgary. Expand services to vulnerable populations – seniors, immigrants, handicapped-disabled before they become homeless.	Need physicians connected to shelters. e.g A Calgary Health Region Physician affiliated with shelters. Need to adopt new care delivery models e.g street nursing
Education	Attempts to provide an awareness of the problem and improve attitudes towards homeless. Reduce resistance to policy changes and eliminate the concept of 'not in my backyard'	Need to educate healthcare providers and the community about homelessness. More education on diversity and the homeless as a diverse population. Need to educate about rights-services as a right, an aspect of citizenship, not charity. Need events to create awareness and address stereotyping homelessness e.g conferences
Health Insurance & drug benefits	Attempts to address gaps in care delivery e.g Homeless clients without health care insurance cards and no means to purchase drugs.	Need to develop a database that is accessible to service agencies. Need to have some medication onsite.
Mental Health & Addictions	Attempts to address causes of addictions, drugs and sex trade	Need to address addictions as a health issue rather than a legal issue. Need to revisit the conduct of 'war on drugs' as it often impedes action on addictions. Need more staff and increase compensation.
Continuum of care	Ensures follow-up treatment, eliminate dual diagnosis and misuse of time and resources	Coordinate discharge and follow up from hospital to shelter e.g Calgary Health Region needs to fund positions of nurse Practitioners (NP) to coordinate care and discharge planning in hospitals.
Funding	Provides a means for sustainable interventions to address homelessness. To ensure continuity of services,	Need for more government involvement, not rely on charities for funding. Need to address the flawed granting process.

	research, service agencies, and staff.	
Poverty	Attempts to provide basic needs for the homeless and provide a pathway to a normal life.	Need to improve cash flow by eliminating restrictions to social assistance. Need to raise social assistance payments. Need to increase minimum wage. Need for programs to train people on specific trades and skills for the industry
Collaboration & Coordination	Allows for more interdisciplinary approach, reduce duplication or service overlap, eliminate dual diagnosis and unnecessary referrals.	Central database. Map service agencies serving the homeless. Have a central phone system where homeless persons can have information on services and programs available. Need to improve on existing programs rather than creating new ones. Explore comprehensive care.
Policy & Legislature	Acknowledges and identifies homelessness as a social crisis, not a minority issue. Attempts to make homelessness a priority for decision makers e.g lots of talk but no action. Involves advocates	Address punitive bylaws, fines that cause obstacles to tackling homelessness. Suggest policy memos to politicians to expose the problem and propose solutions. Need to examine impact of health and social policies on the lives of the homeless.
Research	Attempts to provide a better understanding of homelessness, root causes, and care delivery models.	Need to have a common vision on the definition of homelessness. Need to evaluate the effectiveness of current programs and service delivery models in tackling homelessness. Need to shift research from health issues of the homeless to interventions to address homelessness.