chapter

5

HEALTH AND HEALTH CONDITIONS

Nick Falvo, PhD

Introduction

Persons experiencing homelessness experience far more health challenges—both mental and physical—than do members of the general population. Physically, this includes high rates of hepatitis C, epilepsy, heart disease, cancer, asthma, arthritis/rheumatism, and diabetes. Mentally, it includes high rates of anxiety, depression, bipolar disorder, schizophrenia, and substance use disorders.

As a result of such health challenges, public health spending for persons experiencing homelessness tends to be rather high—rather than receiving consistent, low-cost care, persons experiencing homelessness often receive more expensive care, frequently in Emergency Departments, and very often only once their health challenges worsen. It is also well-established that, largely due to such health vulnerabilities, persons experiencing homelessness die much sooner than the rest of the population.

Persons experiencing homelessness experience far more health challenges—both mental and physical—than do members of the general population.

This chapter provides an overview of health challenges experienced by people experiencing homelessness, while also discussing contributing factors and promising practices.

Common health conditions

"Homeless people in their forties and fifties often develop health disabilities that are more commonly seen only in people who are decades older."

- Stephen Hwang[1]

For persons experiencing homelessness, chronic health conditions are far more prevalent—and prevalent earlier—than for the general population. This reduces both quality of life and lifespan. And for the public at large, it can result in higher healthcare costs.

Mental health challenges. Persons experiencing serious mental health challenges are more likely to become homeless, as mental health can negatively affect employment and other social relations—including relations with family members. Once a person is homeless, mental health challenges can be exacerbated due to stress, trauma and sleep deprivation. Common mental health challenges faced by persons experiencing homelessness include high rates of anxiety, depression, bipolar disorder, schizophrenia and substance use disorders.

Physical health challenges. Persons experiencing physical health challenges are also more likely to become homeless, as physical health challenges can negatively affect employment. With physical health challenges, a skilled trades person may become unable to perform tasks they once found easy; this loss of skill can make that person vulnerable to unemployment. Once homeless, physical health challenges can be exacerbated by challenges in obtaining treatment, including medication. Persons experiencing homelessness are known to have especially high rates of hepatitis C, epilepsy, heart disease, cancer, asthma, arthritis/rheumatism, and diabetes.

Persons experiencing homelessness are more likely to use Emergency Departments than are members of the general population.

High mortality rates. Not surprisingly, persons experiencing homelessness die much earlier than members of the general population. This is one of many reasons why it is important to intervene to stop a person's homelessness from becoming long-term. The faster a person can become housed with appropriate supports—including health care supports—the longer that person can live.

Emergency Department use. While costs to the taxpayer should not be the main consideration when designing policy, they are certainly a major consideration for many senior officials in the sector. And with that in mind, one must remember that persons experiencing homelessness are

1 Quote is from p. 170 of Hwang, S. W. (2004). Chapter 10: Homelessness and health. In J. D. Hulchanski & M. Shapcott (Eds.), *Finding room: Options for a Canadian rental housing strategy* (pp. 167-177). CUCS Press.

more likely to use Emergency Departments than are members of the general population. Once admitted to an Emergency Department, they stay longer than members of the general population. Persons experiencing homelessness also have higher rates of readmission, in part because they are not always able to maintain post-release care plans. The faster we can end a person's homelessness—ideally with permanent housing and appropriate health care supports—the faster we can reduce the use of expensive hospital resources.

Contributing factors

Approximately 300 persons who had experienced at least six consecutive months of absolute homelessness were interviewed for a Canadian study, which found that research participants had suffered child trauma at a rate five times higher than the general population.

Many factors contribute to the health conditions discussed in this chapter. Some of them are:

Low income. Low household income often precedes homelessness, and low income is known to be associated with poor health.[2] While the direction of causation is often debated, low income can negatively impact early childhood development, education, nutrition, exercise, housing quality, social participation and access to health care. Put differently, even before the initial onset of homelessness, a low-income person is already likely to be vulnerable to poor health.

Trauma. Trauma is known to contribute to poor health outcomes, especially poor mental health outcomes. This includes trauma experienced early in life, as well as ongoing physical and sexual assault during homelessness. Approximately 300 persons who had experienced at least six consecutive months of absolute homelessness were interviewed for a Canadian study, which found that research participants had suffered child trauma at a rate five times higher than the general population. Such trauma included neglect, parents with substance use challenges, domestic violence, and abuse.[3]

Exposure to the elements. Living without adequate shelter exposes people to both extreme weather and precipitation, which can compromise their health. Exposure to cold weather can cause frostbite and hypothermia. Exposure to hot weather can lead to heat exhaustion, heat stroke, dehydration and skin cancer. Precipitation can lead to fungal infections and other skin problems. It is also worth noting that exposure to both extreme heat and extreme cold can be fatal.

2 Marmot, M. (2002). The influence of income on health: Views of an epidemiologist. *Health Affairs,* 21(2): 31–46. Retrieved from http://www.healthaffairs.org/

3 Milaney, K., Williams, N., & Dutton, D. (2018). Falling through the cracks: How the community-based approach has failed Calgary's chronically homeless. *The School of Public Policy Publications, 11.*

Congregate living. Most emergency facilities are overcrowded. In some cases, there is just one foot (i.e., 30 cm) separating persons. In other cases, vulnerable persons (including children) are in close proximity to strangers. Such overcrowding both increases infectious disease transmission and contributes to conflict among residents, all of which can negatively impact mental health. There is also often a lack of food, especially healthy food, at emergency facilities.

Sleep deprivation. When people are sleeping outside or in emergency facilities, it can be challenging to maintain proper sleep hygiene. As a result, persons experiencing homelessness can suffer from sleep deprivation, which can negatively impact cognitive function, coordination, decision-making, blood pressure, immunity, and overall mood.

Theft and assault. Considering the many challenges discussed above, it should come as no surprise to readers that persons experiencing homelessness are often victims of theft,[4] physical assault, and sexual assault. This causes further trauma.

Exposure to cold weather can cause frostbite and hypothermia. Exposure to hot weather can lead to heat exhaustion, heat stroke, dehydration and skin cancer.

Lack of primary care. Many people experiencing homelessness do not have a primary care provider (i.e., family physician or nurse practitioner). This may stem from numerous factors, including: service payment mechanisms that do not make providing care to complex patients lucrative, 'cherry picking' by some physicians to avoid caring for people who are experiencing homelessness, not having a telephone, a lack of health insurance (further discussed below), a lack of low-barrier clinic options (e.g., drop-in hours), and frequent moves (e.g., to different neighbourhoods in a large city). As a result, persons experiencing homelessness often receive health care from Emergency Departments, and only once in crisis.

Many people experiencing homelessness do not have a primary care provider (i.e., family physician or nurse practitioner).

Lack of health insurance. Many persons experiencing homelessness lack health insurance—a phenomenon that is especially widespread in the United Sates. And many persons with health insurance are refused health care because they lack identification. Even in countries with universal health insurance, only limited coverage is available for services such as dental care, prescription medication, physiotherapy, mental health counselling, ambulance transportation, routine eye examinations, eyeglasses and contact lenses, birth control pills, and other contraceptives (persons with active labour market attachment might receive such services via extended health benefits provided by an employer).

4 This includes theft of prescription medication.

When persons experiencing homelessness are in hospital, they are often discharged too quickly and with inadequate planning.

Inappropriate discharge planning. When persons experiencing homelessness are in hospital, they are often discharged too quickly and with inadequate planning. Reasons for this include: pressure on hospital staff to discharge patients quickly (often due to insufficient beds); insufficient communication between hospital staff and staff working at local non-profit organizations (both throughout the year and at the time of a patient's discharge); and a lack of information sharing between hospital and local non-profits. Further, most small non-profits lack the necessary infrastructure to support post-discharge recovery. Where does someone go to recover if they cannot stay in a shelter during the day? Where does a person get the assistive devices they may need? How does a person receive physiotherapy if it is not covered by their health insurance? Finally, if a person lacks a primary care provider, how is repeat diagnostic testing done?

Stigma. Persons experiencing homelessness often face stigma when trying to access health care. This limits access to care and reduces its quality when it is accessed. After negative experiences, persons experiencing homelessness sometimes avoid future treatment.

Persons experiencing homelessness often face stigma when trying to access health care.

Promising practices

Fortunately, there are many promising practices that have strong potential to improve health outcomes for persons experiencing homelessness. Some of them will now be discussed.

Fortunately, there are many promising practices that have strong potential to improve health outcomes for persons experiencing homelessness.

Medical respite. Medical respite initiatives are intended for persons experiencing homelessness who are well enough to be discharged from hospital, but not quite well enough to return to a traditional emergency facility. Most medical respite programs in Canada and the United States reviewed by Doran et al. (2013) "are small (fewer than 20 beds), operated by non-profit organizations, and have average lengths of stay of two to four weeks." They are staffed by health care providers—including physicians and nurses—and their services include case management, as well as assistance with housing searches and income assistance applications. Such initiatives are less costly to taxpayers than hospitals and can reduce the likelihood of readmission to hospital. Doran et al.'s (2013) systematic review of such programs found that they reduce inpatient hospital days as well as future hospital admissions, while also improving housing outcomes.[5]

Case management. Case management refers to staff support to vulnerable persons, sometimes provided by social workers. Such support includes assistance in navigating health care systems, as well as in applying for housing, income assistance and other social benefits. It can include physically accompanying clients to appointments and advocacy. Research has found that case management leads to both improved health outcomes and reduced hospital readmissions.[6] Two formalized approaches are Intensive Case Management and Assertive Community Treatment.[7] The former is staffed mostly by generalists and targets persons with more moderate mental health needs; while the latter is staffed largely by specialists and targets persons with more complex mental health challenges.[8]

Harm reduction. Harm reduction often refers to reducing harm caused by the use of illicit substances without requiring total abstinence. Such approaches often target persons experiencing homelessness. Harm reduction approaches include the distribution of clean syringes, safe inhalation kits and supervised consumption services. There is evidence that harm reduction approaches reduce risk-taking behaviour, reduce the risk of transmission of blood-

5 Doran, K. M., Ragins, K. T., Gross, C. P., & Zerger, S. (2013). Medical respite programs for homeless patients: a systematic review. *Journal of Health Care for the Poor and Underserved, 24*(2), 499-524.
6 Davis, E., Tamayo, A., & Fernandez, A. (2012). 'Because somebody cared about me. That's how it changed things": Homeless. *Chronically Ill Patients, 7*(9).
7 Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. *World Psychiatry, 14*(2), 240.
8 Tsemberis, S. (2010). *Housing First: The Pathways model to end homelessness for people with mental health and substance use disorders.* Hazelden.

borne diseases, prevent overdoses, reduce crime, and increase contact with other supports, including health care supports.[9]

Homes First Society (Toronto)

Homes First Society is a large provider of both emergency services and permanent housing in Toronto; they also operated hotels that were repurposed during the COVID-19 pandemic. Building on an approach to 'wellness checks' that they had begun approximately 10 years earlier, Homes First staff working at COVID hotels checked all bathrooms, showers, stairwells and smoking areas every 15 minutes. Most Toronto emergency shelters have similar wellness checks, and the City of Toronto has released a directive and toolkit that includes 'best practice' guidance related to harm reduction and emergency facilities.[10] Homes First Society also provides 24/7 barrier-free access to harm reduction supplies, requires all staff be trained on the use of naloxone for overdose response, and hangs naloxone in public spaces, washrooms, and shower areas for general use. Additionally, Homes First Society collaborates with external harm reduction partners who provide supervised consumption services, peer spotting programs and safer supply programs onsite to improve client safety and reduce overdose deaths.

At some emergency facilities, nurses provide wound care, medication administration, overdose responses and other health-related assessments.

Housing First. Housing First refers to the immediate provision of permanent housing—with appropriate subsidy level and degree of professional staff support—to persons experiencing homelessness. It is usually targeted to persons with serious mental health challenges who have experienced homelessness over several years. A considerable body of research has found Housing First to be associated with positive health outcomes.

Health care at emergency facilities. At some emergency facilities, nurses provide wound care, medication administration, overdose responses and other health-related assessments. It is also common for physicians to make regular visits to some emergency facilities in order to build trust and rapport with residents, provide episodic care for acute health conditions as well as longitudinal care for chronic conditions, and to facilitate the connection of patients to primary care or specialist care at traditional health care settings. During the COVID-19 pandemic, several pharmacists began going to emergency facilities to fill prescriptions written by medical professionals—pharmacists even started keeping regular hours at several

9 Pauly, B. B., Reist, D., Belle-Isle, L., & Schactman, C. (2013). Housing and harm reduction: What is the role of harm reduction in addressing homelessness? *International Journal of Drug Policy, 24*(4), 284-290.
10 City of Toronto (2021, June 10). City of Toronto launches new toolkit to respond to an increase in overdoses in the homeless population. https://www.toronto.ca/news/city-of-toronto-launches-new-toolkit-to-respond-to-an-increase-in-overdoses-in-the-homeless-population/

Toronto emergency facilities.[11] After a person leaves an emergency facility—ideally for permanent housing—care plans should be put in place so that the person does not have to return to the emergency facility in order to continue receiving health care.

Improved hospital discharge. A randomized controlled study undertaken at several Canadian hospitals assessed the impact of on-site, pre-discharge housing assistance for psychiatric clients. With the treatment group, a manager with the local income assistance program fast-tracked social assistance funds for first and last month's rent, while a housing worker was assigned almost immediately to the soon-to-be-discharged patient. The housing worker helped members of the treatment group call prospective landlords, and sometimes visited the housing unit with the prospective tenant. Income assistance staff were able to then provide the fast-tracked funds directly to landlords. "The housing [worker] 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." The intervention significantly reduced the number of persons discharged into homelessness.[12]

11 Falvo, N. (2021). *Innovation in homelessness system planning: A scan of 13 Canadian cities.* Report commissioned by the Calgary Homeless Foundation.

12 Forchuk, C., Godin, M., Hoch, J. S., Kingston-MacClure, S., Jeng, M. S., Puddy, L., Vann R., & Jensen, E. (2013). Preventing psychiatric discharge to homelessness. *Canadian Journal of Community Mental Health, 32*(3), 17-28.

Conclusion

Persons experiencing homelessness are vulnerable to a wide range of health conditions—both mental and physical. Contributing factors include trauma, exposure to the elements (i.e., bad weather), congregate living, sleep deprivation, lack of primary care, lack of health insurance, and inappropriate discharge planning (particularly from hospitals). As a result of these health conditions, and relative to the general population, persons experiencing homelessness access Emergency Departments more frequently and stay longer, costing taxpayers more. Persons experiencing homelessness also die at much younger ages than do members of the general public.

Fortunately, promising practices with strong potential to improve health outcomes abound. These include medical respite, case management, harm reduction, Housing First, health care at emergency facilities, and improved discharge planning from some hospitals.

Further reading

Buccieri, K., Oudshoorn, A., Frederick, T., Schiff, R., Abramovich, A., Gaetz, S., & Forchuk, C. (2019). Hospital discharge planning for Canadians experiencing homelessness. *Housing, Care and Support, 22*(1), 4-14.

Coldwell, C. M., & Bender, W. S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry, 164*(3), 393-399.

De Vet, R., van Luijtelaar, M. J., Brilleslijper-Kater, S. N., Vanderplasschen, W., Beijersbergen, M. D., & Wolf, J. R. (2013). Effectiveness of case management for homeless persons: A systematic review. *American Journal of Public Health, 103*(10), e13-e26.

Doran, K. M., Ragins, K. T., Gross, C. P., & Zerger, S. (2013). Medical respite programs for homeless patients: a systematic review. *Journal of Health Care for the Poor and Underserved, 24*(2), 499-524.

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet, 384*(9953), 1529-1540.

Hwang, S. W., & Burns, T. (2014). Health interventions for people who are homeless. *The Lancet, 384*(9953), 1541-1547.

Jenkinson, J. I., Strike, C., Hwang, S. W., & Di Ruggiero, E. (2021). Nowhere to go: Exploring the social and economic influences on discharging people experiencing homelessness to appropriate destinations in Toronto, Canada. *Canadian Journal of Public Health, 112*(6), 992-1001.

Landefeld, C. C., Pauly, B., Stockwell, T., Nance, M.,& Smith-Bernardin, S. (2023). Commentary: Managed alcohol programs: An innovative and evidence-based solution for adults with severe alcohol use disorder who are experiencing homelessness. *NEJM Catalyst*, https://doi.org/10.1056/CAT.22.0301.

Liu, M., & Hwang, S. W. (2021). Health care for homeless people. *Nature Reviews Disease Primers, 7*(1), 5.

Nelson, G., Aubry, T., & Lafrance, A. (2007). A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry, 77*(3), 350-361.

Pottie, K. et al. (2020). Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience. *Canadian Medical Association Journal, 192*(10), E240-E254.

Reilly, J., Ho, I., & Williamson, A. (2022). A systematic review of the effect of stigma on the health of people experiencing homelessness. *Health & Social Care in the Community, 30*(6). 1-14. https://10.1111/hsc.13884.

About the author

Nick Falvo is a research consultant based in Calgary, Canada. He has a PhD in Public Policy and is Editor-in-Chief, North America, of the *International Journal on Homelessness*. He has academic affiliation at both Carleton University and Case Western Reserve University. Prior to pursuing his PhD, he spent 10 years doing front-line work directly with persons experiencing homelessness.

Acknowledgements

The author wishes to thank the following individuals for assistance with this chapter: Kristy Buccieri, David Campbell, Doug Chaudron, Kathy Hardill, Stephen Hwang, Peter MacKie, Jenny Morrow, Abe Oudshoorn, Joel Sinclair, and Danielle Szabo. Any errors are the responsibility of the author.

About this project

This is Chapter 5 of a sole-authored, open access interdisciplinary textbook intended to provide an introduction to homelessness for students, service providers, researchers and advocates. Focusing on the English-speaking countries of the OECD, it will discuss causes, solutions, challenges, successes, and innovations in the sector. It will serve as 'launching pad' for people new to the sector, as well as a refresher for experienced practitioners.

In addition to being open access, this book is different from other books in two key ways: 1) by focusing on all English-speaking countries of the OECD; and 2) by providing an overview of recent innovations in the sector—i.e., what's new, and what's working well?—making it useful to practitioners.

- The book's **intent** is primarily to serve as the main textbook for a university course designed for senior-level undergraduate as well as graduate students. It also serves as a resource for senior leadership in the homelessness sector.
- Book's **main themes**: contributing factors to homelessness; health conditions and health care challenges of persons experiencing homelessness; the unique needs of various subpopulations; staffing challenges in the sector; an in-depth examination of innovative practices; and solutions to homelessness.
- Book **objectives**: assist readers in understanding the fundamentals of homelessness; introduce them to both successes and ongoing challenges in the sector; and leave them feeling better-informed, able to make critical assessments, confident and empowered to take action within their own respective spheres of influence.

Table of contents (anticipated)

I. THE BASICS
    1. What causes homelessness?
    2. Theory and homelessness
    3. Rough sleeping and encampments
    4. Emergency facilities
    5. Health and health conditions
II. SUBPOPULATIONS
    6. Indigenous peoples
    7. Racialized persons
    8. Women
    9. Youth
    10. Older adults
    11. LGBTQ2S
    12. Intersectionality
III. THE RESPONSES
    13. Tracking, enumerating and categorizing
    14. How officials respond to homelessness
    15. Housing First
    16. System planning
    17. Staffing
IV. EMERGING THEMES
    18. Overdose crisis
    19. Aging population
    20. COVID-19 pandemic
    21. Climate change and mass migrations
V. INNOVATIVE PRACTICES
    22. Artificial intelligence
    23. Prevention initiatives
    24. Taxation earmarked for homelessness

Target audience

- The book is intended primarily for course use, its primary audience being senior undergraduate students, graduate students and course instructors in English-speaking countries of the OECD. It can also be useful to senior leadership in the homelessness sector (e.g., board members, CEOs and staff).
- The book is intended for courses where homelessness is either the only focus or a major focus. For example, a course on housing and homelessness could benefit from this book. Standalone chapters could also be of great value in various disciplines.
- Some of these courses might be taught outside of the university setting—for example, by the UK-based Chartered Institute of Housing and by its counterparts in other countries, such as CIH Canada.
- The book can be used as either a primary or supplementary text.
- The book is intended to have international appeal, focusing on the English-speaking countries of the OECD: Australia, Canada, New Zealand, the United Kingdom, and the United States.
- Homelessness is widely researched and quickly evolving, as new approaches to both prevention and response are being developed. Much of the book's content will therefore be new even to experienced researchers and practitioners.

All material for this book is available free of charge at https://nickfalvo.com/. Newly-completed chapters will be uploaded throughout the year. The author can be reached at falvo.nicholas@gmail.com.