Bus tickets are not enough:
Exploring the experiences of British Columbian social workers discharging patients into homelessness

Prepared by the British Columbia Association of Social Workers Health Advocacy Committee

January 2021

This report was prepared by the British Columbia Association of Social Workers Health Advocacy Committee members based on a province-wide survey project exploring the experiences of social workers in acute care when discharging clients into homelessness.

Lead Project Coordinator: Fiona Lewis

Project Team: Nancy Anderson, Nancy Baker, Kym Bohachewski, Florence Flynn, Cayce Laviolette, Fiona Lewis, Rae Morris, Megan Saul

Special thanks to all of the social workers who contributed responses and to the Health Sciences Association of B.C. for support in distributing this survey.

For additional information, please contact Fiona Lewis, fiona@fionalewis.ca

Executive Summary

In the spring of 2019, the Health Advocacy Committee of the B.C Association of Social Workers (BCASW) conducted an on-line survey of social workers working in acute healthcare settings across the province to explore the discrepancies between health system protocols related to discharging vulnerable patients and actual practice. We specifically wanted to learn the extent to which vulnerable patients were being discharged to unsafe or unhealthy locations as well as the perspectives of social workers in relation to how practice in this area could be improved. Social workers across the British Columbia were recruited through the BCASW newsletter and through an email sent to its social work members by the Health Sciences Association of BC.

Participants included social workers working in direct practice in acute care settings across British Columbia within three months prior to responding. 144 social workers responded and 23 were disqualified due to not working in acute care in British Columbia over the past three months.

This survey results confirmed that the discharge of vulnerable patients from hospital into homelessness is a significant and prevalent problem within BC hospitals and communities. 95% of survey respondents reported involvement with the discharge of homeless patients within the past three months. Moreover, 80% of these social workers reported homeless patients returning to the hospital within 48 hours of discharge.

A thematic analysis of the responses to all four open-ended questions was completed. Four overarching themes emerged: homeless clients are complex due to co-occurring conditions such as struggles with addiction or mental health, systemic obstacles make discharge planning difficult, there is a broad array of community programs and resources that are helpful, and many hospital social workers experience moral distress as they are pressured to discharge homeless individuals into unsafe or inadequate environments.

Our report concludes with a number of recommendations all of which will require ongoing collaboration between different levels and bodies within the health and social services sectors. In addition, we endorse a number of recommendations in a recent report of the Gerontology Research Centre at Simon Fraser University, entitled Supporting Partnerships between Health and Homelessness (Canham, et al., 2019). This report includes the vital perspective of people with lived experience of homelessness (PWLE).

Many health care providers, academics, advocates and PWLEs have pointed to concrete, evidence-based solutions to this crisis – we must work together to ensure these solutions are implemented as soon as possible.

Background and Purpose

The British Columbia Association of Social Workers (BCASW) Health Advocacy Committee is comprised of social workers across the province of British Columbia who are invested in advancing the practice of social work in healthcare. The goals of the committee are to draw attention to policy and practice inequities in the area of health, and to advocate for systemic changes on behalf of clients and social workers in healthcare settings. In December 2016, the Health Advocacy Committee identified housing and homelessness as a key priority. In keeping with our mandate to advocate on health-related issues, we decided to explore the issue of whether patients were being discharged from hospital into homelessness.

Discharge of patients from hospital settings into homelessness or housing crises has been a longstanding issue at the forefront of healthcare in Canada (Forchuk, Reiss, Mitchell, Ewen, & Meier, 2015). Canadian research has indicated that individuals experiencing homelessness present to hospitals at significantly higher rates than individuals with stable housing, partially due to challenges accessing primary and secondary healthcare (Hwang & Henderson, 2010). Higher rates of emergency room utilization and hospital admission among homeless individuals results in a financial burden on the Canadian healthcare system (Gaetz, 2012). Previous studies conducted across North America have shown that when resources are allocated to discharge previously homeless hospital patients into transitional and long-term housing, the outcomes include significant reduction in emergency room visits and hospital admissions (Sandowski, Kee, VanderWeele, & Buchanan, 2009; Stergiopoulos, et al., 2015).

Our interest in discharge into homelessness came about after learning that a region in Ontario was successful in reducing the number of patients discharged into homelessness (London Health Sciences Centre, 2019). One of our members shared with us a protocol from Vancouver Coastal Health (VCH) and Providence Health Care (PHC) entitled *Discharge of Vulnerable Emergency Department Patients*. This protocol "provides a standard for managing the discharge of vulnerable patients from VCH/PHC Emergency Departments in a safe, consistent manner" (Vancouver Coastal Health, Providence Health Care, 2014). As we were considering this document, we became aware of some anecdotal evidence from social workers that vulnerable patients throughout the province were still being discharged to unknown and unsafe locations including locations where health authority home care providers refused to attend to provide services, and locations that exposed residents to multiple health hazards.

In 2017, an online survey was sent out to individuals working across health and social service sectors across Canada to address the question "what are the barriers and system gaps to timely discharge for people experiencing homelessness from hospital to community in Canada?"

(Bucieri, et al., 2019). The results supported the anecdotal evidence that we had heard, acknowledging that many homeless patients were being discharged without sufficient housing and that communication, privacy, and systems pressures were three key gaps contributing to these outcomes. The majority of participants in this study were located in Ontario and were employed in various direct practice roles. While it is likely that many of the participants in this study were social workers, as discharge planning for patients from hospital into community settings is a role often undertaken by social work (Judd & Sheffield, 2010), profession demographics were not collected. There is likely some valuable insight to be gained from social workers with direct practice experiences discharging patients into homelessness or precarious housing across the provinces.

In order to explore the potential discrepancy between health systems protocols and direct service provision outcomes in British Columbia, we decided to conduct a survey of social workers working in acute healthcare settings across the province. We specifically wanted to learn the extent to which vulnerable patients were being discharged to unsafe or unhealthy locations as well as the perspectives of social workers in relation to how practice in this area could be improved.

Method

Recruitment

Social workers across the province of British Columbia were recruited through the BCASW Ebulletin newsletter and through an email sent to its social work members by the Health Sciences Association of BC. The survey link was open for data collection between February 18, 2019 and March 25, 2019. Participants were informed that their participation was anonymous and voluntary, and that they could cease participation at any time with no consequence to them. According to the B.C. College of Social Workers, there are currently just over 4500 registered social workers in British Columbia; however, only a portion of these work in health care.

Participants

Participants included social workers working in direct practice in acute care settings across British Columbia within three months prior to responding. We limited the respondents to only social workers in order to fit with the BCASW mandate and to keep the scope of the project manageable for our volunteer-based committee.

Survey

We created an online survey that included thirteen multiple choice and four open-ended questions. The multiple-choice questions helped to determine the extent to which social workers had experience in discharging patients into homelessness. For example, question 7 asked, "*In the past three months, have you been involved in the discharge of patients who were homeless at the time of discharge?*". Another multiple-choice question explored the health conditions of these patients. The open-ended questions asked social workers to comment on the experiences of these patients and also to offer suggestions for systemic improvements. For example, question 16 asked, "*What comments or feelings, if any, have clients experiencing homelessness expressed to you while being discharged?*". The survey was pilot tested by committee members, some health authority social workers and the BCASW board president.

Results

Demographics

144 social workers responded and 23 were disqualified after the first question, which asked respondents if they were a social worker who had worked in acute care in British Columbia over the past three months. The remaining voluntary questions were answered by between 81 and 112 respondents per question, with an average response rate of 97.

Respondents were asked to indicate the role and hospital in which they worked the majority of hours over the previous 3 months. 101 respondents indicated they work in direct practice, and 6 respondents indicated they work in management roles. The largest number of responses was for Surrey Memorial Hospital (21) followed by Royal Jubilee Hospital (10), and Victoria General Hospital (6). Considering their size, there was a disproportionately small number of respondents from Vancouver General Hospital and St. Paul's Hospital (5 each).

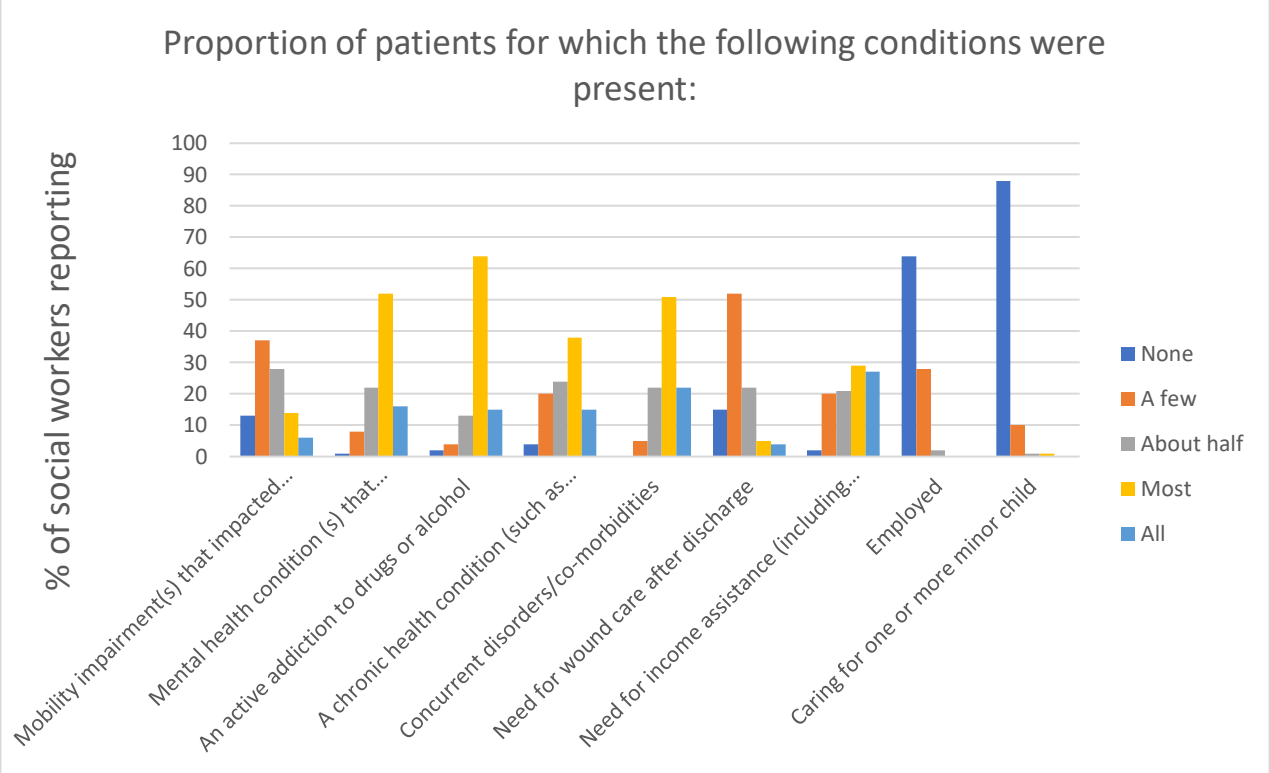
Respondents were asked to indicate in which health authority they work: 55 work in Fraser Health, 11 work in Interior Health, 21 work in Island Health, 5 work in Northern Health, 19 work in Vancouver Coastal Health, and 2 work in the Provincial Health Services Authority.

95% of respondents indicated that in the previous three months, they had worked with patients who were homeless at the time of discharge. All but one respondent had been involved with more than one homeless patient while many reported working with 10 to 20 patients who were homeless.

Quantitative Results

Chart 1 presents the results of a question exploring the existence of co-occurring conditions in patients at risk of homelessness. 65% of respondents indicated that all of their homeless patients had addiction issues, while 50% of respondents noted all of their patients had concurrent disorders. 35% of respondents indicated that the majority of homeless patients they were involved with had mobility impairments. Nearly 30% of respondents reported all of their homeless patients had a need for income assistance. Half of respondents reported having some homeless patients with a need for wound care after discharge.

Chart 1



Over 80% of respondents indicated that they worked with homeless patients who were discharged to locations where necessary health care services could not be provided.

82 respondents indicated that in the past three months they were aware of patients experiencing homelessness who returned to hospital within 48 hours of discharge. 31 respondents indicated that up to 20% of homeless patients returned to hospital within 48 hours of discharge.

Social workers were asked if more than one hospital social worker was involved with the homeless patients they worked with in the past three months. 25% of respondents said that none or only a few of their patients had only one social worker involved.

More than 60% of respondents indicated that their advocacy efforts resulted in homeless patients having a longer hospital stay some of the time. 8% of respondents indicated that their advocacy efforts never resulted in a longer stay for homeless patients.

Qualitative Results

The survey questionnaire included four open-ended questions which were analyzed for common themes. Question 14 asked "*Are there specific programs or resources in your workplace or community that have helped you to meet the needs of homeless patients? If so, please name and describe briefly"*. Twenty three percent of the respondents (19 out 81 respondents) said that although some form of service/program was available in their community, the resources were insufficient and therefore respondents listed a qualifier explaining why or what was needed.

Question 15 prompted the respondents to identify *"What solutions would you suggest to prevent patients from being discharged into homelessness?* ". Twenty respondents suggested community-based resources. Eighteen respondents suggested low barrier/supportive housing, while seventeen responses suggested more shelters and 24-hour drop-in programs. Some other suggestions included affordable housing (n=15), hospital-community coordination of care (n=11), more resources in hospital (n=10), financial supports (n=10), shift in understanding of homelessness (n=10), transitional housing (n=9).

Question 16 asked the respondents *"What comments or feelings, if any, have clients experiencing homelessness expressed to you while being discharged?"* There were 87 responses to this question. Some of the most common themes related to feelings include hopelessness (n=25), anger (n=25), frustrated/disappointed (n=19), scared/fear (n=22). Themes under COMMENTS include health concerns, lack of resources, concerns about shelters.

Finally, question 17 asked for any additional comments on the topic of patients being discharged into homelessness. There were sixty-four responses to this question. These are included in the thematic analysis below.

Themes:

A thematic analysis of the responses to all four open-ended questions was completed. Four overarching themes emerged from the data: Complexity of clients, Systemic Obstacles/ Exacerbators, Community programs/ Resources that are helpful, and Social Work Role.

1. Client Complexity

The first theme identified had to do with the complexity of clients who are dealing with homelessness. Respondents commented that they work with people who were dealing with a variety of health and social conditions that are exacerbated by not having a home to return to. The complexities identified include clients or patients having co-occurring conditions such as struggles with addiction or mental health conditions and those from vulnerable populations (seniors, 'high risk', medical) who are facing homelessness.

The following quotes are examples of this theme:

> *"High proportion struggle with mental health and substance use concerns and have difficulty with some activities of daily living. Many housing resources aren't available for people struggling with sobriety or these resources are located in the DTES. We know that environment can be instrumental for recovery but we struggle to assist clients with accessing stable placements."*

> *"recognizing that there are big gaps for certain populations that do not fit in any one program. Perhaps…increase Supportive Housing; cluster care in shelters for the more vulnerable population that requires additional support."*

2. Systemic Obstacles/ Exacerbators

Respondents identified several systemic obstacles and exacerbators that make discharge planning difficult. These factors include: a lack of shelters/housing, a lack of resources (in hospital and community), the effect of the biomedical/acute focus in hospitals and of the perception/stigma around homelessness, and finally, the pressure to discharge. The following quotes support this theme:

> *"Without proper follow up in a supportive environment there [is a] high probability of a person coming back to ER. They become exacerbated by the limited services, inability to access services, physical limitations, no access to phones/computer, easily intimidated to go to the library."*

> *"There is an overall lack of understanding amongst medical professionals as to the lack of housing and lack of resources. There*

are often, unrealistic expectations as to what is available, or possible, in terms of housing."

"Many patients being discharged into non-ideal situations as once med[ically] stable there is a huge push from higher levels (managers, directors) to discharge ASAP."

"I think there is a huge divide in how we value different peoples' lives and the care they receive."

3. Community programs/resources

The respondents identified that there are community programs/ resources that are helpful. Some respondents identified specialized resources within hospital: *"Enhanced discharge team"; "Hospital housing worker"* while others focussed on accommodation/shelter resources. Modular housing was mentioned by seven people. Specialized housing programs (i.e., supportive, mental health, low barrier, short-term, etc.) was mentioned by forty-one people. Other community resources and programs mentioned by twenty-nine respondents included outreach programs (i.e., housing outreach, case management, urban health outreach, etc.).

4. Impact on Social Workers

The final theme to emerge from the data was the impact of dealing with the issue of homelessness on the social work role. Several subthemes emerged. Many respondents spoke about the moral distress they feel: *"Having a patient cry about having no place to go, when they are already physically ill will not assist in their mental health. As a social worker, I feel that I have failed them and failed my duties."* Respondents spoke of the stress, pressure, and frustration they feel in responding to issues of homelessness: *"The health organization put enormous pressure on SW to 'solve' this problem- find people homes… house people, send them to the shelter, etc."*

Hopelessness was expressed by a number of respondents: *"There are so many systematic issues, poverty, lack of political will to construct housing"; "It is gut-wrenching to send a patient back into an unsafe situation of homelessness, especially when the patient is begging to stay."*

Finally, the respondents spoke of the lack of support and resources in hospital and community:

"Shelters should have social workers and/or support workers available every day 24 hours per day in order to transition care from hospital to shelter more effectively."

"Increase the number of outreach workers. Often individuals cannot get into a program and workers need to go to them."

"SWers feel under resourced, when patients are 'medically cleared', we are expected to find a solution for housing, unfortunately, not much can be resolved right away and patients have to line up at a certain time for shelters..."

Implications and Discussion

This survey confirmed that the discharge of vulnerable patients from hospital into homelessness is a significant and prevalent problem within BC hospitals and communities. 95% of survey respondents reported involvement with the discharge of homeless patients within the past three months. Moreover, 80% of these social workers reported homeless patients returning to the hospital within 48 hours of discharge. This has wide-ranging implications for patients, social workers, and the healthcare system.

People experiencing homelessness while in acute care often face adversities that those with stable housing do not. For example, post-discharge treatments or care such as home care services cannot always be arranged, thereby complicating the patient's recovery. A patient's pathway of care while in hospital is impacted not only by these adversities, but also by stigma or misunderstanding from healthcare providers, a commonly reported occurrence for patients without housing (Purkey & MacKenzie, 2019).

People experiencing homelessness frequently have concurrent conditions such as mental illness, substance use disorders, frailty, mobility challenges and cognitive impairments. Discharging these complex patients into homelessness or unsuitable settings can compromise their health and safety. Unfortunately, even when temporary housing resources (such as shelters) are available, these settings may not be equipped to meet the physical, emotional, or mental health care needs of homeless individuals (Khandor & Mason, 2007).

There are many costs associated with discharging people into homelessness. Certainly, the emotional impact experienced by patients upon discharge can be tremendous, with social workers noting patient hopelessness and anger as the two most reported comments in the survey. The financial implications can also be great. Acute care stays are expensive, and once a person is deemed medically stable, some hospitals will not keep a patient who may be awaiting other housing options (such as transitional or long-term care). Homeless patients can end up in a

variety of ill-suited settings: housing incompatible with their needs, short stay psychiatric units, other emergency rooms, or sometimes even jail. The discharge of vulnerable populations to these inadequate housing settings with unsuitable care and care coordination results in multiple and preventable hospital visits.

The practice of discharging people into homelessness also has wide ranging implications for the social workers assisting these patients. As noted earlier, the moral distress among social workers experiencing this phenomena is high. Inability to help clients meet their needs, pressure to discharge patients, and unrealistic expectations from some hospital staff regarding housing resources and social workers' ability to secure them, all contribute to significant moral distress which can impact a social workers' mental health and work performance (Fantus, Greenberg, Muskat, & Katz, 2017).

The issue of discharging into homelessness is likely to increase as the population ages. Many respondents noted that they are seeing more and more seniors and older adults become homeless (Canham, Custodio, Mauboules, Good, & Bosma, 2020). However, social workers identified numerous strategies to help achieve better health outcomes for people experiencing homelessness including better care coordination within the hospital and between the hospital and community programs and an increase in specialized community-based housing and shelter programs that meet the needs of vulnerable populations.

Recommendations

Social workers in hospitals around B.C. took the time to share passionate and constructive comments about the complex issue of discharging patients at risk of homelessness. The responses confirm that social workers want and need to be involved in generating and implementing solutions to this complex problem. The social work participants also pointed to many best practices and local programs that could be spread to improve outcomes for more people. The following recommendations are based on these suggestions from the survey respondents:

1. Increase the supply and availability of housing options for people across the lifespan.
2. Develop housing resources with flexible admission criteria and expansive supports to meet the needs of people with diverse and complex co-morbidities and presentations .
3. Expand treatment and housing options for people with mental health and/or substance use challenges.
4. Develop transitional/temporary housing that is available immediate after discharge from hospital, where the patient can access the support needed to obtain stable and secure housing.

5. Develop close partnerships between hospitals and community social service and housing agencies, to coordinate discharge planning.
6. Approach the issue of homelessness from a holistic perspective that looks beyond the medical concerns and considers homelessness as a social determinant of health with a range of complexities.
7. Improve access to primary health care and medical management to people experiencing and/or vulnerable to homelessness.
8. Develop close collaboration with all financial resources to provide greater and faster access to income assistance, financial aid, emergency funding and shelter subsidies.
9. Provide the person at risk of homelessness comprehensive and consistent support and assistance to secure and maintain stable housing, through the provision of such services as Outreach/Community Support Workers, intensive case management, counseling/treatment, home supports and other indicated services.
10. Develop a provincial housing strategy that provides a coordinated response to the issue of homelessness.

While this survey focused on the experiences of social workers working in the hospital setting, another equally important group to involve in the search for solutions is people with lived experience (PWLEs) of homelessness. A recent report of the Gerontology Research Centre at Simon Fraser University, entitled, *Supporting Partnerships between Health and Homelessness* (Canham, et al., 2019) gathered additional perspectives. This community-based participatory research project engaged PWLEs, health care staff and shelter/housing providers in identifying best practices in supporting PWLEs in their transition from hospital to community. Our research supports a number of recommendations of this report. We have highlighted the most salient ones below:

1. Identify core training and education competencies about homelessness and homeless populations to reduce stigmatization of PWLEs receiving care.
2. Develop intersectoral visits/tours to shelters/housing & hospitals to improve trust and relationship-building across sectors.
3. Develop and maintain an electronic contact list of key positions in each hospital and shelter/housing to improve communication and collaboration in discharge planning.
4. Conduct a housing assessment in the hospital, both at the time of admission and prior to discharge to improve discharge planning.
5. Engage with shelter/ housing providers to begin planning for discharge as early as possible.
6. Establish dedicated professional and peer-navigator positions within hospitals to support successful transitions from hospital to shelter/housing.

7. Embed a housing liaison or housing outreach worker in the hospital to improve continuing of care and reduce hospital readmissions.
8. Expand case management care (i.e., Assertive Community Treatment, Intensive Case Management, Community Transition Team) and ensure other wrap-around health supports and services are available to PWLEs upon discharge.
9. Develop medical respite options to improve health outcomes for PWLEs and reduce acute care utilization.
10. Increase supply of housing options, including social and supportive housing, in both congregate and scattered site options.
11. Ensure new and existing shelters and housing have adaptable and universal design that can support people with a range of needs.
12. Provide dedicated healthcare staff resources to support shelter providers in meeting the health needs of their guests.

Limitations

A number of limitations of this project should be acknowledged. The recruitment methodology of the study resulted in a self-selected group of respondents whose experiences may not be representative of all acute care social workers in the province. The data was not analyzed according to the location of the respondent so it is unclear if there were differences attributable to urban versus rural hospitals. In addition, there was no effort made to validate responses regarding the number of homeless patients each social worker was involved in. It is possible that multiple social workers were thinking of the same homeless patients when they responded. Furthermore, the moral distress reported by social workers was self-reported.

Conclusion

This survey supports anecdotal and research-based suggestions that much more needs to be done to address the difficult transitions that occur when a homeless individual is discharged from hospital in British Columbia. These transitions can involve a lack of continuity of care as an individual moves from a healthcare setting to inadequate or inappropriate housing. They can also result in considerable distress for hospital social workers who cannot access the necessary resources to assist their patients. The human costs to both the patient and the hospital social workers working with the patient are too high to be ignored or addressed through fragmented or isolated approaches.

Many health care providers, academics, advocates and PWLEs have pointed to concrete, evidence-based solutions to this crisis – we must work together to ensure these solutions are implemented as soon as possible.

References

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.

Canham, S. L., Bosma, H., Mauboules, C., Custodio, K., Good, C., Lupick, D., Seetharaman, K., & Humphries, J. (2019). *Supporting Partnerships between Health and Homelessness*. Vancouver, BC: Simon Fraser University, Gerontology Research Centre.

Canham, S., Custodio, K, Mauboules, C., Good, C., and Bosma, H. (2020). Health and Psychosocial Needs of Older Adults Who Are Experiencing Homelessness Following Hospital Discharge, *The Gerontologist*, 60(4), 715-724.

Fantus, S., Greenberg, R.A., Muskat, B, and Katz, D. (2017). Exploring Moral Distress for Hospital Social Workers, *British Journal of Social Work*, 47(8), 2273-2290.

Forchuk, C., Reiss, J.P., Mitchell, B., Ewen, S., & Meier, A. (2015). Homelessness and housing crises among individuals accessing services within a Canadian emergency department. *Journal of Psychiatric and Mental Health Nursing, 22,* 354-359.

Gaetz, S. (2012). *The real cost of homelessness: Can we save money by doing the right thing?* Toronto, ON: Canadian Homelessness Research Network Press.

Hwang, S.W., & Henderson, M. (2010). *Healthcare utilization in homeless people: Translating research into policy and practice.* Rockville, MD: Agency for Healthcare Research & Quality.

Judd, R.G., & Sheffield, S. (2010). Hospital social work: Contemporary roles and professional activities. *Social Work in Health Care, 49,* 856-871.

Khandor, E., & Mason, K. (2007). The street health report 2007. Toronto, Canada. Retrieved from http://www.streethealth.ca/downloads/the-street-health-report-2007.pdf

London Health Sciences Centre. (2019). Preventing homelessness after hospital discharge. Retrieved from https://inside.lhsc.on.ca/article/fall-2019/homelessness

Purkey, E. & MacKenzie, M. (2019). Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care. *Int J Equity Health* 18, 101.

Sandowski, L.S., Kee, R.A., VanderWeele, TJ., & Buchanan, D. (2009). Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. *Journal of the American Medical Association (JAMA),* 301(17), 1771-1778.

Stergiopoulos, V., Gozdzik, A., Misir, V., Skosireva, A., Connelly, J., Sarang, A., Whisler, A., Hwang, S.W., O'Campo, P., & McKenzie, K. (2015). Effectiveness of housing first with intensive case management in an ethnically diverse sample of homeless adults with mental illness: A randomized controlled trial. *PLoS ONE,* 10(7), 1-21.

Vancouver Coastal Health, Providence Health Care. (2014). *Discharge of Vulnerable Emergency Department Patients*.