# Understanding transitions from hospital to shelter/housing: Perspectives of people with lived experience of homelessness

**by**

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# Declaration of Committee

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# Ethics Statement

## Abstract

People with lived experience of homelessness (PWLEs) have poorer health and higher rates of hospital admissions than stably housed persons. However, PWLEs are often discharged from hospital to unsupportive settings that do not meet their complex health needs, resulting in ongoing and worsening health conditions and prolonged recoveries. To expand on current understandings of hospital-to-shelter/housing transitions and to investigate the differences between younger and older PWLEs, this study conducts a secondary data analysis of 20 in-depth interviews with 11 younger (<45 years) and nine older (>45 years) PWLEs. Findings are organized into three categories: 1) Self-rated health and healthcare use; 2) Discharge planning; and 3) Recovery and follow-up care. Differences between older and younger PWLEs are highlighted. Identifying challenges of hospital-to-shelter/housing transitions and supports needed provides an avenue for healthcare and shelter/housing providers to improve service delivery.

**Keywords**: homelessness, older adult, hospital, shelter, healthcare

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I would also like to acknowledge that the work presented in this document is meaningless unless translated into action. I hope that this work helps affect real change in the provision of care to people with experiences of homelessness and, more broadly, in the way we view, understand, and normalize poverty. Until then, these are just words on a page. Thank you to all the participants, partners, and researchers who were involved in this project and your commitment to action and social justice.

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# List of Acronyms

| | |
|---|---|
| PWLE | People/person with lived experience of homelessness |
| ER | Emergency room |
| M | Male |
| F | Female |

# Glossary

| | |
|---|---|
| Continuity of care | Cooperative and ongoing involvement in healthcare between hospital and community-based settings. |
| Convalescent care | The provision of healthcare in a short-term residential setting to support recuperation for people who no longer need acute hospital care but are too ill to return to shelter/housing. Also known as intermediate or step-down care. |
| Home care | Support services provided in-home to clients who need assistance with some activities of daily living including mobilization, dressing, bathing, housekeeping, etc. |
| Individualized care | Care that incorporates a person-centered and trauma-informed approach (see below) by tailoring care activities to individual needs, experiences, behaviours, feelings, and strengths. |
| Person-centered care | Provision of care that promotes dignity and self-determination to reflect the values, needs, and preferences of the individual. |
| Trauma-informed care | Provision of care that recognizes the impact of traumatic events and their effect overall health and wellbeing by avoiding re-traumatization and focussing on individual strengths and skills. |

# Chapter 1.

# Introduction

Homelessness in Western countries has been increasing since the mid-1980s (Zlotnick, Zerger, & Wolfe, 2013) and the proportion of older people with lived experiences of homelessness (PWLE) has been increasing concomitantly (Crane & Joly, 2014; Gaetz, Dej, Richter, & Redman, 2016; Reynolds et al., 2016). As the populations of Western countries continue to age, homelessness among older persons is likely to become increasingly prevalent (Crane & Joly, 2014; Gonyea, Mills-Dick, & Bachman, 2010; Stergiopoulos & Herrmann, 2003), in part due to a poor economic climate, rising rates of mental health and substance use, divestments in community supports, decreases in social assistance benefits, and limited affordable housing stock (Gaetz et al., 2016; Waldbrook, 2015). However, both research and service responses to this trend have been slow to respond (Crane & Warnes, 2010; Gonyea et al., 2010; Grenier et al., 2016; Waldbrook, 2015).

Homelessness is a broad term that encompasses a continuum of housing instability from being insecurely housed to being entirely without shelter (Canadian Observatory on Homelessness, 2012). The Canadian Observatory of Homelessness (2012) describes a typology of homelessness consisting of four fluid categories: 1) Absolutely homeless, either without shelter or living in places unfit for human habitation; 2) Residing temporarily in an emergency homeless shelter; 3) Provisionally accommodated in a temporary residence that lacks security of tenure; and 4) At-risk of homelessness for reasons that may include economic insecurity, unsafe living conditions, or health concerns. The previous typology describes individuals with *living experience* of homelessness; in this thesis, I will include individuals who were formerly homeless and now housed, because *lived experience* of homelessness has long-lasting effects that resonate across the life course (Brown et al., 2015; Gutman et al., 2018). Of note, this definition does not account for the uprootedness of Canada's First Nations from land, place, and relations due to colonialism, which carries with it a persistent intergenerational burden reflected in the disproportionate number of Indigenous persons represented in homeless populations, and which requires unique consideration (Thistle, 2017).

Rates of both chronic and acute health conditions are much higher among PWLEs compared to the general population (Frankish, Hwang, & Quantz, 2005). Acute conditions from environmental exposure include frostbite, leg and foot ulcers, sleep deprivation, dehydration, dental problems, and upper respiratory conditions (Bottomley, 2001). Moreover, PWLEs of all ages are vulnerable to victimization, assault, and infectious diseases, including hepatitis and HIV (Fazel, Geddes, & Kushel, 2014). Managing and recovering from acute and chronic illnesses is challenging for PWLEs living without secure accommodation because of the lack of opportunity for adequate rest, nutrition, self-care, and access to follow-up health services (Canham, Custodio, Mauboules, Good, & Bosma, 2020; Fazel et al., 2014). As a result, PWLEs use hospital services at a much higher rate than stably housed persons (Hwang et al., 2013; Hwang, Weaver, Aubry, & Hoch, 2011; Raven et al., 2017). Yet, PWLEs of all ages are regularly discharged from hospital settings to no fixed address, resulting in a ‘revolving door’ of hospital admissions and continuing unmet health needs (Forchuk, Russell, Kingston-Macclure, Turner, & Dill, 2006).

Adults under the age of 50 make up the largest age group of PLWEs (Fazel et al., 2014; Gaetz et al., 2016). The majority of younger PWLEs are male (Fazel et al., 2014; Gaetz et al., 2016) and, in Canada, Indigenous persons are overrepresented in both the general homeless population and among homeless youth (age 13-24) (Gaetz et al., 2016). Compared to older PWLEs, younger PWLEs stay in emergency shelters less frequently and for shorter durations (Gaetz et al., 2016). Causes of homelessness among younger PWLEs include poverty, relationship loss and family conflict, untreated or unrecognized mental illness, and childhood trauma or neglect (Embleton, Lee, Gunn, Ayuku, & Braitstein, 2016; Woodhall-Melnik, Dunn, Svenson, Patterson, & Matheson, 2018). Pathways into long-term homelessness have been identified as beginning in childhood, early adulthood, and middle adulthood, and are commonly linked to diverse experiences of trauma (Woodhall-Melnik et al., 2018).

Due to the accumulation of disadvantage in accessing healthcare and secure housing, people experiencing homelessness in later life face increased comorbid health needs (e.g., mobility impairment, falls, frailty, cognitive impairment, and urinary incontinence) and high risk of mortality (Canham et al., 2020; Crane & Warnes, 2010; Garibaldi, Conde-Martel, & O'Toole, 2005; Henwood, Byrne, & Scriber, 2015). Indeed, due to 'accelerated aging,' individuals aged 45 and older commonly exhibit cognitive and physical characteristics of someone 10-20 years older and have a corresponding subjective age identity (Canham et al., 2020; Cohen, 1999; Crane & Joly, 2014; Crane & Warnes, 2001; Culhane, Metraux, Byrne, Stino, & Bainbridge, 2013; Grenier et al., 2016; Hwang, 2001; McDonald, Donahue, Janes, & Cleghorn, 2009; Waldbrook, 2015). The majority of older PWLEs in Western countries are in their 50s, though the number of homeless persons aged 65 and older is on the rise (Crane & Joly, 2014; Culhane, Treglia, Byrne, Metraux, & Kuhn, 2019). Estimates suggest older PLWEs make up 19%-33% of persons living in shelters or on the streets in Canada and the United States (Crane & Warnes, 2010; Gaetz et al., 2016). Between 63% and 92% of older PWLEs in Western countries are male, the majority of whom are socially isolated from family, service providers, and other homeless persons (Crane & Warnes, 2010; Waldbrook, 2015).

Homelessness in later life can be precipitated by a number of factors. Lack of affordable and available housing stock creates the conditions for homelessness to occur among people of all ages (Cohen, 1999; Hecht & Coyle, 2001). It has been suggested that rising housing costs in much of the Western world have contributed to the rise in numbers of older people living without safe and secure housing (Crane & Warnes, 2010). For older adults, and in particular those aged 50-64, limited income and social assistance benefits contribute to precarious housing (Cohen, 1999). Indeed, financial problems such as difficulties with paying rent or mortgage repayments have been found to be the most prevalent cause of homelessness in later life (Crane et al., 2005).

On an individual level, the process of losing one's housing in later life can be either gradual or rapid (Burns & Sussman, 2019). Older adults who experience a gradual pathway into homelessness are likely to have experienced long-term housing instability with little choice in whether to age in place or relocate, while a rapid transition into homelessness is often accompanied by an intense loss and abrupt disconnection from secure housing tenure (Burns & Sussman, 2019). Causes, including mental and physical health problems, alcohol and substance use problems, gambling problems, unemployment, relationship or marital breakdown, and bereavement, have been cited as precipitants of homelessness among older persons (Crane et al., 2005) and can contribute to either gradual or rapid transitions into homelessness (Burns & Sussman, 2019).

In addition, older PWLEs may experience housing loss for the first time in later life (i.e., newly homeless) or have life histories which include one or more episodes of homelessness (i.e., chronically/episodically homeless; Grenier et al., 2016; McDonald, Dergal, & Cleghorn, 2007). Compared to newly homeless older adults, chronically homeless older adults are more likely to be male and to have a substance use history, comorbid mental and physical health issues, and limited social support (McDonald et al., 2007). In contrast, newly homeless older adults are more likely to be female and receive informal social support while experiencing multiple barriers to healthcare and community and homelessness services (McDonald et al., 2007). Research suggests first-time homelessness is becoming increasingly common among older PWLEs (Grenier et al., 2016).

Regardless of the pathway into homelessness in later life, older PWLEs report multiple complex health conditions compared to younger PWLEs (Bottomley, 2001; van Dongen et al., 2019). Prevalent conditions among older PWLEs include depression, anxiety, post-traumatic stress disorder, psychosis, and cognitive impairment (Garibaldi et al., 2005; Stergiopoulos & Herrmann, 2003). In contrast, younger PWLEs are more likely to report substance use disorders and violent victimization, including assault (Fazel et al., 2014; Kellogg & Horn, 2012). PWLEs also experience restricted access to healthcare services compared to the general population (Canham et al., 2020; McDonald et al., 2007) and are most likely to receive healthcare either at hospital emergency departments or through street outreach (Chung et al., 2018; McDonald et al., 2007). Research indicates that healthcare service usage and associated costs among both younger and older PWLEs are high (Larimer et al., 2009; Sadowski, Kee, Vanderweele, & Buchanan, 2009). Shelter/housing interventions, including outreach, rapid rehousing, and medical respite, may reduce healthcare costs by more than half for PWLEs of all ages (Biederman, Gamble, Wilson, Douglas, & Feigal, 2019; Bottomley, 2001; Larimer et al., 2009). Yet, research on hospital discharge and community-based recovery for PWLEs is scarce. In particular, relatively little is known about hospital-to-shelter/housing transitions for older PWLEs (Canham et al., 2020). Moreover, comparisons between younger and older PWLEs' hospital-to-shelter/housing transitions have yet to be explored in the literature.

This thesis will present a review of existing literature and findings from secondary analysis of 20 interviews with younger and older PWLEs about hospital-to-shelter/housing transitions. The overall goal of the study is to contribute to understandings about hospital-to-shelter/housing transitions for PWLEs. In addition, this study seeks to highlight PWLE perspectives to understand the similarities and differences between younger and older PWLEs. Recommendations for policy, practice, and future research will be outlined.

# Chapter 2.

# Literature Review

## Theoretical Approaches

A number of theoretical approaches can be useful when conceptualizing homelessness and hospital-to-shelter/housing transitions for younger and older PWLEs. First, Bronfenbrenner and Morris' (2006) ecological framework to can be used to understand how social and ecological contexts influence individual experiences of homelessness and vice versa. Bronfenbrenner and Morris (2006) theorize that a series of interacting systems influence human biological and social development. The authors identify the microsystem (i.e., immediate and direct interactions between individuals), mesosystem (i.e., interactions between microsystems), exosystem (i.e., settings or events that indirectly affect the individual) and macrosystem (broader culture and sociopolitical customs and contexts). Applied to homelessness, an ecological framework suggests individual-level factors, such as family life, interact with and are influenced by larger ecological contexts, including education, housing availability, and wealth distribution. Therefore, in order to understand factors influencing homelessness, one must consider individual risk factors and life course trajectories as well as broader policies and practices influencing housing availability and poverty (Cohen, 1999). An ecological framework reveals the complex nature of interconnected systems that influence a person's health and housing from an individual, interpersonal, and systems-level perspective.

Second, life course theory, which is a core theoretical framework in the social sciences, has been adopted to understand homelessness among older adults. In a seminal piece, Cohen (1999) presents a conceptual model which incorporates the theories of cumulative advantage/disadvantage and intersectionality to explain how structural risk factors interact with personal risk factors to result in homelessness in later life. In congruence with Bronfenbrenner and Morris' (2006) bioecological framework, this model proposes that structural risk factors (e.g., lack of affordable and available housing, lack of income supports), demographic risk factors (e.g., race/ethnicity, gender), and the accumulation of individual risk factors (e.g., mental illness or substance use disorder, disruptive life events) over the life course can result in homelessness in later life in the absence of effective interventions. According to Cohen, once an individual experiences homelessness, they are subject to ‘enculturation processes’ through which they learn to adapt to life on the street or in insecure accommodation. Structural, interpersonal, and individual risk factors and the presence or absence of effective interventions influence the length of homelessness and/or number of homeless episodes, and prolonged homelessness results in the increasing accumulation of disadvantage over the life course (Cohen, 1999).

Third, the person-environment fit model presented by Lawton and Nahemow (1973) posits that environmental demands may overwhelm an individual’s competencies and compromise their ability to age in place. Following from an ecological perspective, environmental demands may originate from a variety of ecological contexts, including an individual’s home, interpersonal relationships, or the socioeconomic conditions of a society (Bronfenbrenner & Morris, 2006). In the case of older PWLEs being discharged from hospital, such environmental demands may include, for example: unaffordable rents or mortgages, dilapidated or non-existent accommodation, and/or threatening relationships with other tenants (Crane et al., 2005). Personal competencies may be reduced by social isolation, mental illness, or chronic health conditions, as examples (Crane et al., 2005). As a result, Burns (2016) theorized that older PWLEs may experience ‘oscillating in and out of place’ as they move through various shelter/housing settings (e.g., being discharged from hospital to a shelter or temporary/transitional housing setting).

Combining the above theoretical approaches, this thesis has been organized using an ecological framework as a way of understanding varying experiences over the life course in different environmental contexts.

## Literature Review Methods

To situate this study amongst the previous literature, a literature review on hospital-to-shelter/housing transitions for PWLEs was conducted. The review process consisted of five steps: 1) identification of the research question; 2) identification of relevant studies; 3) study selection; 4) data charting; and 5) collation, summarization, and reporting of the results (Arksey & O’Malley, 2005). The purpose of the review was to summarize the nature and breadth of existing academic literature on the topic, rather than evaluate the quality of evidence. The research question guiding the review was: What are the understandings of the experiences or outcomes of hospital-to-shelter/housing transitions for PWLEs?

Seven databases were searched (**APPENDIX A**) for English-language, peer-reviewed journal articles published 2000 – 2020. An initial keyword search for literature on older PWLEs included various combinations of homeless*, older adult*, hospital*, etc. A second, broader search was conducted to identify literature on PWLEs of all ages using the following keywords: hospital to shelter, hospital to housing, and hospital to shelter/housing. (*For full list of search terms and search strategies see **APPENDIX A***). Results revealed 1360 sources, of which 486 duplicates were removed (*see **APPENDIX B** for PRISMA flow diagram*). Titles and abstracts of 874 articles were assessed, resulting in 47 articles for full-text review. Articles were included based on the following criteria: 1) aimed to understand the experiences or outcomes of hospital-to-shelter/housing transitions for PWLEs; and 2) English-language, peer-reviewed literature (not including literature reviews, poster abstracts, or conference proceedings). Based on these criteria, 26 studies were excluded for the following reasons: wrong topic or population (*n*=17); and wrong publication type (*n*=9). Twenty-one articles remained for inclusion in the review.

Data extracted from the 21 primary sources include location of study, topic/aim, study design (i.e., qualitative, quantitative, mixed-methods) and participants, and main findings (**APPENDIX C**). Findings were analyzed using thematic analysis, during which the findings were summarized and organized into loose categories using descriptive codes (Braun & Clarke, 2006). Through an iterative process of reading and re-reading the sources and descriptive codes, relationships and patterns were identified (Braun & Clarke, 2006), resulting in three broad categories.

## Key Findings from the Literature

Findings from the literature review were organized into three categories: 1) Challenges to hospital discharge and follow-up care for PWLEs; 2) Key characteristics of hospital-to-shelter/housing interventions; and 3) Outcomes of hospital-to-shelter/housing interventions for PWLEs. Within each category, findings were organized based on an ecological framework from individual-level factors to interpersonal- and systems-level factors.

## Challenges to hospital discharge and follow-up care for PWLEs

Multiple challenges exist to ensuring appropriate discharge from hospital, as well as to follow-up care in the community for PWLEs. Challenges identified in the literature include: 1) PWLEs' complex health and psychosocial needs; 2) Stigma and discrimination; 3) Limited resources upon hospital discharge, including limited shelter/housing stock; and 4) Barriers to system navigation and continuity of care.

### *PWLEs' complex health and psychosocial needs*

The health and psychosocial needs of PWLEs upon hospital discharge are distinct from stably housed individuals and are often complex and challenging to meet without an array of supports (Canham et al., 2020; Drury, 2003, 2008; Hauff & Secor-Turner, 2014). PWLEs present to emergency departments and psychiatric inpatient wards repeatedly and more frequently than stably housed individuals (Drury, 2003). Upon discharge, PWLEs are challenged to secure shelter/housing, transportation, and finances and income security, and to manage crises, trauma, and medications (Drury, 2008; Hauff & Secor-Turner, 2014). Without an array of housing, health, and social supports, PWLEs may prioritize more immediate needs over follow-up health care (Drury, 2003). Older PWLEs, in particular, often live with multiple chronic and complex health conditions that are challenging to manage in insecure shelter/housing settings and are uniquely vulnerable to victimization in shelter settings while convalescing (Canham et al., 2020).

### *Stigma and discrimination*

Literature suggests that PWLEs face stigma and discrimination both in hospital and upon discharge (Drury, 2003, 2008; Greysen, Allen, Lucas, Wang, & Rosenthal, 2012; Greysen, Allen, Rosenthal, Lucas, & Wang, 2013; Whiteford & Simpson, 2015). For instance, PWLEs have reported withholding their housing status in hospital due to fear of inferior care (Greysen et al., 2013). Health and social service providers have reported that community-based follow-up services refuse or restrict access to clients who may be "undesirable" or who present with challenging behaviours or circumstances

(Whiteford & Simpson, 2015). When assistance is provided, it is often unsatisfactory (Whiteford & Simpson, 2015). Ethnographic research has identified that PWLEs and health and social service providers operate in two culturally-distinct worlds, contributing to stigma which challenges effective delivery of healthcare shelter/housing services in hospital and upon discharge (Drury, 2008). For PWLEs, repeated poor experiences with healthcare providers and disjointed service coordination result in a lack of confidence in the healthcare system and delays in seeking care (Greysen et al., 2012). No literature was identified that focused on the experiences of stigma and discrimination among older PWLEs during hospital-to-shelter/housing transitions.

### *Limited resources upon hospital discharge, including limited shelter/housing stock*

Findings from the review indicate a paucity of supportive services and locations for PWLEs following discharge from hospital (Canham et al., 2020; Drury, 2008; Forchuk et al., 2006; Hauff & Secor-Turner, 2014; Lamanna et al., 2017). For instance, community-based follow-up care and services that are flexible to meet the needs of PWLEs are limited (Forchuk et al., 2006). Even when available, strict eligibility criteria and staff who are untrained to work effectively with PWLEs limit the effectiveness of follow-up care and services (Whiteford & Simpson, 2015). Furthermore, literature has identified the lack of appropriate and available shelter/housing stock for PWLEs managing complex health conditions post-discharge (Canham et al., 2020; Drury, 2008; Hauff & Secor-Turner, 2014; Lamanna et al., 2017). For example, shelters are unable to support PWLEs with multiple comorbidities (Forchuk et al., 2006; Hauff & Secor-Turner, 2014), including older PWLEs (Canham et al., 2020).

### *Barriers to system navigation and continuity of care*

Finally, research suggests that multiple systemic barriers and disjointed services challenge continuity of care following hospital discharge (Albanese, Hurcombe, & Mathie, 2016; Drury, 2003, 2008; Hauff & Secor-Turner, 2014; Lamanna et al., 2017; Whiteford & Simpson, 2015). The complex health and psychosocial needs of PWLEs require an array of integrated services, yet research suggests that health and social systems of care operate in distinct bureaucratic arenas often dictated by funding streams, and do not match the needs of PWLEs (Drury, 2008; Lamanna et al., 2017). Highlighting the barriers between healthcare and homelessness services, research has found that healthcare outreach workers are reluctant to provide care in shelter settings (Whiteford & Simpson, 2015) and a majority of PWLEs report not receiving a housing assessment while in acute care (Greysen et al., 2013). Holistic interventions that attempt to integrate multiple service sectors are challenged by the short-term nature of funding, overdemand, and barriers to information sharing (Albanese et al., 2016). For PWLEs of all ages, managing multiple bureaucratic systems to address different health and psychosocial needs can be confusing and results in unsatisfactory care (Drury, 2003; Hauff & Secor-Turner, 2014). As a result, discharge from hospital to homelessness is a regular occurrence in (Drury, 2003; Forchuk et al., 2006) and results in repeated hospital use (Forchuk et al., 2006).

## Key characteristics of hospital-to-shelter/housing interventions

In order to address the challenges to post-discharge care for PWLEs, review findings indicate distinct characteristics of effective hospital-to-shelter/housing interventions: 1) Individualized care; 2) Continuity of care; and 3) Cross-sector collaboration.

### *Individualized care*

To support PWLEs in the health and social care system, a holistic approach that addresses the social determinants of health (e.g., income, food security, employment, housing; Bartley et al., 2005) as well as direct health needs is required (Serge & Gnaedinger, 2003). A holistic approach involves both person-centered and trauma-informed care (Pottie et al., 2020; Serge & Gnaedinger, 2003). Person-centered care promotes dignity and self-determination in the delivery of care to reflect the values, needs, and preferences of the individual (Cloninger et al., 2014). Trauma-informed care recognizes that PWLEs have encountered traumatic events that affect their overall health and wellbeing, and that in order to provide appropriate care, healthcare and service providers must avoid re-traumatization and focus on individual strengths and skills (Hopper, Bassuk, & Olivet, 2010). Both approaches to care are central to effective healthcare and housing interventions for PWLEs (Henwood, Shinn, Tsemberis, & Padgett, 2013; McGhie, Barken, & Grenier, 2013; Pottie et al., 2020) and have been found to improve trust, help-seeking behaviours, and recovery (Cloninger et al., 2014; Tran Smith, Padgett, Choy-Brown, & Henwood, 2015).

Individualized care incorporates a person-centered and trauma-informed approach by tailoring care activities to individual needs, experiences, behaviours, feelings, and strengths (Papastavrou et al., 2015). In order to deliver individualized care to PWLEs during hospital-to-shelter/housing transitions, research suggests that frequent and early contact, relationship building, and humane treatment is needed to promote trust in hospital staff and engagement in follow-up care (Greysen et al., 2013; Lamanna et al., 2017). Providing individualized, one-on-one support and advice to PLWEs in hospital and community care settings has been found to improve patient experiences and outcomes (Lamanna et al., 2017; Minter, 2012). In particular, individualized assistance with service coordination, navigation, and advocacy is needed upon hospital discharge (Lamanna et al., 2017; Wood et al., 2019). Other needs include transportation, housing assessments upon hospital intake and discharge (Greysen et al., 2012, 2013), and a range of post-discharge shelter/housing options that meet the needs of diverse PWLEs, including older PWLEs (Canham et al., 2020). However, research suggests that training for cultural competency and trauma-informed care is needed in the healthcare sector (Hauff & Secor-Turner, 2014; Hochron & Brown, 2013) that should involve increased awareness of the uniqueness of older PWLEs' housing and healthcare issues (Minter, 2012).

### ***Continuity of care***

Effective hospital discharges for PWLEs require a continuum of accessible and appropriate care that follows patients from hospital to community-based settings (Albanese et al., 2016; Canham et al., 2020; Hochron & Brown, 2013; Khan, Haine, & Dorney-Smith, 2019; Lamanna et al., 2017). Research suggests that follow-up care is most effective when it is flexible, easy to access, and provided at the patients' discharge location, whether it be a shelter, convalescent care setting, or transitional or permanent housing (Albanese et al., 2016; Hochron & Brown, 2013). Indeed, access to a community-based general practitioner that is connected to the PWLE's hospital-based care team has been suggested as one intervention to support PWLEs' ongoing engagement in healthcare management (Khan et al., 2019). For older PWLEs, community-based follow-up care needs include regular check-ins, assistance with daily activities, and mobility supports (Canham et al., 2020). Additional continuity of care needs to be addressed by hospital-to-shelter/housing interventions include accompaniment to follow-up appointments, medication management, and accessibly located services (Canham et al., 2020; Lamanna et al., 2017).

### *Cross-sector collaboration*

Finally, research has identified the importance of improved collaboration between healthcare, homelessness, and shelter/housing sectors to support effective hospital-to-shelter/housing transitions (Whiteford & Simpson, 2015). In particular, research suggests the need for increased communication between hospital and shelter/housing settings (Greysen et al., 2012) and flexible and streamlined referrals (Albanese et al., 2016). Effective hospital-to-shelter/housing interventions identified in the literature centered around cross-sector partnerships to streamline patient transitions (Albanese et al., 2016; Barr et al., 2013; Barrow & Medcalf, 2019; Hochron & Brown, 2013; Lamanna et al., 2017; Minter, 2012; Wood et al., 2019; Wyatt, 2017). Moreover, research has highlighted the need for the healthcare and shelter/housing sectors to take equal responsibility in partnerships that respond to PWLEs' shelter/housing needs (Albanese et al., 2016; Hochron & Brown, 2013). Collaborative cross-sector partnerships enable closer monitoring and understanding of patient issues, timely service responses (Wood et al., 2019), and more effective continuity of care (Hochron & Brown, 2013).

Research suggests that cross-sector collaboration can be achieved through the use of multidisciplinary teams (Albanese et al., 2016; Hochron & Brown, 2013; Khan et al., 2019; Whiteford & Simpson, 2015; Wood et al., 2019). Research has identified the need for in-hospital housing teams, that include some combination of housing workers, nurses, and physicians to link PWLEs with accommodation following discharge (Albanese et al., 2016). Following hospital discharge, research suggests that community-based multidisciplinary case management teams that include general practitioners, care coordinators, psychiatrists, and nurses/nurse practitioners are needed (Hochron & Brown, 2013; Khan et al., 2019). Regular communication between community-based and hospital-based teams is critical to supporting PWLE health and housing outcomes (Greysen et al., 2012; Khan et al., 2019). However, no literature was identified that focused on how cross-sector collaborations impact older PWLEs specifically.

## Outcomes of hospital-to-shelter/housing interventions for PWLEs

In addition to identifying hospital-to-shelter/housing needs for PWLEs, research has also examined outcomes of hospital-to-shelter/housing interventions for PWLEs, which include: 1) Improved PWLE health and housing outcomes, and 2) Improved healthcare delivery and cost-effectiveness.

### *Improved PWLE health and housing outcomes*

Hospital-to-shelter/housing interventions have been found to result in improved access to housing, engagement with healthcare, and health and wellbeing for PWLEs (Albanese et al., 2016; Barr et al., 2013; Barrow & Medcalf, 2019; Forchuk et al., 2013; Hochron & Brown, 2013; Khan et al., 2019; Podymow, Turnbull, Tadic, & Muckle, 2006; Wood et al., 2019). For example, Forchuk et al. (2013) examined a pre-discharge intervention that provided income, employment, and housing coordination and advocacy to PWLEs and found that 92.5% of clients who accessed the intervention acquired affordable permanent or temporary accommodation. Moreover, the I intervention was found to reduce discharges to no fixed address (Forchuk et al., 2013) Positive discharge experiences have been reported by PWLEs participating in intervention programs PWLEs (Albanese et al., 2016). Furthermore, research has found that between 40% and 71% of PWLEs who access hospitals with multidisciplinary housing teams have been matched to appropriate permanent housing (Khan et al., 2019).

Convalescent care settings, such as medical respite, provide safe temporary accommodation linked to health and social services for PWLEs recovering from illness or injury (Barr et al., 2013; Barrow & Medcalf, 2019; Podymow et al., 2006) Convalescent care settings have been found to improve PWLEs' wellbeing and feelings of security (Barr et al., 2013). Convalescent care has also been found to improve medication adherence, attendance at follow-up appointments, connection to community-based health and social supports (Podymow et al., 2006), and engagement with staff in the housing search (Barrow & Medcalf, 2019).

### *Improved healthcare delivery and cost-effectiveness*

In addition to positive impacts on PWLE health and housing outcomes, hospital-to-shelter/housing interventions have been found to positively affect healthcare staff and healthcare usage, and are cost effective (Barrow & Medcalf, 2019; Biederman et al., 2019; Forchuk et al., 2013; Minter, 2012; Murphy, Harradine, & Hewitt, 2020; Wood et al., 2019; Wyatt, 2017). For instance, Barrow and Medcalf (2019) found that hospital staff were less willing to discharge PWLEs without a discharge location and more likely to believe that housing is the hospital's responsibility following the implementation of a hospital-to-shelter/housing intervention program. Both convalescent care programs and multidisciplinary case management have been found to reduce hospital readmissions and inpatient days (Biederman et al., 2019; Wyatt, 2017), while contributing to community-based referrals and outpatient follow-up (Podymow et al., 2006). Moreover, hospital to shelter/housing interventions are cost effective and streamline discharges to safe housing settings (Barrow & Medcalf, 2019; Biederman et al., 2019; Forchuk et al., 2013; Minter, 2012; Murphy et al., 2020; Wood et al., 2019; Wyatt, 2017). The above improvements have been found for PWLEs of all ages, but no research was identified that investigated the health and housing outcomes and effectiveness of healthcare delivery for older PWLEs specifically.

## Gaps in the Literature

There is a paucity of literature on hospital-to-shelter/housing transitions for PWLEs, and particularly for older PWLEs. Similarly, there is a lack of literature examining differences by age groups. As a result, our knowledge of PWLEs' experiences during hospital-to-shelter/housing transitions and how best to implement effective interventions for different age groups is limited. In general, much of the scarce literature on hospital-to-shelter/housing transitions explores the nature and outcomes of interventions from provider perspectives. Of the 21 sources identified in this review, only five present qualitative research examining the perspectives of PWLEs. Furthermore, while one study (Canham et al., 2020) identified older PWLEs as a unique sub-population, only perceptions of shelter/housing and healthcare providers were reported. No studies were identified that explored the hospital-to-shelter transition experiences of older PWLEs. However, the unique health and shelter/housing needs of older PWLEs likely result in unique hospital-to-shelter/housing experiences which have yet to be identified. Without a robust understanding of preferences for and outcomes of hospital-to-shelter/housing transitions for older PWLEs, and with limited insights on hospital-to-shelter/housing transitions from the perspectives of PWLEs of all ages, it remains a challenge to design effective policy and practice solutions.

## Study Purpose

This thesis seeks to address the above gaps by examining PWLE perspectives of hospital-to-shelter/housing transitions. To address the gap in research representing the perspectives of older PWLEs, this study compares the experiences of younger PWLEs to older PWLEs.

Objectives:

a) Examine hospital-to-shelter/housing transitions for PWLEs; and,

b) Identify differences in experiences and perceptions of younger and older PWLEs who are discharged from hospital.

## Research Questions

a) What are the experiences and perceptions of hospital-to-shelter/housing transitions for both younger and older PWLEs?

b) Are there similarities and differences between younger and older PWLEs' hospital-to-shelter/housing transition experiences and perceptions? If so, what are the similarities and differences?

# Chapter 3.

# Methods

## Study Design

I conducted a secondary analysis of qualitative data collected as part of a larger project on hospital-to-shelter/housing transitions for PWLEs. The original project adopted a community-based participatory research approach (Israel et al., 2005) to examine the health and psychosocial support needs of PWLEs following hospital discharge. The project conducted 40 semi-structured qualitative interviews (20 with healthcare and shelter/housing providers and 20 with PWLEs) between November 2017 and January 2018. The current study analyzed data collected from the 20 interviews with PWLEs. Ethics approval was obtained from Simon Fraser University's Office of Research Ethics both for the original study and for the current study.

### Study participants

Study participants included 20 PWLEs who had directly received services associated with hospital-to-shelter/housing transitions in Metro Vancouver, BC, within the previous 12 months (i.e., having visited and been discharged from a hospital). Participants' ages range from 23 to 59 years (*M*=40 years). Because research suggests PWLEs commonly exhibit cognitive and physical characteristics of someone 10-20 years older and have a corresponding subjective age identity (Canham et al., 2020; Cohen, 1999; Crane & Joly, 2014; Crane & Warnes, 2001; Culhane, Metraux, Byrne, Stino, & Bainbridge, 2013; Grenier et al., 2016; Hwang, 2001; McDonald, Donahue, Janes, & Cleghorn, 2009; Waldbrook, 2015), age 45 and older was used to define an older PWLE in this study. Of the nine participants age 45+ (*M*=53 years), three are female and six are male. Of the 11 participants under age 40 (*M*=30 years), seven are female and four are male. Of the nine participants age 45+, two were residing in a single-room occupancy hotel at time of interview, while two were residing in a shelter, one in mental health supported housing, one in subsidized housing, and three in an unknown location. Of the 11 participants under age 40, four were residing in a single-room occupancy hotel, two were residing in a shelter, one in mental health supported housing, and four in an unknown location.

## Data collection

To recruit PWLE participants, the project team invited known healthcare and shelter/housing services providers to share a recruitment flyer with PLWEs in their networks. Potential participants expressed interest by contacting the research team using the contact details on the recruitment flyer. Participants were screened over the phone for inclusion. Inclusion criteria were: (a) age 19+; (b) directly received services associated with hospital-to-shelter/housing transitions in Metro Vancouver (i.e., having visited and been discharged from a hospital in Metro Vancouver within the last twelve months); (c) able to speak conversational English; (d) capable of participating in an interview for up to one hour; and (e) able and willing to provide informed consent. Written informed consent was obtained from all participants prior to their interview.

Qualitative semi-structured interviews were conducted. Interview guides were collaboratively designed by the project team and were informed by existing literature on hospital-to-shelter/housing transitions (*See **APPENDIX D** for interview guide*). Throughout the interview process, the questions were reviewed and revised to better address emerging themes and topics. Participants were asked to reflect on their most recent hospital discharge experience in Metro Vancouver.

Interviews ranged from 15 to 61 minutes (*M*=35 minutes). Interviews were conducted in-person in the participant’s location of choice by two researchers (a graduate research assistant and a social worker). Seven interviews were conducted in a hospital, six in a single-room occupancy hotel, four in shelter settings, two in mental health supported housing, and one in a drop-in resource centre. Interviews were audio-recorded and transcribed verbatim along with field notes, including notes about the interviewer’s perceptions of the interview and any extraneous factors that may have influenced the interview. All transcripts were anonymized and audio-recordings were destroyed before the data was shared with me. No information that could potentially identify participants remained in the transcripts or field notes.

## Data analysis

### *Secondary analysis of qualitative data*

Secondary analysis of qualitative data involves re-examining qualitative data from a study which the researcher may or may not have been involved with (Ruggiano & Perry, 2019; Szabo & Strang, 1997). Based on Hinds, Vogel, and Clarke-Steffen's (1997) typology of approaches to qualitative secondary analysis, my approach involved extracting a subset of cases from an original dataset for a more focused analysis of a similar topic (in this case, the experiences of PWLE participants). Strengths of this approach include the potential to explore new questions, generate new knowledge, and support or develop existing theories (Hinds, Vogel, & Clarke-Steffen, 1997; Long-Sutehall, Sque, & Addington-Hall, 2011; Szabo & Strang, 1997)

Challenges of qualitative secondary data analysis include access to and completeness of the original dataset, ensuring sensitivity to the context of the original study, and ethical considerations surrounding informed consent (Hinds, et al., 1997; Ruggiano & Perry, 2019). However, the dataset I was working from was complete and intact, access to the data was permitted by the research lead of the original project, informed consent was collected during the original study, and the socio-historical context had not changed significantly in the time between collection of the original dataset (November 2017-January 2018) and the current study (2020). Moreover, though I was not involved in original data collection or analysis, I was involved in the later stages of the original study, which informed my understanding of the original research context and methodology.

Secondary analysis of semi-structured interviews was chosen because semi-structured interviews are effective for exploring individual perceptions and experiences of phenomena (Charmaz, 2014; Hesse-Biber, 2011; Patton, 2015). Key advantages of semi-structured interviews include: (a) appropriate for gaining knowledge on a focused topic; (b) an avenue for understanding phenomena that are not directly observable; (c) useful for accessing hidden or excluded knowledge, including that of marginalized populations; and (d) require co-creation of knowledge between the interviewer and interviewee, leading to expanded and diversified understandings of the phenomenon under study (Charmaz, 2014; Hesse-Biber, 2011; Patton, 2015). In this thesis, semi-structured interviews were selected for their effectiveness in understanding the experiences and perceptions of PWLEs transitioning from hospital to shelter/housing.

### *Establishing trustworthiness*

In order to maintain rigor and accuracy throughout the analysis process and to support confirmability of the findings, I engaged in reflexive and methodological memo writing, data analysis logs, and regular check-ins with my supervisory committee detailed by an audit trail (Lincoln & Guba, 1985). Specifically, preliminary findings were reviewed with the research lead of the original project, Dr. Sarah Canham (committee member) as well as my senior supervisor (Dr. Habib Chaudhury) during the data analysis to strengthen the validity of the analysis and ensure credibility of findings (Hinds et al., 1997; Lincoln & Guba, 1985). Moreover, while the data used for this study was based in Metro Vancouver, BC, the rigor of the community-based participatory approach to data collection during the original project facilitates transferability to other contexts. Ensuring credibility, dependability, transferability, and confirmability supports the trustworthiness of my findings (Lincoln & Guba, 1985).

### *Data analysis procedure*

Rather than using pre-existing frameworks to interpret the data, an inductive approach to data analysis was used whereby patterns and themes were generated by closely describing the qualitative data. Thematic analysis of the qualitative data followed Braun and Clarke’s (2006) six-step process: 1) familiarization with data through immersive reading and re-reading of transcripts; 2) generation of initial descriptive codes; 3) identifying overlap and commonalities between descriptive codes to generate categories or themes; 4) reflective review of categories/themes in relation to descriptive codes and dataset as a whole; 5) defining and distinguishing category/theme names; and 6) writing the final report, during which codes and categories were further refined in an iterative process.

First, transcribed audio-recordings of interviews were read in full to gain familiarity with the data. Following, the transcripts were organized and separated into two cohorts (the 11 younger PWLEs and the nine older PWLEs) and re-read in full in order to identify preliminary similarities and differences within and between the cohorts.

Initial ideas based on the readings were noted in memos. The transcripts were then imported into Nvivo 12 (QSR International, 2019) for data analysis.

Guided by my research questions, the cohorts were analyzed separately; transcripts of the nine older PWLEs were analyzed first, followed by the 11 younger PWLEs. Following steps two and three of Braun and Clarke's (2006) process, initial descriptive codes were generated, organized, and grouped together into preliminary categories within each cohort before any comparison was done. In step four of the process, codes and categories were compared between cohorts for similarities and differences. Codes were reviewed, reorganized, and revised in a constant iterative process. Through this process, categories of codes emerged that were similar across cohorts, which were defined and distinguished during step five. In step six, similarities and differences across cohorts and between categories were further refined during the writing process.

My analysis and interpretations of the data may have been influenced by my social position and privilege. As a white male graduate student who is stably housed, my understandings of homelessness, trauma, and disenfranchisement are influenced by my social circumstances and life experiences, including my formal education. Moreover, I do not have lived experience of homelessness, stigma, discrimination, and institutional trauma. As such, my understandings of such experiences are limited and the ways in which I interpret others' language and expressions of experience may not fully reflect their realities. Nevertheless, I have taken efforts to ensure the data analysis is as grounded as possible in the narratives of the participants.

# Chapter 4.

# Findings

Findings were organized into three categories: 1) Self-rated health and healthcare use, 2) Discharge planning, and 3) Recovery and follow-up care. An ecological framework was used to organize findings within each category according to individual-, interpersonal-, and systems-level challenges and supports needed. Findings unique to younger and older participants have been discussed separately, where applicable. By and large, differences between younger and older participants were minimal. Both younger and older participants reported similar health needs, healthcare use, and discharge planning challenges and support needs. Moreover, while younger and older participants reported a number of unique recovery and follow-up care needs and challenges, overlapping needs and challenges were also identified. Finally, participants in both age cohorts similarly discussed independence and social support during discharge planning and follow-up care, though expressions of agency and personal choice were more prevalent among younger participants. A full list of categories as they relate to both age cohorts can be found in **APPENDIX E.**

## Self-rated Health and Healthcare Use

Participants described their: 1) Self-rated health, and 2) Hospital and healthcare use. Participants reported managing multiple chronic and acute conditions that were exacerbated by ongoing homelessness, with some differences between older and younger PWLEs. Moreover, participants noted frequent hospital use and appreciated accessible community-based healthcare.

### Self-rated health

On an individual level, both younger and older participants described their health as generally poor and reported managing one or more chronic or acute health conditions. Noted health conditions included diabetes, seizures, Crohn’s disease, depression, anxiety, and substance use disorders. One younger participant (M, 31) noted, “I have some major ongoing health problems, like Hepatitis C, and I had a concussion from being struck on the head with a crowbar . . . and ongoing addiction problems." An older participant (F, 59) described, "I have a new tumor . . . on my lungs and I have also colitis and pneumonia and I'm not very well at all." Moreover, participants reported challenges recovering from acute health crises and managing ongoing health needs while living in shelters, on the street, or in substandard housing, which exacerbated health problems. For example, one younger participant (F, 32) stated, "I get sick from being cold too much [living] on the streets."

Narratives of younger participants also highlighted worries about the future and of long-term effects of untreated or recurring illnesses, as one younger participant (M, 32) articulated,

> I'm diabetic and not having regular timed meals really fucks with your blood sugar. So, I'm starting to see the long-term effects with the diabetes as well. My feet are in terrible shape and I don't really get any chance to get off of them. . . . [I'm] scared because I don't want to lose my feet.

In contrast, older participants described managing pain and discomfort, chronic illness, and cognitive impairment from injury or long-term substance use, as one older participant (M, 53) narrated,

> I had some pretty bad accidents and those types of things. . . . One of them was an attack so bad I got epilepsy and another one I fell 30 feet out of a tree when I was working and broke my back. So, I'm waiting to have surgery on my back. . . . I was on quite a bit of morphine after that happened and … they wanted to take me off.

Another older participant (F, 50) described,

> I have a heart condition now and have to take like ten pills a day. I'm not very happy about that and previously I was in major car accident. . . . I walk with a cane all the time and the pain in my legs is bad.

Participants also noted challenges related to ongoing substance use. While both younger and older participants reported substance use challenges, reports were more prevalent among younger participants. Drug and alcohol use, in particular, were reported to impact participants' health, including interacting with or exacerbating other conditions or resulting in overdose. One older participant (M, 45) stated, "My biggest challenge is heroin and speed. . . . I've used heroin . . . and I overdosed." Moreover, participants noted living in precarious housing situations due to challenges managing addictions; for example, one younger participant (F, 32) described their struggles with addiction in the context of maintaining their housing: “I don’t want to [use], I do want to, I don’t want to, I do want to, it’s so hard. [But] it’s not worth it using drugs, especially if you have a place and everything.”

## Hospital and healthcare use

Participants noted individual- and systems-level factors influencing their healthcare use. Both younger and older participants reported frequent hospital use. Participants cited ongoing and worsening health conditions, as well as challenges with recovery, as reasons for frequent hospital use. For example, one younger participant (F, 23) reported, “I use the ER [*emergency room*] a lot when I have [asthmatic] flare ups . . . like on a weekly basis.” Similarly, an older participant (M, 51) stated, “In the course of a year I’d say I average probably five hospitalizations and maybe six or seven trips by ambulance. So, that’s pretty heavy usage.”

Participants associated their frequent hospital use with their lack of housing, which challenged their ability to recover from and manage illnesses. One older participant (M, 45), who averaged one hospital visit a month for two years related to a leg infection, discussed how their prolonged homelessness caused their health condition to worsen:

> I told [the hospital staff], ‘If I leave here I’m going to end up coming back a month later with the same problem in my leg – and maybe worse this time – if we can’t find a new place for me to go, and if you guys discharge me with nowhere to go.’

Both younger and older participants also reported frequent visits to community-based clinics as part of managing their ongoing health needs and the availability of healthcare services in the community was regarded positively. Participants noted that healthcare professionals at local clinics provided good care and were flexible in meeting patients’ needs. For example, an older participant (M, 55) noted, “Everything I need is there [at the clinic]. So, they help me out a lot. . . . The doctor would see me any time, I had no problems.” One younger participant (M, 31) elaborated, “I have [the] clinic, they’re kind of my go-to hub for pretty well everything that’s non-acute emergency. So, that way it’s been a lot easier with having them involved [in my health].” In addition, while participants reported appreciating nursing and home support available in shelter or housing locations on a weekly or bi-weekly basis, many did not use these services.

## Discharge Planning

Younger and older participants reported disorganized and stressful discharge experiences. In addition, older participants presented narratives of losing housing while in hospital, which was not shared by younger participants. However, participants in both age cohorts noted how a lack of communication with hospital staff during the discharge process challenged their understanding of diagnoses and follow-up care instructions. Moreover, participants felt they were often left out of discussions about their care and housing and reported negative interactions with hospital staff. Participants also underscored experiencing stigma and discrimination. As a result, participants reported feeling confused and frustrated during the transition from hospital to shelter/housing.

Both cohorts reported needing similar supports to ensure effective discharge planning, including communication and information, informal social support, formal support delivered in through a person-centered approach, transportation upon hospital discharge and post-discharge, and increased affordable and available housing stock. Younger participants also reported the need to allow for self-determination during the discharge process. Sub-categories and differences and similarities between age cohorts are summarized in **Table 1.**

**Table 1. Comparison of “Discharge planning” sub-categories by age cohort**

| Category | Sub-category | Younger | Older |
|---|---|---|---|
| Challenges | Individual level | | |
| | Disorganized and stressful discharge experiences | X | X |
| | Losing housing while in hospital | | X |
| | Interpersonal level | | |
| | Lack of information and communication with hospital staff | X | X |
| | Lack of involvement in discharge planning | X | X |
| | Negative interactions with hospital providers | X | X |
| | Systems level | | |

| | | | |
|---|---|---|---|
| | Stigma and discrimination | X | X |
| Supports needed | Individual level | | |
| | Opportunities for self-determination during discharge process | X | |
| | Interpersonal level | | |
| | Increased communication and information | X | X |
| | Support from friends and family | X | X |
| | Formal support and a warm hand-off | X | X |
| | Systems level | | |
| | A person-centered approach to care | X | X |
| | Transportation upon hospital discharge and post-discharge | X | X |
| | Increased affordable and available housing stock | X | X |

## Challenges to discharge planning

Challenges to discharge planning included: 1) Disorganized and stressful discharge experiences, 2) Losing housing while in hospital, 3) Lack of information and communication with hospital staff, 4) Lack of involvement in discharge planning, 5) Negative interactions with hospital providers, and 6) Stigma and discrimination. Uniquely, only older participants reported losing housing while in hospital.

### *Disorganized and stressful discharge experiences*

On an individual level, both younger and older participants reported disorganized and stressful discharge experiences. Participants reported feeling rushed and being treated carelessly by hospital staff. For example, one older participant (M, 53) stated, “I was under the impression . . . they’d keep me [in the hospital] for quite a while, but they didn’t. They just kind of kicked me out. . . . It was kind of a mess.” A younger participant (M, 31) outlined how being discharged too soon resulted in confusion and stress:

> I feel I was discharged way too soon. . . . It was a really kind of just odd and difficult hospitalization and it seemed to end way too quickly because I was discharged in basically a blacked-out state and I don't remember a lot of what happened. . . . I really don't know what happened, but it was not a positive experience, I can tell you that.

Similarly, another younger participant (M, 24) recalled, "waking up on the floor [of a shelter], recovering from a sleeping pill, and no blanket, no pillow, no bed to sleep on, and no sense of direction. I didn't even know where I was." Participants agreed that being quickly discharged to a shelter or to the street was a negative experience that perpetuated homelessness and prolonged their recovery. One older participant (M, 45) summarized, "It's all been a disaster every time I've been discharged. I'm always back to the same situation . . . stuck on the street, shelters, nowhere to go."

### *Losing housing while in hospital*

Uniquely, older participants reported losing housing and shelter beds during extended hospital stays. As one older participant (M, 51) described, "The place where I was [living in] just rented out to somebody else. I financially wasn't able to keep up with it [while in hospital] so they just rented it out." Another older participant (M, 53) stated, "I went to [name of hospital's] mental health ward and I lost my apartment, [so] I was homeless." Becoming homeless while in hospital was reported to impact older participants' discharge experiences by creating uncertainty about where they would go following discharge. No younger participants reported becoming homeless while in the hospital.

### *Lack of information and communication with hospital providers*

On an interpersonal level, participants in both age cohorts described a lack of communication with hospital providers during the discharge process. Participants felt they were given insufficient information about their health conditions, medications, and follow-up care, which affected their ability to recover. For example, one older participant (M, 55) who was required to use a mobility aid for recovery following a hospital stay explained,

> I only had the walker for two weeks and then I went on crutches. I should have stayed on the walker for four [weeks] but nobody [at the hospital] told me that . . . I didn't find out until about five months after it happened [when] the physiotherapist said . . . I was walking wrong.

Some participants reported feeling too rushed or too unwell to remember necessary information, as one younger participant (M, 31) articulated,

> Nothing was explained to me, like why my treatment was changed or why I was discharged so early. There was very little communication, or if there was I guess I don't remember it. And, if I don't remember it, then that would probably be an indication that I probably shouldn't have been discharged that early, because if I don't understand what decisions I'm making for my health, how could I possibly be responsible for it at that point?

Indeed, without clear and effective communication, participants reported feeling confused, alone, and frustrated. One younger participant (F, 23) summarized,

> The most crystal-clear thing I remember from [my discharge] was walking out of [the hospital] doors and being like, 'What the fuck do I do now?' I don't know what to do, I don't know where to go, I don't know who to call. That was the only thing on my mind at that point.

When given medical information, participants reported that it was often unclear or couched in medicalized language that was difficult to understand. One older participant (M, 53) noted, "I wanted to know what the diagnosis was, but they couldn't tell me. . . . There were some words or some medical reasons, or medical terms for my condition, but there was nothing specified." Another older participant (F, 59) stated that they, "just couldn't understand" their follow-up care instructions. Without sufficient information about their condition and discharge plan, participants reported experiencing stress and confusion about what to expect during recovery, as one younger participant (F, 33) described,

> I didn't know if, once I got medication, should I be getting my strength back [quickly]? It took me over a month to get most of my strength back... Nobody told me that's expected. . . . None of this has ever happened to me before, so now I'm freaking out even more. Nobody told me those things that I would need to know.

Similarly, participants reported feeling unsure and afraid about how their diagnoses would impact their lives going forward, as one younger participant (F, 32) explained,

> I found out I caught hepatitis C and I was like 'I caught hepatitis C, oh my god, what's going to happen to me in twenty years?' [The hospital staff] said, 'Oh don't worry about it, it's in twenty years.' . . . Don't worry about it? It's my life, how can I not worry about that?

Participants also reported that discussions about housing with hospital staff were rare, even when hospital staff were aware of the participants' housing situation. A younger participant (M, 31) articulated, "No one's ever talked to me once about trying to get out of homelessness or even to get into detox or treatment. . . . [The hospital] suggested I go get help, it wasn't just through them." Indeed, participants reported that hospitals offer little information about homelessness services, as one older participant (M, 55) stated, "There is not information [at the hospital]. . . . They say, 'Go across the road to the homeless place and they'll tell you,' and I just think that's wrong." Lack of communication and intervention regarding participants' housing was reported to result in worsening health and repeated hospital visits, as one older participant (M, 53) narrated, "There was no plan ahead, they just discharged me. . . . I went just back to [housing without supports] and repeated history again. I started drinking again and then back to the hospital several times."

### ***Lack of involvement in discharge planning***

Both younger and older participants highlighted their lack of involvement in the discharge planning process, particularly regarding decision-making about shelter/housing placements. A younger participant (M, 33) raised concerns about not being notified about where they would be discharged to, stating, "I wasn't notified about where I was going to be living. . . . Not letting me know until after the fact . . . was an issue with me." Participants described feeling invalidated when their opinions were not considered, as one older participant (M, 51) noted, "I find sometimes with medical staff, that it's, 'Here, this is what we're going to do,' as opposed to [me] being more involved in [the planning]. . . .  I didn't feel like I was validated." Moreover, participants were wary of being discharged to shelters that would not meet their needs and to unsuitable housing locations, including living with abusive or enabling relations. One older participant (M, 53) posited, "They should at least allow me to go and look at the place and let me make my own decision about where they are going to put me. . . . [But] they made the decision for me."

### ***Negative interactions with hospital providers***

Younger and older participants described negative interactions with staff members in the hospital, which caused feelings of mistrust towards healthcare service providers. Some participants reported interactions with service providers who seemed disinterested in their concerns, as one younger participant (F, 33) noted: “[The hospital staff] are very short, maybe because there they have so many people they got to deal with . . . [but] it’s almost like ‘It’s my way or no way.’” Other participants characterized hospital staff as contemptuous, as one older participant (F, 59) described, “They were mean people. They just weren’t working for me, that’s all. . . . One [staff member] wanted to send me over to [Metro Vancouver municipality] and I have nobody there.” As a result, participants reported feeling isolated by the lack of support from formal networks and frustrated by the lack of concern for their needs. One younger participant (M, 31) explained, “It is so disheartening to know that sometimes there just is no help and then you just have to suffer and then hope for the best.” Moreover, frustration from negative experiences with staff reportedly caused participants to engage in maladaptive and harmful behaviour. A younger participant (M, 33) elaborated, “If the nurses or the doctors are . . . very rude and ignorant I tend to just say, ‘Fuck it’ and walk out and suffer, or . . . go get high and numb the pain.”

Due to negative experiences with providers, participants reported a reluctance to engage with hospital staff about their health and housing needs and challenges. Some cited fear of stigma and poor treatment as reasons for not disclosing housing status, while others reported being treated poorly in the past which resulted in mistrust of healthcare providers. For example, one younger participant (F, 37) described feeling embarrassed about their housing situation and therefore not disclosing to hospital staff: “I never even told them I was homeless. . . . I’m embarrassed because I think in my head, I’m thinking I have a place, which I don’t, and I don’t want people to know that, I guess.” Another younger participant (F, 35) stated, “I’m frustrated, period, with hospitals. I don’t feel like I get my healthcare stuff dealt with seriously. And if I don’t get to feel worthwhile and they don’t care, then what the hell, you know?”

### *Stigma and discrimination*

On a systems level, both younger and older participants described facing stigma and discrimination when accessing healthcare. In particular, participants cited homelessness as a reason for poor treatment from hospital staff. One older participant (M, 53) described avoidance of healthcare services because of the treatment they and their family members had received in the past:

> I am using [healthcare services] less and less and less. I am a little bit angry with some of them, the way they've treated me . . . and my family . . . and how it's affected them as well. . . . I guess that is pretty hard to live with.

A younger participant (M, 31) described how facing stigma from hospital staff impacted their trust in the healthcare system and negatively affected their recovery:

> It just makes you feel like less of a person. . . . A hospital is supposed to be a place of total safety and . . . I should be able to feel as though I am going to be okay here. Because if I don't have that feeling, if I feel scared, or fearful, or apprehensive, or angry or whatever, that's not going to help my healing process, and I'm not going to have good health returns.

In order to avoid stigma when accessing healthcare services, one older participant (M, 55) reported filling out a fake address on forms. However, this participant still reported feeling judged by healthcare staff: "[They ask] 'Are you sure you're not homeless?' . . . They scan you. None of that is right." Indeed, stigma and discrimination were reported to significantly harm participants' sense of self-worth, resulting in traumatic healthcare experiences, as one younger participant (M, 31) summarized,

> I trust in my medical [professionals] to also look at me the same way I look at myself. [Stigma] is hard to deal with. It's scary because you trust your doctors to look at you as a human being. [*Crying*] And when they stop doing that it sucks. Because there's not many other people that do look at us like human beings, right? It was a really negative experience.

In addition to homelessness, participants reported experiencing stigma and discrimination in the healthcare system related to their substance use. One older participant (F, 37) stated, "It's like we [substance users] are not human beings." A younger participant (M, 31) described how their treatment in the hospital changed once staff became aware of their substance use history: "It seemed to me as soon as they discovered that [my condition] revolved around drugs there was an entire attitude shift around some of the people that were working with me. . . . I noticed the treatment began to change." Participants also felt that certain hospitals and clinics were more likely to treat substance users differently than others, resulting in inconsistent care. In particular, staff in hospitals that frequently see substance use-related illnesses and crises, including overdoses, were reportedly less compassionate to PWLEs' needs. Moreover, participants who do not use substances reported experiencing discrimination when requesting pain relief medication:

> When I say I'm having pain and I need pain medicine, they don't want to give you pain medicine and they feel that you just want to be high or something. Since I've been homeless . . . that's how they see me, as a drug addict. (Younger participant, F, 35)

Finally, participants reported experiencing stigma and bullying based on mobility and disability. For example, one younger participant (F, 37) narrated an experience with other shelter guests who made fun of them for using a mobility device at a young age:

> I started crying because I get emotional thinking why are they talking to me like that? They don't even know me. I have to walk with [my mobility device] because sometimes . . . I'll just fall. . . . They don't know that. They'll just judge you.

Related, an older participant (M, 51) with a non-visible disability described being overlooked when seeking referrals for treatment:

> There's so many people that have so many needs, it's so easy to get lost in the shuffle and feel like you're an invisible voice. . . . They can only see from how you present yourself. But there are so many underlying issues that go with disability that people don't see or understand.

Moreover, being labeled with a disability was an undesirable outcome for some participants. Indeed, some participants feared that being labeled with a disability would influence the level of care they would be able to receive, as one younger participant (F, 23) remarked, "I don't want to have that label [of disability] over myself, just because I've got health issues, in every other way I'm competent. . . . So, the minute I go on [disability benefits] I feel like I'm just screwed."

## Supports needed during discharge planning

In order to ensure effective discharge planning, participants identified needing: 1) Increased communication and information, 2) Opportunities for self-determination during discharge process, 3) Support from friends and family, 4) Formal support and a warm hand-off, 5) A person-centered approach to care, 6) Transportation upon hospital discharge and post-discharge, and 7) Increased affordable and available housing stock. Uniquely, only younger participants reported on the need for opportunities for self-determination during the discharge process.

### *Opportunities for self-determination during discharge process*

On an individual level, younger participants uniquely highlighted the importance of freedom and self-determination in their hospital-to-shelter/housing transitions. Younger participants described standing up for themselves and demanding treatment and services in a way that suited their needs and preferences. For example, one younger participant (F, 33) described a recent encounter at a hospital during which they made their treatment preferences clear:

> Their job is to give you healthcare and if they send you away without giving you a solution, that is not care. So, I let them know that I . . . will go to a doctor in the community and have it treated then [instead]. . . . And when [I told them] that they couldn't [treat] me, they got really uptight. It was almost like I was taking away their power or something. . . . [But] I've been standing my ground, being more supportive of myself.

Similarly, younger participants emphasized their right to be involved in choosing their discharge location while in hospital. One younger participant (M, 33) described standing up for themselves during their discharge planning:

> When they were about to discharge me, they let me know, 'We found this place for you, we want you to move in there.' And I kind of looked at them, like . . . 'What if I don't want to move in there? That's not for you to decide, that's for me to decide.'

Another younger participant (F, 32) shared a similar sentiment, stating, "I think everybody deserves a say in where they go, where they feel more comfortable. . . . There's a difference between being asked and being told." Moreover, younger participants who used substances advocated for multiple shelter/housing options to be made available to them to support their lifestyle choices:

> If I wanted to be a drug user and I wanted to safely use, then we could look at a shelter that supports that, but if I don't, then somewhere that is drug free where [there is] more support for people that don't want to use drugs and want to get off the street [should be available]. (Younger participant, F, 24)

Finally, younger participants underscored their independence and their ability to take care of themselves." Indeed, younger participants' stories illustrated their ability to bounce back from adversity and figure out how to manage the discharge process on their own. When asked about what went well in a troubled discharge process, one younger participant (F, 24) stated,

> What worked well is my ability to figure out what I was doing because . . . if I didn't have that ability I probably would have sat [in the hospital] a lot longer. I wanted to be discharged, I did not want to be there for that long.

Moreover, younger participants took responsibility for their follow-up care, expressing a desire for independence and self-reliance. As one younger participant (F, 23) simply stated, "I feel like I'm a grownup, I can do it, I can make my own appointments."

### *Increased communication and information*

On an interpersonal level, the most prominent need identified by both younger and older participants was the need for increased communication and collaboration with hospital staff during discharge. A younger participant (F, 25) described how an ideal discharge would involve "explaining my medication and making sure that . . . I would follow-up with my doctor in the next day. . . . I'd want to understand what's going on." Others agreed, including one younger participant (M, 24) who wished to be "given my medication and be told where I'm going . . . and knowing what to do the next day."

Participants appreciated receiving information and updates about what was happening and what to expect, even if the information was incomplete, as one older participant (F, 59) reported,

> They explained everything to me, what was going on . . . and they wanted to keep me long enough to make sure [I was okay], but they couldn't get the results back right away. So, they had to let me go because they needed the bed, but they took very good care of me.

Moreover, collaborating with a social worker was suggested by one younger participant (F, 24) as a way to identify suitable housing options: "Someone coming and meeting with you and seeing the kind of person you are and fitting you with places that you're going to strive [in] and not end up back in the hospital." A younger participant (M, 33) summarized, "As long as there's that open, honest, available communication, I think that that makes life a lot easier for everybody."

Being provided with documentation about their condition upon discharge was suggested by one younger participant (M, 31) as a way to help PWLEs communicate their health needs to other professionals in the community:

> A letter or something could have been given to me from the hospital. . . . Sometimes people, like myself or other individuals who have some sort of

> anxiety, mental illness, or are still just recovering from an injury, they're not going to be so good at communicating what professionals had suggested. So, there should just be a bit more hard communication that way. Send the patient with something, don't just kind of rely on them to do it for themselves because sometimes it's just we're not in a place to do that.

Participants also desired access to and information about resources for follow-up care while in hospital. One older participant (M, 55) emphasized, "All the information for whatever is available should be made available to everybody. . . . Have the social worker come [to you], give you all the papers . . . all the shelter numbers, the free meal numbers in a folder or something."

### *Support from friends and family*

Both younger and older participants highlighted the importance of informal support in their health and recovery, including friends and family. Participants who were able to rely on informal support valued opportunities to have friends and family involved in their hospital visit and discharge. One younger participant (F, 32) stated,

> I liked staying at the hospital because they gave me lots of time with my mother, they gave me eight hours a day to go out with my mother every day. . . . My mom [came] to pick me up every day to take me out.

An older participant (M, 53) suggested that an ideal discharge would involve informal support whenever possible: "[An] ideal discharge would be, in my opinion, making sure that the patient being discharged had family or support of some type to be with them." Indeed, participants reportedly valued having their family notified of their health and whereabouts. Moreover, participants expressed gratitude when the hospital was willing to be flexible and include close, trusted relations in their discharge. Doing so reportedly encouraged feelings of safety and security during the hospital-to-shelter/housing transition, as one younger participant (F, 33) narrated:

> [The hospital] arranged that my husband could come . . . onto this little tiny bus [from the hospital] with us, so that way I wouldn't have to go back by myself. So, I was thankful for that because at that point I'm barely keeping my eyes open. I don't do people very well, so I don't even have any friends out here yet.

### *Formal support and a warm hand-off*

Participants detailed the value of having positive relationships with service providers, particularly for PWLEs who have limited or no informal support networks to rely on. Notably, participants valued the support of workers in the hospital to help them navigate the complex health and shelter/housing systems to find appropriate solutions. As one younger participant (F, 24) described:

> Filling out those forms, helping you make the calls, being there with you. Maybe throwing in some ideas of safe places to go. Because if I didn't know of [shelter name] . . . I could have ended up somewhere else, which wouldn't have been good. I probably, you know, could have relapsed, because a lot of other shelters aren't drug-free.

Moreover, participants occasionally relied on hospital or shelter staff members to provide transportation to their discharge location, which made them feel more comfortable during the hospital-to-shelter/housing transition. One younger participant (F, 25) noted, "The social worker drove me [to the shelter] from the hospital. Because they were going to give me a bus ticket and I'm like, 'Well, I don't even know where to go.' So, they got a social worker to come." Similarly, an older participant (F, 59) recognized and appreciated the effort put in by a housing worker to ensure a fluid hospital-to-shelter/housing transition:

> [Housing worker] is the one that helped me get back here [to the shelter]. . . . I didn't see him in the hospital, but I heard people talking about him and everybody says he's a very hard worker. He gets his work done and I believe that.

Having a formal connection from hospital to shelter/housing was reported to improve participants' discharge experience. For example, developing a personal connection a with support worker reportedly made participants feel more comfortable in their discharge location, as one older participant (F, 57) described:

> [Shelter staff member] the one that brought me here [to the shelter]. She really made me feel at home and we talked many times, we've talked and she's good. . . . We talked for an hour, hour after hour, talking about things.

### *A person-centered approach to care*

On a systems level, both younger and older participants emphasized the need for a person-centered approach to care throughout the hospital-to-shelter/housing transition. Specifically, participants highlighted the need to honour PWLEs' dignity and to be treated with respect. When delivering person-centered care, participants recommended that service providers recognize individual needs and treat clients fairly and humanely. As one younger participant (M, 31) stated, "Treating each other with that same mutual respect is a big deal. There's really no reason for any disrespect in any human interaction in this [discharge] process." The opportunity to engage in meaningful interactions was reported by one younger participant (F, 23) to improve their overall wellbeing in light of the poor treatment they regularly receive as a result of experiencing homelessness:

> Human connection is really important. . . . When you're homeless, you don't get that; the human connections that you do have are really shitty and toxic and when you do find a good human connection it feels really good and that feeling lasts with you, it stays.

Related, participants discussed the importance of building trust in the staff-client relationship and suggested that being treated as an individual would increase the likelihood that they would disclose information to service providers:

> If we were to establish more personal contact, I'd be a lot more comfortable explaining my situation. You get a certain level of trust . . . as opposed to just being in the system, which is tough because so many are in the system. (Older participant, M, 51)

> Trust [is important]. It's hard to earn anybody's trust. . . . I wouldn't [worry], 'Oh I'd better not say this,' or, 'I better not tell them this because it's going to . . . escalate into something else.' (Younger participant, F, 37)

Participants appreciated flexibility on the part of hospital and healthcare providers in meeting their unique needs. In particular, participants suggested that hospitals be accommodative of PWLEs' pets and guests when able. For example, a younger participant (F, 33) described bringing their dog with them to the hospital while receiving treatment, which they appreciated: "They actually allowed me to bring my dog with me. I don't have a little dog, I have a full-grown Pitbull. . . . They had no problem with me bringing her in there, so that was nice. They were accommodating of that." Another younger participant (F, 32) recalled being given extra time to rest and recuperate after and emergency hospital visit, even though there was high demand for the bed: "One [hospital staff member] said . . . not to worry, that I could keep the blankets on me, I could stay warm, and I could just lay there. . . . So, that was nice." Moreover, participants valued healthcare staff taking time to address their needs in a holistic manner, rather than just focussing on their health, as one younger participant (M, 31) explained,

> Taking that extra little bit of care can make a difference. . . . Those little things that really don't seem like a big deal or aren't maybe medically super necessary, but as a person and as a patient, you'd like to see done.

According to participants, an essential component of effective, person-centered care was spending time with clients. By and large, participants reported brief and rushed encounters with staff, particularly in the healthcare system. As such, participants expressed a desire for increased time to engage with staff and discuss their healthcare and housing needs. For example, one older participant (M, 51) discussed the need for, "More one-on-one time with someone like a social worker . . . to assist and guide from [discharge] on." A younger participant (F, 24) agreed: "[I would like] more one-on-one [time]. Someone . . . [employed by] the hospital, helping people transition out of the hospital, making sure that . . . they're going where they're going." In particular, participants noted that healthcare workers should engage with PWLEs about their wants and needs on their own time, rather than pushing them to make rushed decisions. One older participant (M, 45) elaborated, "I'd like to see . . . social workers . . . spend more time with the patients that need the help. Ones that are actually willing to work on their discharge." A younger participant (M, 31) shared similar preferences and suggested that providing a high level of individualized care to PWLEs would result in improved health outcomes:

> Many of us, we are trying to get better at our own pace and in our own way. [Staff need] to keep that faith and really just show us the same level of care and attention as you would anybody else. I think you'd be very surprised to see how people's health . . . starts actually coming back positively just from that.

### ***Transportation upon hospital discharge and post-discharge***

Participants emphasized the need for transportation upon hospital discharge. As one older participant (F, 57) stated, "More support [is needed] with rides. . . . What happens if you walk out of the hospital and you collapse or something? . . . So, [the hospital should ask] questions about . . . transportation." Participants recalled receiving bus tickets and taxi vouchers on hospital discharge, though taxi vouchers were preferred as a simpler and more convenient option. As one younger participant (F, 33) explained, "[It] was nice knowing that I didn't have to try and scrounge up cab fare, I didn't have to get on the bus and try to remember what stop to get off at." Indeed, having safe transportation arranged at the time of hospital discharge was reported to reduce PWLEs' stress during the often abrupt transition from hospital to shelter/housing setting. Moreover, according to some participants, transportation is also needed post-discharge to assist with attending follow-up hospital visits:

> Once you leave the hospital you know that you have to get appointments from here to there and then back home. . . . Setting up a system of being able to get . . . back to the hospital for your appointment and then back home would be important to me. (Older participant, M, 53)

### ***Increased affordable and available housing stock***

Finally, participants suggested more affordable and available housing stock was needed to support PWLEs upon hospital discharge. Participants described being in a constant search for housing before, during, and after hospitalization. One older participant (M, 53) stated, “I’m on my ninth month [in transitional housing] and they’re still looking for a place for me to live, and it’s very difficult because there’s no places to live.” Participants cited long waitlists as a barrier to accessing housing. Moreover, participants highlighted that the limited housing that is available is often unaffordable. As a consequence, participants felt forced into undesirable living situations:

> I don’t think my entire check would be enough for a place to live. . . . I don’t feel comfortable going into someone else’s housing unit [where] I don’t know people, or getting a place where you have roommates that’s going to cost me my entire check or more. (Younger participant, M, 32)

> It’s so expensive out there nowadays, and there’s certain places I don’t want to live, like on the Downtown East Side. I don’t want to live here no more. It’s bad. I want to get away from all the drugs; I want to have a new life. (Older participant, M, 45)

In order to meet the housing needs of PWLEs being discharged from hospital, participants suggested increasing the amount of affordable housing options. One older participant (M, 53) opined, “There needs to be more social housing for the people because we have thousands of people who are homeless that need a place to live.” Participants also agreed that more housing was needed that catered to a variety of needs and lifestyles, including low-barrier options that allow safe drug use, as one younger participant (F, 32) suggested, “I want a place where you’re allowed to use drugs and there’s no places like that. There’s no housing for people . . . who use drugs or . . . who drink or anything.”

## Recovery and Follow-up Care

Younger and older participants identified multiple challenges to their recovery post-discharge. Participants noted the impact of homelessness on their ability to attend follow-up appointments and keep track of medications. Moreover, participants were challenged to recover when living in unsupportive shelter settings, and older participants also noted challenges living and recovering in unsuitable housing environments and experiencing victimization. Lack of support from friends and family was also cited as a challenge, as were disjointed healthcare and social services systems. Indeed, participants reported that they were left to navigate the complex healthcare, shelter/housing, and social services systems with little assistance from professionals

Participants reported needing assistance with individualized follow-up care needs including medication management, income and financial support, food security and nutrition, employment services, hygiene and clean clothes, and home care. Participants also suggested the need for to include informal support when available and shared a desire for healthcare professionals to take the initiative to engage with PWLEs in their follow-up care. Finally, participants highlighted the need to have their own space to recover and suggested the need for convalescent care settings. Older participants uniquely identified needing home care, while younger participants uniquely identified needing assistance with employment, as well as opportunities for hygiene and clean clothes. Sub-categories and differences and similarities between age cohorts are summarized in **Table 2**.

**Table 2. Comparison of "Recovery and follow-up care" sub-categories by age cohort**

| Category | Sub-category | Younger | Older |
|---|---|---|---|
| Challenges | Individual level | | |
| | The impact of homelessness on PWLEs' ability to follow up | X | X |
| | Living and recovering in shelter settings | X | X |
| | Victimization and loss of possessions | | X |
| | Recovering in unsuitable or unsupportive housing | | X |

|  |  |  |  |
|---|---|---|---|
|  | Interpersonal level |  |  |
|  | Lack of support from friends and family | X | X |
|  | Systems level |  |  |
|  | Disjointed healthcare, shelter/housing, and social services | X | X |
|  | Lack of assistance with system navigation | X | X |
| Supports needed | Individual level |  |  |
|  | Medication management | X | X |
|  | Income and financial support | X | X |
|  | Food security and nutrition | X | X |
|  | Employment services, hygiene, and clean clothes | X |  |
|  | Home care |  | X |
|  | Interpersonal level |  |  |
|  | Informal support from friends and family | X | X |
|  | Support from shelter staff and case workers | X | X |
|  | Regular check-ins and follow-up | X | X |
|  | Systems level |  |  |
|  | PWLEs’ own private space | X | X |
|  | Convalescent care and bed rest | X | X |

## Challenges to recovery and follow-up care

Participants noted challenges to recovery and follow-up care related to: 1) The impact of homelessness on PWLEs’ ability to follow up, 2) Living and recovering in shelter settings, 3) Victimization and loss of possessions, 4) Recovering in unsuitable or unsupportive housing, 5) Lack of support from friends and family, 6) Disjointed healthcare, shelter/housing, and social services, and 7) Lack of assistance with system navigation. Older participants were unique in reporting challenges regarding victimization and loss of possessions, as well as recovering in unsuitable or unsupportive housing.

### *The impact of homelessness on PWLEs' ability to follow up*

On an individual level, the very experience of being homeless challenged participants' ability to follow up with ongoing care needs. Being homeless resulted in participants misplacing or forgetting follow-up information and referral contacts, or having those items stolen. One older participant (M, 45) elaborated,

> I was never able to make it to the appointments because I'm homeless. I lose all the information, the paperwork that I had, my medication. You lose it once you're homeless. It gets stolen, your bags get stolen when you're sleeping out on the street. So, that's what happened. As hard as you try to keep a hold on your stuff it doesn't work because you end up falling asleep, you wake up, everything is gone.

Both younger and older participants reported forgetting their appointments and prioritizing other more immediate needs over attending follow-up care appointments. One younger participant (M, 32) reported being distracted by more pressing needs: "I forgot the date because they set it really far in the future and my phone went missing… I kind of lost track because it was so far [in the future] and I was distracted." Others felt as though following up was not worth the effort if their needs were not going to be met, as well as feeling too exhausted to manage their appointments. A younger participant (F, 37) described multiple barriers to their ability to follow-up:

> Mentally I was lost. . . . I [couldn't afford] my phone, [didn't] have any money at all, just to survive that day or the next day . . . so I couldn't get in touch with anybody and . . . I couldn't get anywhere, I couldn't walk.

Indeed, the experience of homelessness reportedly left participants feeling disenfranchised and disinterested in engaging in self-care. One older participant (M, 45) summarized, "I haven't tried. I've been too busy being homeless, and using drugs, and forgetting everything, forgetting everybody. I just haven't tried."

### *Living and recovering in shelter settings*

Related, participants reported challenges to recovering in shelter settings due to the chaotic environments, other shelter guests' way of life, and lack of safe and clean spaces to rest. An older participant (M, 55) elaborated, "I had some health issues [including] shortness of breath. . . When you are in a shelter setting, it's not very congenial [to recovery]. There's a flu episode, this and that." Moreover, shelter environments are reportedly ill-equipped to support PWLEs in their recovery. One older participant (M, 55) recalled their experience on returning to a shelter after a surgery: "I was doing pretty bad here [in the shelter] because . . . I was . . . on the top bunk with a broken hip." Related, an older participant (F, 50) identified wound care following surgery as a significant challenge in shelter settings where it is difficult to maintain hygiene: "[I don't want an] open wound in this place, that's just a sure way of giving me something toxic forever, I mean I wouldn't survive." A younger participant (F, 37) stressed that wound care was particularly challenging when staying in shelters that require guests to leave during daytime hours: "When you're homeless . . . [and] sitting outside all day long with a big open sore, it's going to get infected." Indeed, limited hours of operations of shelters reportedly left PWLEs without options for rest and recovery during daytime hours:

> You're tired because you just spent half the day at the hospital and now you've got to go sit in the breezeway at the shelter because you can't actually get into the shelter for another five hours. . . . When I'm sick I want to be in my bed. (Younger participant, F, 33)

In addition, participants noted that other shelter guests' drug use challenged their ability to stay sober and have caregivers visit. Moreover, participants reported that other shelter guests may take advantage of them while they are resting and recovering, as one older participant (F, 57) expressed, "My challenge is the people I meet . . . in [the] shelter and in [the] shelter you usually have to share a room. . . . I'm paranoid about [my] stuff going [missing]." The chaotic nature of shelter environments meant that PWLEs were challenged to find time to focus on themselves and their needs, as a younger participant (F, 32) noted, "There's no places just to relax for a while, right? . . . There's no places to bathe or to put on your makeup or to do things you have to." Another younger participant (M, 32) agreed, noting that shelter conditions were detrimental to their ongoing health needs: "There's nowhere I can take my shoes off and let my feet go. I'm just always on my feet and [my condition] just gets worse."

### *Victimization and loss of possessions*

Older participants described instances of being victimized while recovering in shelters and on the street, as well as losing their possessions or having them stolen.

Multiple participants presented narratives of being taken advantage of during their housing search and losing their money to scammers or untrustworthy informal relations. For instance, one older participant (M, 55) described losing their housing due to a predatory landlord, summarizing: “I gave her money for rent for a month . . . and she kicked me out ten days before the end of the month. . . . She didn’t give me a receipt for it so now I have to pay the money back.” In a similar story, another older participant (F, 59) recalled losing money to a scammer who had offered them a place to live that was unfit for human habitation: “I gave her my name and then I turned around and gave her more money. [But] by the time it ended, by the time I got brains in my head, she roped me for $500.”

Other older participants recalled having their property stolen while living in shelters or on the street. One older participant (M, 55) narrated, “I got robbed one time. They knocked me over at the park, took all my money. . . . I lost $540; it was almost my whole welfare check.” Furthermore, older participants reported that losing possessions, including medication and follow-up information, is a regular occurrence when living on the streets. One older participant (M, 45) explained,

> I lose all the information, the paperwork that I had, my medication. You lose it once you’re homeless. It gets stolen, your bags get stolen when you’re sleeping out on the street. So that’s what happened. As hard as you try to keep a hold on your stuff it doesn’t work because you end up falling asleep, you wake up, everything is gone.

### ***Recovering in unsuitable or unsupportive housing***

Older participants also indicated that living in unsuitable housing without adequate supports for their daily health needs challenged their ability to recover and maintain housing. Some older participants described living in single room occupancy hotels with limited onsite supports to aid their recovery from both acute and chronic health conditions, including substance use. In addition, one older participant (M, 53) described living in supportive housing that was understaffed and therefore unable to meet their care needs, resulting in ongoing substance use challenges:

> They were understaffed there in the [supportive housing]. They were giving me my medications at different times, not the correct time. And then on top of that I was drinking and I would refuse my medication because I knew that the pills and the liquor did not mix. So, I would be doing more drinking and not taking my medication.

Finally, older participants noted challenges with landlords and roommates that lead to precarious housing situations and negatively impacted their ability to engage in follow-up care, as one older participant (M, 55) explained,

> I was [in the hospital] for three days. . . . I had a place to live. But I came home for a week and my hydro got cut off because my roommate likes to gamble. So, I went through four months of no hydro and then I was homeless. . . . I had $600 every month and I just couldn't [afford follow-up care]. . . . I had to feed myself every day.

Younger participants did not report similar challenges with unsuitable or unsupportive housing.

### *Lack of support from friends and family*

On an interpersonal level, participants in both age cohorts reported weak informal support networks and difficulties in their personal life, which impacted their housing and their ability to manage their health and recovery. Strained and abusive relationships were cited as a cause of homelessness for some participants. One younger participant (F, 32) explained, "My boyfriend . . . used to drink. He choked me a couple times . . . and it was really scary and I had nowhere else to go, I had nowhere to stay." Furthermore, an older participant (M, 55) revealed that the death of a parent and estrangement from other family members contributed to their loss of housing:

> I just miss my mom so much. . . . I wouldn't have been homeless [if she were alive]. . . . [My kids] didn't want to see me all bad and messed up like that, so I said, 'That's fine.' They're grown up. I hardly ever see them.

A lack of social support was also cited by participants as reasons for ongoing homelessness. Some participants discussed how a lack of support from friends and family left them struggling to find alternative housing options following housing loss, while others reported not telling friends and family that they were experiencing homelessness. For example, one older participant (M, 55) expressed, "I tried to find another place to live. It was tough, I couldn't find [anything], nobody knew [I was homeless]. I had five family, [but] they wouldn't help me. So, it was tough." Another older participant (F, 50) revealed,

> I still don't have a family member that knows that I'm [homeless]. . . . My significant other knows that I've had this . . . stroke, [but] they don't know

> that I've recovered at all or where I am. . . . I have very few friends, my last husband . . . died and since then I had one relationship, but it was not [good].

Due to the lack of informal support, participants underscored challenges to their health and worries about their ongoing recovery and management of health conditions. Participants reported feeling alone and not having anyone to reach out to for assistance with follow-up care. One younger participant (F, 32) described needing to make the difficult and emotional decision to separate from their partner due to challenges with substance use:

> I had to leave all my friends behind and everything and say goodbye to them [to stay sober]. It was very difficult. My boyfriend and everything. . . . But I have to live a new life where I'm clean and sober and he's still using, so it's not good. I still love him.

Moreover, participants reported worries about the future should their health continue to decline, as one younger participant (F, 37) disclosed, "I worry now because my mom's dead, I got no one else, only one person who I can depend on, and [I worry] one day I can't even get up and I'll [realize], 'No one's going to [help me].'" Furthermore, participants expressed grief and loss due to the death of family members, which impacted their immediate health. One older participant (M, 53) articulated, "My father died last Christmas . . . and that's been really affecting [my health] a lot." Another older participant (M, 45) elaborated,

> I just gave up on everything after my mom passed away and my son was killed. I just gave up on everybody. I gave up on my family, my relationship, myself. I just didn't know what I wanted. And now that it's getting to the point, [my health is] getting really serious, where I might lose my leg [due to complications].

### *Disjointed healthcare, shelter/housing, and social services*

On a systems level, both younger and older participants highlighted challenges following up with their healthcare needs after hospital discharge. In particular, participants identified disjointed services and lack of communication and collaboration between the hospital, community healthcare professionals, and shelter/housing providers as contributors to disruptions in continuity of care:

> It doesn't seem like there ever is any connection between doctor, hospital, patient, and then staff at a shelter or any other institution. It's like there's

> no continuum of care there, it's just like three little islands of care that sometimes have to communicate maybe once, but there's never a continuum it seems. (Younger participant, M, 31)

When attempting to access follow-up care, participants recalled barriers resulting from a lack of streamlined communication between services providers, which often left them feeling frustrated and unsure about the appropriate steps to take with their care. For example, one younger participant (F, 23) recalled a dialogue with a follow-up care provider:

> [The provider said] 'Your doctor actually has to fax [your information] to us,' and I was like . . . 'I don't know when he's in next and I don't know why he didn't fax it,' . . . I was very specific when I [went to get the referral]. I knew what I needed to ask for, I directly asked for it and he didn't do it.

Moreover, disjointed services left PWLEs feeling confused about who was responsible for their follow-up care, as one older participant (M, 53) described, "[My] housing person came to my appointments and I think that we were both under the assumption that the doctor would get both my neurosurgeon and the cardio on an appointment, but I haven't heard from them." Another older participant (F, 50) similarly stated, "[I had] one appointment [with a specialist] and I never heard from them again, whether they were supposed to [follow up] or not, I don't know." In addition, a number of participants reported not having a regular doctor, which contributed to uncoordinated follow-up care. One younger participant (M, 51) elaborated, "The thing that didn't work well was not having a primary care physician. So, you kind of get bounced around and you're going through many different doctors. There's inconsistencies."

Participants also identified scheduling challenges, noting that the operational hours of some community-based follow-up services did not suit their lifestyle. Others reported long waitlists to access follow-up services such as community clinics, as one older participant (F, 50) described,

> You have to get [to the clinic] the first half hour of the day, first-come, first-serve. I would get there 7:30 in the morning and I might not get an appointment . . . 'til 5:00 in the afternoon. . . . Or you can have booked appointments . . . but there's never a space.

### *Lack of assistance with system navigation*

Due to disjointed and inconsistent support from healthcare and other service providers and lack of informal support networks, participants revealed that they were often left to navigate complex health and social service systems on their own. Participants described receiving minimal help throughout the hospital-to-shelter/housing transition, which left them feeling overwhelmed and burdened by their recovery. As one younger participant (F, 24) explained, “I was on the phone trying to figure out where I was going to go, and they weren’t helping me with it . . . I [didn’t] have anywhere to go when I got out… [but] no one was helping me with anything.” Instead, participants suggested that the responsibility to manage the hospital-to-shelter/housing transition fell to them, even though they were rarely involved in discharge planning and were often preoccupied with pressing health and housing needs. As one younger participant (M, 31) elaborated,

> It seems like the onus will be 100% on the patients to take care of themselves. There really isn’t that much of a plan for them. It’s just like [the service provider] will explain to you what you need to do, and then that’s it.

An older participant (M, 51) described similar challenges when searching for a safe discharge location following their hospital visit:

> [Call] this person, this person, this person, maybe call this place and you may get lucky. So, it was really more trial and error, just trying to find a safe place… [All they said was] ‘Here’s a list of shelters, good luck.’

In light of these challenges, participants described feeling unsure about how much responsibility to attribute to the hospital in ensuring they were discharged to a safe location. Instead, participants shifted the responsibility for their housing and other needs to themselves. One younger participant (M, 31) made this explicit: “I don’t blame hospitals for not [housing] me because that’s not their job really, it’s everybody’s, it’s my responsibility as well. So, I don’t expect them to go do everything for me, obviously.” Similarly, an older participant (M, 53) noted, “Health is a two-way street.” Indeed, participants differentiated between housing and healthcare needs and recognized that the hospital is primarily a healthcare service rather than a housing service. Participants also acknowledged the limited capacity of hospitals to meet their housing needs, as one younger participant (F, 23) stated, “The hospitals here just don’t have the resources necessary to [help with housing].” Related, an older participant (M, 51) highlighted prior disappointing experiences with the healthcare system as a reason to lower their expectations about the level of assistance they could expect to receive:

> What worked well would probably be my own prior experience. . . . Having gone through it already once, my expectations were not as high, so my disappointment level wasn't as high either if things didn't work out the way I had hoped it would.

Despite this, participants lamented over their housing situation and expressed a desire for assistance with their housing needs:

> Coming into the hospital being homeless, I don't know if the hospital feels that they are responsible to take care of that. I would like to leave the hospital with somewhere to go, because I don't want to go back on the street because it's hard. It's really hard. It's hard on you; it's hard on a person. (Older participant, M, 45)

Participants also described avoiding using available services and avoidance of care for fear of being a burden on the system. One younger participant (M, 32) noted, "I don't really utilize much of the stuff that is offered. I do a lot of stuff myself." Another younger participant (F, 37) similarly stated, "I haven't really asked [for help], because I try to do it all on my own." In some cases, participants described feeling unworthy of accessing follow-up care and that their needs were not great enough to warrant concern. An older participant (M, 55) elaborated, "A skeleton service would be appropriate because I'm mostly very autonomous. . . . And in the end, you can . . . rest [easy] . . . without saying that you . . . skipped the line up so that other people that were in need were not served."

## Supports needed for recovery and follow-up care

Participants identified a number of supports needed to ensure PWLEs are able to engage in follow-up care, including: 1) Medication management, 2) Income and financial support, 3) Food security and nutrition, 4) Employment services, hygiene, and clean clothes, 5) Home care, 6) Informal support from friends and family, 7) Support from shelter staff and case workers, 8) Regular check-ins and follow-up, 9) PWLEs' own private space, and 10) Convalescent care and bed rest. Older participants uniquely identified the need for home care, while younger participants uniquely identified needing support with employment, hygiene, and clean clothes.

### *Medication management*

On an individual level, participants discussed supports needed to manage pain and medications following hospital discharge. Participants emphasized the need for assistance with picking up and organizing their medications, which may be numerous. As one younger participant (F, 33) noted,

> I can barely walk. . . . So, it would have been nice if the doctors actually go drop [your medications] off for you [or] bring it to you before you leave [the hospital]. And that would have been kind of nice, because when I got back [to the shelter] I'm thinking, I need [my medication] because I'm in so much pain and I'm so sick.

In addition, participants reported needing assistance keeping track of their doses and keeping their medication in a secure location. Indeed, one older participant (M, 55) recalled misplacing their medication, which shelter staff assisted in replacing: "I had my meds back there [in the shelter] . . . and lost two weeks [worth] of them. . . . So, that's quite a bit of money. But I got them back. [The shelter staff] bought some more for me."

### *Income and financial support*

Participants highlighted the need for financial assistance and income support following hospital discharge. Without financial security, participants described feeling unable to move forward with their recovery and rehousing. One younger participant (F, 22) elaborated on these needs: "Just making sure you have some financial assistance available because . . . [being discharged to] an empty room . . . it's like, 'Okay, what's next?' And it's like back to the same thing." Another younger participant (M, 33) agreed and suggested needing, "Finances to help you get some food and all that kind of stuff. . . . Because when you discharge somebody from the hospital . . . and then you go to a place and you have nothing, that's a struggle." For some participants, assistance accessing welfare or disability benefits was needed. An older participant (F, 59) described the value in collecting disability assistance: "I'm on disability [benefits] so all my meds and stuff like that are covered. . . . If I lost that then I'd lose everything, for sure, again."

### *Food security and nutrition*

Participants in both age cohorts emphasized the need for food security, including access to healthy food. Participants' low income reportedly limited their ability to eat well, which contributed to their overall health and wellbeing. For example, one younger participant (M, 33) questioned,

> Am I supposed to live on noodles and macaroni and maybe chocolate bars? Because I don’t really eat junk, right? I like to be healthy. . . . I just wish I had more support [for groceries] while I was here [in transitional housing] in the first couple of weeks just starting out.

An older participant (F, 57) shared similar needs and suggested it would be helpful to have food delivered to them while they recovered, stating, “I would like . . . to get food [delivered], because I know some people get food brought to them, and [I’m not] able to access food sometimes. Healthy food.” Having access to healthy food reportedly helped participants manage their conditions. And, while some shelters and drop-in centres were reported to provide meals to PWLEs, such services were inconsistent, as one younger participant (M, 32) living with diabetes noted, “[I need] food for my low blood sugar. And [while] certain shelters do supply food at times, others don’t. Some are more nutritious than others. So, it’s hit and miss with that.”

### *Employment services, hygiene, and clean clothes*

Unlike older participants, younger participants reported needing assistance to re-enter the labour force. One younger participant (F, 33) desired to be connected to “somebody to help you get a job or something. Like, a resume program or something like that to help you work on your resume.” Related, younger participants described needing regular access to a shower and clean clothes, in part to assist with finding a job and to improve their self-worth. As one younger (F, 32) participant articulated,

> When you look good, you feel good, so [hygiene] would be important. . . . When you’re nice and clean and things you can do things better, right? All professionals are clean, they shower every day and everything, so should everybody else, right? Then we can do things more accurately and maybe help more people and do [more] things.

### *Home care*

In contrast, older participants noted needing home care to assist with daily tasks and maintain their home. Upon hospital discharge, one older participant (F, 50) reported, “What I thought I needed was some home care, meaning to get showered and stuff, because I didn’t think [the shelter] was going to [support me].” One older participant (M, 55) elaborated,

> Everyday care would help. A little bit of home care, [someone who] is aware of your daily medications, your needs, and your appointments, and what have you. And also make sure your home is secure and in good shape.

### ***Informal support from friends and family***

On an interpersonal level, participants emphasized the role of informal support networks in managing their recovery and follow-up care. Participants reported leaning on available family members for support with their health, as one older participant (M, 53) described, “My wife usually helps me [with my health]. . . . Usually she’s the most [involved].” Similarly, a younger participant (F, 23) described how their sister provided ongoing support with recovery and engagement in self-care:

> My sister is . . . a nurse and we’ve been working on exercises and stuff so that I can recognize a flare up. So that when it does happen, I don’t always have to come here [to the hospital] because it is a pain to always have to come here.

Friends and acquaintances were also noted as valuable resources for participants’ recovery following hospital discharge. For example, one older participant (M, 55) described receiving assistance from their roommate, who provided transportation from the hospital and helped collect the mobility devices the participant required:

> [My roommate] picked me up at the hospital and then she went the next day and we got the wheelchair and the walker . . . from the Red Cross. She went and got that for me and took the one back from the hospital I borrowed.

Related, a younger participant (F, 32) valued their involvement in support groups, through which they were able to cultivate new informal relationships, outlining, “We have a spirituality prayer group . . . and we have a healthy living group where we do a calendar groups or we do little workshops . . . [where] we just do certain activities that keep us busy.”

### ***Support from shelter staff and case workers***

Participants relayed how building relationships with workers was, in some ways, a substitute for the absence of informal relations. A number of participants reported a desire for human connection, which was supplied by service providers. One younger participant (F, 24) noted, “If, say, [shelter staff member] wants to go for coffee, we’ll go for coffee. Just like a companion kind of thing.” Moreover, participants sought security in knowing that someone was looking out for them, as one younger participant (F, 32) explained, “To have a worker that you can relate to . . . [who] you can always call in case you’re in trouble . . . to keep on making sure that you’re okay [is important].” An older participant (F, 59) similarly stated, “If I had to have somebody look after me, [I] would be okay. I know I don’t absolutely need it, but if that’s the way I could get out of [homelessness], I would definitely do it.” Participants who had cultivated such relationships with support staff reported feeling more confident about their health and recovery and less isolated. One younger participant (F, 23) noted, “Having that one person, even if I know you’re getting paid, you feel not as isolated, for sure.”

Indeed, participants reported feeling grateful for the support received from shelter staff in managing their recovery:

> [The shelter staff] just wanted to make sure that I was okay. . . . I happen to find that shelters are pretty good about, if there’s doctor’s letters or letters of instruction for care, they follow them pretty well. And, they’re interested in making sure that their [guests] are safe. . . . So, I know that they took [my health] seriously and that was nice. (Younger participant, M, 31)
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> [The shelter staff] are so good to me. They got me everything I need. . . . They did it all, the staff at nighttime. . . . And they just keep coming back, working. I don’t know if I could do it. I’d probably lose it. (Older participant, M, 55)

### *Regular check-ins and follow-up*

Related, participants reported a desire for regular check-ins from service providers, as well as regular opportunities for to access follow-up for their health needs. One younger participant (M, 33) suggested healthcare providers reach out to them on a regular basis to support them to manage their ongoing care needs:

> Follow up [should be] that [healthcare providers] call me, ‘Are you okay? Do you need anything?’ . . . They should be following up with me and making sure everything’s up to date, make sure I’m doing my medication properly, making sure that I’m doing things that I need to for my health.

Another younger participant (F, 33) agreed and suggested that check-ins are an effective way of ensuring PWLEs understand their discharge plan and follow-up instructions:

> [Healthcare providers] need to give me a phone call . . . [to] touch base, so that way we’re still sitting on the same page. Because I know sometimes

> when I leave the hospital I think, ‘Okay I understand everything that they said to me,’ and I get home and then . . . it turns out, you know what, sometimes I’m wrong.

Being contacted by a healthcare worker following discharge was reported to be encouraging and empowering for participants and contributed to their engagement in their follow-up care. For example, one older participant (M, 55) noted that regular follow-ups from healthcare workers encouraged help-seeking behaviour, “[Regular follow-ups] help me out a lot. . . . I would just make an appointment and go [to the clinic] if I needed to talk to somebody . . . any time, [with] no problems.”

### *PWLEs’ own private space*

On a systems level, younger and older participants suggested the need to have their own space following hospital discharge. Recovery was noted as a time when participants valued dignity and privacy. One younger participant (F, 33) articulated,

> When you’re laying in a bed [recovering], I find it to be a time when I want to be private. . . . [In a shelter] you pass out and you wake up and your butt’s hanging out of the blanket or something.

One older participant (F, 50) recalled feeling supported when discharged to a supportive transitional housing setting: “The staff . . . let me have whatever time I needed; they would give me all the stuff I needed. . . .I got my own shower, in my own room, my own everything.”

Participants expressed a desire to have a home or apartment that they could call their own, which would help them regain a sense of normality. One older participant (M, 53) elaborated,

> Just a basic apartment with a toilet, a bathtub, stove, and fridge. Like a bachelor apartment. It doesn’t have to be big or anything like that, but just . . . to have a normal apartment and a normal life.

Participants suggested that having a home would provide them the opportunity to maintain good hygiene and would make them feel safe and secure, as one younger participant (F, 37) stated, “At your own home . . . you can go to your bathroom, and you can have your things with you.” Moreover, participants desired a home that they could call their own and that they did not have to share with strangers who they may not trust. One younger participant (M, 32) suggested, “I don’t feel comfortable going into someone else's life and jumping into a family or a housing unit that I don't know people." Indeed, independent housing was preferred over shared or highly supportive spaces where participants had less autonomy. As one older participant (F, 57) stated,

> I'm 57, I want to be independent, I want to have my home, bachelor suite, my own bathroom, my own kitchen, where I'm independent. Here [in supportive housing], sure you've got a community kitchen, you have a microwave and fridge in your room, but you're just in your room, and I feel like I'm locked [in].

### *Convalescent care and bed rest*

Finally, both younger and older participants suggested that convalescent care spaces should be available for PWLEs who are being discharged from hospital to no fixed address. Convalescent care would reportedly allow PWLEs to rest and recover in a safe setting that meets their needs. One younger participant (F, 33) suggested these convalescent settings could be located in the hospital:

> If you're not going home . . . [having] a building for the hospital. . . . Kind of like an outpatient thing, but [patients] would live there, so . . . they still have a little bit more intense follow-up treatment to make sure that their infections were clearing up and stuff. That would be nicer for somebody who's in situations where they don't have somewhere to go.

Alternatively, an older participant (M, 55) suggested shelters could be adapted to support the health needs of guests who have been recently discharged:

> When people come out of the hospital and go to the shelter, they got to be ready to go to the shelter, not half better. . . . They should have a shelter for people that are sick and have wheelchairs and crutches or whatever, they should all be in one shelter and then they can get the help they need.

According to participants, having the opportunity to rest and recuperate in a safe setting was beneficial to their overall recovery. One younger participant (M, 31) who was able to rest and recover in a shelter articulated,

> As far as a recovery from the injury goes, it's been a good recovery. I think that's a direct result of the follow-up care and the fact that the shelter was amenable to make sure that I had the rest that I needed.

# Chapter 5.

# Discussion

This study examined PWLEs' perspectives and experiences of transitioning from hospital to shelter/housing. Participants discussed challenges during the transition process and highlighted supports required to meet their health and follow-up across three thematic categories based on individual-, interpersonal- and systems-level factors. While there were many similarities between younger and older participants, notable differences were identified. Characterizing the hospital-to-shelter/housing challenges and support needs of both younger and older PWLEs reveals key areas to focus future research, planning, and policy. Using an ecological framework to understand interconnected individual, interpersonal, and systems-level priorities can support the development and direction of appropriate interventions. Furthermore, differentiating between the needs and challenges of younger and older PWLEs offers an opportunity to address the unique concerns of both cohorts when creating effective discharge and follow-up care protocols.

## Contextualizing the Findings

### Self-rated health and healthcare use

Consistent with previous research (e.g., Garibaldi et al., 2005; Hwang, 2001), participants in this study self-reported poor health. Participants cited the negative impact that living on the streets, in shelters, and in precarious housing had on their health. Indeed, living on the street increases likelihood of exposure to illness, injury, and victimization (Fazel et al., 2014) and shelters have been found to be unsuitable environments for PWLEs' with complex health needs, including older PWLEs (Burns, 2016; Canham et al., 2020; Fazel et al., 2014). Notably, younger participants underscored worries about the future of their health, while older participants described living with and managing complex chronic health conditions. While previous research suggests older PWLEs live with increased complex health conditions compared to younger PWLEs (Bottomley, 2001; van Dongen et al., 2019), in this study, participants from both age cohorts reported similarly poor health. This may have been due to sampling bias, as only participants who had recently been discharged from hospital and were therefore recovering from an acute or chronic health condition were recruited for the original study.

However, while substance use and mental illness were reported by both younger and older participants, these disorders were more often reported by younger participants. Similar findings have been reported in previous research (Kellogg & Horn, 2012) and may be related to increased mortality among persons living with substance use disorders or mental illness, as well as older PWLEs reducing substance use over time (Crane & Joly, 2014; Crane & Warnes, 2010). Therefore, hospital-to-shelter/housing interventions for younger and older PWLEs should consider the unique health needs of both age cohorts.

Frequent hospital use was common among all participants. Previous research has identified similarly high usage among PWLEs (Hwang et al., 2013, 2011; Raven et al., 2017). Such patterns of healthcare use are expensive and largely ineffective in meeting the long-term healthcare needs of PWLEs (Drury, 2003, 2008; Frankish, 2010; Hwang et al., 2011). Findings also align with previous research suggesting younger and older PWLEs access hospital services at similar rates, but present with different conditions (Brown & Steinman, 2013), and add that younger PWLEs may be worried and unsure about how their health may change over time. Findings suggests younger PWLEs' anxiety about ongoing health needs may be a result of stressful, confusing, and traumatizing experiences with healthcare services. As such, increased efforts are needed to build trust with younger PWLEs during hospital-to-shelter/housing transitions to ensure engagement with follow-up care and to improve health outcomes.

In addition, both younger and older participants reported attending community clinics to receive care, suggesting that accessible, community-based healthcare can address some of the health needs of PWLEs. Increasing the accessibility of community-based care has been noted an effective method of addressing younger and older PWLEs' healthcare needs (Canham, Davidson, et al., 2019; Ramsay, Hossain, Moore, Milo, & Brown, 2019).

Cohen (1999) suggests that, for PWLEs, disadvantage and intersectional risk factors accumulate over the life course. In this study, younger PWLEs reported poor health and worries about their future health. According to Cohen (1999), in the absence of effective interventions, PWLEs' health may continue to deteriorate over time. Additional structural and individual risk factors may further influence PWLEs' ability to access support services and manage ongoing health needs as they age. For example, long-term care settings are often unaccommodating of PWLEs with complex behaviours (McGhie et al., 2013)  As a result, older PWLEs are often left managing chronic conditions from long-term, untreated illnesses, as noted in findings for the current study. Worsening health contributes to disadvantages in employment, transportation, and housing, further perpetuating homelessness through later life (Cohen, 1999).

## Discharge planning

Participants discussed individual and interpersonal challenges surrounding disorganized discharge experiences, lack of communication and information during the discharge process, and lack of involvement in discharge planning. Previous research has characterized PWLEs' discharges as chaotic and stressful (Drury, 2003, 2008). Moreover, lack of communication between healthcare, shelter/housing, and other social services has been noted as a barrier to continuity of care for PWLEs (Albanese et al., 2016; Drury, 2008; Hochron & Brown, 2013; Lamanna et al., 2017). Uniquely, findings for the present study highlight PWLEs' perspectives, which emphasize the need for inclusion and consultation during hospital stays and discharge. Furthermore, findings suggest that respecting PWLEs' agency and autonomy is necessary to ensure effective hospital-to-shelter/housing transitions.

Notably, older PWLEs discussed losing housing while in hospital. Previous research based on provider perspectives suggests that older adults may experience first-time homelessness due to housing loss while in hospital (Canham et al., 2020) Alignment between provider and PWLE perspectives suggest housing loss while in hospital is a critical issue for older PWLEs to be addressed in discharge policy. Moreover, findings suggest a need for services that meet the needs of both first-time and chronically homeless older PWLEs, which has been noted in previous research (Canham et al., 2020; Humphries & Canham, 2019).

In contrast, findings revealed that younger participants value their freedom and right to self-determination. Respecting individual choices and preferences in housing and service delivery has been recognized in previous literature (D’Amico & Nelson, 2008; Goering et al., 2014; Serge & Gnaedinger, 2003). Uniquely, findings from this study reveal that older PWLEs place did not emphasize individual choice as did younger PWLEs. However, both younger and older participants expressed desire for clear communication and involvement in their health and housing.

Participants also discussed systems-level needs including increased affordable and available housing stock and transportation upon hospital discharge. These findings align with previous research, which has similarly highlighted the lack of appropriate and available shelter/housing stock (Canham et al., 2020; Drury, 2008; Forchuk et al., 2006; Hauff & Secor-Turner, 2014; Lamanna et al., 2017). Increasing housing options for PWLEs that meet their unique needs, including older PWLEs, is an essential component of effective hospital-to-shelter/housing transitions (Canham et al., 2020; Forchuk et al., 2006). Research suggests a range of shelter/housing options for PWLEs is needed to meet diverse needs (Canham, Bosma, et al., 2019), including age-related needs (Humphries & Canham, 2019; McGhie et al., 2013). Moreover, shelter/housing options for older PWLEs should recognize distinct pathways into homelessness by addressing the unique needs of both chronically and first-time homeless older PWLEs (Humphries & Canham, 2019).

Transportation following hospital discharge has also been previously identified as a systems-level need for PWLEs to streamline transitions to discharge locations and to encourage ongoing engagement with follow-up care (Greysen et al., 2012). Findings suggest that without transportation, PWLEs may feel stressed and unsafe about commuting to a discharge location and may be unable to access community-based healthcare services. Direct transportation to discharge locations via taxi was highlighted as a way to ensure safe and effective transitions.

An additional challenge to discharge planning, systemic stigma and discrimination against PWLEs is pervasive in both healthcare and social service sectors (Drury, 2003, 2008; Greysen et al., 2012, 2013; Whiteford & Simpson, 2015). Study findings support previous literature which suggests PWLEs may not disclose their housing status when engaging with healthcare providers due to fear of poor treatment (Greysen et al., 2013). In addition, findings suggest that both younger and older PWLEs experience stigma based on their housing status, substance use, and disability, and add that PWLEs recovering from acute health crises are vulnerable to victimization from peers. Therefore, efforts to incorporate destigmatization into hospital discharge and follow-up care processes are necessary. Moreover, findings emphasize the need to ensure the safety and security of PWLEs recovering from illness or injury in shelter settings.

Related, participants reported a lack of engagement with hospital staff due to mistrust and trauma. Mistrust in services among PWLEs has been found to result in poorer engagement with healthcare (Greysen et al., 2012). At the systems level, institutional trauma is caused by formal institutions, such as healthcare, intentionally or unintentionally exacerbating traumatic experiences of patients or clients (Smith & Freyd, 2013). Moreover, cumulative disadvantage may influence PWLEs' trust and engagement with health services as they age, in light of negative past experiences (Cohen, 1999). In order to address institutional trauma and ensure PWLEs feel safe in hospital settings, findings suggest person-centered, trauma-informed care and understanding of PWLEs' unique life circumstances be adopted throughout the healthcare system. Indeed, previous research has highlighted the importance of cultural competency and trauma-informed care in reducing negative discharge experiences (Greysen et al., 2013; Hauff & Secor-Turner, 2014; Hochron & Brown, 2013).

## Recovery and follow-up care

Participants in the current study recognized the disjointedness of healthcare and shelter/housing systems as a barrier to streamlined hospital discharge experiences. When service providers operate in silos, PWLEs may delay seeking care, resulting in poor health outcomes (Greysen et al., 2012). Yet, PWLEs' health and housing are often intertwined, and what affects one is likely to affect the other (Dunn, Hayes, Hulchanski, Hwang, & Potvin, 2006). For example, PWLEs living in substandard housing are more likely to be exposed to physical, chemical, biological, and interpersonal hazards that can impact their health (Dunn et al., 2006). And, PWLEs managing complex health conditions, including older PWLEs, may be challenged to maintain housing without adequate support (Crane & Warnes, 2005; Fazel et al., 2014). Therefore, findings suggest a need for integration of healthcare and shelter/housing service systems to better support PWLEs in the hospital-to-shelter/housing transition.

In light of disjointed health and shelter/housing services, findings revealed that PWLEs often feel unsupported in the hospital-to-shelter/housing transition. As such, participants reported challenges navigating complex and bureaucratic systems on their own. However, without support, previous research suggests PWLEs are likely to prioritize more immediate needs such as food security and safety over health and recovery, resulting in worsening health (Hewett, Halligan, & Boyce, 2012). Findings suggest assistance with system navigation and increased one-on-one time with staff is needed.

Participants also expressed a strong desire to have their own space in which to live and recover. The concept of aging in place proposes that older adults prefer to remain in their homes and communities as long as possible in later life (Greenfield, 2012; Wiles, Leibing, Reeve, & Allen, 2012). Recent expansions on the concept recognize that where and how a person lives impacts their ability to age in place (Golant, 2015). Thus, aging in the *right* place emphasizes the importance of ensuring housing settings meet the unique needs of older adults from diverse backgrounds (Golant, 2015), including older PWLEs (Burns, 2016; Humphries & Canham, 2019). Adopting this perspective provides a lens for understanding the finding that PWLEs, including older PWLEs, desire to live as independently as possible following hospital discharge in a long-term housing setting that meets their needs.

Because PWLEs are challenged to rest and recover when living in shelter environments or on the street, there is a need for convalescent care spaces (Albanese et al., 2016; Biederman et al., 2019; Canham et al., 2020; Hochron & Brown, 2013). Convalescent care, such as medical respite, offers opportunities for PWLEs to manage immediate health needs in a safe and supportive environment (Albanese et al., 2016; Hochron & Brown, 2013). Improvements to PWLEs' health following participation in convalescent care programs have been identified previously (Biederman et al., 2019). In addition, convalescent care allows improved continuity of care and timely discharge (Podymow et al., 2006).

Beyond designated convalescent care settings, findings suggest that accessible supports in the community can support PWLEs to manage their recovery. Participants highlighted individual-level needs surrounding medication management, income and financial support, and food security. Indeed, recognizing and addressing the holistic needs of PWLEs is an important step in improving immediate health needs (Greysen et al., 2013; Lamanna et al., 2017). Unlike older participants, younger participants discussed the need for assistance returning to the labour force. For those who are able, returning to work has been identified as an important component in empowering PWLEs to reconnect meaningfully with themselves and their communities (Tanekenov, Fitzpatrick, & Johnsen, 2018). However, older participants did not prioritize employment needs, instead focusing on managing chronic health and housing issues. As such, findings reveal the need for additional community-based health supports, including home care, for older PWLEs recovering post-discharge (Canham et al., 2020) and highlight some unique follow-up care needs of younger and older PWLEs.

## Support networks

Findings across all categories highlighted the need to support PWLEs in developing interpersonal relationships with staff, peers, and family throughout the hospital-to-shelter/housing transition. Lack of informal support can be both a cause and a result of homelessness (Burns & Sussman, 2019; Corinth & Rossi-de Vries, 2018). Without social support, PWLEs are challenged to meet their health needs (Henwood, Stefancic, et al., 2015; Pahwa, Smith, Yuan, & Padgett, 2019). Findings suggest that relationships with formal support staff, including social workers and housing workers, may substitute informal relationships for PWLEs who are discharged from hospital and that support from shelter staff can foster a sense of belonging and empowerment for PWLEs and encourage engagement in care.

On a systems level, adopting a holistic, person-centered approach to care has been previously suggested as a method of effectively engaging with PWLEs in healthcare settings (Lamanna et al., 2017; Minter, 2012; Serge & Gnaedinger, 2003). A person-centered approach involves tailoring care to meet the needs of individuals by acknowledging their personal needs, beliefs, and preferences (Cloninger et al., 2014; Papastavrou et al., 2015). Relationship building and one-on-one support have been identified as central to the provision of care for PWLEs during hospital-to-shelter/housing transitions (Greysen et al., 2013; Lamanna et al., 2017; Minter, 2012; Wood et al., 2019) and in community-based service provision (Ploeg, Hayward, Woodward, & Johnston, 2008). Findings suggest that service provision for PWLEs discharged from hospital adopt a person-centered approach to care through respect, trust-building, increased time with PWLEs, and flexibility on the part of providers.

While participants highlighted a lack of informal support, findings suggest that opportunities for including friends and family in the hospital-to-shelter/housing transition are welcome. Indeed, social support has been identified as a buffer against homelessness (Corinth & Rossi-de Vries, 2018), including among older PWLEs (Crane et al., 2005; Crane & Warnes, 2001). Furthermore, building social connections is a significant factor in promoting long-term tenancy for older PWLEs (Serge & Gnaedinger, 2003). Study findings similarly suggest that emphasizing the involvement of informal social relations in the hospital-to-shelter/housing transition can improve PWLEs' discharge experiences, which may lead to positive post-discharge health and housing outcomes.

## Similarities and differences between age cohorts

Overall, the challenges and needs expressed by younger and older participants were similar. As such, findings reveal that hospital-to-shelter/housing transitions are experienced through a similar lens of homelessness, regardless of age. However, some differences between age cohorts were identified in this study, providing a nuanced understanding of the hospital-to-shelter/housing challenges and needs of younger and older PWLEs. Differences may be attributed to different life course trajectories and pathways into homelessness (Woodhall-Melnik et al., 2018), as well as accumulation of disadvantage and marginalization over time (Cohen, 1999).

Younger PWLEs reported unique challenges and needs that involved individual expression and respect, as well as long-term concerns about health and employment. Indeed, findings also suggest younger PWLEs value being treated with respect and being involved in the direction of their future. Additionally, findings suggest younger PWLEs are acutely aware of stigmas and discriminatory treatment. Therefore, services for younger PWLEs should engage with clients on a personal basis to understand their needs and preferences and ensure their involvement in care throughout the hospital-to-shelter/housing transition.

Older PLWEs' unique challenges and needs centered on housing. Older participants discussed losing housing while in hospital, recovering in unsupportive or unsuitable housing, and needing home care following hospital discharge. These findings reveal that older PWLEs require additional housing support compared to younger PWLEs. Moreover, older PWLEs discussed managing chronic health conditions, which can be challenging when living in unsupportive settings. Housing solutions for older PWLEs should match their unique health needs and pathways into homelessness (Humphries & Canham, 2019). Therefore, while younger and older PWLEs face similar challenges and have similar needs during and following hospital discharge, additional emphasis should be placed on ensuring older PLWEs are matched to shelter/housing settings that will support their long-term health needs.

The person-environment fit model (Lawton & Nahemow, 1973) can be used to understand PWLEs' unique housing needs following hospital discharge at individual, interpersonal, and systems-level contexts. The demands of managing follow-up care needs without adequate informal and formal support may reduce PWLEs' personal competencies. In particular, older PWLEs reported being discharged to unsuitable environments that do not meet their needs and cause additional stress due to unaffordability or conflict with tenants and landlords. As such, Lawton and Nahemow (1973) would suggest that the environmental press may overwhelm personal competencies, resulting in maladaptive behaviours, such as delays in help-seeking or problems managing follow-up care. For younger PWLEs, findings suggest self-determination in the rehousing process may contribute to alignment between personal competencies and environmental press, resulting in person-environment congruence. In contrast, older PWLEs, whose complex health needs cause frequent hospital use and unstable shelter/housing, may experience 'oscillating in and out of place' (Burns, 2016) as they move through various shelter and housing settings that do not meet their needs. As a result, older PWLEs discharged from hospital without adequate and appropriate shelter/housing are precluded from aging in place and require a range of options to meet their unique needs (Canham, Davidson, et al., 2019; Humphries & Canham, 2019).

For both younger and older PWLEs, Cohen's (1999) life course model can be used to understand hospital-to-shelter/housing transitions across ecological contexts. Complex health conditions that are inadequately addressed at a younger age worsen with age and influence PWLEs' to manage and navigate their health and housing. By taking a life course perspective and recognizing the disadvantages faced by PWLEs that accumulate over time, it becomes apparent that nuanced solutions are needed in both the health and shelter/housing sectors to address hospital-to-shelter/housing transitions. Indeed, adopting a holistic approach and recognizing the social determinants of health that influence PWLEs' health, housing, and healthcare use, is critical when designing effective interventions that influence the trajectories of homelessness in later life.

Findings from this thesis are represented in a variety of ecological contexts, from micro-level individual and interpersonal challenges and supports to systems- and policy-level challenges and supports (Bronfenbrenner & Morris, 2006). Notably, the ecological framework used to organize this thesis differs from the framework presented by Bronfenbrenner and Morris (2006). Alongside the micro- and macrosystems, the authors identify the mesosystem (i.e., interactions between microsystems) and exosystem (i.e., settings or events that indirectly affect the individual). However, due to limitations in the data as a result of the original interview guide, differentiating between meso-, exo-, and macro-level factors did not meaningfully contribute to interpretation of the data. Instead, a broader, "systems-level" approach to understanding these factors was adopted. As a result, the framework used in this thesis highlights both individual and interpersonal factors of the microsystem while acknowledging macro-level factors discussed by participants.

Using this framework, it is possible to identify how individual health outcomes for PWLEs are tied to social determinants and influenced by interpersonal interactions and broader systems of health and housing inequity. Notably, factors categorized at one level are not isolated from others, but exist in an interconnected system of contexts each of which influences and is influenced by the other (Bronfenbrenner & Morris, 2006). For example, an individual's life history influences and is influenced by their interactions with hospital staff during an acute health crisis, whose actions are dictated, in part, by hospital policy framed by a larger societal biomedical understanding of healthcare and hospital services. Addressing challenges and supports through each ecological context can lead to improved policy and practice for safe hospital discharge of PWLEs and the development of a range of shelter/housing solutions for diverse individuals. While it may be more practical to influence and updated individual-level policies and practices in the short-term, longer-term initiatives should consider the ways in which housing, health, and homelessness are framed culturally and socio-politically to create systems-level change in service delivery. By using an ecological framework, individual life course trajectories and experiences of aging into or through homelessness can be understood and addressed in a variety of contexts to influence individual health outcomes.

## Recommendations for Policy, Practice and Future Research

In light of the findings from this study, a number of policy, practice, and research recommendations can be made:

1) As discussed in previous literature (Hauff & Secor-Turner, 2014; Hochron & Brown, 2013; Minter, 2012), health, shelter/housing, and social service providers working with PWLEs should be trained in trauma-informed care using a person-centered approach. Service providers working with PWLEs should treat their clients with dignity and respect. Each client's needs and preferences should be at the forefront of discharge planning and follow-up care.

2) Hospital and community-based services should be coordinated to support continuity of care for PWLEs. Moreover, increased inter-sectoral collaboration and communication between healthcare, shelter/housing, and social services is recommended (Greysen et al., 2012; Wood et al., 2019).

3) Health, shelter/housing, and social service providers should work ensure clear, concise, and timely communication with PWLEs. Information should be shared with PWLEs in a way they can understand. Communication should include information and discussion about housing choices (Barrow & Medcalf, 2019) and follow-up care (Minter, 2012). Moreover, service providers should work with PWLEs to assist with system navigation.

4) Service providers should recognize their role in the lives of PWLEs and engage in trust- and relationship-building. Providers should engage with PWLEs early and often to promote engagement with services and self-care (Lamanna et al., 2017). When available, family and friends should be included in the hospital-to-shelter/housing process.

5) In recognition of the social determinants of health (Hankivsky & Christoffersen, 2008), increased affordable housing stock is needed to support the long-term tenancies of PWLEs. Shelter/housing options should be available to support diverse PWLEs with a range of needs, including older PWLEs (Canham et al., 2020; Humphries & Canham, 2019; McGhie et al., 2013).

6) While there are many similarities between younger and older PWLEs, health, shelter/housing, and social service providers should adopt a life course perspective to understand the unique pathways and care needs of younger and older PWLEs. Follow-up care and shelter/housing solutions should be tailored to suit younger and older PWLEs based on need (Canham et al., 2020). Moreover, in light of increasing numbers of older PWLEs, shelter/housing and services designed for older PWLEs should be expanded.

7) Future research should further examine the distinctions between younger and older PWLEs transitioning from hospital to a variety of environments, including permanent supportive housing and long-term care. Such research should explore the effectiveness of various supportive housing settings in meeting the needs of PWLEs transitioning from hospital, including older PWLEs.

8) Future research should explore stigma and discrimination experienced by PWLEs in hospital and other healthcare settings in order to understand ways to reduce care inequities and increase PWLE engagement in healthcare.

9) Future research should examine intersectionalities of healthcare inequity based on race/ethnicity, Indigenous status, age, substance use, immigrant status, and gender and sexual identity to provide a more nuanced understanding of hospital-to-shelter/housing transitions.

10) Future research should take a participatory action approach to involve PWLEs as partners in the research process. Researchers should make efforts to ensure the inclusion of PWLEs from a variety of intersectionalities, including race/ethnicity, Indigenous identity, age, substance use, immigrant status, and gender and sexual identity.

## Strengths and Limitations

This study has several limitations. First, by using data that had already been collected, I was limited to exploring the topics that were covered in the original study. The interview guides for the original project were informed by a different literature review and sought to answer different research questions than my own. Second, there was no opportunity to revise the interview questions based on emerging themes and findings, as would be the case if conducting primary data analysis during the interview period. However, maintaining regular contact with my thesis committee for advice and input ensured analysis was as robust as possible. Moreover, the research questions chosen for this thesis were designed to align with the pre-existing data and the secondary analysis revealed relevant findings.

Third, while the number of older and younger PWLE participants were roughly equal (*n*=9 and *n*=11, respectively), the sample was not purposefully selected this way. Moreover, the interview guides did not explicitly seek to understand the differences and similarities of experiences between older and younger PWLEs. Instead, I answered this research question by analyzing the data from older and younger PWLEs separately and comparing the findings. By keeping this framework in mind, I was able to identify commonalities between the age cohorts as well as distinctions. Fourth, because all data had been anonymized, I was unable to conduct member checks with study participants to improve credibility of my findings. However, rigor was maintained through an iterative process of reading and re-reading the transcripts and comparing emerging themes to those identified in the literature review.

Finally, data on cultural variations in experiences, including the experiences of Indigenous persons, were not collected in the original dataset. As such, understandings about intersectional disadvantages that impact the hospital-to-shelter/housing transition were not identified. However, this thesis contributes unique understandings about similarities and differences across age cohorts, which has not been explored in previous research.

This thesis addresses a neglected area of research by examining the perspectives of PWLEs, which have been traditionally underrepresented. Moreover, the findings in this thesis provide evidence to support the integration of healthcare and housing through cross-sector collaboration and continuity of care. Additionally, the use of an ecological framework to organize the findings can help practitioners, policy makers, and researchers to effectively identify successes and challenges that impact PWLEs at the individual, interpersonal, and systems level and match interventions to outcomes at each level.

## Conclusion

As numbers of PWLEs increase, it is imperative to investigate solutions and identify opportunities to intervene in the experience of homelessness. Specifically, understanding the unique needs and vulnerabilities of older PWLEs is becoming increasingly important in healthcare and shelter/housing delivery (Culhane et al., 2013). This study examined the perspectives and experiences of younger and older PWLEs transitioning from hospital to shelter/housing. By emphasizing the voices of PWLEs, this research provides evidence grounded in the lived experience of a traditionally marginalized population. As such, the findings in this thesis present a unique understanding of the healthcare and shelter/housing systems. Findings illuminate important domains to consider when designing solutions that address the challenges faced by PWLEs during and following hospital discharge. Leveraging this evidence, researchers, policy makers, and service providers should reassess policies and practices related to hospital-to-shelter/housing transitions for PWLEs. Moreover, while challenges and supports were found to be similar across both age cohorts, findings suggest unique considerations for both populations. Understanding distinctions between younger and older PWLEs provides an avenue for designing and tailoring health and shelter/housing services to address the complex needs of both populations.

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# Appendix A.

# Selected databases and keyword search terms

**Table A1. Selected databases and search terms**

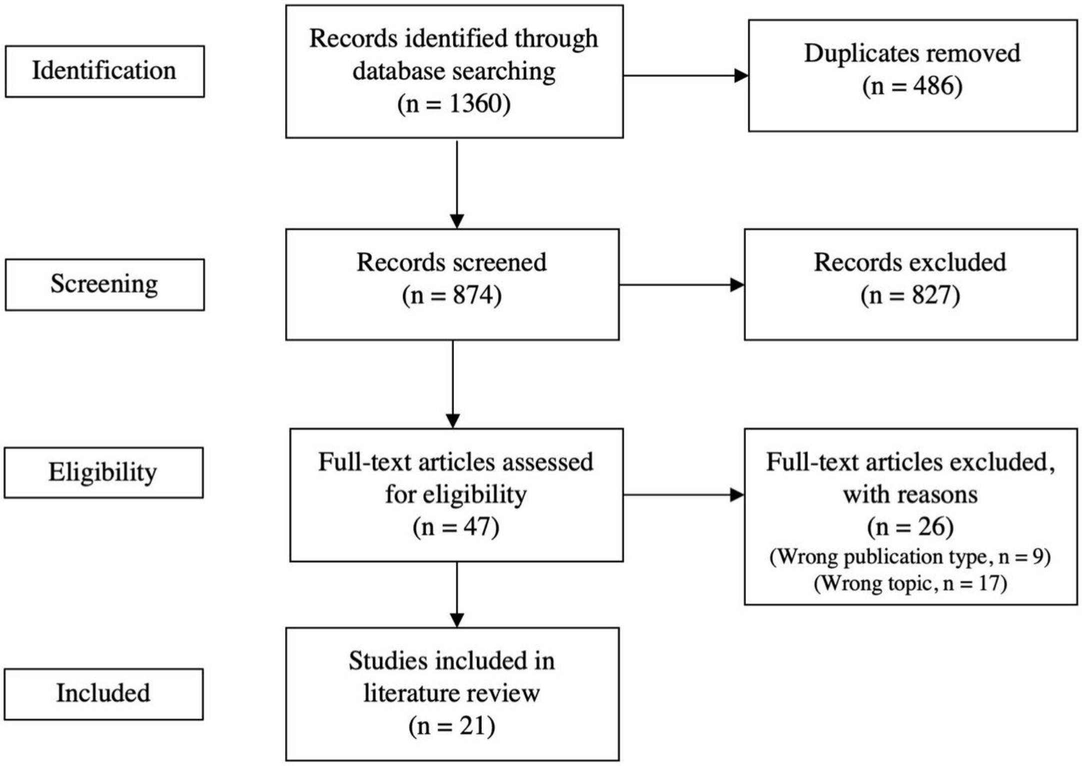
| Database(s) | Search terms and search strings |
|---|---|
| Academic Search Premier, Ageline, CINAHL Complete, Global Health, Medline with Full Text, PsycINFO, Social Sciences with Full Text | Search 1:<br>(homeless* OR housing insecur* OR housing secur*)<br>AND (older adult* OR senior* OR older person* OR elder* OR aging OR ageing OR age-related OR late life OR later life)<br>AND ((hospital OR respite OR convalesc* OR medical stabilization OR discharge) |
| | Search 2:<br>(hospital to shelter)<br>OR<br>(hospital to housing)<br>OR<br>(hospital to shelter/housing) |

*Note:* Keyword strings searched in AB (abstract) and TI (title)

# Appendix B.

# PRISMA diagram

**Figure B1. PRISMA flow diagram of literature sources**



# Appendix C.

# Summary review table

## Table C3. Summary review table

| Author(s). (Year). Title | Country of publication | Topic/aim | Study design and participants | Main findings |
|---|---|---|---|---|
| Albanese, F., Hurcombe, R., & Mathie, H. (2016). Towards an integrated approach to homeless hospital discharge: An evaluation of different typologies across England | UK | Presents findings from an evaluation of the Department of Health "Homeless Hospital Discharge Fund"(HHDF) in England | Mixed method. Telephone interviews with 52 project staff, online surveys with 48 project staff, outcomes data collected by projects, 30 semi-structured interviews with patients and nine in-depth interviews with providers | • Identified six typologies of hospital-to-shelter/housing projects, including housing link workers, nursing link workers, both housing and nursing link workers, a multidisciplinary “Pathways” team, at least one of the above worker(s) linked with accommodation, and accommodation only<br>• Collaboration between health and housing teams provide more effective health and housing outcomes for the patient<br>• Provision of follow-up support once patients were discharged improved housing and tenancy sustainment outcomes<br>• Challenges to the projects centered around the short-term nature of funding, last-minute referrals, and information sharing<br>• Successful projects focused on streamlined referrals and flexibility<br>• 70% of survey participants responded that the process of accessing accommodation for patients worked “very well” or “quite well” and patients reported positive experiences while in hospital |
| Barr, W., Brown, A., Quinn, B., McFarlane, J., McCabe, R., & Whittington, R. (2013). How effective is high-support community-based step-down housing for women in secure mental health care? A quasi-experimental pilot study | UK | Compares outcomes of supportive step-down accommodation for female psychiatric patients vs control group with no step-down housing | Quasi-experimental. Structured questionnaire administered to 37 women receiving psychiatric care. (Control group: 28 women in hospital/institutional care on waitlist for community housing; Intervention group: Nine women living in two community step-down houses) | • Higher psychological wellbeing was found in the intervention group compared to the control group<br>• The intervention group was found to have significantly lower security needs than the control group |

| | | | | |
|---|---|---|---|---|
| Barrow, V., & Medcalf, P. (2019). The introduction of a homeless healthcare team in hospital improves staff knowledge and attitudes towards homeless patients | UK | Evaluates impact of introducing a dedicated homeless housing officer to provide housing navigation services and case management to patients with no fixed address at a district hospital in England | Mixed method pre-post. De-identified document review of medical records for 50 homeless individuals treated and discharged from emergency department (ED) or a ward and comparison of structured questionnaire administered to hospital staff and providers pre-intervention (2013) and post-intervention (2014 and 2016) | • Discussion between staff and patients regarding accommodation increased from 10% to 79% following the intervention<br>• In the first 12 months, the hospital observed an approximate saving of £50,000<br>• Following the intervention, proportion of staff unwilling to discharge patient without a discharge location rose from 24% to 33% in ED and 14% to 58% on ward<br>• Percentage of staff with belief that housing is hospital’s responsibility rose from 0% to 56% in ED and from 29% to 74% on ward after implementation of the intervention |
| Biederman, D. J., Gamble, J., Wilson, S., Douglas, C., & Feigal, J. (2019). Health care utilization following a homeless medical respite pilot program | US | Evaluates a medical respite pilot program for PWLEs to understand impacts on participants’ healthcare utilization and cost-benefit outcomes | Quantitative pre-post. Compares medical records, demographics, patient characteristics, and scores on a housing screening tool of 29 patients experiencing homelessness on admission to a medical respite program and within one year of program completion | • Post-intervention hospital admissions decreased by nearly 37%, inpatient days decreased by 70%, and outpatient visits tripled, but ED visits remained the same after participation in medical respite program<br>• Medical system costs for program participants decreased by 48.6% from the year prior to the year following medical respite |
| Canham, S. L., Custodio, K., Mauboules, C., Good, C., & Bosma, H. (2019). Health and psychosocial needs of older adults who are experiencing homelessness following hospital discharge | Canada | Examines characteristics of older PWLEs and the health and psychosocial supports needed upon hospital discharge | Qualitative. Twenty semi-structured interviews with shelter/housing (*n*=10) and healthcare providers (*n*=10) | • Older PWLEs have unique needs on hospital discharge, including comorbidities and complex health conditions<br>• General population shelters are unable to support recovery for older PWLEs following hospital discharge<br>• Limited appropriate and available shelter/housing settings for older PWLEs with complex health and social needs<br>• A range of supportive shelter/housing options, including medical respite/convalescent care as well as community supports are needed to support older PWLEs on hospital discharge |
| Drury, L. J. (2003). Community care for people who are homeless and mentally ill | US | Characterizes the experiences of 60 PWLEs and living with mental illness following hospital discharge through a Health and Housing Care (HCP) program designed to secure housing and support services for PWLEs | Longitudinal qualitative. Participant observation, case worker reports and community contact reports used to characterize experiences of 60 PWLEs | • Prior to referral to HCP, patients often had multiple presentations in ED or psychiatric inpatient ward and hospital visits were brief<br>• Prior to HCP, hospital staff felt PWLEs should not stay in hospital after immediate health needs were addressed<br>• PWLEs are often discharged without a plan to meet their basic needs (i.e., housing, money, food, clothing) which can become a priority over follow-up health care<br>• PWLEs must manage multiple bureaucratic systems to address needs (e.g., social assistance, mental health) which can be confusing and causes disruptions to care<br>• PWLEs face stigma and discrimination when trying to access follow-up services in the community |

|  |  |  |  |  |
|---|---|---|---|---|
| Drury, L. J. (2008). From homeless to housed: Caring for people in transition | US | Examines the experiences of PWLEs during the transition from street life into community housing following hospital discharge through a Health and Housing Care (HCP) program | Qualitative. Sixty PWLEs were followed over two years from hospital discharge to the community using ethnographic participant observation | • PWLEs and service providers operate in separate, culturally distinct worlds, which challenges design and delivery of appropriate shelter/housing and services on hospital discharge<br>• Provider perspectives suggest the onus is on the person experiencing homelessness to manage and access care; not the responsibility of the system. This stigma is resistant to change<br>• Limited available and appropriate shelter/housing for PWLEs upon discharge<br>• Siloed systems of care do not match the complex care needed to support PWLEs upon hospital discharge<br>• Central concerns include housing, transportation, income, and crisis management |
| Forchuk, C., Russell, G., Kingston-Macclure, S., Turner, K., & Dill, S. (2006). From psychiatric ward to the streets and shelters | Canada | Determines frequency of discharging patients with mental illness from acute care to shelters or the street in a Canadian city | Mixed method. Analysis of hospital data sources recording discharge locations, as well as semi-structured interviews with 300 patients at-risk of being discharged from acute care to shelters or no fixed address | • Discharge from hospital to homelessness or no fixed address occurred regularly<br>• Of 1588 discharges from a psychiatric ward, 6% were discharged to homelessness or no fixed address (including patients who were readmitted and discharged more than once)<br>• In one calendar year, 211 referrals were made to shelter from psychiatric ward<br>• Follow-up care for people with no fixed address is limited<br>• Shelters are unable to support complex physical and mental health needs |
| Forchuk, C., Godin, M., Hoch, J. S., Kingston-MacClure, S., Jeng, M. S., Puddy, L., Vann, J., & Jensen, E. (2013). Preventing psychiatric discharge to homelessness | Canada | Assesses the effects of an intervention designed to provide on-site, pre-discharge housing assistance for psychiatric clients in a Canadian city | Quantitative. Analysis of medical records and discharge locations for 251 psychiatric patients discharged from acute (*n*=219) and tertiary (*n*=32) hospital sites | • The intervention involved income, employment, and housing coordination and advocacy<br>• Between 2002 and 2008, the intervention significantly reduced the number of individuals discharged to homelessness or no fixed address according to shelter and tertiary care data, but no significant change was found according to acute care data<br>• 92.5% of clients who accessed the intervention acquired affordable permanent or temporary accommodation<br>• The costs of implementing and maintaining the intervention were less than the increased medical costs associated with homelessness and housing individuals in shelters |
| Greysen, S. R., Allen, R., Lucas, G. I., Wang, E. A., & Rosenthal, M. S. (2012). Understanding transitions in care from hospital to homeless shelter: A mixed-methods, community-based participatory approach | US | Seeks to understand patients' experiences of transitions from hospital to a homeless shelter, and determine aspects of these experiences associated with perceived quality of these transitions | Mixed method. Semi-structured survey and interviews with 98 PWLEs at a shelter who reported at least one acute care visit to an area hospital in the last year | • Increased communication between hospital and shelter at discharge is needed<br>• Patients' do not expect efficient and effective coordination of services, which exacerbates delays in seeking care<br>• Hospital staff should assess patients' housing status<br>• Hospital discharge planning should include safe transportation |

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| Greysen, S. R., Allen, R., Rosenthal, M. S., Lucas, G. I., & Wang, E. A. (2013). Improving the quality of discharge care for the homeless: A patient-centered approach | US | Explores relationships between assessment of housing status by hospital staff and quality of discharge perceived by patient experiencing homelessness | Mixed method. Assessment of discharge documentation and semi-structured survey to 98 PWLEs staying at a shelter who had visited a local hospital for acute care in the past year | • Over half (56%) of patients reported hospital staff did not assess their housing status during acute care episode<br>• Patients witheld housing status due to stigma, discrimination, and fear of inferior care<br>• Assessment of housing status by hospital staff is associated with higher patient-reported quality of discharge care<br>• To combat embarrassment of disclosing housing status, hospital staff should emphasize concern for patients' wellbeing and safety |
| Hauff, A. J., & Secor-Turner, M. (2014). Homeless health needs: Shelter and health service provider perspective | US | Examines healthcare needs and barriers to healthcare access for PWLEs | Qualitative. Twenty-four semi-structured interviews with shelter (*n*=10) and health staff (*n*=14) | • Limited available and appropriate shelter/housing options on hospital discharge<br>• PWLEs are challenged to navigate complex health and social systems and access appropriate resources upon hospital discharge<br>• Shelters require additional resources to support PWLEs following hospital discharge, including medical staff and nurses, case managers, clean space, funding for transportation, and supplies<br>• Medication management is a challenge for PWLEs<br>• Cultural competence and trauma-informed care training needed in the healthcare sector |
| Hochron, J. L., & Brown, E. M. (2013). Ensuring appropriate discharge practices for hospitalized homeless patients | US | Describes the "Safe Transitions" hospital discharge initiative in Maryland, a collaborative case management approach to ensuring appropriate follow-up care for PWLEs on hospital discharge | Quantitative case study. Uses client and program referral, housing intake, and health insurance data. | • Intervention involves a team of nurses collaborating to arrange post-hospitalization accommodation and services for PWLEs<br>• Follow-up care provided at discharge location<br>• Intensive training for staff is needed to detect and work effectively with PWLEs<br>• Collaborative partnerships between hospital and community-based service providers are central to effective continuity of care<br>• Program has resulted in an increase in referrals for case management and a decrease in discharges to shelters |
| Khan, Z., Haine, P., & Dorney-Smith, S. (2019). The GP role in improving outcomes for homeless inpatients | UK | Explores the role of general practitioners employed in secondary care to support improved health and housing outcomes for PWLEs on hospital discharge and safe transfer of care into community services | Mixed method. Participant observation, clinical data of patients experiencing homelessness at community clinics, and structured interviews with 10 members of "Pathways," a community case management team | • Involving a GP with client's care team (e.g., psychiatrist, care coordinator) helps support client's ongoing health needs in the community following discharge<br>• The GP is a main avenue of communication between hospital and community-based health team<br>• Implementation of a Pathways team influences the approach of hospital staff towards socially excluded groups<br>• Between 40% and 71% of patients seen at hospitals employing a Pathways team have been matched to appropriate permanent housing<br>• Interviews revealed that GPs were valued members of Pathways team, but were sometimes overworked and unable to liaise with team on a regular basis |
| Lamanna, D., Stergiopoulos, V., Durbin, J., O'Campo, P., Poremski, D., & Tepper, J. (2017). Promoting continuity of | Canada | Examines the role of a brief interdisciplinary intervention providing case management, primary and psychiatric care, and peer | Qualitative. Three focus groups and 29 semi-structured interviews with 52 service providers (*n*=22) and program users and people with lived experience of | • For PWLEs, continuity of care is supported by accompaniment to appointments and accessibly located services<br>• Timeliness of follow-up care and promptly addressing unmet needs was needed and valued by patients |

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| care for homeless adults with unmet health needs : The role of brief interventions | | accompaniment in supporting continuity for PWLEs following hospital discharge in a Canadian city | homelessness (*n*=30) | • Frequent and early contact, relationship-building, and humane treatment promotes engagement in follow-up care<br>• Service coordination, navigation, and advocacy helps patients independently manage unmet needs<br>• Limited available and appropriate shelter/housing options on hospital discharge<br>• Fragmented health and social services act as a barrier to continuity of care |
| Minter, J. (2012). Making the links: Integrating housing, health and care | UK | Examines the integration of housing help in a hospital setting in the “Care and Repair” program in England | Mixed method case study. Summarizes cost savings data and findings from semi-structured interviews with project staff, health staff and beneficiaries of the home from hospital information advice and support services | • Collaboration between healthcare and housing agencies is required to ensure the success of the Care and Repair program<br>• Staff training needed in the hospital to raise awareness of older patient’s housing issues<br>• Providing information to the patient about follow-up care immediately before or after discharge results in better uptake<br>• One-on-one advice and support is more effective than information brochures or other media<br>• Program provides cost savings by preventing hospital admissions and streamlining discharges to safe housing settings |
| Murphy, P., Harradine, D., & Hewitt, M. (2020). Evaluation of an early discharge from hospital scheme focussing on patients’ housing needs: The ASSIST Project | UK | Calculates a return on investment of the “ASSIST Project,” an early discharge from hospital scheme focusing on improved responses to patients’ housing needs | Mixed method pre-post. Qualitative interviews and focus groups with 28 hospital staff, examination of program records, and calculation of return on investment from pilot project initiation (2014) to expanded program operations (2015-2016) | • Return on investment calculated at £3.03 for each £1 invested<br>• The mean bed days saved per admission was 4.5 and the mean bed days cost saving per admission was £1,013<br>• Annual savings calculated at £107,000<br>• As the ASSIST program has expanded, so too have the number of available housing services in the community |
| Podymow, T., Turnbull, J., Tadic, V., & Muckle, W. (2006). Shelter-based convalescence for homeless adults | Canada | Examines program participant characteristics and outcomes of a shelter-based convalescence program | Quantitative. Examines program records of 140 PWLEs referred to a 20-bed shelter-based unit providing up to 3 months stay post hospital discharge, or for treatment of addictions or for those too ill to remain in the general shelter | • 8% of patients were admitted to the program because of concerns that they were too elderly or frail to cope safely in the regular shelter system<br>• New family physicians were obtained for 18.6% of patients<br>• 25% of patients required referral or follow up in a hospital outpatient department<br>• Adherence to medication and attendance to follow-up appointments was improved<br>• Upon discharge from the program, 24.3% of patients obtained housing, 6.6% were discharged to palliative care, and 36.5% were discharged to a general shelter |

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| Whiteford, M., & Simpson, G. (2015). Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people | UK | Explores connections between housing, social work, and health care in supporting the development of policy and practice for effective and safe discharge of PWLEs | Qualitative case study. Semi-structured interviews with 18 housing, healthcare, and social service providers | • Cross-sector partnerships and case management teams are needed to support PWLEs on hospital discharge<br>• Strict eligibility requirements for housing and services results in inadequate or insufficient post-discharge support<br>• PWLEs face stigma and discrimination when accessing follow-up services, including community-based healthcare<br>• Healthcare workers may feel unsafe providing follow-up care in chaotic shelter environments |
| Wood, L., Wood, N. J. R., Vallesi, S., Stafford, A., Davies, A., & Cumming, C. (2019). Hospital collaboration with a Housing First program to improve health outcomes for people experiencing homelessness | Australia | Presents findings from a collaboration between a hospital, a specialist general practitioner service, and a Housing First project in an Australian city aimed at meeting housing and healthcare needs of PWLEs. | Mixed method case studies. Participant observation and clinical client data from hospital, community clinic, and Housing First program databases. | • Implementing a hospital homelessness team improves continuity of care<br>• Hospital homelessness team improves ability to assess for housing status and provide appropriate housing intervention while patient is in the hospital<br>• Maintaining regular contact with rehoused clients supports client health and wellbeing<br>• PWLEs need advocacy and assistance with system navigation<br>• Cross-sector collaboration enables closer monitoring and understanding of client issues and timely service responses<br>• In-hospital housing interventions are cost-effective and reduce ED readmission |
| Wyatt, L. (2017). Positive outcomes for homeless patients in UCLH Pathway programme | UK | Examines patient outcomes and post-discharge acute healthcare usage following case management from a multidisciplinary “Pathways” team and discharge planning in England | Quantitative. Audit of hospital admission records, patient discharge summaries, emergency department records, physiotherapy and occupational therapy notes, and “Pathways” team patient assessments | • Pathways intervention resulted in a 37.6% decrease in acute care and ED presentations, 66% decrease in hospital admission, and 78.1% decrease in days spent using a hospital bed for former program participants<br>• Hospital cost savings estimated at £200 a day |

# Appendix D.

# Original interview guide

### *Healthcare needs and supports*

1. How would you describe your current state of health?

2. What are your most common health needs?

### *Extent of problem*

3. How often do you use hospital services?

4. Can you describe what your last visit to the hospital was like?

5. Can you describe what it was like the last time you were discharged (released) from hospital?

   a. PROBES: Were you involved in your discharge plan? If so, how? Were you given information that helped you understand your discharge plan and/or prescriptions received (if applicable)? Were you given helpful information on services and support available in the community?

   b. What would you say worked well with your discharge experience?

   c. What could have been improved with your discharge experience?

   d. What could have been improved?

6. Was your housing situation discussed with you before you were discharged?

7. Where did you go after you were discharged from the hospital? What time were you released from the hospital? How did you get from hospital to shelter/housing? Did shelter staff ask about your hospital care and any follow up (i.e. discharge instructions) you may need?

8. What (supports), if any, helped in your transition from hospital to shelter/housing?

   a. What supports would you have liked that were unavailable/not arranged?

   b. What issues have been most challenging to get help with?

   c. What issues have been the least challenging to get help with?

9. What challenges have you experienced in accessing follow up care? Or accessing the healthcare system?

10. What successes have you experienced in accessing follow up care? Or the healthcare system?

    a. Probe for system functioning – questions about accessing services (e.g., were you able to see a doctor soon after discharge? Did you see a nurse? Did the nurse come to the shelter or did you need to go to a clinic? Did a home support worker come to the shelter to help you? Etc.)

### *Interventions/Solutions*

11. Can you describe what a good discharge from hospital would look like for you?

    What else do you think is needed to better help people with health issues easily move from the hospital to housing and/or shelter?

### *Conclusion:*

12. Do you know any persons with lived experience who may be interested in participating in this research?

# Appendix E.

# Summary table of categories

**Table E1. Summary table of categories and sub-categories notated by age cohort**

| Category | Sub-category | Younger | Older |
|---|---|---|---|
| Self-rated health and healthcare use | | | |
| Self-rated health | Generally poor health | X | X |
| | Managing complex conditions | X | X |
| | Mental health and substance use challenges | X | X |
| | Managing pain and chronic illness | | X |
| | Worry about future and recovery | X | |
| Hospital and healthcare use | Frequent and repeated hospital use | X | X |
| | Successes when accessing community-based healthcare | X | X |
| Discharge planning | | | |
| Challenges | Individual level | | |
| | Disorganized and stressful discharge experiences | X | X |
| | Losing housing while in hospital | | X |
| | Interpersonal level | | |
| | Lack of information and communication with hospital staff | X | X |
| | Lack of involvement in discharge planning | X | X |
| | Negative interactions with hospital providers | X | X |
| | Systems level | | |
| | Stigma and discrimination | X | X |
| Supports needed | Individual level | | |
| | Opportunities for self-determination during discharge process | X | |
| | Interpersonal level | | |
| | Increased communication and information | X | X |
| | Support from friends and family | X | X |
| | Formal support and a warm hand-off | X | X |
| | A person-centered approach to care | X | X |
| | Systems level | | |
| | Transportation upon hospital discharge and post-discharge | X | X |
| | Increased affordable and available housing stock | X | X |
| Recovery and follow-up care | | | |
| Challenges | Individual level | | |
| | The impact of homelessness on PWLEs' ability to follow up | X | X |
| | Living and recovering in shelter settings | X | X |
| | Victimization and loss of possessions | | X |
| | Recovering in unsuitable or unsupportive housing | | X |
| | Interpersonal level | | |
| | Lack of support from friends and family | X | X |
| | Systems level | | |
| | Disjointed healthcare, shelter/housing, and social services | X | X |

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| | Lack of assistance with system navigation | X | X |
| Supports needed | Individual level | | |
| | Medication management | X | X |
| | Income and financial support | X | X |
| | Food security and nutrition | X | X |
| | Employment services, hygiene, and clean clothes | X | |
| | Home care | | X |
| | Interpersonal level | | |
| | Informal support from friends and family | X | X |
| | Support from shelter staff and case workers | X | X |
| | Regular check-ins and follow-up | X | X |
| | Systems level | | |
| | PWLEs’ own private space | X | X |
| | Convalescent care and bed rest | X | X |