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Kristy Buccieri, Abram Oudshoorn, Tyler Frederick, Rebecca Schiff, Alex Abramovich, Stephen Gaetz and Cheryl Forchuk

Abstract

Purpose – *People experiencing homelessness are high-users of hospital care in Canada. To better understand the scope of the issue, and how these patients are discharged from hospital, a national survey of key stakeholders was conducted in 2017. The paper aims to discuss this issue.*

Design/methodology/approach – *The Canadian Observatory on Homelessness distributed an online survey to their network of members through e-mail and social media. A sample of 660 stakeholders completed the mixed-methods survey, including those in health care, non-profit, government, law enforcement and academia.*

Findings – *Results indicate that hospitals and homelessness sector agencies often struggle to coordinate care. The result is that these patients are usually discharged to the streets or shelters and not into housing or housing with supports. The health care and homelessness sectors in Canada are currently structured in a way that hinders collaborative transfers of patient care. The three primary and inter-related gaps raised by survey participants were: communication, privacy and systems pressures.*

Research limitations/implications – *The findings are limited to those who voluntarily completed the survey and may indicate self-selection bias. Results are limited to professional stakeholders and do not reflect patient views.*

Practical implications – *Identifying systems gaps from the perspective of those who work within health care and homelessness sectors is important for supporting system reforms.*

Originality/value – *This survey was the first to collect nationwide stakeholder data on homelessness and hospital discharge in Canada. The findings help inform policy recommendations for more effective systems alignment within Canada and internationally.*

Keywords *Canada, Privacy, Hospital, Patients, Homelessness, Systems alignment*

Paper type *Research paper*

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Homelessness is an experience that intersects with multiple social determinants of health, such as inequitable income distribution, unemployment, food insecurity, inadequate housing, disability and social exclusion (Mikkonen and Raphael, 2010). Yet despite health inequities, many individuals who experience homelessness do not have a regular physician and instead rely on hospitals for care. Researchers have found high rates of hospital use among individuals experiencing homelessness (Tadros *et al.*, 2016), most commonly for injuries resulting in sprains, strains, contusions, abrasions and burns (Mackelprang *et al.*, 2014). Canadian studies have recorded high percentages of homeless individuals who report at least one hospital visit in the preceding year, with figures as high as 77 percent (Hwang and Henderson, 2010). This indicates that a large number of homeless individuals rely on hospitals for their health care needs, sometimes on multiple occasions throughout any given year (Kushel *et al.*, 2002).

In Canada, homelessness costs the Canadian economy $7.05bn annually and institutional care, such as hospitalization, contributes significantly to this amount (Gaetz *et al.*, 2013). Recent indicators suggest that the annual cost of hospitalization of homeless persons is $2,495 compared to $524 for housed persons (Gaetz, 2012; Hwang and Henderson, 2010). Examining expenditures in four Canadian cities, Pomeroy (2005) calculates the cost of institutional responses to homelessness, such as hospitalization, as adding up to $120,000 per person annually. Clearly, there are social and economic costs associated with inadequate levels of care for persons experiencing homelessness.

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Although individuals experiencing homelessness may have a higher acuity or co-morbid conditions that partially explain their more frequent use of hospitals, a notable concern is whether they are receiving timely and appropriate discharge (Cornes *et al.*, 2017). The purpose of conducting this national survey was to understand how Canadian hospital and homeless-serving stakeholders perceive hospital discharge processes and outcomes for these patients.

Canadian context

Canada is a wealthy nation with a population of over 36m. The most recent national data indicate that at least 235,000 Canadians experience homelessness every year and that of these individuals 27.3 percent are women, 18.7 percent are youth, and within shelter populations 24.4 percent are older than 50 and 28–34 percent are identified as indigenous (Gaetz *et al.*, 2016). Individuals identified as lesbian, gay, bisexual, transgender, queer or 2-spirit are disproportionately represented among the homeless population in Canada (Abramovich, 2016; Gaetz *et al.*, 2016).The homeless population has changed over time in Canada, from a small number of single adult males in the 1980s to a mass problem in the mid-2000s (Gaetz *et al.*, 2016). The increase in homelessness and the demographic changes can be traced to federal divestment in affordable housing through policy changes made in the 1980s and 1990s; the dismantling of Canada's national housing strategy at that time had arguably the most profound impact on the rise of homelessness (Gaetz, 2010). At present Canada is undergoing a renewed investment in affordable housing, through new initiatives such as the National Housing Strategy (Government of Canada, 2017) and Homelessness Strategy (Government of Canada, 2018). This shift away from an emergency response toward prevention and transition is in part due to the widespread adoption of Housing First, a recovery-oriented model that aims to rapidly and securely house individuals and then provide the wrap-around supports they need. Housing First was developed at Pathways to Housing in New York (Padgett *et al.*, 2016) and was proven effective in the landmark multi-site Canadian evaluation of over 2,000 participants, known as the *At-Home/Chez Soi* study (Goering *et al.*, 2014).

The Housing First approach increasingly being adopted in Canada represents a shift toward integrated systems approaches (Nichols and Doberstein, 2016). This work is informed by the Calgary Homeless Foundation's (2014) "systems of care" planning, which is comparable to the London Pathway approach (Hewett, 2013; Powell and Hewett, 2011). There are several national bodies that inform and advocate for coordinated systems approaches, such as the Canadian Observatory on Homelessness and the Canadian Alliance to End Homelessness. However, the organization of Canada's political system into federal, provincial/territorial, and municipal governments makes it challenging to align factors such as mandates, budgets and information sharing (Buccieri, 2016). For instance, since health care is managed at the provincial and territorial level in Canada, there are 13 independent ministries that oversee service planning and provision based on geographic location. Furthermore, housing is also a provincial-level issue but is overseen by different ministries than health, and many provinces further download housing and homelessness planning to municipal governments, many of whom operate alongside non-for-profit organizations. Thus, each level of government has its responsibilities and oversight but they are not always well integrated.

The unintended outcome of this political approach is disjointed health and social care, particularly for vulnerable populations. Canada operates under universal health care but researchers have found that hospitals have limited resources to meet increasing needs and are frequently overcrowded (Zhao *et al.*, 2015). While the international standard for safe occupancy is 85 percent, in the summer of 2017 half of the hospitals in Ontario, Canada's most populated province, were at or above 100 percent occupancy, sometimes reaching as high as 140 percent (Ontario Hospital Association, 2018). Delayed discharge can increase occupancy and lead to capacity strain in emergency departments and increased wait times across the system (Forster *et al.*, 2003). Therefore, the fact that 13 percent of hospital beds in Canada are occupied by those no longer requiring hospital care but awaiting discharge to an appropriate service (CIHI, 2010) is of vital concern. The literature review that follows details what is known about hospital usage and discharge planning for persons experiencing homelessness in Canada and establishes the foundation for the study.

Literature review

Discharging individuals from hospital directly to shelters or the street is common but under-explored in the Canadian literature (Forchuk *et al.*, 2006). Pauly (2014) notes that in Canada, clients get "dumped into the community" through discharge to shelters or the street without any discharge planning around housing and community supports. However, some North American research clearly shows that when coordinated discharge planning for homeless individuals occurs, it leads to decreases in hospital visits (Raven *et al.*, 2011; Sadowski *et al.*, 2009), supports housing stability (Forchuk *et al.*, 2008), is cost-effective (Forchuk *et al.*, 2013) and is possible using a systems-approach that integrates sectors (Stergiopoulos *et al.*, 2016) through the implementation of evidence-based practices (Best and Young, 2009). Yet, despite this literature showing the positive outcomes of coordinated discharge, inappropriate or incomplete discharge practice is a common occurrence for individuals experiencing homelessness.

Patients with complex social needs may require a dedicated discharge planner in order for discharge to occur in a timely manner. For people experiencing homelessness, increased length of stay is seen both in acute beds and in Alternate Level of Care beds, meaning patients who do not require acute care resources but remain hospitalized (Hwang *et al.*, 2011). While much of the literature on health care utilization among those experiencing homelessness focuses on high emergency department use, these high rates carry into admitted acute care as well (Fazel *et al.*, 2014). For example, Hwang *et al.* (2013) analyzed health service utilization among 1,165 people experiencing homelessness and found a 4.22 rate ratio for medical-surgical hospitalization compared to the general population. Similarly, Russolillo *et al.* (2016) studied admissions and length of stay for 433 individuals in the 10 years prior to their intake into a Housing First program; they found an average of 6 admissions over 10 years, increasing from 0.3 to 1.2 over the 10-year period. Likewise, mean days in hospital increased from 2.4 to 16.9. These admissions are in part due to compounding factors of higher rates of morbidity with lower rates of access to health services in the community, such as primary care.

Within hospitals, patient discharge may be the responsibility of nurses but often they have not received training about how to address the non-medical needs of homeless individuals (Doran *et al.*, 2014). Without formal instruction, health care providers may not know what issues to consider and/or how to address them. For instance, one American study of discharge practices found that over half of the homeless participants were not asked about their housing status (Greysen *et al.*, 2013). There are several complicating factors common at discharge for any hospital patient, including discontinuity between health care providers, changes to medication regimes, new self-care responsibilities, stressors to available resources and complex discharge instructions (Kripalani *et al.*, 2007). In addition to managing these potential difficulties, patients experiencing homelessness live with unstable social situations that may challenge standard discharge care (Best and Young, 2009). This is evidenced in one study of recurrent hospitalization that found that overcoming difficult life circumstances posed a greater barrier to recuperation than did a lack of medical knowledge, strongly indicating a need to address underlying issues (Strunin *et al.*, 2007).

Following discharge, re-presentation to hospital is common for patients experiencing homelessness (Moore *et al.*, 2010). Fader and Phillips (2012) note that patients experiencing homelessness often lack access to the resources needed to maintain their health independently. Sometimes referred to as a "transition of care" (Kripalani *et al.*, 2007), properly executed discharge planning should identify and organize the services that a person with mental illness, substance abuse and/or other vulnerabilities needs when leaving an institutional or custodial setting and returning to the community (Backer *et al.*, 2007).

Recently some discharge models have begun to identify problem areas and show promising interventions for vulnerable patients. Medical respite programs, for instance, have been shown to assist people in their transitions of care from hospital and to provide ongoing support in the community (Fader and Phillips, 2012) and coordinated discharge checklists have been shown to be effective for discharge of patients experiencing homelessness (Best and Young, 2009). Among the few reported studies on discharge of patients experiencing homelessness from acute mental health services, the findings indicate that discharge directly to transitional and/or supportive housing drastically improves housing stability (Forchuk *et al.*, 2006, 2008, 2013), reduces readmission rates (Stergiopoulos *et al.*, 2016) and lowers health care expenditures (Forchuk *et al.*, 2013).

Research question

Given the high system impact of service utilization by people experiencing homelessness and the likelihood of delayed discharge, more information is needed to understand barriers and gaps regarding timely discharge. Therefore, this paper addresses the question:

RQ1. What are the barriers and system gaps to timely discharge for people experiencing homelessness from hospital to community in Canada?

Methodology

The data presented in this paper were collected through an online survey conducted in July 2017. The Canadian Observatory on Homelessness distributed a brief description of the survey and the link to its members through e-mail and social media accounts. The purpose of the survey was to collect national data on the issues impacting discharge planning for patients experiencing homelessness. To capture a broad range of stakeholders, individuals working within health care, non-profit sectors, government, research or other related fields within Canada were eligible to participate. A total convenience sample of 660 participants completed the survey. All participants provided informed consent, participation was voluntary and no remuneration was provided to respondents. The study was reviewed and approved by the Research Ethics Board for research involving human participants at Trent University.

To collect broad data from a large range of stakeholders, the survey was intentionally designed to take no more than five minutes to complete and consisted of only eight questions. The first six questions were basic demographics to situate participants geographically and in specific sectors or roles. For the seventh question participants were given a series of eight statements (see Table II) and asked to rate their level of agreement on a scale of 0–100, with 100 indicating the highest level of agreement. For the last question, participants were provided with an open box and asked, "Is there anything you would like to say about hospital discharge planning and/or coordinated health care efforts for persons experiencing homelessness in your community?" Slightly more than half (51.5 percent) of the participants responded to this final question, resulting in 340 comments for analysis.

Data from each of the eight questions are reported in this paper. The geographic, employment and statement data from questions 1 to 7 are presented in chart form. The qualitative data from question 8 were analyzed using a method of deductive coding (Guba and Lincoln, 1989), moving from general to particular themes. The quotes were read several times, sorted into broad categories and divided into sub-themes, identifying new ones as they emerged until saturation was achieved.

Findings

Demographics

The demographic data indicated that more than half of the participants were located in the province of Ontario, which is in Central-east Canada. Despite being clustered heavily in one province, the geographic size was evenly distributed between small, mid-size and major metropolitan areas. The majority of participants were employed in the social service or non-profit sector and worked predominantly in non-managerial positions that involved direct contact with persons experiencing homelessness (Table I).

Scope of the issue

Following from the literature on high rates of hospital usage by persons experiencing homelessness (Hwang and Henderson, 2010; Kushel *et al.*, 2002; Mackelprang *et al.*, 2014; Tadros *et al.*, 2016), and discharge planning (Stergiopoulos *et al.*, 2016), a series of statements were constructed for the survey. For instance, based on Wen *et al.* (2007) finding that individuals experiencing homelessness often feel unwelcome in health care settings, we posed a statement about how well-supported stakeholders believe these patients are in hospitals. Questions about

Table I Participant demographics

n = 660	*n*	%		*n*	%
Geographic location			*Sector*		
Ontario	383	58.0	Social service/non-profit	428	60.8
British Columbia	100	15.2	Hospital/health care	125	17.8
Alberta	68	10.3	Government	56	8.0
Manitoba	22	3.3	Other (legal, emergency)	43	6.1
Nova Scotia	12	1.8	Research	20	2.8
Quebec	8	1.2	Education	15	2.1
Newfoundland and Labrador	7	1.1	Policy	14	2.0
New Brunswick	6	0.9	*Length in position (years)*		
Saskatchewan	6	0.9	0–5	214	34.9
Yukon	2	0.3	6–10	175	28.6
Northwest Territories	1	0.2	11–20	127	20.1
Prince Edward Island	1	0.2	> 21	94	15.3
Geographic size			*Work involves homelessness*		
Smaller metropolitan	183	29.7	Yes, directly	529	80.6
Mid-sized metropolitan	178	28.9	Yes, indirectly	120	18.3
Major metropolitan	174	28.3	No	3	0.5
Non-metro small city	36	5.8			
Small town	35	5.7			
Decision-maker in organization					
No	405	68.9			
Yes	171	29.1			

integration between health care and social care emerged from the work of Nichols and Doberstein (2016), and questions about the discharge process were primarily informed by the psychiatric discharge studies conducted by Forchuk *et al.* (2006, 2008, 2013).

Participants were asked to rate their agreement with each statement using a scale of 0–100, with higher numbers indicating stronger agreement. Across all statements, the data indicated strong consensus that the need for improved discharge planning for this population is extremely high. The data presented in Table II, particularly the median and mode for each statement, demonstrate that stakeholders across Canada are struggling with the negative effects of uncoordinated discharge planning for persons experiencing homelessness.

Barriers and gaps

Participants were given an opportunity to share any information they wished about discharge planning and/or coordinated care for persons experiencing homelessness in their community. Analysis of the 340 submitted responses identified three contributing factors that serve as barriers or gaps to the coordinated discharge of patients experiencing homelessness from hospital into supportive housing.

Communication

Participants, particularly those working in shelters, expressed frustration over the lack of communication between sectors. A characteristic statement was, “In 5 years of working at a shelter for those experiencing homelessness, I have never had or witnessed hospital staff (physical or mental health facility), include us in a hospital discharge plan.” While there was recognition that some hospital staff were familiar with the local agencies, this was viewed as a function of the individual and not a systems-level practice. Participants expressed that, “Hospital discharge planners are often not aware of the resources in the community,” “Hospital social workers need to continue to network with the community services” and that communication from hospitals is “too haphazard and frustrating.” Support workers shared the concern that without their involvement discharge plans for their clients were not practical. One participant stated, “We have occasions when people are discharged without appropriate clothing/shoes.

Table II Participant agreement

	$\bar{x}$	*Median*	*Mode*
Hospital discharge planning for patients experiencing homelessness is an issue that needs to be better addressed in my community	92.88	100	100
Persons experiencing homelessness have unique health care needs	89.14	98	100
Improving hospital discharge planning could help reduce chronic homelessness	82.98	100	100
Persons experiencing homelessness are usually discharged from hospitals to the streets or a shelter	82.67	91	100
Hospitals and homelessness sector agencies work well together to coordinate care	24.33	20	0
Persons experiencing homelessness are well supported in health care settings	22.07	20	0
Persons experiencing homelessness are usually discharged from hospitals with treatment plans that are clear and easy to follow	17.56	10	0
Persons experiencing homelessness are usually discharged from hospitals into supportive housing	11.09	4	0

We have tried to communicate with our hospital to participate in discharge planning but have not been successful." Another wrote, "We have identified a trend in our community whereby the hospital will discharge homeless or mentally ill patients late at night and typically on the weekend in order to place inappropriate clients in our shelter."

Siloing between sectors was identified as a primary reason for the lack of mutual communication. One participant noted that although their local hospital is trying to improve their discharge planning they are, "doing so using the typical silo methods that mean they will announce their process changes to community service agencies and then be surprised when those same agencies don't agree with the changes and won't comply." Poor communication between hospitals and shelters was perceived to be contributing to the ongoing lack of coordinated discharge for persons experiencing homelessness in Canada.

Privacy

The lack of communication was attributable, at least in part, to privacy concerns around the sharing of confidential information. Participants working in social service sectors felt that medical professionals would benefit from their knowledge about the client but that they were not receptive to non-family members, citing health professionals as being, "often dismissive of factual evidence witnessed and provided by shelter staff supporting the individual." One participant wrote:

> Many times I have tried to share information with a hospital only to be told that this information is not as accurate as the client. Example: a client stated that with the minor surgery they were having, and the 2 days of rest they needed afterwards, that they could stay with a family member. When I explained that would not be the case as the family member lived in another city and that there was no contact with them due to the addictions of the client, I was informed that the hospital will allow him to be discharged to the family home.

For confidentiality reasons, hospital staff may be reluctant to accept information from shelter workers and are even less inclined to provide information. One participant stated, "Even where there is a care plan in place, the medical profession and particularly the hospitals are not prepared to share critical information with housing and support provider(s)."

Privacy policies were a source of frustration for many participants working in shelters and non-profit agencies. According to one, "Privacy is the main reason given for lack of collaboration with not-for-profits in the homeless serving sector. It's a cop out, I think. Models exist that show public health/not-for-profit collaboration can have positive impact on the homeless population." However:

> It should also be acknowledged that at times communication from hospital to community organizations does not occur due to lack of consent from the client. At times the client does not wish to engage in discharge planning for a number of reasons and that also needs to be respected.

Privacy was identified as a barrier to communication between hospitals and shelters; many felt that while it has to be respected when requested by the client, the goal should always be to have consent in place so that information can be freely shared.

Systems pressures

Each sector has its own pressures that negatively impact their ability to engage in coordinated discharge planning for persons experiencing homelessness. Hospitals experience the burdens of being, "under so much utilization, wait times and flow pressures; their focus is narrow and the goal is time and resource efficiency." While some participants noted that, "Holding onto patients for an extra day or two is very helpful," the general consensus from hospital staff was that, "we are not able to keep patients in the hospital just because of housing," and that, "there are literally no free beds in hospitals." As one participant wrote, "Often the pressure of 'making beds free' puts people in vulnerable situations when they are discharged. It's a broken system and the most vulnerable people are falling through the cracks." Individuals working within hospitals were equally frustrated with the lack of beds and pressure to discharge but felt confined by the policies of their institutions. "Individual hospital staff are flexible and patient-centred. It is systemic policies such as hospital performance measures regarding length of stay that are the barriers." Overcoming the barriers can require extreme measures, such as one community outreaches nurse who recalled blocking an unsafe discharge from the ICU, "by withholding an electric wheelchair, so the person had no means of leaving the hospital." Participants stated that "Nobody wants to discharge a patient back to the shelter; it is a terrible situation for everyone involved, especially the patient" but that, "It is not about improving the discharge plan, it's (about) changing the policies."

Discharge to shelter was not considered to be a viable option by many participants. For instance, they stated that "Shelter services are not equipped to provide the level of care or support for these individuals," "shelter staff are not typically trained in proper after-care or one-to-one care that many patients need" and that to protect their wellness sometimes the only option is, "advocating that the client cannot return to the shelter." Without on-site health care, shelters are rarely a suitable option for patients with medical needs. What these patients often require is home care but "with no known address, it is virtually impossible to provide." However, just as there are limited beds in hospitals, "There is no housing. You can discharge plan all you want, but waiting for housing would mean inpatient stays for years and years." The lack of affordable housing was believed to undermine any efforts at discharge planning. Several participants wrote about the lack of affordable housing options in Canada as being a crisis. Participants wrote that, "People need to actually transition out of transitional housing; there is no movement in the housing crisis." "Hospital discharge planning is only a small piece of a much larger crisis. There is little in the way of affordable housing in this city." "Hospitals can do better to coordinate discharge planning with shelters, but they cannot fix the crisis. We need access to affordable housing." Pressure is put on hospital staff to free up beds but the lack of affordable housing stock means that persons experiencing homelessness have nowhere to go. Accordingly, "One can have all the coordinated efforts they can muster, but if there is no place for people to go, it is a bit like shouting into the abyss."

Discussion

The federal decision to withdraw from affordable housing in the 1980s and 1990s has led to an increase of homelessness in Canada, with current annual figures reaching 235,000 individuals and a cost of $7.05bn (Gaetz *et al.*, 2013, 2016). At the same time, Canadian hospitals are facing chronic overcrowding (Ontario Hospital Association, 2018; Zhao *et al.*, 2015) and a 13 percent bed occupancy rate for patients who are not in need of medical care but lack appropriate referral services (CIHI, 2010). Furthermore, Canadian research indicates that persons experiencing homelessness are frequent hospital users (Hwang and Henderson, 2010), contribute to the high cost of health care provision (Gaetz, 2012; Pomeroy, 2005) and are commonly discharged to shelters or the street (Pauly, 2014). Given these combinations of factors, the current study sought to obtain stakeholder opinions on the state of hospital discharge planning for patients experiencing homelessness.

This paper reported findings from a survey of 660 national stakeholders in Canada. The research question guiding this investigation was, "What are the barriers and system gaps to timely discharge for people experiencing homelessness from hospital to community in Canada?" Consideration of the scope of the issue was based on knowledge from the

literature and revealed strong consensus that persons experiencing homelessness have unique health care needs, improving discharge planning for this population could help reduce chronic homelessness and persons experiencing homelessness are usually discharged to the street or a shelter. Results also indicated a strong general consensus that hospitals and homelessness sector agencies do not work well together to coordinate care, persons experiencing homelessness are not well supported in health care settings, patients experiencing homelessness are not usually discharged with plans that are clear and easy to follow and these individuals are rarely discharged into supportive housing. These findings support the literature from Canada and the USA that shows individuals experiencing homelessness often have complex health needs that lead them to seek hospital care (Kushel *et al.*, 2002; Mackelprang *et al.*, 2014; Tadros *et al.*, 2016), discharge is currently not well coordinated between hospitals and community supports (Pauly, 2014) and that coordinated discharge into supportive housing could reduce hospital visits (Raven *et al.*, 2011; Sadowski *et al.*, 2009) and increase housing security (Forchuk *et al.*, 2006, 2008, 2013).

Analysis of the qualitative data was conducted to identify the current barriers and gaps that prevent coordinated discharge of patients experiencing homelessness. A general lack of communication was an issue, particularly with hospital staff not reaching out to agencies; when communication did occur, it was usually because of the individual staff member being aware of services and not because of institutional practices. As previously noted, within Canada health care is a provincial matter but many service providers are municipally funded or not-for-profit. Working across governments and sectors reduces communication and leads to a lack of transparency. When communication lacked, the non-profit workers generally felt that claims to privacy were made. While they supported client-requested privacy, many felt that hospitals used privacy as a shield for not providing or accepting information about shared clients. Shared databases in community services have shown that multi-agency information sharing is possible with proactive consent. Systems integration is increasingly becoming recognized in Canada (Nichols and Doberstein, 2016) but has been slow to move from theory to practice.

The third barrier identified was the existing system pressure on hospitals, shelters and affordable housing stock. It is well documented that hospitals in Canada are at- or over- capacity (Zhao *et al.*, 2015), and that despite the adoption of Housing First (Goering *et al.*, 2014), there are high rates of homelessness and limited affordable housing (Gaetz *et al.*, 2016). Survey participants were particularly frustrated with what they described as crisis-level situations, whereby there were no free beds to keep patients in hospital, limited medically equipped shelters and no housing options available. These systems pressures meant that individuals had to sometimes undertake extreme measures, such as withholding a wheelchair at hospital or refusing admission at a shelter, to prevent early or inappropriate discharge. While participants perceived individuals within these systems to be client-centered, there was a consensus that the pressures of high demand and low capacity pervaded hospitals and housing sectors.

Some models of discharge planning, such as direct entry into supportive housing upon psychiatric discharge, have been effective in Canada (Forchuk *et al.*, 2006, 2008, 2013) but without more affordable housing stock across the country, the implementation of this method will be restricted. In the shortage of affordable housing options, medical respite programs (Fader and Phillips, 2012) may be an alternate option that serve as an intermediary between hospitals and housing, relieving some of the identified systems pressures. Coordinated discharge checklists, shown to be effective (Best and Young, 2009), may also improve communication if they are adapted to be jointly shared across sectors. Effective and sustainable approaches to discharge for patients experiencing homelessness are possible but will require consideration of communication, privacy and constraints within the existing systems.

Limitations

The data were collected through an online survey of national stakeholders. Given its distribution through the Canadian Observatory on Homelessness, there was likely a self-selection bias, in which participants who were actively working in homelessness agencies or with persons experiencing homelessness were more likely to respond. This is supported by the

high percentage of non-profit workers. Additionally, the survey was predominantly completed in the province of Ontario and may have had different results if more geographically dispersed. No patient views were collected in this study.

Conclusion

Within Canada, hospitals and affordable housing are both at full-capacity and working at odds with one another. The national adoption of Housing First, while having the potential to rapidly house individuals in need such as those leaving hospitals, is only possible if a sustainable source of affordable housing exists. Canada is on the verge of another major shift in its approach to homelessness, reversing the federal devolution of affordable housing with the 2018 National Housing Strategy (Government of Canada, 2017) and Homelessness Strategy (Government of Canada, 2018). Reducing the burdens on health care and housing sectors requires that they be viewed and funded as two interconnected issues and not as parallel systems. As these new initiatives unfold, Canadian leaders are called upon to invest in affordable housing, as a means of supporting Housing First and offering a resource for hospital discharge planners. Coordinated discharge for persons experiencing homelessness would help improve the capacity of both sectors, but it depends on overcoming the barriers of communication, privacy and systems pressures.

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