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Facilitating Healthcare Utilization of Homeless Persons

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ABSTRACT

The physical and mental health of homeless people is considerably worse than that of the general population. The prevalence of mental disorders, substance misuse, affective disorders, and anxiety disorders is significantly elevated in individuals who have been homeless for long periods of time. Historically, homeless people have had poor engagement with healthcare services due to a lack of financial resources, health insurance, and accessibility. Solutions to slow homeless persons' continued cycle of poor health include improving access to healthcare via outreach services that leverage mobile treatment options, and establishing rapport and trust in clinical settings by placing an emphasis on the quality of communication between provider and patient and by removing the social stigma associated with homelessness in healthcare. We make a conceptual analysis of the available literature to explore the ethical considerations associated with caring for the homeless, offer methods to improve health service utilization, and minimize the stigma that homeless individuals face in the clinical setting.

Keywords: Health, Homelessness, Clinical Ethics, Stigma

INTRODUCTION

The physical and mental health of homeless people is considerably worse than that of the general population [1]. The prevalence of mental disorders, substance misuse [2], affective disorders, and anxiety disorders is significantly elevated in individuals who have been homeless for long periods of time [3]. The negative impact of homelessness on physical health is also well documented [4], with many homeless persons showing disproportionately high rates of malnutrition, infestations, respiratory illness, and cardiovascular disease [5]. As a result, homelessness is associated with higher rates of premature mortality compared to the rest of the population. Prior research6 has also shown that homeless patients are more vulnerable to suicide attempts [6] and accelerated rates of aging.

Historically, homeless people have had poor engagement with healthcare services due to a lack of financial resources, health insurance, and accessibility8. Physicians' offices are rarely located in areas where homeless people tend to congregate and are usually open only during regular office hours, posing significant transportation and scheduling challenges. In addition, intake requirements requiring the homeless patient to produce proper identification, insurance, and a permanent address [6] may also serve as barriers for accessing treatment in a timely fashion. Exacerbating the situation is the homeless person's natural tendency to achieve physiological needs such as food, shelter, water, and sleep. Prioritization of health issues takes a backseat when these needs are unmet [7]. This causes delayed clinical presentation and leads to increased reliance on emergency departments and higher rates of hospitalization for preventable conditions [6-8].

Solutions to slow homeless persons' continued cycle of poor health [7] and inappropriate usage of emergency departments for treatment include (1) improving access to healthcare via outreach services that leverage mobile treatment options, and (2) establishing rapport and trust in clinical settings by placing an emphasis on the quality of communication between provider and patient and by removing the social stigma associated with homelessness in healthcare. This will foster the usage of primary care services amongst the homeless and provide a warm, nonthreatening, and nonjudgmental clinical environment for patients regardless of their social class or background [9].

OUTREACH TO VULNERABLE POPULATIONS

Challenges and Considerations

Outreach services and drop-in centers are the most frequently utilized types of services offered to the homeless and often act as a gateway to other forms of assistance [10,11]. Patients utilizing these services are significantly more likely to access medical, dental, and mental health services.

Establishing a communications pipeline to the homeless via multi-disciplined outreach programs can be a plausible step towards ensuring basic healthcare needs are addressed. However, barriers to enacting such outreach programs are significant.

Many homeless people show a lack of knowledge of specialized systems of care, leading to negative perceptions of service provision and delivery [12]. As a result, those in greatest need often have mistrust of established institutions such as clinics or hospitals and are uninterested in speaking with anyone connected to these institutions [13]. Furthermore, much of this demographic lives nomadically or in hard-to-find locations [10], making continuation of treatment difficult for service providers.

Proposed Solutions

Setting up mobile or temporary clinics in homeless drop-ins and shelters can alleviate critical access barriers and enable health care providers to build trust and engage with the homeless community [11]. Outreach teams can leverage mobile services by bringing with them the necessary medical equipment and supplies to provide treatment for acute and chronic conditions. Mobile services may also provide screening, counseling, and educational interventions to minimize traditional barriers like cost and transportation [13] and reduce referrals to the ED. The care, comparable to that of traditional hospitals and clinics [12], would be provided in the presence of a consistent, unbiased clinician to engender the trust of the patient and improve the quality of engagement between the patient and caregiver. In addition to providing access to medical, mental health, and addictions services, these multidisciplinary outreach teams can facilitate access to after-jail services, social services, and the criminal justice system [14] to improve the overall health of patients and encourage later usage of mainstream medical services.

Appropriate service provision and outreach to this population requires sensitivity to street culture and methods of communication15. Providers who make judgments and decisions based on their own values and beliefs will likely misjudge situations associated with these groups, resulting in services that do more harm than good [15]. Flexibility and awareness are key, as those in need of outreach form a broad and heterogeneous group that changes frequently. Service providers must recognize the complexities of street survival and develop a strong, trusting relationship with their patients if these services are to be effective.

STIGMA AND DISCRIMINATION AGAINST THE HOMELESS POPULATION IN HEALTHCARE

Current Landscape

Discrimination on the part of the caregiver is a common risk that undermines the efficient delivery of medical care for the homeless. A homeless person seeking treatment will likely feel that disclosing their housing status will result in stigmatization from care providers [16]. In addition to wariness from the patient’s perspective, another major barrier to delivering care for the homeless is the behavior of physicians towards homeless patients during consultation. Apathy and unwelcomeness demonstrated by physicians during patient in-take and rude behavior during the treatment process erodes trust and has a dehumanizing impact on the patient. These attitudes stem from the perception that homeless people are ‘undeserving’ of treatment and are prone to violence and antisocial behavior [17]. Some homeless people may also face a further risk of exclusion because of their age, gender, or ethnic background [18].

Many homeless patients have reported intense emotional responses to unwelcoming experiences in clinical settings, citing that these experiences negatively influenced their desire to seek healthcare in the future [19]. Such behaviors increase homeless persons’ sense of alienation or despair and have a direct impact on their overall responsiveness to health services [20]. Consequently, this lack of engagement can lead to decreases in the effectiveness of counseling and treatment recommendations [21] by clinicians.

Studies [21-27] have suggested that stigma is an additional dimension of these interactions. Stigma is “a special kind of relationship between attribute and stereotype” in which an objective attribute (e.g., “homelessness”) is linked to a stereotype that is often of a discrediting nature (e.g., “lazy”) [24]. Society focuses on these attributes as the root cause of homelessness, shifting the onus onto the victim rather than addressing larger antecedent social and economic forces such as unemployment or limited affordable housing [22].

Diversity in the patient population creates the opportunity for caregivers to stereotype and potentially discriminate. Social stigma can occur in clinical settings where there is an unequal distribution of social, economic, and political power amongst the patient population [23]. For example, many homeless patients have reported suboptimal primary care interactions in which they felt they had been disrespected30 by physicians when seeking care for chronic pain. In these scenarios, primary care physicians were reluctant to prescribe narcotics to homeless patients with a known history of substance misuse, instead choosing to take a more conservative approach with a potentially less-effective outcome.

Proposed Actions

Social stigma and discrimination have implications for the health of those experiencing social inequities [23-27]. Homeless patients are more likely to continue to engage with healthcare services when they feel providers listen to them, trust them, are accessible to address their concerns in between visits, and use patient-centered approaches to establish goals and treatment plans26. Many patients have cited the importance of being treated as ‘equals’ to service providers, rather than being categorized as ‘inferior’ due to their homelessness [26]. As such, it is imperative that clinicians refrain from excluding people from healthcare services on account of homelessness or possible drug-using [28] culture. Medical professionals must be equipped with training that allows them to manage their personal reactions to the homeless population during clinical encounters.

Non-Stigmatizing healthcare services can improve the overall health of this population and decrease further need for acute medical attention [23-29]. By creating a system that is more trauma-informed, equity-enhancing, and accessible to people experiencing homelessness, negative experiences of care can be minimized [30]. Educational programs and modeling of non-stigmatizing behavior can teach healthcare providers the importance of providing unbiased care [31].

By involving homeless patients in the treatment process, gaps in health provision can be identified and remedied. Such efforts help counter the social exclusion that contributes to ill-health. This follows the principle that all individuals, irrespective of status, should be allowed opportunities to participate in decisions affecting them [28]. To this end, the self-help and advocacy groups provided by outreach programs can help to proactively identify critical needs of patients and reduce discrimination against the homeless in healthcare [28, 32].

CONCLUSIONS

Homelessness exacerbates existing health problems and creates new ones that are often a complex mix of physical, mental, psychological, and social challenges. While no amount of healthcare will replace the benefits of having a home, maintaining a high quality of treatment will improve homeless patients' wellbeing. Utilization of mobile outreach programs, health promotion campaigns, and educational interventions for service providers will better the treatment process by increasing civility in therapeutic communication. As a whole, this will augment patients' awareness of the importance of being receptive towards seeking out available healthcare as a life necessity that is integral to their wellbeing.

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