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"It Wasn't Just One Thing": A Qualitative Study of Newly Homeless Emergency Department Patients

Kelly M. Doran, MD, MHS, Ziwei Ran, MSW, Donna Castelblanco, MBE, Donna Shelley, MD, MPH, and Deborah K. Padgett, MA, PhD, MPH

ABSTRACT

Objectives: Emergency departments (EDs) frequently care for patients who are homeless or unstably housed. One promising approach taken by the homeless services system is to provide interventions that attempt to prevent homelessness before it occurs. Experts have suggested that health care settings may be ideal locations to identify and intervene with patients at risk for homelessness, yet little is known even about the basic characteristics of patients who might benefit from such interventions.

Methods: We conducted in-depth, one-on-one qualitative interviews with ED patients who had become homeless within the past 6 months. Using a semistructured interview guide, we asked patients about their pathways into homelessness and what might have prevented them from becoming homeless. Interviews were digitally recorded and professionally transcribed. Transcripts were coded line by line by multiple investigators who then met as a group to discuss and refine codes in an iterative fashion.

Results: Interviews were completed with 31 patients. Mean interview length was 42 minutes. Four main themes emerged: 1) unique stories yet common social and health contributors to homelessness, 2) personal agency versus larger structural forces, 3) limitations in help from family or friends, and 4) homelessness was not expected.

Conclusions: These findings demonstrate gaps in current homeless prevention services and can help inform future interventions for unstably housed and homeless ED patients. More immediately, the findings provide rich, unique context to the lives of a vulnerable patient population commonly seen in EDs.

Homelessness is a persistent and vexing problem throughout the United States. In many cities, the numbers of people who are homeless remain persistently high.[1–3] In New York City, for example, the homeless shelter census has risen over the past 10 years—to more than 60,000 in 2017—despite tens of thousands of people being provided with permanent supportive housing or rental subsidies.[4] As some people exit homelessness, however, others stream through the "front door" to take their place. Accordingly, policymakers have increasingly focused on homelessness prevention as a key strategy for reducing homelessness,

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Received October 23, 2018; revision received December 17, 2018; accepted December 18, 2018.
Research reported in this publication was supported by the National Institute on Drug Abuse of the National Institutes of Health (K23DA039179, PI Doran), the United Hospital Fund (PI Doran), and the Doris Duke Charitable Trust—NYULMC (PI Doran). The content is solely the responsibility of the authors and does not represent the official views of any funder.
KMD received grant funding for this study from the NIH/NIDA, the United Hospital Fund, and the Doris Duke Charitable Trust—NYULMC as noted above. The other authors have no potential conflicts to disclose.
Author contributions: KMD, DS, and DKP conceived of the study and developed the interview guide; DC and KMD conducted the interviews; DC, ZR, and KMD conducted data analysis, including coding the interviews; KMD drafted the manuscript and all authors provided critical feedback and approved the final version.
Supervising Editor: Harrison J. Alter, MD, MS.
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ACADEMIC EMERGENCY MEDICINE 2019;00:1–12.

© 2019 by the Society for Academic Emergency Medicine
doi: 10.1111/acem.13677
ISSN 1553-2712

with growing proportions of homeless services budgets going toward efforts to prevent homelessness.[3,4]

While homelessness prevention services are generally provided in community-based settings, some experts have suggested that hospitals may be important sites to identify people at high risk for homelessness and refer them to services.[5] Prior research has shown that emergency department (ED) patients have particularly high rates of housing instability and vulnerability for homelessness.[6–9] EDs may therefore be promising sites for homelessness risk screening and prevention services. Hospitals and health systems may be interested in preventing homelessness since copious prior research has shown that homelessness is associated with negative health outcomes and higher than average use of hospital-based care including ED visits.[10–15]

Understanding how to best prevent homelessness requires knowing about why people become homeless in the first place. Prior research has found that homelessness is associated with poverty, interpersonal conflict and abuse, job loss, substance use, mental health, "life shocks" such as birth of a child or illness, and criminal justice system involvement, among many other factors.[16–26] Much of the past research on correlates of homelessness has been cross-sectional, limiting the ability to determine temporality and causality of the observed relationships. Given the complexity of interrelated factors that may lead to homelessness, qualitative research is particularly well suited to exploring pathways to homelessness. There has been little prior qualitative research, however, that has specifically examined reasons for and precipitants of homelessness in the words of people who have been affected by it.[27–31] Further, to our knowledge no prior research has examined pathways to homelessness among ED patients, a potentially unique group. To fill this gap, we conducted a qualitative study using in-depth interviews with ED patients who had recently become homeless to explore their self-identified reasons for becoming homeless.

METHODS

We conducted one-on-one, in-depth, semistructured qualitative interviews with 31 ED patients who had recently become homeless. This study was part of a larger body of research aiming to develop homelessness prevention interventions for ED patients. Study methods and results are presented in accordance with the consolidated criteria for reporting qualitative research (COREQ).[32]

Study Setting and Population

The study was conducted at an urban, public hospital ED and contiguous urgent care center. English-speaking patients 18 years or older with a new-onset homelessness (defined as living in a shelter or on the streets) episode in the past 6 months were eligible. We chose this time frame because we felt that patients would be most likely to remember details about how and why they became homeless when it was a relatively recent experience. Patients were eligible regardless of whether this was their first time ever homeless or if they had past experiences of homelessness. Patients were ineligible if they were too intoxicated to provide consent, otherwise medically unfit (e.g., critically ill), psychologically distressed, in police or prison custody, or could not understand study consent (e.g., dementia).

Participants were recruited in two ways. First, ED care providers (doctors, nurse practitioners, physician assistants, nurses) were informed of the study and asked to alert the study team for any patients whom they learned had become homeless in the past 6 months. The majority of participants were recruited in this manner. A smaller number of participants were recruited via direct screening of ED patients for eligibility by study staff. Because one of the overall study's goals was to examine the relationship of homelessness and substance use, we used purposive sampling to ensure that patients with unhealthy alcohol or drug use were adequately represented in addition to patients without substance use.

Interview Procedures

One of two study authors (KD, DC) conducted the interviews. KD is an emergency physician with formal qualitative research training and experience and extensive past experience working on issues related to homelessness. DC was a study research coordinator with a background in bioethics. KD trained DC in qualitative research techniques and reviewed all interview transcripts to ensure interview quality. Neither interviewer was part of the participants' medical care teams. All participants provided written informed consent. Participants received $20 to compensate them for their time. Each participant was interviewed only once. The study was approved by the NYU School of Medicine Institutional Review Board.

Interviewers used a semistructured interview guide (Table 1) to ensure that key concepts were covered

while allowing flexibility in question sequencing and probes to enhance interview flow. The interview guide was pilot tested with two ED patients prior to beginning the study. Interviewers also collected basic demographic information and recorded brief field notes immediately after the interview.

Interviewers took steps to ensure participant privacy and comfort in the ED setting. When possible, interviews were conducted in private treatment areas such as a single room or single curtained bay without other patients nearby. Interviews were conducted with only the participant present; visitors were asked to leave the area.

Interviews were digitally recorded. A professional transcription company transcribed all interviews. One of the study authors (DC) checked each transcription against the digital recording for accuracy, making any needed edits prior to analysis.

Table 1
Interview Guide Questions

Can you tell me about the most recent time you became homeless?
Probe: How long have you been living [in the shelter, outside, etc.]?
Probe: Where were you staying right before you became homeless?
Have you ever had other times in your life when you've been homeless? Can you tell me about those?
Probe: How were those past times you've been homeless resolved/ended?
What do you think led to your becoming homeless [this time]?
Probe: Different reasons like they lost a job, mental illness, etc.
Probe: Of the reasons you mentioned, what do you think was the most important? Why?
Probe: If they have been homeless before probe reasons for previous episodes of homelessness.
Before you became homeless did you turn to any organization, person, or place for help?
Probe: For example, did you use any homelessness prevention programs? Or speak to a social worker? Or go to an ER for help? Have you heard of homelessness prevention services offered by NYC called Homebase?
Probe: Did someone refer you to these services, or did anyone refer you to services that you did not use? Why or why not?
Probe: What were your experiences with these services? Were they able to help you or not? Why or why not?
Is there anything you can think of that might have prevented you from becoming homeless?
Probe: For example, any help that you might have received from friends or family, or from organizations designed to help people?

Not shown: interview guide questions on the relationship between homelessness and substance use and participant thoughts on ED-based homelessness prevention interventions, which were part of the larger research study and less central to the current paper.

Data Analysis

We identified a list of seven key domains a priori based on the prior literature and our overall study goals, but allowed new codes and themes to emerge organically from the text in the grounded theory tradition.[33,34] A core team of two to three researchers reviewed transcripts independently and then met to discuss differences in code interpretations. All interviews were coded by KD and ZR (a research assistant with a background in social work); DC also coded the majority of interviews. All coders had prior professional experience working with homeless populations or with other populations vulnerable to homelessness.

Interviews were conducted and coded in blocks of two to three interviews. We used the constant comparison method, identifying new codes, refining existing ones in an iterative manner, and adjusting the code structure accordingly for each early block of interviews.[35] The codebook was solidified after the first 12 interviews had been coded and did not require further modification; the final codebook contained 27 codes. We continued interviews until theoretical saturation—the point at which no new major themes were emerging from subsequent interviews—had been achieved.[35] We used Dedoose (version 8.0.42) to assist in data management and organization.[36]

In addition, we maintained a case summary matrix that collated demographic information; homelessness, substance use, work, and health history; and other interview notes for each participant. Following best practices for validity in qualitative research, we also maintained an audit trail including field notes taken after each interview, individually coded transcripts, and comments and revisions from group coding meetings.[34]

RESULTS

Interviews were conducted April 2017 through June 2018. Sixty-six patients were screened for eligibility; 33 were ineligible (primarily due to not having a new episode of homelessness in the past 6 months), two were eligible but refused to participate, and 31 agreed and completed interviews. Participants were primarily male, represented a mix of race and ethnicities, and had a mean age of 50 years (Table 2). The majority (67.7%) had at least one other episode of homelessness prior to the current episode.

Interviews lasted a mean of 42 minutes, with a range of 19 to 87 minutes. Four main themes emerged: 1) unique stories yet common social and

Table 2
Participant Characteristics (n = 31)

Sex	
Female	3 (9.7)
Male	28 (90.3)
Ethnicity	
Hispanic/Latino	11 (35.5)
Not Hispanic/Latino	20 (64.5)
Race	
Asian	3 (9.7)
Black	10 (32.3)
White	8 (25.8)
Other	10 (32.3)
Age (years)	
Mean (±SD)	50 (±11.6)
Range	20–69
Homelessness history	
First episode	10 (32.3)
Not first episode	21 (67.7)
Substance use*	
Unhealthy alcohol use	17 (54.8)
Drug use	13 (41.9)
No unhealthy alcohol or drug use	11 (35.5)

Data are reported as n (%) unless otherwise specified.
*All participants completed screening questions for past year unhealthy alcohol or drug use. Unhealthy alcohol use defined as at least 1 day binge drinking. Drug use defined as at least one day using any drugs, including marijuana.

health contributors to homelessness, 2) personal agency versus larger structural forces, 3) limitations in help from family or friends, and 4) homelessness was not expected. Table 3 summarizes the themes and provides illustrative quotes.

Theme 1: Unique Stories yet Common Social and Health Contributors to Homelessness

Participants recounted a wide array of life stories and recent events leading to homelessness. Yet despite the uniqueness of each individual's situation, there was significant commonality in the broad underlying factors contributing to homelessness. These factors encompassed both "traditional" health issues (i.e., substance use and physical health problems), as well as a variety of social factors that—in addition to contributing to homelessness—are also known to contribute to ED visits and overall health.[7] The most common contributors to homelessness mentioned by participants were job loss, not having enough money, not being able to live with family or friends, moving from another city or state, substance use, and other physical health problems. Less commonly endorsed were institutional discharge (e.g., jail/prison, hospital) and domestic or other violence.

More than half of participants reported job loss as a contributor to homelessness. Some described job loss as the main reason for their homelessness, including Participant 24 (woman in her 40s), who explained, "I had a job and an apartment and everything, and my employer lost their biggest client which was half their revenue. And they laid off like half the workforce and I was one of the people. After that I couldn't pay my rent so I ended up having to lose my apartment." Some participants had savings or could borrow money from friends or family, but those resources eventually waned. As Participant 3 (man in his 50s) explained, "I've been looking for work since the beginning of the year; it's been very slow. What happened was, I went through my savings in January and mid-February and then I borrowed some financial help from family and friends and then that sort of ended and then by end of March-April, I had to find some other means of housing." Other participants were already behind on rent and job loss was a "final straw." Health conditions were common precipitants of job loss. Fewer participants reported being fired for lateness or interpersonal conflict. While job loss was the most common financial precipitant of homelessness, some participants reported other types of financial problems. A minority of participants noted trouble with spending or financial planning or having bills—including for medications/medical care and telephones—limiting the amount of money they had for rent.

Participants commonly reported living with family or friends and then becoming homeless when those arrangements ended. Sometimes this occurred when friends or family members died. For example, Participant 8 (man in his 40s) recounted, "I had an apartment in Jersey. So I gave that up. I moved back home. I was taking care of my grandmother and my mom. And then my mother passed. My grandmother went to my aunt's house. And I had no place to go …." In other cases, participants reported being "kicked out" by friends or family due to various disagreements or tensions. In some cases, participants seemed to have more choice in the matter, such as Participant 56 (man in his 60s), who was living with his mother and stepfather but reported that his stepfather "had all this plan also, that once I was there, he was gonna make my life miserable," so eventually he chose to leave.

Table 3
Summary of Themes

Theme	Illustrative Quotes
Theme 1: Unique stories yet common social and health contributors to homelessness	
1A. Job loss/lack of money	"We had to leave [the apartment] because when I got injured I couldn't work so we owed the landlord $1,200 for that month." (Participant 33; man in his 20s)
1B. Could not live with friends/family	"I was living with my mother. And then she gave me the kick out and so I took the kick out 'cause I'm not gonna argue or fight about it, so I had to go." (Participant 9; woman in her 40s)
1C. Moves	"Jersey doesn't have stuff that New York offers, you know?" (Participant 8; man in his 40s)
1D. Substance use	"The drugs is what drag me down." (Participant 64; man in his 40s)
1E. Health conditions	"When they know that I'm [on] dialysis, they'd be like, 'Oh no. You got to get out. . . . You cannot work for me. Because I don't want something to happen to you.'" (Participant 38; man in his 50s)
Theme 2: Personal agency versus larger structural forces	
2A. Rent/housing market	"He locked me out illegally, totally illegally, everybody there. It wasn't the proper eviction. There were so many things he did wrong and illegal but still here I am, he's still renting the place to somebody else, he's still cashing the public assistance rental system checks that they've been sending him." (Participant 32; man in his 60s)
2B. Job market	"I get a security license and I've done security work for like a week and a half. But the guy wanted us to buy our own uniform and pay $1.00 less than the minimum wage." (Participant 30; man in his 60s)
2C. Narratives emphasize personal choice	"I'm a grown man. I put myself in this situation." (Participant 8; man in his 40s)
Theme 3: Limitations in help from family or friends	"[My daughter] had three kids, husband's not working that much and she's working and I don't wanna put an entire burden on them . . ." (Participant 6; man in his 60s)
Theme 4: Homelessness was not expected	"So many people in those subways out there homeless and just—and I never thought I'd be like—join with these guys." (Participant 56; man in his 60s)
	"I should've been worrying about if things didn't work out. And then things didn't work out. . . . I didn't worry about that until it was too late." (Participant 11; man in his 50s)

Several participants moved into homelessness in NYC from other states in pursuit of jobs, better health care (including substance use treatment), or public services/benefits or to get away from friends or family. In most cases, participants were not in particularly stable situations in their prior locations, however. For example, Participant 33 (man in his 20s) had been living with his mother in Florida but moved away because he was caught up in illegal activity there: "I'm in this predicament because I moved from and I was doing horrible things there and I wanted to change my life. . . . We kinda knew we're gonna be homeless if we came up here but we didn't think it was going to be like this."

Participants recounted that substance use contributed to homelessness via pathways including job loss, severed relationships with friends and family, lack of money due to spending it on substances, and what they identified as poor decision making. Around half of participants expressed other health problems as contributors to their homelessness, including via job loss as noted above. For example, Participant 4 (man in his 30s) reported that after he started treatment for hepatitis C, his retail job "started noticing a difference in my look, how I look and acted, and they put me on medical leave." He was on leave for 12 weeks—the maximum available time—and returned to work while still experiencing medication side effects and was subsequently fired. Participants noted inability to do certain types of work (e.g., construction) due to health conditions including back pain, vertigo, seizures, kidney disease, and partial paralysis. In some cases, participants wanted to work but were turned away. Participant 35 (man in his 30s) reported being told "you're a liability" when looking for a job due to his seizure history. Other participants reported having been in accidents with injuries that either prevented them from working or—in two cases—led to opioid dependence, which ultimately contributed to homelessness. In a few cases, participants entered homelessness immediately after hospitalizations or nursing home stays. Overall, participants perceived little protection related to their health conditions in seeking and maintaining employment, even despite employment laws such as the Family Medical Leave Act (FMLA) that might be designed to provide certain protections.

When asked what caused their homelessness, participants often stated initially the one or sometimes two

most prominent or proximal causes of their homelessness. In listening to their stories, however, it was clear that for most people homelessness resulted from a series of several different factors. Participant 12 (man in his 40s) explained, "It was a lot of factors. It was just hitting me all at once. I mean there was a million things." Many participants described their homelessness as a rather sudden event, although careful analysis of their stories generally indicated that homelessness seemed at least several months or years in the making, with hardships sometimes beginning during childhood.

Theme 2: Personal Agency Versus Larger Structural Forces

We observed a tension between narratives that highlighted personal agency, choice, or self-determination yet which also underscored the role of larger external structural factors—over which an individual would have little control—in contributing to homelessness. Twenty-three participants mentioned contributors to their homelessness that could be considered structural factors, in particular high rental costs and employment challenges. Several participants commented on the high price of rent. Participant 29 (man in his 60s) recounted, "I started looking for a place and you know apartments are $1,500 [for a] studio." Related to the rental market, some participants reported unscrupulous—and in some cases illegal—landlord practices. Participant 1 (woman in her 50s) summarized that when new management took over her building, "They finally tried to evict us [because] . . . they want to raise the rent and move other people, tenants, in." While she and other residents tried to fight for a while, she eventually "wound up leaving." Other participants reported being forced out of their apartments after they complained about repair or safety issues, including Participant 56 (man in his 60s):

> When I call NYC, the city, to complain about my apartment then she [landlord] . . . started eviction procedures. And it took over a year for her to get me out. But when she finally did, the marshal came and then they took me out.

Several participants reported living in informal "cash for room"–type arrangements, in which they paid to live in a room in an apartment belonging to someone unrelated to them. Such arrangements could be more affordable than having one's own apartment, yet participants also felt they had few options in these unofficial arrangements when they could no longer pay the rent.

The job market was another structural factor commonly brought up by participants. Some participants noted a lack of available jobs for people like them, whether due to age, medical conditions, or lack of particular qualifications. Participants noted losing jobs because of layoffs due to changing technology, because employers found cheaper labor, or simply because their prior companies had shut down. Participants who did manage to find work reported low pay and lack of job security or benefits. For example, Participant 24 (woman in her 40s) noted having had a "temp" job in which "they can fire you anytime they wanted." Once losing their jobs, some participants reported difficulty receiving unemployment benefits. Overall, much as with the rental market, the job market appeared to be stacked against participants, who had comparatively little power or recourse.

Less commonly mentioned structural factors that appeared contributive to participants' homelessness included insufficient government benefits, bureaucracy of child protective service cases, lack of social services, lack of insurance or health care, and eligibility restrictions of housing subsidy programs.

Despite the role of these external structural factors, some participants emphasized their own choices in recounting the stories of how they became homeless. For example, Participant 27 (man in his 60s) said he chose to leave a nursing home because "I'm tired of sitting in there doing nothing all day." Two participants reported moving from more stable living situations in other states because they preferred NYC; Participant 10 (man in his 50s) reflected, "I don't think North Carolina is ever gonna be ready for me. . . . The days are long and I'm a New Yorker." As will be described with the next theme, several participants reported choosing not to live with friends or family even when such arrangements were available.

Theme 3: Limitations in Help From Family or Friends

While many participants reported receiving help—most commonly financial assistance or a place to stay—from family or friends, nearly all reported significant limitations in the amount of assistance they received. Commonly, these limitations resulted from family/friends themselves having limited resources. For example, Participant 38 (man in his 50s) had an older

sister who helped pay for him to move to NYC but could not provide other help "because she gotta pay her bills, you know?" Rarely, participants reported that family members had resources but did not want to help.

Some participants reported that they did not want to bother family members, whether because family members had their own struggles or, conversely, because they felt family members were doing well and they did not want to interfere. Participant 25 (man in his 50s) reported, "My nieces are doing great. I don't need to be interrupting their lives." Participant 65 (man in his 60s) had a sister nearby who he could stay with but "I don't [want to] bother her," which he explained was because she had children and he was also worried about her learning that he was HIV-positive. Some participants reported valuing their privacy over a place to stay. For example, Participant 64 (man in his 40s) said, "I got family all up in the Bronx, all over New York. It's just that I don't like having people all over my business." Other participants expressed having too much pride or feeling embarrassment about their situation.

Several participants reported that they did not have family or friends to whom they could turn, sometimes due to deaths or because family lived in other states. Death of friends/family was described by approximately half of participants. In a few instances such death directly precipitated homelessness when a participant had been living with the person who died. In other cases, deaths of family/friends resulted in participants having fewer social connections upon whom they could draw for support. Participant 60 (man in his 40s) noted, "My mother is dead, my father is dead, my brother is gone, my other brother's dead, my mom—my one brother's, uh, moved up to Vermont like 12 years ago. I haven't spoken to him in 12 years. I have no family. None."

Interestingly, some participants who said initially that they had no family went on to describe multiple family members who actually lived nearby. Some participants may have felt that they functionally had no family given alienation from or other limitations in their relationships. As Participant 21 (man in his 40s) explained, he had family nearby but "They're a bunch of creeps. Yeah, because if they got money and they doing good, they really don't care about the next that's messed up like me … so here I am." Other participants reported being estranged from family, such as Participant 8 (man in his 40s) who said, "I'm the black sheep of the whole family, you know? I mean that's on me too. I did 10 years in prison over heroin."

Theme 4: Homelessness Was Not Expected

Participants often noted surprise at finding themselves homeless, such as Participant 33 (man in his 20s) who reflected, "I did not expect for this to happen, not at all." Others commented on how quickly homelessness seemed to fall upon them, such as Participant 12 (man in his 40s): "If this happened so quick, this can happen to anybody." Similarly, Participant 50 (man in his 30s) reflected, "I can't tell the future—well, like see, my story is I wasn't gonna know that I was gonna be homeless in a short period of time."

In fact, while some participants had clearly spent time ruminating on the factors leading up to their homelessness, others commented that they had never before been asked about how they became homeless or even really thought about it. When asked what led to him becoming homeless, Participant 10 (man in his 50s) remarked, "you have damn good questions. I wish I could give you an answer. I don't know. I've never seen this. I've lived pretty decently, responsibly, and then this happened." Such responses were surprising because from the perspective of an outsider, all participants recounted life stories and recent situations rife with risk factors for homelessness. For example, Participant 10 had a history of substance use, chronic health problems, incarceration for assault, and poor family relationships. Further, two-thirds of participants had prior episodes of homelessness, which makes it additionally surprising that so many participants reported that their homelessness was unexpected.

Relatedly, when participants were asked what might have prevented their homelessness or homelessness for other people, they had difficulty conceptualizing the idea of homelessness prevention. Participant 29 (man in his 60s) struggled to reply to a question on preventing homelessness:

> Help from becoming homeless? [pause]. Ah that's a rough one because it just happens, you know? You don't—these are things that, uh, people's lives are not together in certain ways. So they would have to be able to see that they're about to … not have a home … you'd have to be able to see that and a lot of times they don't really know. It just happens, you know?

Similarly, Participant 24 (woman in her 40s) reflected, "I was back on my feet. I was doing all the right things and I ended up losing everything anyway. So, you know, I don't know what to tell you about

how to help other people. I really don't." When asked how their homelessness might have been prevented, many participants reverted to providing critiques of existing shelters. Nearly universally, participants had not sought formal services available to help prevent their homelessness, either because they were unaware such services existed or because they had not expected to become homeless. Some participants noted, only in retrospect, that they saw signs that they might have been at risk for homelessness and wish they had been more prepared. Participant 7 (man in his 30s) admitted, "Yes and I kinda saw it. I just didn't think it was gonna happen."

DISCUSSION

Through in-depth interviews with recently homeless ED patients we identified four themes related to their pathways to homelessness: 1) unique stories yet common social and health contributors to homelessness, 2) personal agency versus larger structural forces, 3) limitations in help from family or friends, and 4) homelessness was not expected. Many of our findings affirmed prior quantitative research, which has suggested multifactorial contributors to homelessness including substance use, job loss, structural factors such as high rents, relationship breakdown or challenges, and health issues. Our study contributes to the literature by providing more in-depth context to these reasons—in participants' own voices—than possible via survey or other quantitative research.

Participants' stories revealed multiple contributors to their homelessness. When asked directly about what might have prevented their homelessness, however, most participants struggled to answer. This difficulty is perhaps not surprising considering that experts also debate about the best ways to prevent homelessness.[37] It may also reflect a "present orientation" borne of immediate needs and an overall lack of awareness of homelessness prevention services. This speculation is supported by the fact that only a minority of people who enter shelters in NYC have previously accessed available homelessness prevention services.[4] Prior research has suggested high rates of traumatic brain injury and cognitive impairment among people who are homeless,[38–41] which may have also been somewhat contributory to our findings, although we did exclude patients who were not able to understand the study informed consent process.

A few prior studies have used qualitative research to examine pathways to homelessness among various subgroups of people. Padgett et al.[42–44] published a series of papers based on qualitative interviews with homeless and formerly homeless adults with mental illness. Similar to the findings of our study, interview participants reported that family members had been able to offer only limited support because they were "in the same boat" themselves.[42] Also similar to our findings and despite including only participants with mental health issues, Padgett et al. found a notable lack of direct discussion of mental illness in participant interviews, with themes around substance use and other health problems taking more prominence. For our study specifically, it is also possible that we found less prominence of mental illness among our sample of newly homeless patients than if we had focused on people who were chronically homeless.

In another qualitative study, Metraux et al.[29] conducted interviews with post-9/11 era veterans and reported some similar findings to ours—including the centrality of unemployment and relationships—while also identifying specific challenges in postmilitary life and access to VA services. Similarly, focus groups with homeless women veterans identified a constellation of contributors to homelessness both related and not related to military service, including unemployment, relationship problems, and lack of social support.[45] Qualitative research with homeless families in Canada and homeless adults in England also identified limitations in social support and relationship breakdown as central in pathways to homelessness.[27,31] Another study, of drug users in Connecticut, found that personal factors including lack of social support and substance use interacted with structural factors such as lack of housing subsidies to contribute to homelessness.[46]

We were interested in observing a tension between what participants identified as broader structural factors contributing to their homelessness and personal narratives that often emphasized the role of choice. Such emphasis on personal agency and self-determination may be an ego-protection mechanism and has been observed in prior research with homeless populations. In *Sidewalk*, an ethnography of NYC Street vendors, Mitchell Duneier observed that "the people I wrote about sometimes took complete responsibility for their own failures, unable to comprehend the obstacles and opportunities in their lives, the pressures and constraints they may have faced, and thus the probabilities of particular outcomes independent of

their own actions."[47] He therefore cautioned against taking participants' stories solely "at face value."[47] In our paper we have attempted to balance portraying participants' own explanations for their homelessness while also being attuned to the deeper messages evident when taking a broader, holistic view of their stories. Our research included only the perspective of ED patients experiencing homelessness themselves; future research could triangulate qualitative or other research with social service providers, for example, to further elucidate barriers in the human services sector that might contribute to homelessness.

To our knowledge, no prior research has examined pathways to homelessness among ED patients. McCormack et al.[48] conducted in-depth life history interviews with chronically homeless, frequent visitors to the ED who also had alcohol dependence. This study was conducted among a very unique subpopulation of ED patients and did not specifically explore pathways to homelessness. Homelessness plays an oversized role in U.S. EDs, in part due to the ED's role as a medical and social safety net and in part due to the greater than average health needs of people who are homeless.[13,15,49,50] Research spanning multiple localities and types of EDs has found that a disproportionate number of ED patients are homeless.[7,15] Other research has found that ED providers struggle to provide optimal care to patients who are homeless, which may lead to provider burnout.[51,52]

In addition to seeing large numbers of patients who are already homeless, EDs also serve many patients who are unstably housed and at risk for future homelessness.[6,7] Some experts have proposed that EDs may, therefore, be important sites for homelessness risk screening and preventative interventions.[5] Such interventions are well aligned with the health care system's increasing emphasis on social determinants of health such as housing.[53–55] The current study was designed in part to inform the development of such an intervention, which will be studied in future research. For example, the finding that patients were often surprised at becoming homeless may explain prior observations that most people who become homeless have not sought homelessness prevention services,[4] and it speaks to the potential benefit of universal homelessness risk screening in the ED rather than relying on patients to self-identify a need for services. Also, we discovered in this sample of ED patients that health conditions were often strong contributors to homelessness; such cases may be particularly ripe for health system collaboration to help prevent homelessness. Our finding that patients had significant limitations in support from family or friends suggests that future interventions may need to provide material or other support to strengthen any existing relationships or provide new forms of social support such as through peer navigator or community health worker models. Finally, our finding that structural issues such as the job market and affordable housing availability were significant contributors to homelessness suggests that these issues must also be addressed in larger initiatives to prevent homelessness. While it may seem that such issues are outside the scope of health care, some health care institutions have actually attempted to change their communities by building affordable housing or providing employment opportunities to community residents.[53,56]

LIMITATIONS

Our study was conducted among patients at a single NYC ED and thus may not be generalizable to other populations. Women were underrepresented in our study, potentially due to the study hospital's proximity to a large men's shelter. As we did not intend to compare experiences of women versus men in our study, we did not attempt to oversample women. In addition to experiences shared with men, women may have additional reasons for homelessness including pregnancy[24] and domestic violence;[23] past qualitative research has specifically examined pathways to homelessness among women.[45] Further, unlike for quantitative research, qualitative research does not seek to be generalizable as much as it seeks to produce information that readers might find transferable to other contexts.[57] While we conducted our interviews in a busy ED, we took multiple steps to ensure participant comfort and generally were able to conduct interviews in a private manner. Finally, we did not perform participant checking of themes because we did not want to collect identifying or contact information given the sensitive nature of the interview questions; we did, however, follow multiple other best practices for rigor in qualitative research as described under Methods.[34]

CONCLUSION

In this qualitative study of recently homeless ED patients, we found multiple contributors to homelessness that can inform future homelessness prevention

interventions. More broadly, our findings may help ED providers to better understand the life experiences of their patients that contribute to their health and ED use.

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