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Homeless people's experiences of medical respite care following acute hospitalisation in Denmark

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Abstract

The aim of this study was to explore homeless people's health perspectives and experiences of a 2-week medical respite care programme following acute hospitalisation. There is a high level of health inequality when comparing the health status of homeless people to the general population, including increased mortality and morbidity. Homelessness predisposes an increased risk of infectious disease, cancer and chronic illness, such as diabetes and cardiovascular disease. Moreover, homeless people have a higher frequency of acute hospitalisation than general population estimates. In order to facilitate the transition from hospitalisation back to life on the streets, homeless people who were acutely hospitalised in the Capital Region of Denmark were offered 2 weeks of medical respite care from the day of discharge by a non-governmental organisation. This is a qualitative study with a phenomenological hermeneutical approach based on narrative interviews of 12 homeless people who received medical respite care from 1 March 2016 to 30 September 2016. Data were collected through individual semi-structured interviews and analysed according to Lindseth and Norberg's presentation of Paul Ricoeur's theory of interpretation. The analysis identified four themes: (i) basic needs are of highest priority; (ii) a safe environment provides security and comfort; (ii) social support is just as important as healthcare; and (iv) restitution facilitates reflection. The findings indicated that the medical respite care centre provided a place of rest and restitution following hospitalisation, which made room for self-reflection among the homeless people regarding their past and present life, and also their wishes for a better future. This study also indicates that a medical respite care stay can contribute to the creation of a temporary condition in which the basic needs of the homeless people are met, enabling them to be more hopeful and to think more positively about the future.

KEYWORDS

community care, homeless, homelessness, hospitalisation, medical respite care, restitution

1 | INTRODUCTION

In developed countries, homeless people face substantial health challenges as their morbidity and mortality rates are more than triple that of the general population (Beijer, Andréasson, Agren, & Fugelstad, 2007; Buchanan, Doblin, Sai, & Garcia, 2006; Fazel, Geddes, & Kushel, 2014; Hwang & Burns, 2014; Kertesz et al., 2009; Nordentoft & Wandall-Holm, 2003; Nusselder et al., 2013). The high mortality rate is partly explained by the significant exposure to risk factors such as drugs, alcohol, mental disorders and smoking (Nielsen, Hjorthøj,

Erlangsen, & Nordentoft, 2011). In Denmark, the number of homeless people was estimated to be 6,138 in 2015, corresponding to 0.1% of the population. This is an increase of 23% since 2009 where the number of homeless people was 4,998 ("Statistics Denmark", Benjaminsen & Hesselberg Lauritzen, 2015).

This high morbidity rate is primarily related to infectious diseases such as HIV and hepatitis (Fazel et al., 2014; Saab, Nisenbaum, Dhalla, & Hwang, 2016), but there is also a higher prevalence of cancer and chronic diseases such as chronic obstructive pulmonary disease, diabetes and cardiovascular diseases among people affected by homelessness (Baggett et al., 2015; Beijer & Andréasson, 2009; Fazel et al., 2014). The prevalence of all psychiatric diagnoses is high compared with general population estimates (Beijer & Andréasson, 2010; Fazel, 2008), and there is a strong association between drug misuse and homelessness (Kemp, Neale, & Robertson, 2006).

American studies have shown that homeless people are more likely to be admitted to the hospital and have an increased duration of hospitalisation with readmission rates up to 50% (Doran, Ragins, Iacomacci et al., 2013; Kertesz et al., 2009). Likewise a Canadian study has shown that homeless people have an acute readmission rate of 3.8 compared to a sex- and age-matched control group of individuals with low socioeconomic status (Saab et al., 2016). At the same time, however, the average time of admission in medical wards at hospitals both nationally and internationally has decreased significantly in recent years (Statistics Denmark 12/07/2017, OECD Statistics 12/07/2017).

When homeless people are admitted to the hospital, there is a common dilemma as to when discharge is most appropriate since they often require continued rest and care, which is difficult to attain while living on the streets (Saab et al., 2016). Medical respite care is intended to provide temporary housing and post-acute medical care for those who are too sick or frail to be discharged to the street or a shelter (Bauer, Moughamian, Viloria, & Schneidermann, 2012; Doran, Ragins, Gross, & Zerger, 2013). Studies have shown that homeless patients who receive medical respite care following hospitalisation have fewer hospital readmissions (Kertesz et al., 2009) and shorter hospital stays during readmission compared to homeless people discharged directly to the streets (Doran, Ragins, Gross et al., 2013). This has been attributed to the patient receiving both individualised care with consideration for complex issues related to being homeless, as well as better opportunities regarding stable housing following the medical respite care (Doran, Ragins, Gross et al., 2013; Kertesz et al., 2009). However, there is lack of evidence that medical respite care directly results in better outcomes for the homeless person. The literature on medical respite care for homeless people, however, is sparse and mostly based on quantitative registry data. There is a lack of knowledge on homeless people's preferences and perspectives on health, and their views on receiving medical respite care (Doran, Ragins, Gross et al., 2013; Hwang & Burns, 2014). Our aim was to study homeless people's health perspectives and experiences of a 2-week medical respite care programme following acute hospitalisation.

What is known about this topic

- Homeless people have higher rates of mortality and morbidity compared to the general population.
- Medical respite care for homeless people has been shown to reduce hospital admissions and readmissions and the number of hospitalisation days.
- There is a gap in the literature regarding homeless people's experiences of medical respite care.

What this paper adds

- Health and disease management must start by fulfilling basic human needs.
- Both health-related and social issues must be addressed when designing interventions for homeless people.
- A safe environment following hospitalisation provides a window of opportunity to make positive changes in lifestyle and living conditions.

2 | METHODS

2.1 | Study design and setting

This qualitative study had a phenomenological hermeneutical approach based on individual interviews. The Danish welfare system is based on free and equal healthcare, with public healthcare services financed through general taxation (Green-pedersen, 2002). To give the homeless people an opportunity for restitution and to optimise the benefits of treatment following hospitalisation, Red Cross Copenhagen offers medical respite care in Copenhagen, Denmark. Red Cross Copenhagen has received governmental funding for a period of 3 years to run the medical respite care centre. In Denmark, the responsibility for taking care of the homeless people lies within the municipality. The Red Cross respite care centre differs from the existing municipally initiatives in three essential ways: there is no waiting list, no user-payment and no restrictions regarding use of alcohol and drugs. Being the only medical respite care centre in Denmark, this service helps homeless people who under normal circumstances would not be able to receive this kind of help following hospitalisation. The programme comprises 2 weeks of free room and board from the day of discharge after acute hospitalisation in the Capital Region of Denmark. Since the medical respite care centre is only staffed during the daytime and some evenings, patients offered this kind of stay must be capable of self-care. There is capacity for eight homeless people in shared rooms, with a maximum of two people per room. The head of the medical respite care centre functions as the on-site nurse, and the staff members include two part-time employees and volunteers. During the stay, it is possible to receive help with health-related issues, such as caring for wounds or monitoring blood glucose, while social issues can also be addressed by the employees and volunteers.

2.2 | Participants

Inclusion criteria were >18 years of age and a homeless/functional homeless status evaluated by nurses specialised in working with this population and working in the hospitals in the Capital Region of Denmark. We applied the European Commission's definition of homelessness to include situations of living in temporary, insecure or poor-quality housing (Homelessness - Employment, Social Affairs & Inclusion - European Commission). The designation functional homeless status applies to someone who has a home but is unable to live there because of unpaid rent, violence or threats, or because the home is in very poor condition (Thorley et al., 2015). Study participants had to have received medical respite care following an acute hospitalisation. They were excluded if they could not speak sufficient Danish and/or English, were significantly affected by alcohol or drugs at the time of interview, or if it would be unethical to include them in the study (e.g. if the participant was suffering from a serious psychosis). These criteria were assessed in co-operation with the daily head of the medical respite care centre, who has many years of experience working in the field.

2.3 | Procedure and data collection

The participants were recruited while staying at the medical respite care centre. The head of the centre facilitated a meeting between the researcher (MP) and eligible participants to allow MP to introduce the study. Participant interviews took place in a private setting at the end of the medical respite care stay (day 10–13) so that they were familiar with the centre when asked about their experiences. To explore the participants' perspectives, we developed a semi-structured interview guide with open-ended questions (Appendix S1). The interview guide was validated by researchers and by experienced employees working in the field.

A purposeful sampling strategy was applied in identifying participants (Palinkas et al., 2015). Data were collected from 1 March 2016 to 30 September 2016. The interviews were performed by the author (MP) and the data collection continued until no new information was obtained (Malterud, 2001). The interviews lasted 13–43 min. Some of the participants had difficulty maintaining focus during the interviews, but all of the participants' narratives are represented in this paper.

Twelve participants were included in the study and their mean age was 52 years. The majority of them had been homeless for at least a year. Table 1 presents the overall characteristics of the participants.

2.4 | Analysis

Lindseth and Norberg's adaption of the French philosopher Paul Ricoeur's theory of interpretation was used to analyse the empirical narrative interviews (Lindseth & Norberg, 2004; Ricœur, 1976). We used this phenomenological hermeneutical approach to achieve an interpretation of the text while seeking to find something new in what otherwise might be taken for granted, which is an advantage for exploring the lived experience of homeless people.

The interviews were audio-recorded, transcribed verbatim and transferred to the software program NVivo 11.0.0 for analysis (Binderkrantz & Bøgh Andersen, 2013). MP analysed the transcribed interviews based on Lindseth and Norberg's (2004) adaption of Paul Ricoeur's theory for interpretation (Lindseth & Norberg, 2004), and the themes were afterwards validated and discussed by the researchers: CB, NB, OA, JP, MJ, until agreement was reached. The analysis was performed in three steps: naive reading, structural analysis and comprehensive understanding. First, the narrative interviews were read several times with an openness

TABLE 1 Participant characteristics

ID	Gender	Age[a] (years)	Ethnicity	Reason for admission[b]	Abuse[b]	Homelessness[b]	Plans following MRCC[b,c]
01	M	19	Denmark	Abdominal pain	Hash	<1 year	Street
02	M	53	Denmark	Headache	None	>1 year	Shelter
03	M	55	Greenland	Cardiovascular disease	Alcohol, hash	<1 year	Street
04	F	43	Denmark	Sepsis, endocarditis, emboli	Cocaine	<1 year	Shelter
05	M	58	Finland	Cardiovascular disease	Alcohol	<1 year	Street
06	M	57	Turkey	Respiratory infection, urinary retention	None	<1 year	Shelter
07	M	59	Denmark	Acute intoxication	Alcohol	>1 year	Street
08	M	35	Denmark	Acute intoxication	Alcohol	>1 year	Shelter
09	M	58	Denmark	Diabetes type II	Partly alcohol	<1 year	Shelter
10	F	69	Denmark	Abdominal ulcer	None	<1 year	Street
11	M	62	Denmark	Head trauma	None	<1 year	Street
12	F	55	Denmark	Social reasons	Partly alcohol	>1 year	Apartment

[a]Mean age 52 years (range 19–59).
[b]Self-reported by participants.
[c]Medical Respite Care Centre.

and willingness to experience immediate impressions (naive reading). Second, a search for evidence to support the impressions was identified using meaning units comprising "what is said" in the text (excerpts) and reformulated into "what is meant" by the text (meaning), which was then condensed into various themes (interpretation). Third, the themes were analysed in the context of relevant literature and theory (comprehensive understanding) (Lindseth & Norberg, 2004; Singsuriya, 2015). The discussion section of this paper presents comprehensive understanding.

2.5 | Ethics approval

The study was carried out in accordance with the ethical principles of the Helsinki Declaration (Slavicek & Forsdahl, 2009). The study is also registered at the Danish Data Protection Agency (AHH-2016-017). Before each interview, participants were given information on the purpose of the interview and were reminded of the voluntary and anonymous nature of their responses. Each participant gave written and verbal consent before the interview.

3 | FINDINGS

3.1 | Naive reading

The participants experienced a safe environment, leading to a feeling of calmness and security that had a positive impact on their physical and mental well-being. Furthermore, they felt that their individual needs were understood and supported at the medical respite care centre. In contrast, they described daily life on the streets or in homeless shelters as very stressful, with a lack of attention given to their health and social needs.

Staying at the respite care centre facilitated reflective thoughts on past decisions, their current homeless situation and hopes and wishes for the future.

3.2 | Structural analysis

The structural analysis entailed an interpretation of the interview transcripts that involved moving dialectically between quotes and the interpreted meaning. The analysis identified four themes, which are presented in Figure 1. As Figure 1 demonstrates, even though the themes will be described independently, they are not to be understood as being mutually exclusive, but rather as being interactive, reflecting the homeless people's experiences of a 2-week stay at a medical respite care centre.

3.2.1 | Theme 1: Basic needs are of highest priority

In their current situation as homeless, the participants' perceptions of health were mainly focused on their basic needs. Having a place to sleep, a bath, good mouth hygiene, food and proper warm clothing were some of the most important factors regarding their health, and if these basic needs were not taken care of, it affected their ability to stay healthy:

> *I have this thing that I want to shower as often as possible. I want to shower at least once a day—just to be on the safe side.* *(Male, participant 01)*

> *Keeping healthy is about dressing properly, checking the weather before going out, keeping an eye on what I'm eating and keeping an eye on not walking around outside in wet clothes.* *(Female, participant 04)*

The participants described life at the medical respite care centre as the polar opposite of life on the streets, partly because their basic needs were met at the centre, which had a positive impact on their health. In addition, they characterised life at the medical respite care centre as luxurious, again illustrating the huge contrast between street life and life at the centre:

> *You know, it's very luxurious. There's warm food; there's a refrigerator filled with food; there's coffee and tea, and they always ask what we want and then they go buy it; very luxurious.* *(Male, participant 07)*

Regarding health behaviour, the participants also talked about their interest in different kinds of sports activities; however, the type of activity was always a sport that they had done in their childhood or youth and not related to their current situation as a homeless person:

> *I don't bike like I used to. I skateboarded, rollerbladed, climbed and things like that. I haven't done any of that for*

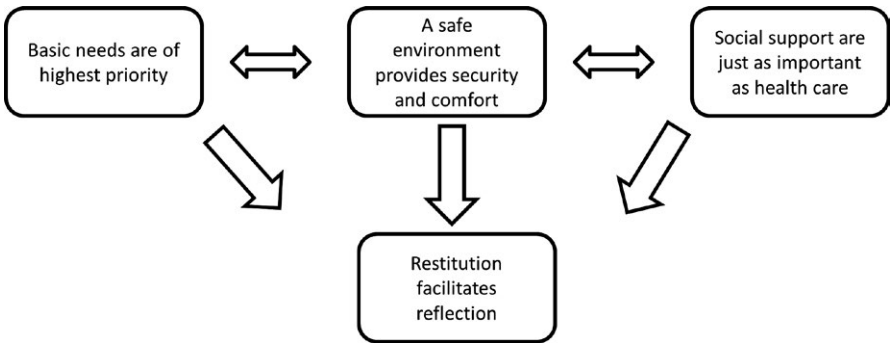

FIGURE 1 The themes described are interactive, reflecting the homeless people's experiences of a 2-week stay at a medical respite care centre

many years now. I would like to start doing strength training again. *(Male, participant 08)*

3.2.2 | Theme 2: A safe environment provides security and comfort

The participants unanimously reported that they experienced a feeling of calmness and tranquillity at the medical respite care centre, which they said was important for their well-being and recovery. The street life and life at homeless shelters, in contrast, was described as very stressful. The participants' expectations were not necessarily high before arriving at the medical respite care centre as they were accustomed to a noisy, brutal and abusive environment at the shelters or on the streets:

I can relax instead of running around being stressed and not knowing where I'll spend the night. *(Male, participant 03)*

There are drugs everywhere and many fights all the time [at a shelter]. Not much is going on here. *(Male, participant 08)*

The participants talked about how they appreciated the straightforward code of practice, which allowed them to feel free to be themselves but at the same time clear about what was acceptable behaviour while staying at the centre. Thus, the environment at the medical respite care centre kept the participants feeling safe, allowing them to recuperate and concentrate on their recovery:

It's been really good for me as a person just to be anonymous and not to have to deal with anything (…). It was a setting where I could begin to get my bearings again. *(Female, participant 12)*

There's kind of a clear position on how to behave as a resident here (…) so that makes it a calm place. *(Male, participant 02)*

The experiences at the medical respite care centre were positive, but the 2-week timeframe was viewed as too limited and several participants would have appreciated the opportunity to stay longer. Also, many participants would have preferred a single room because sharing a room with someone else while in such a vulnerable situation following hospitalisation was seen as intrusive.

3.2.3 | Theme 3: Social support is just as important as healthcare

The participants explained how they felt supported by the staff. The support was usually described as ongoing assistance with practicalities such as navigating the social welfare system or more basic things like getting warm clothes. The help, however, could also be health-related and involve ensuring correct and appropriate care and treatment or guidance in learning to live with a new diagnosis. Thus, the medical respite care centre was able to facilitate initial contact to the social welfare system and more than half of the participants said during their interviews that they had been offered an alternative to the streets following the medical respite care stay, for the most part, a bed in a shelter (Table 1):

You know, for me, it has been the help and support you can get just by asking, 'Do you know what to do in this situation?' The employees always say that they will find out (…). Just the feeling of security to know you can ask. *(Male, patient 08)*

The nurse taught me how to monitor my blood glucose. Now I know how to do it myself. *(Male, participant 09)*

The help and support were given with kindness and acceptance, providing participants with a sense of security and a feeling of safety knowing that someone was actually caring for them.

This place is filled with love. And it means the world that I was able to stay here. *(Female, participant 04)*

Additionally, there was a feeling of kinship and solidarity among some of the participants, which developed into a peer and social support system while staying at the medical respite care centre. The participants seemed to appreciate the everyday life activities associated with living together with a small group of people. This motivated and activated them as they began to take responsibility for the centre by keeping it tidy, clean and peaceful, and also by taking responsibility for each other and by developing relationships:

This just feels like some guys living together, making food together, watching television and having a nice time. *(Male, participant 08)*

3.2.4 | Theme 4: Restitution facilitates reflection

A medical respite care stay was like a wakeup call for some of the participants. Being at the medical respite care centre allowed time for reflection on revising their present life and on creating self-reflection for a better existence after medical respite care. Furthermore, the participants talked about changes they wanted to make, such as ending or reducing their drug and alcohol abuse:

I've had time to think about how I need to change my pattern of life. And I've gotten the courage to get started again, to contact my old network. Like—now I want to get out of this. *(Male, participant 08)*

In addition, some of the participants described how they had already made lifestyle changes as a direct consequence of hospitalisation and the medical respite care stay. Thus, a temporary condition was created that allowed them to change their perspective and make lifestyle adjustments, such as ceasing to take drugs and abuse alcohol:

> *I haven't taken any drugs since I was admitted to the hospital. Normally I take a lot of cocaine. I also fixed my methadone. I haven't done that since I was admitted or while staying here.* *(Female, participant 04)*

> *I've been sober since I was admitted to the hospital. Now I have said to myself: I'm 35. Half my life is gone, more or less. I also have a daughter. I cannot live like this because everything goes to pieces around me, including me. I want some help now.* *(Male, participant 08)*

Figure 1 demonstrated how the four themes most likely interacted to explain the homeless people's experiences of a 2-week medical respite care stay. It appeared that basic needs, a safe environment and social support were equally as important, as healthcare facilitated reflection among the participants. As the participants were individuals with different situations and needs, there were variations in what they benefitted from the most. As the above-mentioned themes illustrated, one participant benefitted most from not being stressed about where to sleep and what to eat, while someone else who had been homeless for a short period benefitted from the rest and receiving help to navigate the social welfare system. As a result, the progress of the participants at the centre differed, but in each case it seemed as if the medical respite care stay facilitated reflection on their situation, probably because the help they received was to some extent tailored to the needs of the individual:

> *I've had time to think about revising my life a bit, and my mind and my brain has gotten a new perspective, that something is going to happen now, so this has perhaps been a wakeup call for me.* *(Male, participant 11)*

> *It's calm here, and you begin to eat again (…). And then you talk a lot with the other people here, who also have issues one way or the other.* *(Male, participant 07)*

4 | DISCUSSION

This study explored homeless people's health perspectives and experiences of a 2-week medical respite care programme following acute hospitalisation. The analysis identified four themes: (i) basic needs are of highest priority; (ii) a safe environment provides security and comfort; (iii) social support is just as important as healthcare; and (iv) restitution facilitates reflection.

4.1 | Comprehensive understanding

The health perspectives of the participants focused particularly on simple, basic human needs such as the housing, food and clothing the medical respite care centre provided. This finding is supported by Maslow's hierarchy of needs (Maslow, 1943) and is consistent with other studies on homeless people (Gelberg, Gallagher, Andersen, & Koegel, 1997; Riley et al., 2011). Riley et al. (2011) found that basic needs such as hygiene and nutrition are the most important factors associated with physical and mental well-being in homeless women living with HIV, even more important than their vital antiviral treatment. In this study, although all the participants suffered from acute or chronic conditions, their basic needs were often more important than the severity of disease, which in part probably explains why homeless people have fewer encounters with ambulatory care and higher readmission rates than people with stable housing (Gelberg et al., 1997). This knowledge can be important in future work with this population because a failure to meet basic needs is a major barrier to homeless people moving forward.

In this study, several participants reflected on their health behaviour and thought about reducing alcohol or drug use while staying at the centre, considerations that the medical respite care stay appeared to facilitate. These reflections were expressed in both genders, across medical history and among people both with and without substance abuse. Therefore, both young and elderly people affected by homelessness expressed thoughts of healthy behaviour.

A teachable moment is often defined as the particular event or set of circumstances that leads individuals to change their health behaviour in a positive direction (Lawson & Flocke, 2009). The literature defines a teachable moment in various ways, but one is as a specific event or context, i.e. acute disease causing changed behaviour (Lawson & Flocke, 2009). The findings of this study contradict this supposition to some extent because acute hospitalisation and disease were not mentioned in the homeless people's perspectives on health; however, several participants revised their lives while at the medical respite care centre. Yet, evidence suggests that a teachable moment can also be viewed as a co-created event through interactions (Lawson & Flocke, 2009). In our study, two factors were important for the experience of receiving medical respite care. First, there was a sense of solidarity and development of close relationships with the employees and the other homeless patients that made them feel comfortable and valued. Second, the familiar atmosphere at the medical respite care centre created a safe environment, which enabled more focus on recovery. These findings are supported by a study from the UK that found relations to family, social workers and other hostel residents to boost the social and recovery capital among homeless people (Neale & Stevenson, 2015). Nevertheless, Neale et al. found that social relations can be limited and unpredictable in the ever-changing environment among homeless people. Staying at the medical respite care centre facilitated self-reflection among the medical respite patients that can in theory be understood as a teachable moment co-created between the homeless person, the staff and other residents at the centre (Lawson & Flocke, 2009). Dorney-Smith et al. found medical respite care in

the UK to be complex due to the diverse needs of homeless people. However, the clients felt that the psychosocial support from the employees was a central and necessary part of medical respite care for them. In addition, the study showed that it was an advantage if the medical respite care was a stand-alone unit rather than being part of an existing hostel creating a more suitable environment for recovery (Dorney-Smith, Hewett, & Burridge, 2016). The present study also found the familiar and safe atmosphere at the medical respite care centre to facilitate a co-created teachable moment for the homeless patient. As a result, medical respite care following hospitalisation can represent a window of opportunity for facilitating social contact for health behaviour changes in people affected by homelessness.

Van Straten et al. identified predictors of housing stability among homeless people 2.5 years after shelter admission, which included, among others, social support (family and friends) and a feeling of autonomy. On the other hand, cannabis use, alcohol use, unmet basic needs, depression and somatisation had a negative association with housing stability (Van Straaten et al., 2016). According to the participants, alcohol and/or drug use, social support and having basic needs met appeared to be managed or improved during the medical respite care stay. These improvements could indicate that some of the identified themes in this study are important for homeless people's prognosis in the long run. Therefore, the medical respite care stay did not only create space for reflection but also to some extent facilitate practical and relational support that enabled some of the homeless people to exit their homelessness or to begin recovery from substance misuse.

4.2 | Strengths and limitations

A semi-structured interview guide with open-ended questions was a useful method to collect data as it enabled the informants to speak in depth about their experiences and perspectives with regard to the purpose of the study.

The multidisciplinary research team enhanced the study by incorporating different perspectives in the study development phase, the analysis and the interpretation phase. The NVivo software created an audit trail and strengthened the creditability and trustworthiness of the study.

First, it is important to note that the homeless people referred to the medical respite care centre represent a selected group. They must be able to walk to the first floor, be alone during the night and be able to live in close proximity to seven other people. As a result, a medical respite care stay in Copenhagen is not targeted all homeless people as not all the people affected by homelessness are being referred to the medical respite care centre in the first place. Second, another point to consider is that at the time of interview, more than half of the participants in the study believed they would be offered a place to stay following the medical respite care stay. This was facilitated by the medical respite care centre. This illustrates the social help provided at the centre and this could have affected the participants' experiences positively and in an undifferentiated direction. Third, the participants could have a tendency to answer positively if they thought it could affect their treatment overall, even though they were told that this was not the case, as this population is, to some degree, dependent on the social welfare system.

Results from this study can be transferred to other settings where homeless people are discharged from the hospital. The identified themes somewhat reflect what it means to be homeless in Denmark and discharged to a medical respite care stay, and what is important for them, which increases the study's transferability. The findings of this study can be useful in the development of future initiatives targeting homeless people; bear in mind, however, the setting is important as policies and economics in different countries have a strong influence on homelessness and the clinical practice and reality surrounding them (Geddes & Fazel, 2011).

It would be interesting to explore if the behavioural reflections and changes that some participants talked about in the current study are maintained prospectively, but this would require a follow-up period. In Denmark, a current randomised controlled trial is evaluating whether a medical respite care stay is cost-effective compared to a control group discharged to the street (Unpublished work: Bridge Copenhagen—Respite Care for Homeless People—Clinical Trails.gov (NCT02649595)). The study also looks into how a medical respite care stay can affect health-related quality of life, treatment of alcohol use disorders, redeemed prescriptions and number of acute admissions over a 3-month period.

5 | CONCLUSION

In conclusion, medical respite care following hospitalisation provided homeless people with a time-out from life on the streets while providing and fulfilling basic care needs. Respite care was an opportunity for the homeless people to distance themselves temporarily from their homeless situation while accepting the support needed to recover. Because medical respite care constituted a place of peace and rest following hospitalisation, it also enabled reflection about life among homeless people including critical thoughts regarding their past and more hopeful reflections regarding their present situation and the future. However, the 2-week stay at the medical respite centre was considered too short for a complete recovery, and therefore it is important to further study whether full recovery and lifestyle changes can be expected. Further research is needed to explore the long-term benefits of medical respite care, i.e. 3 or 6 months after discharge from medical respite care.

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CONFLICTS OF INTEREST

No conflicts of interest have been declared.

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SUPPORTING INFORMATION

Additional Supporting Information may be found online in the supporting information tab for this article.

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