**Practice Pointer**

**Caring for patients experiencing homelessness**

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**What you need to know**

- People experiencing homelessness face multiple barriers to accessing health care and have high mortality and morbidity from preventable or treatable conditions.

- Clinicians should consider preventative care, harm-reduction and the increased rates of multi-morbidity and early-onset frailty when caring for people experiencing homelessness.

- Trauma informed practice provides a framework to enable respectful, safe, collaborative, and empowering relationships.

**Introduction**

There has been a worldwide rise in homelessness over the past 10 years.(1) On a single night in 2023, roughly 653,100 people in the United States were experiencing homelessness, the highest figure since reporting began in 2007.(2) Equivalent figures in England showed that on a given night in 2022, 1 in 100 households were experiencing homelessness.(3)

Health and homelessness are closely interconnected, and there is much that can be done by health care professionals to improve the lives of people experiencing homelessness. This article starts by exploring the health impacts of homelessness and barriers to accessing healthcare, with a focus on adults in high-income countries. The second part of the article examines practical considerations for clinicians providing care to people experiencing homelessness.

**How does homelessness impact health?**

Patterns of homelessness are complex and diverse and include rough sleeping, staying in temporary accommodation such as night shelters, hostels, women’s refuges, and hidden forms of homelessness such as staying with friends, sofa surfing, living in squats or ‘beds in sheds.’(3) The support needs of people experiencing homelessness are also diverse. A person who has become homeless due to a job loss but without other risk factors may require little support and be able to return to housing quickly. For many however, homelessness can be a longer term problem, resulting from an accumulation of risks and traumatic experiences at different points along the life course.(4)

The landmark Marmot Review in 2010 drew widespread attention to the inequalities across socioeconomic groups in the UK, showing that the lower a person’s socio-economic position, the worse their health.(5) More recently, a systematic review and a cross sectional study, both from the UK, have compared health outcomes in homeless populations against the housed population and describe extreme differences’.(6, 7) The average age of death for the homeless population is around 30 years lower than for the general population.(8) A population-based cross-sectional study of linked hospitalisation and mortality data in England has estimated that 30% of these premature deaths are due to causes amenable to timely and effective health care.(9)

Recent systematic review data has shown that people experiencing homelessness face significant stigma and discrimination from healthcare professionals.(10) Poor understanding of the underlying causes of homelessness by healthcare professionals means that individual choices are often blamed (11) despite robust research illustrating the complex interaction between the structural, economic, and individual factors involved, most of which are outside the control of those affected.(12) (See figure 1) Homelessness typically represents only one indicator of social exclusion, intersecting with multiple different forms of marginalisation. This is particularly relevant for clinicians because it is not only the lack of housing which impacts a person’s health needs. Other aspects of social exclusion may precede or occur because of homelessness. For example, a history of childhood trauma, or substance use disorder may have a more profound or immediate effect on health needs than homelessness itself.

**Figure 1: Table on the causes and impacts of homelessness in high-income countries (6, 7, 9, 12-15)**

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| --- | --- |
| **Underlying causes of homelessness****Structural, societal and economic factors:** * Poverty and inadequate social security benefits
* Unaffordable housing
* Unemployment
* Social exclusion
* Discrimination
* Unmet health and social care needs

**Individual factors:*** Adverse childhood experiences
* Mental health problems
* Problem drugand alcohol use
* Poor physical health
* Experience of the care system as a child
* Experience of the criminal justice system
* Experience of migration and seeking asylum
* Loss of work or benefits
* Neurodiversity
* Brain injury
* Death of a family member
* Relationship breakdown
* Experience of violence
* Experience of domestic abuse
* Lack of social support networks
 | **Impacts of homelessness*** Stigma and discrimination
* Increased mental ill health including substance dependency
* Higher rates of self-harm and suicide
* Increased use of acute hospital and emergency care
* Increased risk of TB, hepatitis C, HIV
* Increased physical long term conditions including epilepsy, asthma, COPD and cardiovascular disease
* Premature deaths from preventable and treatable conditions
* Average age of death 30 years below the general population
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**What are the barriers to healthcare?**

People experiencing homelessness commonly face multiple difficulties accessing and using health care. Active removal of these barriers by clinicians is needed to improve the accessibility and quality of services.

A systematic review of homeless persons’ experiences, with data mostly from the US and Canada, described individuals not feeling welcome or cared for when seeking medical attention, feeling labelled and stigmatised, and being treated with a lack of respect and empathy.(16) Internalized barriers among people experiencing homelessness are also recognised. Individuals may develop a presumption of their own poor health or early death resulting in an ambivalence towards addressing their health issues, an expectation of rejection from services or a feeling of embarrassment about personal hygiene that restricts confidence when accessing care.(17) Resulting patterns of health care usage include late presentation of illness (often when a crisis point is reached), increased rates of missed appointments, self-discharge before treatment is complete, and an increased use of emergency and acute secondary care rather than primary care services.(13, 18)

Administrative barriers can also contribute. Volunteers with lived experience in a 2024 mystery shopper study attended 13 London GP surgeries to request an appointment for a problem requiring urgent medical attention.(19) Over half of the visits ended with refusal to register the person, most of which were wrongly based on the person’s inability to provide proof of identification or address. Hospital discharge processes have also been shown to have considerable impact on people experiencing homelessness.(20) Health care professionals working in mainstream and specialist inclusion health services report that people experiencing homelessness are discharged from hospital with unmet health needs often or all of the time.(11) Almost half of the people experiencing homelessness in the same study who had been admitted to hospital were discharged either to the streets or to unsuitable accommodation. Problems with discharge letters and poor communication between services have also been linked to patients losing access to care and falling through gaps in the system.(20).

**Practical considerations for clinicians providing care to people experiencing homelessness**

Encounters with healthcare professionals can have a profound impact when a person is experiencing homelessness.(16) Fortunately, there is now a wealth of research evidence and guidelines (13) to inform effective, compassionate best practice.

*Trauma informed practice (TIP)*

Psychological trauma and homelessness are closely interlinked. A recent systematic review of adults experiencing homelessness in the USA, Canada and the UK showed that the lifetime prevalence of one or more adverse childhood experiences was 89.8%.(21) Trauma also often happens as a result of homelessness, for example experiencing or witnessing violence or sexual assault. (22)

Trauma informed practice is an approach grounded in an understanding of how trauma exposure affects an individual’s neurological, biological, psychological, and social development (BOX 1). (23) Clinicians practicing this approach will recognise how trauma can impact a patient, their ability to feel safe, their behaviour and their engagement. This allows you to prioritise the patient’s physical and psychological safety and avoid re-traumatisation. Establishing trust, allowing choice, collaboration, and empowerment are key.(24)

Box 1: Examples of how to apply the principles of Trauma Informed Practice in consultations (23)

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| **Consider Safety**Ensure physical, emotional and social safety, ask - “Are you safe?” or “What would help you to feel safe?”Avoid re-traumatization, for example, avoiding redundant repetition of potentially distressing aspects of a person’s history**Collaboration and choice**Askthe person experiencing homelessness what their priorities are and what support they want - “I won’t tell you what to do”Explain choices clearly and transparently – “There are some options…. what do you think?”**Establish trust**  Practice authentic empathyBe positive and supportive, not just with words but with body language and where possible, the environment. **Empowerment**Understand that someone who has experienced trauma may feel powerless and have low self-worth, support them to make decisions and to act on themValidate the patient’s experience – “Thanks for telling me. I have some sense of how difficult that was for you. It helps me when trying to think through the best support that we can offer” |

**Patient perspective**

*“The sores on my leg were getting worse, the smell of rotten flesh followed me, I was 25 and fearful that with repeated injecting I was going to lose my leg. I could not face another trip to A&E no matter what support the hostel workers tried to give me. Years on the streets and repeated negative encounters with medical professionals made me fear going. A drop in I visited occasionally for a shower and to use their phone had a nurse on a few days a week. Slowly with chats over coffee in the building I began to trust a health professional, it took a while, but she supported me to hospital, attending the appointment with me to get the treatment I needed. From this I began to engage with other services, reassured that not all professionals have such negative attitudes. I now work in recovery helping others.”*

Tracey

*Prescribing*

Explore a patient’s social context when creating shared management plans adapted to their living conditions. Patients may not be able to safely store medication if sleeping rough, sofa surfing or in accommodation projects without locked safes, so could benefit from weekly or even daily dispensing. Taking medication four times a day may not be achievable for a person managing challenging life circumstances, so consider whether a more appropriate regime, such as once daily dosing, can be prescribed.

Further considerations may include:

* If a medication should be taken with food, alternatives may need prescribing for patients who don’t have regular, easy access to meals.
* Home oxygen may not be safe if a patient is living in a hostel in proximity with people smoking tobacco or other drugs.
* If a medication requires refrigerator storage (e.g. insulin), ascertain whether a refrigerator is accessible. If not, you may need to consider how this can be safely stored and your advocacy role in securing accommodation.
* If a medication may require easy access to bathrooms (e.g. diuretics or bowel preparation), ascertain the accessibility of appropriate facilities .
* If a medication has sedating effects, discuss safety with a patient who may be sleeping in risky places.

*Prevention*

As people experiencing homelessness have more limited access to primary and preventative health care, utilise any contact as an opportunity for preventative care. This could include; screening for blood-borne viruses, sexually transmitted infections, hypertension and diabetes; giving vaccinations; smoking cessation and nutrition advice; referral to drug and alcohol recovery services.(13)

Clinicians can also utilise a harm reduction approach wherever possible. This may include street drug overdose prevention planning, education about safer injection practices, opioid substitution treatment and mental healthcare safety planning.(25) These offers of input need to ensure collaboration with the patient at all times so that you are working at a pace where the patient’s priorities for care take precedence and they do not feel overwhelmed, even if they do not align with your aspirations.(23)

*Long-term conditions and frailty*

People experiencing homelessness have higher rates of long-term conditions and multimorbidity than the general population so require comprehensive assessment to identify health issues and timely communication with other services (see figure 1).(6) Frailty and age-related conditions (particularly cognitive impairment) may present earlier and at higher rates in people experiencing homelessness. Comparisons have shown similar frailty scores between people experiencing homelessness in their 40s and 50s versus housed individuals in their 70s and 80s.(26)Be conscious therefore that screening for cognitive impairment, frailty and access to support and services usually directed at older people may be appropriate at a much younger age.

*Inclusive design of primary care services*

Dedicated primary care centres for people experiencing homelessness do exist in many cities and allow the delivery of flexible, holistic, integrated care.(27) These services may only be viable in locations with large numbers of people experiencing homelessness, but they can serve as models for how trauma informed service design can reduce barriers and support engagement. Examples include providing flexibility with appointments, drop-in services, longer appointment times and close partnership working with local hospitals and community homeless services. Specialist services also demonstrate inclusive registration policies that don’t discriminate against people without an address, this is a key policy that should be applied by all primary care services. (13)

Research and guidance are increasingly showing the value of involving people with lived experience of social exclusion in developing and improving services.(28) Co-designing services with people with experience of homelessness can assist with removing many of the barriers in access to care that have been discussed.

Box 2: Safe discharge from hospital (29, 30)

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| An admission to hospital can be a vital opportunity to address the health and social needs of a person experiencing homelessness, to ensure they have the necessary support in the community on discharge and reduce the risk of readmission. * **Communicate with housing providers:** Patients experiencing homelessness or at risk of becoming homeless should be identified as soon as possible on admission to hospital. If they don’t have anywhere safe to stay on discharge, seek their consent to make a referral to the local housing authority. In England, this is a statutory requirement for hospital trusts under the Homelessness Reduction Act 2017. Where the individual is being discharged to temporary accommodation such as a hostel, it is important to liaise with the service prior to discharge to agree to discharge plans and establish whether their ongoing care needs can safely be provided in that setting. If their needs cannot be safely met, consider if there is a local intermediate care pathway available or liaise with other professionals in the community to facilitate a safe discharge.
* **Avoid unmanaged self-discharge:** On admission, enquiries should be made to understand vulnerabilities that may put a patient at risk of self-discharge. This can include drug and alcohol dependence, meaning it is important to follow hospital protocols for the management of withdrawal and ongoing care in a timely manner. Support from a keyworker or peer advocate can help enable the patient to engage with treatment during an admission. If mitigating steps have failed and a self-discharge can’t be avoided, ensure that the community services supporting the patient have been informed and that discharge details are communicated to their GP (by phone or letter depending on the risk and urgency).
* **Involving relevant partners and services:** Work with the patient to identify any professionals who may be involved and can help with discharge planning.Ensure that people experiencing homelessness are registered with a GP service on discharge to enable important primary and preventative care. If there are any safeguarding concerns, a referral to the local safeguarding team should be considered. If there are any concerns about capacity including capacity to refuse treatment or help with housing, then a capacity assessment must be carried out. Specialist multi-disciplinary in-reach teams or Pathway teams have been established internationally to support homeless patients in hospital and to coordinate their discharge planning, find out if there is a team in your hospital and if not consider if one should be established.
* **Involve the patient:** To enact trauma informed care, involve the person experiencing homelessness in decisions about their discharge and aim to confirm plans as far in advance as possible
* **Consider auditing discharges:** To improve the quality of care and avoid self-discharges or discharging patients back to the streets, consider auditing the discharges of people experiencing homelessness from your department.
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*Advocacy*

At an individual level, clinicians can utilise every contact as an opportunity to address their patient’s social needs. This could involve onward referrals, for example to housing or alcohol and drug recovery services or providing evidence to help with a housing application. A short letter setting out any health problems or disabilities, how the condition affects the patient and how being homeless could impact their vulnerability can help a council to decide if the patient has a priority need for housing. Beyond individual advocacy, clinicians can also use their position to advocate at a broader level and help change structures and policies contributing to the rise in homelessness. This could involve joining campaigns, writing to politicians, and educating other health care professionals about care for people affected by homelessness, poverty, and social exclusion.

**Patient perspective**

*“I was lucky, some people do not make it this far. I had the right interventions, at the right time, with the right level of support from my own GP. I used to hide from the world and my health issues held me back, today I fight each day to help others, to make positive changes for those homeless, whose health is affected by this.”*

Majid

**Education into practice**

* How does your experience of providing care for people experiencing homelessness accord with the information in this article? Are there any aspects that feel particularly pertinent to you?
* Are there any changes you might consider making in your communication or consultations with people experiencing homelessness?
* What changes could you make to the organization of your service to reduce barriers to access for people experiencing homelessness?

**Additional resources on homelessness for health care professionals**

NICE guideline 214 Integrated health and social care for people experiencing homelessness <https://www.nice.org.uk/guidance/ng214>

Ward A, Andrews L, Black A, Williamson AE. Communicating effectively with inclusion health populations: 2022 ICCH symposium. Patient Educ Couns. 2023;117:107977.

Pathway- Homeless and Inclusion Health <https://www.pathway.org.uk/>

National Health Care for the Homeless Council. <https://nhchc.org/clinical-practice/>

Pottie K, Kendall CE, Aubry T, et al. Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience. CMAJ. 2020;192(10):E240-E254.

**How this article was created**

We combined information from recent research articles and key reports with our professional, clinical and personal experiences in inclusion health.

**Contributorship and the guarantor**

GA conceived the article and wrote the initial draft which was revised and approved by AW, MP and SH. GA, AW and SH are guarantors. MP was the contact for patient involvement. The authors thank the patients who contributed their personal stories but wish to remain anonymous.

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**How patients were involved in the creation of this article**

One of the authors, MP, has lived experience of homelessness and works for Pathway as the Lived Experience Programme Manager. She has provided the personal insights and perspectives included in this article from her own experiences and those of colleagues with lived experience. Patient perspectives have been given pseudonyms to maintain anonymity. MP’s opinion was sought on what should and shouldn’t be included in the article and she was involved in revision and editing.

**Conflicts of Interest**

*The BMJ* has judged that the authors have no disqualifying financial ties to commercial companies that are relevant to this paper.

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