Delivering Healthcare to Homeless People:
Lessons from Scandinavia and the USA

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URBAN VILLAGE MEDICAL PRACTICE
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About the author

I am a Team Manager for the Homeless Healthcare Service at Urban Village Medical Practice in Manchester. Urban Village Medical Practice provides primary healthcare to over 800 homeless patients in Manchester as well as providing in-reach services to homeless people admitted to Manchester Royal Infirmary through the mpath service. I have been with the team for five years and I am currently responsible for the operational management of the service, maintaining relationships with other agencies in the city and progressing the strategic development of the service.
Summary

With homeless numbers rising consistently for the last 8 years increasing pressure is being placed on politicians and public sector services to respond to the growing crisis. While lack of affordable and suitable housing is a significant factor in this increase the relationship between homelessness and health must not be ignored. It is well documented that health issues are a common contributing factor to someone becoming homeless, health issues are exacerbated by a person’s homeless situation and the experience of homelessness leads to poor health outcomes. Although homeless people experience chronic health issues they often face significant barriers in accessing healthcare and as a result disproportionately utilise emergency and acute services compared to the general population. These services not only fail to provide continuous healthcare for an individual they are also incredibly costly to the NHS.

Specialised healthcare for homeless single people has been delivered in the UK since the 1970’s with the aim of supporting patients to address their health issues in the community. In 2010 the Department of Health recognised four typical models of healthcare delivery for homeless single people:

- Mainstream practices providing services for homeless people.
- Outreach team of specialist homelessness Nurses.
- Full primary care specialist homelessness team.
- Fully coordinated primary and secondary care.\(^1\)

Model 4 was described in the report as the optimum standard of healthcare to homeless people and included specialised primary care, outreach services, medical respite and hospital in-reach. According to recent research there are currently 123 homeless health services operating in England, the majority delivering models 1 and 3. While there are a number of examples of model 2 these are quite limited and there are very few services delivering model 4.\(^2\)

The purpose of this report is to illustrate different ways of delivering healthcare services based on the recommendations of model 4. With the support of the Winston Churchill Memorial Trust Travelling Fellowship I travelled to Norway, Denmark and the USA to identify best practice that could be adapted and replicated in a UK setting particularly focusing on examples of street medicine; low-threshold clinics; medical respite and mobile health clinics.

Through the Fellowship I determined that while the experience of homelessness and healthcare structures differed in each of the areas I visited there were some common principles that can be transferred to the delivery of healthcare to homeless people in the UK:

- Homeless healthcare requires a specialised approach that is proportionate to the level of need within the population.
- Where healthcare services are not engaging with homeless people that is a failure of the healthcare system and innovative ways of providing healthcare must be sought.
- Any delivery of homeless healthcare should sit within mainstream healthcare services.

Based on the findings of my Fellowship I have made the following recommendations to improve the delivery and effectiveness of homeless healthcare in the UK:

1. Bring healthcare to homeless people.
2. Transition patients to mainstream healthcare settings.
3. Ensure healthcare professionals have access to training in homeless health.
4. Increase involvement of students in homeless healthcare.
5. Use peers to promote engagement with healthcare services.
6. Utilising the potential of electronic medical records.
7. Expansion of medical respite services.

Introduction

1.1 Homelessness and Health

Homeless figures in the UK have been steadily increasing since 2010. Recent research by Shelter estimates that there are 307,000 people rough sleeping or living in temporary accommodation in Great Britain. However, this doesn’t take into account the indeterminate number of ‘hidden-homeless’ people living in unsupported temporary accommodation, such as B&Bs and houses of multiple occupancy, or those sofa surfing and squatting. Although lack of accommodation is a leading characteristic of homelessness it is not the only cause of homelessness. Causes of homelessness are incredibly complex and often involve a combination of multiple personal and structural factors that result in an individual experiencing homelessness. Lack of accommodation, housing policy and problems accessing social welfare are examples of structural factors that contribute towards homelessness. Individual risk factors associated with homelessness include: adverse childhood experiences such as physical and sexual abuse, family history of substance misuse or mental health issues and time spent in care; domestic violence; time spent in an institution such as prison or the armed forces; financial issues such as debt or rent areas; and health problems, particularly substance misuse and mental health.  

Existing health issues instrumental in causing homelessness can deteriorate as a result of being homeless, such as increased substance misuse. The experience of homelessness can also result in the manifestation of new health issues, often those that are intrinsically linked to homelessness such as trench foot and frostbite in the rough sleeping population. Research conducted by Homeless Link with homeless individuals found that 73% reported that they had a physical health problem, 41% advising that this was a long-term problem; 80% reported experiencing a mental health problem; 39% had or were recovering from a drug problem; and 27% had or were recovering from an alcohol problem.  

In spite of the high level of complex health needs evident in the homeless population they often face significant barriers in accessing healthcare services. Homeless people are often prevented from engaging with healthcare services because of the disruption associated with having no fixed abode. GPs regularly request proof of address or ID to register patients and letter-based appointments and telephone triaging can be difficult to coordinate for homeless patients without access to a secure address or phone. Homeless patients often fail to prioritise their health over other competing immediate needs such as finding accommodation, food and clothing, or dependency to drugs or alcohol. Previous negative treatment by healthcare professionals can discourage homeless patients from engaging in healthcare due to fear of discrimination and mistrust of the health service. These factors combined with the chaotic nature of homelessness result in homeless people accessing acute healthcare services disproportionately to the general population. Research undertaken by London Pathway evidenced that homeless people attend A&E up to 6 times more often than the general population, are 4 times more likely to be admitted and once admitted stay 3 times longer. Each homeless person costs the NHS an average of £4,298 each year.

Homelessness is not just bad for your health, it also kills. The combination of extremes of poor health and difficulty engaging in healthcare services result in high mortality rates in the homeless population, in the UK the average age of death for a homeless man is 47 and for a homeless woman is 43. Recent Guardian research reported that the number of homeless people dying on the streets or in temporary accommodation has doubled in the last 5 years. Those working in homeless healthcare in the UK state that homeless people do not die as a direct result of being homeless, they die of treatable medical conditions and therefore require a specific response for healthcare services to promote engagement, improve health outcomes and reduce mortality rates.

Specialised primary healthcare for single homeless people in the UK is not a new concept, examples of health services that have been established to meet the complex needs of homeless people date back to the 1970’s. Recent research by King’s College London identified 123 specialist primary healthcare services for homeless people in England. The research recognised various models of delivery of healthcare to homeless people including homeless health centres, GP practices providing specialist services for homeless patients, and mobile health teams. Over 72% of services delivered healthcare from a fixed location whilst 13% represented mobile health services for homeless people.
The predominant model in the UK of delivering specialised healthcare services to homeless people from a fixed location does improve access to healthcare for this population. However, homeless people still face significant barriers accessing and engaging with healthcare services. Under the terms of the Health and Social Care Act 2012 the NHS has a legal obligation to reduce health inequalities between patients in relation to their ability to access health services and to improve outcomes through the provision of health services. Homeless people are one of the most marginalised populations of society, in order to effectively reduce health inequalities in this population a range of healthcare delivery models should be applied.

In 2010 the Department of Health described 4 models of delivering healthcare to single homeless people:

1. Mainstream practices providing services for homeless people.
2. Outreach team of specialist homelessness Nurses.
3. Full primary care specialist homelessness team.
4. Fully coordinated primary and secondary care.

The report acknowledged that model 4 was an optimum standard of healthcare loosely based on the work of Boston Healthcare for the Homeless Program and included specialised primary care, outreach services, medical respite and hospital in-reach. In 2010 this model wasn’t evident in the UK although it was identified that areas with high populations of homeless people could benefit from this model. Since then some homeless healthcare providers have been able to develop services to enhance the level of care they offer for example the 8 hospital in-reach services based on the Pathway model. Although there is limited evidence of services delivering the 4th model of healthcare Bevan Healthcare in Bradford have demonstrated that it can be replicated in a UK setting.

The purpose of this report is to identify and describe different methods of delivering elements of this enhanced delivery model that could be applied by services in the UK.

1.2 Homelessness and Health in Manchester

In Manchester the homeless population has increased significantly over the last 5 years, according to recent research there are approximately 3,511 homeless people in the city. Between 2012-2017 Manchester experienced an increase of 248% in the number of rough sleepers reported in the city and an increase of 20% in the number of statutory homelessness decisions made by Manchester City Council. According to official statistics there are 3,433 people living in temporary accommodation in Manchester; however, this does not account for the vast numbers of people living in unsupported temporary accommodation and sofa surfing in the city.

Urban Village Medical Practice is a GP practice with over 10,000 patients, it is also the only commissioned healthcare service for homeless people in Manchester. The team at the practice have been providing healthcare to homeless people in Manchester since 1991. With over 850 homeless patients registered at the practice Urban Village have developed a ‘one-stop shop’ approach to homeless healthcare delivery, ensuring that patients have flexible access to full GP registration and primary care services as well as a range of services provided at the surgery from partner organisations including: substance misuse

Bevan Healthcare CIC

Established in 2003 as a primary care service for vulnerable and marginalised people they have developed services that are responsive to the needs of their patients. With over 6,500 patients across Bradford and Leeds in addition to primary care services they also have a dedicated Street Medicine Team who work with patients on the street and via a mobile medical van; they deliver the Pathway hospital in-reach service; in partnership with Horton Housing they provide Bradford Respite and Intermediate Care Support Service (BRICSS), short-term accommodation to people being discharged from hospital; and most recently they opened a wellbeing centre which delivers support services to patients and members of the community to improve their lives through a social prescribing model.
assessment and treatment; dentist; mental health; podiatry; tissue viability; needle exchange; and a blood borne virus clinic. Since 2012 the homeless healthcare team at Urban Village have also delivered the mpath service, an in-reach service at Manchester Royal Infirmary supporting homeless inpatients and homeless A&E frequent attenders. The homeless team is a multi-disciplinary team, GPs and Nurses provide clinical care while non-clinical team members support patients to engage with healthcare through proactive outreach work and case management of patients with complex health and social care needs. Since 2017 Urban Village have also delivered a Nurse-led healthcare service at The Beacon centre, a day centre for homeless people run by the charity Barnabus Manchester. The Big Lottery funded health services offers visitors to the centre basic health interventions and health promotion services. A Nurse from the team also regularly visits hostels across the city to engage homeless people with healthcare. In addition to operational work, Urban Village has also strived to ensure that homelessness is a strategic priority in the city and has developed and delivered a range of training on homeless healthcare including the ‘Homeless Healthcare Standards’ to people working with homeless people and ‘Know Your Rights’ training to empower homeless people to access healthcare. Although Urban Village Medical Practice prides itself on promoting flexible and accessible healthcare, in recent years it has become increasingly evident that there is significant unmet health need in the homeless population. Regular outreach on the streets, in daycentres and hostels has identified a growing number of chaotic, chronic homeless people who for whatever reason are not engaging with healthcare services. The mpath service also reports an increase in the number of patients admitted to hospital with complex health problems which are not being treated in the community.

In order to evidence growing concern about unmet health need in 2016 Urban Village Medical Practice produced Manchester’s first Homeless Health Needs Audit18. Using the Homeless Link Toolkit over 230 homeless people in the city were interviewed about their health needs and utilisation of services. The audit reported that:

- 83% of respondents reported at least one physical health problem, 70% advised that this was a long-term problem.
- 73% reported a mental health problem.
- 71% reported using illicit substances in the previous 12 months.
- 23% reported drinking almost daily.
- 42% of respondents had used an ambulance in the previous 12 months.
- 47% had attended A&E in the previous 12 months, 13% had attended 3 or more times.
- 61% had been admitted to hospital at least once.

Additional research was undertaken by Urban Village in July 2017 utilising information gathered from monthly headcounts of rough sleepers in the city centre. Of the 104 rough sleepers identified, 93% were known to the team and 72% were registered with Urban Village Medical Practice as their GP. Of the registered patients 63% had attended at least one appointment in the previous 3 months, however 67% of these patients had only attended only once. Given the known complex health problems of this population this is not enough to effectively address health needs.

1.3 Winston Churchill Memorial Trust Travelling Fellowship

Established in 1965 on the death of Winston Churchill the Fellowship provides a unique opportunity for UK citizens to travel overseas to bring back fresh ideas and new solutions to today’s issues for the benefit of others in the UK. Each year more than 100 Fellowships are awarded for a wide range of projects under the ethos “travel to learn, return to inspire”.

In response to the increasing homeless population in Manchester and growing concern around unmet health need I applied for and was awarded Fellowship with the aim to identify methods of providing healthcare to homeless people that:

- Engage homeless people with healthcare at the community level.
- Reduce the pressure on acute and secondary services.
- Promote partnership working between multi-disciplinary services to meet the complex health and social care needs of homeless people.

Based on the Department of Health report19 four principal models of healthcare deliver were identified that have the potential to meet these objectives:

18 http://www.uvmp.co.uk/website/P84673/files/Homeless%20Health%20Needs%20Audit%202016.pdf
Street Medicine:
Provision of healthcare directly to those living on the street. Removing barriers to accessing healthcare for homeless people and developing relationships with patients where they feel comfortable.

Low-threshold clinics:
Flexible and accessible healthcare clinics based in the community that provide easy access to appointments and make few demands on patients.

Medical Respite:
Clinically supported intermediate care for homeless people in the community who are too ill to be on the streets or in temporary accommodation but do not require a hospital admission.

Mobile Health Clinics:
Use of vehicles to extend healthcare to homeless people in the community.

Examples of good practice for each delivery model were identified through conversations with peers, and additional examples of homeless healthcare delivery were recommended by professionals working in the cities visited and meetings arranged. The purpose of the visits was to directly observe the delivery of healthcare services and to have the opportunity to speak with staff and patients about the various benefits and challenges of the service. In total I travelled to 6 cities, in 3 countries, over 6 weeks. Each chapter details the examples of good practice observed in each country and concludes with lessons learnt from the visit. These are used as the basis of the recommendations of the report.

2. Norway

In 1996, Norway conducted the first comprehensive census of its homeless population. During a week in late November surveys were undertaken with individuals and organisations working with homeless people at the local and national level to gather information on the specific circumstances of all homeless individuals known to them. The first census reported that there were 6,200 homeless people in Norway. Since then subsequent censuses conducted in 2003, 2005, 2008 and 2012 demonstrated little change in the overall homeless population for the country. However, in 2016, marking 20 years since the original census was completed, the Norwegian Institute of Urban and Regional Research (NIBR) reported a 37% decline in the homeless population with an annual figure of 3,909.

The reduction in the overall number of homeless people in Norway is largely attributed to the long-term investment in a number of different policies implemented since the original census in 1996 specifically designed to improve accommodation options for homeless people and to prevent eviction. A combination of housing led initiatives to provide permanent housing, rather than temporary shelter, and case management support have been deemed to be the most effective approach to reduce homelessness and increase housing stability.

Despite the reduction in the overall number of homeless people the NIBR 2016 Report acknowledges that there has been little fluctuation in the demographic of the population in the 20 years of recording. In 2016 the report summarises the following:

- **Gender:** 75% of homeless people are male and 25% female.

- **Country of origin:** 77% of homeless people are born in Norway. With the largest group of foreign-born homeless people coming from Africa and Asia.

- **Age:** 22% of the population are under 25 years of age; 31% between 25-34; 21% between 35-44; 18% between 45-54; and 8% over 55.

- **Accommodation status:** 37% of homeless people in Norway stay temporarily with friends or relatives (sofa surfing); 29% are in temporary accommodation; 21% are in an institution or correctional facility; and 5% sleep rough or stay...
in night shelters where they have to spend the majority of the day outdoors.

- **Substance misuse and mental health:** 57% of the homeless population have substance misuse issues; 34% have a mental health problem; and 72% of people with a mental health problem also have a substance misuse problem (dual diagnosis).

In 2006 Norway published its national strategy to reduce social inequalities in health and cited homeless people, those with mental health issues and those with substance misuse issues as vulnerable populations who directly experience health inequalities. The strategy recognised the benefit of existing practices to improve access to health services for these populations such as field clinics for drug users and medical street outreach for the homeless, injecting drug using population.

Norway has a long history of substance misuse issues, most significantly heroin dependence, and reports one of the highest drug overdose death rates in Europe. With an estimated 9,015 high risk opioid users in Norway many of the health interventions accessed by the homeless population are low-threshold, assertive services designed to prevent outcomes for drug users.

### Demographic of Oslo’s homeless population:

- **Gender:** 72% of homeless people are male and 28% female.

- **Country of origin:** 66% of homeless people are born in Norway, 8% from other Nordic or European countries, 17% from Africa, 7% from Asia; and 2% from North or South America.

- **Age:** 10% of the population are under 25 years of age, 26% between 25-34, 29% between 35-44, 25% between 45-54 and 10% over 55.

- **Accommodation status:** 38% are in temporary accommodation; 27% stay temporarily with friends or relatives (sofa surfing); 23% are in an institution or correctional facility; and 7% sleep rough or stay in night shelters where they have to spend the majority of the day outdoors.

- **Substance misuse and mental health:** 51% of the homeless population have substance misuse issues, 34% have a mental health problem and 72% of people with a mental health problem also have a substance misuse problem (dual diagnosis).

### Medical Respite

#### Gatehospitelet (The Street Hospital)

The Street Hospital (photo 2.1) is a 3 ward, mixed gender, medical respite facility run by Freisearmeen (The Salvation Army). It is situated in Grønland, approximately 15 minutes walk from Oslo central station.

In 2004 the Salvation Army repurposed a floor of one of their existing buildings and paid to convert

23 [https://www.regjeringen.no/contentassets/bc70b9942ea241cd900299559b1f72d3c/en-gb/pdfs/1fn200620070520005en Paths.pdf](https://www.regjeringen.no/contentassets/bc70b9942ea241cd900299559b1f72d3c/en-gb/pdfs/1fn200620070520005en_paths.pdf)

24 [https://www.thelocal.no/20140527/norway-tops-heroin-overdose-ranji](https://www.thelocal.no/20140527/norway-tops-heroin-overdose-ranji)


27 [http://www.hioa.no/Om-HIOA/Senter-for-velferds-ogagbeidslystforsknings/NIBR/Publikasjoner/Boastedloese-i-Norge-2016](http://www.hioa.no/Om-HIOA/Senter-for-velferds-ogagbeidslystforsknings/NIBR/Publikasjoner/Boastedloese-i-Norge-2016)
the space to a clinical ward providing 8 beds for men and women with substance misuse issues and a significant health problem. Since then, with the support of both the municipality and The Salvation Army, an additional 2 wards have been opened. The Street Hospital now has a 9 bed male ward; an 8 bed female ward and a mixed gender 7 bed ward that provides care for palliative patients and patients who require a longer period of admission.

The Street Hospital provides medical respite care to its patients and provides both a step-up from the streets, to prevent hospital admission, and a step-down from hospital approach. Purpose of the hospital is to manage addiction while treating physical health issues and promoting wellbeing.

**Referrals:** The majority of referrals are via community health workers, social workers and hospitals. In 2016 The Street Hospital received 432 referrals, 55% for male patients and 45% female. The referrer completes an application form and the referral is registered on the database. All applications are assessed and prioritised by need to ensure that those with the greatest level of medical need are admitted first.

**Criteria:** The criteria for acceptance is that the person must have a substance misuse issue, wither alcohol or drug, and a physical health condition significant to warrant admission. Drug users do not have to be in drug treatment to be admitted as treatment can be initiated as an inpatient. Patients are not allowed to use any substances during admission.

**Length of stay:** The average length of stay for a patient is 2-3 weeks however this can be extended if needed. In 2016 a total of 199 patients spent 5,558 bed days in both The Street Hospital and palliative care beds.

Each admitted patient is allocated to a room with a hospital bed, cupboard, bedside table, TV and sink (photo 2.2 and 2.3). Shower and toilet facilities are shared and located on each ward.

There are also treatment rooms and sluice rooms on each ward.
Staffing
There are three shift patterns for the staff of The Street Hospital: Day, evening and night.

Day shift:
7:30am—3:30pm: Each ward has a Ward Manager who manages shift and an additional 2 staff. There are always 2 nurses on each ward.

Evening shift:
3:30pm — 10:30pm: There are 2 staff on each ward, 1 of these staff members is a Nurse.

Night shift:
10:15pm — 8:00am: There is a nurse on each ward and a nurse who floats between all three wards.

The Street Hospital employs two Doctors who work Monday to Friday. They undertake ward rounds, create management plans for patients and rationalise medication to ensure patients are on manageable doses to be continued in the community. Additional staff include a Hospital Leader, Admin staff, healthcare assistants and cleaners. In June 2017, there were a total of 65 employees working at The Street Hospital. The most notable thing about the staffing at The Street Hospital is that staff have a lot of time for the patients, they are incredibly attentive to the needs of the patients and they treat the patients with a high level of respect. They demonstrate excellent team work, there is very clear communication between all staff members and morale is very high.

Healthcare
Patients are admitted with a range of presenting health problems, common treatments for patients include:

- **Wound care:** dressings are changed regularly and medication is prescribed including antibiotics.
- **Treatment initiation and stabilisation:** admission can be used to initiate patients into treatment for conditions such as Hepatitis C and renal failure. The Street Hospital has a fibroscan machine and works closely with the local hospital to engage patients with dialysis.
- **Substance misuse:** can initiate patients into substitution drug treatment following hospital protocol.
- **External appointments:** patients are taken to appointments to address multiple health needs during stay such as the dentist, hospital etc.

Timetable on a typical day:

7:30am: Handover from night staff to day staff. Double check and sign all medications to be administered. Allocate jobs for the shift.

8:00am: Medication administered. Only one staff member responsible for administering all medications to reduce risk of double dosing and to discourage drug seeking behaviour.

8:30am: Breakfast.

9:00am: Ward rounds undertaken by one Nurse and one Doctor. All other staff members spend the morning providing healthcare to patients; accompanying patients to external appointments; liaising with other agencies to facilitate support required for the patient on discharge such as accommodation or drug treatment; arranging and holding multi-disciplinary team (MDT) meetings for patients to agree joint care plans.

12:30pm: Lunch. Staff will continue to support the patient with healthcare, appointments and MDT working. Staff can also accompany patients to the shop or for a walk.

3:15pm: Handover from day staff to evening staff. Double check and sign all medications to be administered.

4:30pm: Dinner.

10:15pm: Handover from evening to night staff.

Multi-disciplinary working
Much emphasis is placed on promoting multi-disciplinary case management of the patient during their admission. Staff at The Street Hospital arrange and facilitate multi-disciplinary team (MDT) meetings with a range of professionals including: social workers; accommodation workers; Doctors and Nurses from the patient’s community healthcare provider; substance misuse workers; and support workers. This is an opportunity for the patient to be placed at the centre of the decision-making process when facilitating an appropriate and successful discharge.

Palliative care
The Salvation Army had been lobbying for specialised palliative care for people with substance misuse issues for a number of years. They took the decision to fund the conversion of offices into a ward designated for palliative care and long stay patients which was completed in 2014. However, funding to deliver the service wasn’t agreed until 2016 and the ward officially opened in April 2016. The ward has capacity for 7 patients, 3 are reserved for palliative care patients and 4 for patients who require treatment that necessitates a longer admission such as chemotherapy.

Wellbeing
Although The Street Hospital is a clinical environment, much consideration is given to creating a safe and welcoming space for patients. All areas are decorated
with neutral colours and no perfumes or fragrances are used to minimise the risk of triggering negative memories for the patients. On the female ward, there is a therapeutic room (photo 2.7 and 2.8) for women where they can have a bath; a massage; have their hair washed and cut; and receive tactile therapy to promote touch as a positive intervention. Tactile hand massage is offered for men. To build self-esteem of patients during their admission the staff ask patients quiz questions from newspapers each morning as they recognise the boost a patient receives when they get a question right.

Low-threshold Clinics

There are 2 Feltpleien (field clinics) in Oslo. Feltpleien Urtegata is run by the Salvation Army and Prindsen Mottakssenter is the clinic delivered by Oslo municipality. Healthcare is also provided at Bymisjon 24/7, a drop-in centre based in the city. The purpose of the clinics is to provide accessible healthcare services to treat physical health conditions associated with substance misuse and homelessness.

Feltpleien Urtegata

The Salvation Army clinic is located in Tøyen, above a daycentre that provides services for people with active substance misuse issues.

Criteria and information sharing: Anyone accessing the daycentre can be seen in the clinic. Patients can remain anonymous and they are provided with an identification number. Information is shared with the patient’s GP if consent is given. This is overridden if there are significant concerns regarding mental health.

Staffing: The clinic is open from 9am-3pm daily and is a drop-in service. The clinic is predominantly Nurse led and employs 4 full time Nurses who undertake all administration duties as well as providing healthcare. Two Doctors are present for two sessions per week. The clinic also has a volunteer foot therapist who attends once a week.

Healthcare: The clinic provides care for physical health conditions. Common treatments include: wound care; foot care; draining abscesses; BBV screening; and administering vaccinations. No pain relief or mental health medications are provided at the clinic. There is also a big focus on harm reduction and staff provide information and guidance to patients on the use of naloxone to prevent overdose. In 2016 520 individuals attended a total of 4,200 times.

Prindsen Mottakssenter

The Oslo municipality run feltpleien is situated in a large multi-purpose centre on Storgata, a few minutes’ walk from the centre of Oslo that provides services for people with substance misuse issues and is staffed 24/7. In addition to the clinic the centre also has a supervised consumption room; a needle exchange; emergency accommodation; social support teams; and Hepatitis C treatment team.

Feltpleien

Offering similar services to The Salvation Army clinic, Prindsen Mottakssenter offers drop in health services which are free of charge. A Nurse led clinic which provides care for physical health conditions. Doctors also undertake regular sessions and can prescribe limited pain relief. In 2016 800 people attended 7000 times.

Supervised consumption room and needle exchange

Initially opened as a pilot programme from 2005-2009 the full service commenced in 2012 and funded by Oslo city’s welfare department. Establishment of the supervised consumption room was in reaction to the open drug scene in Oslo on the recommendation of Police, NGOs, the municipality and substance misuse organisations.

On the first visit the patient is registered and given an ID number. Since 2012, 3000 numbers have been given out. The supervised consumption room only accommodates injecting drug users and patients are permitted to inject one bag of heroin only. On each visit the patient is requested to read and sign a contract and asked to complete information about recent heroin use and any other substance misuse. The consumption room seats 6-8 people who are each allowed 30 minutes. Each seat has a mirror for monitoring and for guidance for patients injecting into their neck. In 2016 300 overdoses were treated in the project which reduced likelihood of overdose related deaths.

The needle exchange is accessed via a hatch located at the front of the centre. Both the needle exchange and the supervised consumption room are open from 9am-10pm Monday to Friday and 11am-6pm Saturday and Sunday.
Emergency accommodation

Homeless people in need of emergency accommodation can be accommodated for up to 3 days via a social services referral. Prinssen Mottakssenter has 17 rooms equipped with a single bed and 3 sit up beds. Support workers based at the centre work with people to move them on as quickly as possible. This can include repatriation in and outside of Norway and support to access longer term accommodation.

Social support teams

Service has two social teams, one based in the centre and a mobile team working in the community. Both teams can help to engage the person with services such as accommodation and substance misuse and they can help people to attend appointments.

Hepatitis C treatment

Treatment can be initiated at the centre and a team assertively follow the patient around in the community to ensure continuation of treatment. Over 100 patients have successfully completed treatment since 2013.

Kirkens Bymisjon 24SU

Kirkens Bymisjon (Church City Mission) is a large charity that provides services across Norway predominantly for homeless people; people with substance misuse issues; male and female sex workers; and people in crisis. 24SU is a drop-in centre in Oslo located less than 5 minutes from Oslo Central Station. Opened in 2009 with the aim to improve health outcomes and increase social inclusion for the most vulnerable people with substance misuse issues, the centre offers a range of services to meet the immediate needs of the population they serve as well as offering support to engage with services that can affect long lasting change. Open 24 hours a day, 7 days a week, services provided at 24SU include:

Immediate needs provision

Users of the service can drop in to the centre from 9:30am-6pm and have a shower, a place to rest and access hot food. Outside of these hours people can still come to the centre for support via a consult at the door. The centre also has a limited number of fold-out beds that can be used to provide emergency, overnight provision for people in crisis (photo 2.9 and 2.10).

Healthcare

24SU provides low-threshold, primary care services free of charge. The centre employs two Doctors, four Nurses and a Psychologist.

Substance misuse services

The centre provides a needle exchange service for clients. The medical team can also initiate patients into substitute prescribing drug treatment. Treatment is started and maintained until the client is ready to transfer care to LAR which is Oslo’s drug treatment provider.

Support services

Aim is for all users of the service to engage with support staff. Staff try to find out about the history of the person, identify professionals connected to the person and motivate people to accept the help available to them. 24SU staff help the client to navigate care systems to access the help they need. Agencies involved with the client are contacted to create an individual care plan for the client. Support workers can accompany people to appointments and often the emergency beds are used to accommodate people who have appointments the following morning.

Mobile Medical Clinic

Sykepleie på hjul (Nurses on wheels)

Fransiskushjelpen is a medical NGO that has 2 main services: palliative care for people in need and a nursing on wheels service, Sykepleie på hjul (SPH), providing outreach with the use of a mobile medical van (photo 2.11 and 2.12).

SPH has been providing outreach services to people with substance misuse issues and sex workers since 2003.

- The service operates Monday-Friday 9am-4:30pm and provides 2 evening outreach sessions per week and is staffed by 4 Nurses who all have hospital experience working with people with substance misuse issues. The service also utilises medical volunteers who have a contract with the welfare system to provide indemnity insurance to cover them for the work they undertake.
• The delivery model is to be where the patients are. This involves conducting regular outreach to known areas of high drug use activity, which can be street based or outside hostels with high numbers of drug users. Patients can also contact the service by phone and request a visit to their specific location.

• SPH predominantly deal with low threshold physical health problems and harm reduction services, including: wound care; needle exchange; prescribing naloxone; and providing barrier contraception.

• The service also has the capacity to take patients to appointments to address more complex health problems and engage with substance misuse services.

• In 2016 SPH had 3,809 contacts with 1,067 patients. In the same year they also gave out 87,530 needles and had 58,920 returned.

### 2.2 Lessons from Norway

- Medical Respite care offers an opportunity for meaningful multi-disciplinary working with the focus on person-centred care. Providing a platform for health and social care agencies to communicate effectively with the patient ensures that the patient’s wishes are heard and accounted for wherever possible.

- In addition to providing respite care, medical respite facilities have the potential to provide tailored palliative care to patients with complex needs in an environment sensitive to their specific health needs and by staff who are understanding of their social history.

- Partnership working with charities and other organisations can increase the scope of healthcare services provided through shared resources and the ability to access additional funds. Co-locating healthcare services with additional support services for marginalised people with complex needs promotes engagement with healthcare and reduces the level of unmet health need within the population.

- Although multiple providers of healthcare can serve to increase provision of healthcare to marginalised populations, communication between providers and continuity of healthcare is limited when health services are fragmented.
3. Denmark

Denmark has been undertaking national homeless surveys every 2 years since 2007. Using a similar approach to Norway, services that come into contact with homeless people are required to complete a 2-page survey for all of the individuals known to them during a set 1-week period. The most recent survey, conducted in 2017, reported the total homeless population in Denmark is 6,635, which is an 8% increase since the previous survey in 2015.28

According to the 2017 survey the homeless population of Denmark can be summarised by the following demographics:

- **Gender**: 75% of the homeless population are male and 25% female.
- **Country of origin**: 82% of the population are from Denmark, 7% of this population are Danish citizens from Greenland; 6% from Middle Eastern countries; 5% from African nations; 3% from EU countries; 2% from other countries in Europe; and 1% from other Nordic countries.
- **Age**: 0.5% of the homeless population are under 17 years of age; 20% are aged between 18-24; 16% 25-29; 21% 30-39; 20% 40-49; 17% 50-59; and 5.5% over the age of 60.
- **Accommodation status**: 10% of the homeless population are rough sleeping; 4% stay in a night shelter; 35% in a hostel or hotel; 33% stay temporarily with friends and family; 3% are under the care of the criminal justice system or in hospital; and 2.5% are in short term accommodation provided on release from prisons or institutions (11% are categorised as other or unexplained).

In addition to collecting information relating to the demographic of the nation's homeless population, the 2017 national survey in Denmark also reports on the health issues experienced by the homeless population.

- **Physical health**: Approximately 20% of the population report a physical health condition. While there is little disparity in terms of gender or accommodation status, people over the age of 40 are twice as likely to have a physical health problem when compared to the younger homeless population.
- **Mental health**: 53% of the homeless population report mental health problems, 61% of homeless women report mental health problems and 50% of homeless men.
- **Substance misuse**: 67% of homeless men report a substance misuse issue and 42% of homeless men. Information is recorded on the use of alcohol, cannabis, narcotics and medication. The highest reported use is amongst the rough sleeping population with 75% using at least one substance the most common of which is alcohol. Those under the care of the criminal justice department report the highest use of narcotics and cannabis.
- **Dual diagnosis**: 32% of homeless men and 28% of homeless women report dual diagnosis of mental health issues and substance misuse issues.

Denmark has adopted a principle of universal healthcare, free at the point of contact. Almost 84% of healthcare is publicly funded, the remaining 16% is funded by patients, predominantly in the form of prescription charges.29 As in the UK, GPs are the primary contact for the patient and provide the referral pathway into other specialist services. For individuals not eligible for healthcare, such as refused asylum seekers and undocumented migrants, The Red Cross provides free healthcare and medication at 2 clinics in Denmark through the use of volunteer medical professionals.30

A study into how socially marginalised populations (including homeless people, people with substance misuse and mental health issues) utilise health services in Denmark reported that this population are three times more likely to use the emergency room or be hospitalised when compared to the general population.31

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30 http://newtimes.dk/health-clinics-for-undocumented-migrants-in-denmark/
3.1 Homeless Healthcare: Copenhagen

With a population of nearly 1.3 million, Copenhagen is the largest city in Denmark. According to the 2017 homeless survey there are 1,482 homeless people residing in the city, 61% of which report that they are rough sleeping, staying in a night shelter or in a hostel in comparison to 48% nationally. Copenhagen also has a significantly larger population of people who have experienced long-term homelessness with 42% of the population reporting that they have been homeless for 2 years or more compared to 25% nationally.

Demographic of Copenhagen’s homeless population

Age: less than 1% are under the age of 17; 14% are aged between 18-24; 14% 25-29; 23% 30-39; 24% 40-49; 20% 50-59; and 6% are over 60.

Accommodation Status: 12% of the homeless population are rough sleeping; 8% stay in a night shelter; 41% in a hostel or hotel; 24% stay temporarily with friends and family; 3% are under the care of the criminal justice system or in hospital; and 0.5% are in short term accommodation provided on release from prisons or institutions (11.5% are categorised as other or unexplained).

Health issues: 21% physical health issue; 41% mental health issue; 66% substance misuse issue; 23% dual diagnosis; and 18% no mental health or substance misuse issue.

In 2005 the City of Copenhagen conducted an evaluation of services that had been implemented for homeless people with substance misuse issues, this included completing health surveys and physical examinations with members of the population. The evaluation identified that two thirds of homeless people were not residents of Copenhagen, with the majority originating from other areas of Denmark making it difficult for them to access healthcare appropriately in the city. People were more likely to access the hospital to receive healthcare with 64% reporting that they have no contact with a GP or do not feel they need their own GP. It was also acknowledged that homeless people were most likely to access emergency healthcare for acute problems rather than continual healthcare for the treatment of chronic conditions.

The recommendations of this report influenced the development healthcare delivery services to the most marginalised populations in Copenhagen in order to decrease mortality rates and improve patient outcomes. The model of delivery is to provide low-threshold services for patients with complex needs such as substance misuse, chronic health conditions and mental health issues. These services are supported by a Street Health Team who provide more intensive healthcare support to patients who find it difficult to access the low-threshold services and improve coordination and communication between services.

Street Medicine

SunhedsTeam

The base for the SunhedsTeam is in Sundholm which is south of the city of Copenhagen. Sundholm opened in 1908 as an infirmary for people who were deemed unable to fit into general society and were given work to do based on their capabilities. Whereas previously Sundholm increased exclusion for vulnerable populations today the area welcomes socially marginalised populations and provides numerous services to not only meet the immediate needs of homeless people but also to provide them with support and skills to move out of homelessness (photo 3.1 and 3.2). Owned by the municipality, Sundholm has hostel accommodation for men and women with complex needs; a low-threshold, nurse led health centre; a drop-in café; a community garden; an activity centre; and opportunities for small social enterprises to provide training to socially marginalised people such as the bike repair shop and Bybi, the bee keeping and honey making project.
SundhedsTeam was initially implemented as a pilot project to introduce health outreach to the already established social outreach provided to homeless and socially marginalised by the municipality. Based on the principles of contact, motivation and referral the aim was to find homeless people where they were such as daycentres and hostels, find out about their health needs and build positive relationships with them to encourage them to engage with services. The pilot identified that each person had an average of 13 diagnosed health conditions including chronic diseases, substance misuse and mental health conditions. As a result of the complex health needs of the population and poor engagement with mainstream services in 2005 SundhedsTeam became a permanently commissioned service fully integrated with the municipality homeless services.

Although the team is based at Sundholm (photo 3.3) the service is a primary care outreach service employing 2 Doctors and 4 Nurses, predominantly travelling around the city on bikes the team is commonly known as ‘Nurses on Wheels’ (photo 3.4). The aim of the service is to provide healthcare to patients with complex needs who are not engaged with any health services including the 4 low-threshold clinics in the city. The nurses each work intensively with an active caseload of approximately 15-20 patients providing care where the patient feels comfortable including the streets, additional support is provided from the team doctors. The nurses are responsible for conducting health assessments, engaging patients with medication plans to address their health conditions with the ultimate aim of encouraging the patients to invest in their health by engaging with mainstream health services and paying for prescription medication. The 2 team GPs also provide regular, weekly sessions at drop in centres, low-threshold clinics, shelters and the supervised consumption room as these services are nurse led.

The team work with 150 new patients each year, although no time limit is placed on engagement with the service the average length of time a patient stays under the care of the team is 2 years. Since 2005 the team have worked intensively with over 1,500 patients.

SundhedsTeam Summary

**Staffing:** 2 Doctors and 4 Nurses operating a 5 day service.

**Referral:** Referrals to the team are made by telephone and can be made by anyone, including self-referral from the patient. Referrals are most commonly made by social workers, police, hospital staff, daycentre staff and hostel staff.

**Criteria:** Homeless people with complex needs who, for whatever reason, are not accessing healthcare through the mainstream provision.

**Assessment:** Appropriate referrals to the team are prioritised by need and contact is made with the individual within 7 days and an assessment is undertaken. The holistic assessment includes a health check where vital statistics are recorded along with full medical and social history.

**Common health conditions:** Substance misuse related health problems, mental health problems, infections, TB, Hepatitis C, Hepatitis B, asthma and diabetes.

**Mobile healthcare:** The team travel around the city on bikes and carry rucksacks with medical supplies and equipment including: dressings; limited medications such as antibiotics; stethoscope; BP monitor; and thermometer. Nurses aim to diagnose and treat any conditions they can, GPs provide additional support through physical assessment of the patient arranged by the nurse or can prescribe based on assessment of health conditions via telephone.

**MDT working:** The team work in close coordination with all organisations, statutory and voluntary, that provide services to homeless people to make contact and engage with the patient and to help them to meet all of their health and social care needs. The team form part of the health and social outreach provision for homeless people provided by the municipality and work very closely with the Social Workers that form part of this offer. One of the main objectives of the service is to form a link between the homeless person and mainstream health services including local hospitals, the team can refer patients to the hospital when necessary and arrange follow up appointments.

Photo 3.3 (SundhedsTeam office) Photo 3.4 (team bikes)

http://www.hjemlosesundhed.dk/downloads/Extract%20of%20the%20Health-project%20evaluation%20report.pdf
Low-threshold Clinics

There are 4 low-threshold clinics for homeless and socially marginalised people in Copenhagen. The clinics are nurse led with additional support provided by the SundhedsTeam Doctors.

**Sundholm:** An open access clinic staffed by 3 nurses, open 5 days a week. Patients can drop in for a hot drink, breakfast and shower with the aim to engage them with the healthcare services available. Approximately 60-80 patients attend each day. Common health problems seen at the clinic include wound care, alcohol related injuries, infections, long-term conditions and allergies. Community alcohol detoxification can be provided where appropriate and patients can receive medication from the clinic each day. A Doctor from the Sunhedsteam provides a weekly session.

**Sundhedsrummet:** A 7 day, nurse led clinic situated in an area of high homelessness close to a day centre and the supervised consumption room. Nurse led with support from a social worker, a podiatrist runs three sessions each week and weekly sessions are provided by a GP.

**Hillerøgade:** A nurse led clinic based in a hostel providing healthcare for residents with a GP running one session a week.

**Mændenes Hjem (Men’s Home):** A shelter that provides a range of services for residents and non-residents including health services, supervised drug consumption facilities and a women’s night café. 22 nurses work at the home with GP support once a week.

Supervised Consumption Room

**H17**

Opened in 2016, H17 is the largest supervised consumption room in Europe (photo 3.5). In response to the increase in open drug use in Vesterbro and successful supervised consumption pilots the municipality of Copenhagen wanted to create a safe and inviting place to engage drug users with safe practices and access to support services. The large centre is aesthetically welcoming and use of warm colours, mood lighting, plants and an aquarium serve to create a calm atmosphere in spite of the chaotic nature of population that access the centre (photo 3.6). Users of the service can use any drugs and can remain anonymous if they wish.

**H17 Summary**

**Staffing:** Core staff is comprised of 10 nurses and 5 social workers.

**Opening hours:** The centre is staffed 24 hours but closes from 7-9pm daily for cleaning, in this time users can access the supervised consumption room at the nearby Men’s Home.

**Supervised facilities:** Users of the service can either smoke or inject drugs. There are 8 smoking cubicles with capacity for up to 20 users at a time (photo 3.7). Sessions operate every 30 minutes with users required to have at least a 30 minute break between sessions. There are also 12 cubicles available for injecting drug users (photo 3.8). All areas are glass to ensure that users can be supervised at all times and any equipment required is provided by the centre.

**Healthcare:** The centre has 2 clinical rooms which can be used by the nurses that work there, a GP from the SundhedsTeam also runs a weekly drop in session. Drug workers conduct regular sessions at the centre undertaking initial assessments with people interested in accessing drug treatment.

**Effectiveness of service:** On average 600 smoking sessions and 150 injection sessions are accessed each day with over a million sessions accessed since the service opened. As of June 2017 over 600 overdoses had been prevented, there has also been a reported reduction of 80% in drug paraphernalia being found in the local area.
Medical Respite

Thorsgade Centre

Opened in 2014 the Thorsgade Centre provides medical respite to homeless people for up to 14 days. The centre is managed by The Red Cross with funding from the government and provides 8 beds for both men and women. The respite centre operates as a step-down facility for people leaving hospital and step-up for patients on the street who do not require hospital admission. The estimated cost of 24 hours in the respite centre is 400 DKK compared to 6000-12000 DKK for 24 hours of hospital care. An evaluation of the service reported 75% savings in healthcare costs in terms of reduction in: length of hospital admission; hospital readmission; and missed appointments.

Staffing: Nurse, support workers and volunteers

Referral: hospitals and homeless services.

Healthcare: Dressings; observations; administering medications; and support to attend healthcare appointments. Patients under the care of the SundhedsTeam can receive additional healthcare interventions from them during admission.

Mobile Healthcare

Sociolancen

Although not a typical form of mobile health care to homeless people Sociolancen is an innovative pilot project implemented by the municipality of Copenhagen, launched in December 2015 the pilot is due to end in March 2018. Sociolancen is a mobile van staffed by a paramedic and a social worker and responds to situations where it is unclear if someone needs medical or social help (photo 3.9). The purpose of Sociolancen is to increase support to socially vulnerable people in crisis in Copenhagen by joining up health and social care at the point of contact. It can also reduce the pressure of acute services such as ambulance, police and hospital; It should be noted that Sociolancen is not a replacement for these services but a method of providing additional support to ensure the needs of the patient are fully met.

Operating from 11am-11pm 7 days a week the service can be dispatched directly by call handlers receiving emergency calls or can be summoned by social workers or other emergency services responding to a call. Staff undertake a full health and social assessment of the patient and then agree the most appropriate response which can include providing emergency healthcare and linking in with social care services such as emergency accommodation.

3.4 Lessons from Denmark

- There will always be a cohort of patients who will not engage with healthcare services even with increased provision of low-threshold clinics. In order to fully meet the health needs of these patients a more assertive approach is needed to meet immediate health needs of the individual and to support them to engage with mainstream healthcare services.

- Within the medical respite model there are different ways of delivering care to homeless people. The example in Copenhagen, while not providing clinical care, shows that a safe place to stay with limited interventions is less expensive to establish and deliver but still demonstrates improved patient outcomes and healthcare cost savings.

- As well as providing harm minimisation services to drug users and reducing the impact of public drug use, supervised consumption rooms have the potential to engage people with healthcare services in an environment where they feel comfortable.

- Integrating health and social care in crisis response for vulnerable and marginalised people can help to address the complex health and social needs of the population to improve outcomes and reduce pressure on acute services.
4. USA

4.1 Homelessness and Health in the USA

In the USA homelessness is recorded by assessing the number of sheltered and unsheltered homeless people on one single night\(^{36}\). According to the 2017 Annual Homeless Assessment Report\(^{37}\) on a single night in January there were 553,742 homeless people in the USA, 67% of which were homeless individuals. Of the homeless individuals identified, 48% were recorded as unsheltered homeless, meaning they spent the night in a public or private place not designed for human habitation. Since 2016 the number of homeless individuals has increased by 4% with the cohort of unsheltered homeless individuals experiencing the largest increase with a rise of 12% while unsheltered homeless individuals decreased by 3%.

Demographic of homeless individuals

- **Gender:** 71% of homeless individuals are male; 28.3% female; 0.5% transgender; and 0.2% other gender.
- **Age:** 1.4% are under the age of 18; 10.3% are aged between 18-24; and 88.3% are aged over 24.
- **Ethnicity:** 81.3% non-Hispanic and 18.7% Hispanic.
- **Race:** 52.2% White; 35.9% African American; 6.2% multiple races; 3.3% Native American; 1.3% Asian; and 1.1% Pacific Islander.

Health services in the USA are predominantly funded through private health insurance paid for by employers. In the 1960’s the US government developed 2 programmes to ensure access to healthcare for more vulnerable populations. Medicare is a federal funded programme designed to provide insurance for people over the age of 65 and people with severe disabilities; Medicaid is a joint funded federal and state programme for people on low income\(^{38}\). The Affordable Care Act (ACA) of 2010 aimed to expand the Medicaid programme to increase the number of people who would qualify for support under the scheme and reduce the number of uninsured citizens. Many states did implement the expansion and the number of people nationally without insurance has fallen from 16% in 2010 to 9% in 2016. However, because some states did not opt to expand Medicaid significant inequalities in healthcare access exist between states\(^{39}\).

Homeless people in the USA commonly suffer from complex physical and mental health problems alongside substance misuse issues and according to research have a life expectancy of between 42 and 52 years\(^{40}\). Healthcare is predominantly provided in health centres, drop in services for homeless people and through medical outreach services. The expansion of Medicaid has provided an opportunity to improve engagement with healthcare services by homeless people and has enabled them to access a wider range of services to improve health outcomes. Although the ACA has improved the availability of healthcare to homeless people in some states they do still experience barriers to accessing healthcare. A survey of homeless people reported many have difficulty understanding the programme and are unsure if they are eligible. Access to healthcare is not unlimited or without charge and even small financial contributions can be difficult to make. Lack of access to a phone or the internet can also make the application process difficult\(^{41}\).

**Health Care for the Homeless Program (HCH)**

HCH Program was established in 1985 with the aim to evaluate if a standard model of delivering healthcare to homeless people could improve health outcomes for this population. In 1987 the program received federal funding to expand the delivery of healthcare services and in 1996 HCH was combined with other health centre services for vulnerable people to form the Consolidated Health Centre Program. HCH receives 8.7% of the total budget for the Consolidated Health Centre Program and there are currently over 200 HCH Programs in the USA with at least 1 in every state. Community based healthcare providers that work with low income, vulnerable populations apply to be a HCH Program and if accepted receive annual grants from the HCH budget\(^{42}\).

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\(^{36}\) Physical counting of unsheltered homeless people occurs every 2 years.

\(^{37}\) [https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf](https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf)


\(^{39}\) [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4633529](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4633529)

\(^{40}\) [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4633529](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4633529)


4.2 Homeless Healthcare: Pittsburgh

Pittsburgh, Pennsylvania is the county seat of Allegheny County. In 2016 Allegheny County reported a total homeless population of 1,175. Healthcare to homeless people is provided primarily through health centres including the Health Care for the Homeless Health Centre; low threshold clinics; and mobile healthcare including a street medicine team.

Demographic of Allegheny Country homeless population

Gender: 58% male and 42% female.

Accommodation status: 51% accommodated in transitional housing; 40% in emergency shelters; 5% in safe havens (accommodation for homeless people with severe mental illness); and 4% unsheltered.

Race: 58% Black; 33% White; 7% Mixed Race; 1.4% Hispanic/Latino; 0.6% Asian; and 0.03% Native American.

Health: 43% of the homeless population reported experiencing a mental health problem and 30% reported chronic substance misuse.

Operation Safety Net

Operation Safety Net (OSN) is widely regarded as the organisation that pioneered the Street Medicine model of healthcare delivery to homeless people. In the early 1990’s Dr Jim Withers, Medical Director of Operation Safety Net, enlisted the support of a formerly homeless person and took to the streets of Pittsburgh to meet homeless people who were unable to access care. He aimed to find out about the health of the homeless population, address their immediate health needs, and engage them with healthcare services. Originally funded by the Sisters of Mercy, Operation Safety Net is now part of Pittsburgh Mercy and provides healthcare to homeless people through street medicine, low-threshold clinics and a mobile medical clinic.

In 1992, I began to dress as a homeless person and go out at night with a formerly homeless man to make “house calls” to the people sleeping on the streets of Pittsburgh. My intention was to strip away my medical-control structure and find a way to become a part of the street world. From my work as a faculty member in the Department of Internal Medicine at The Mercy Hospital of Pittsburgh, I was well aware that street people were frequenting our hospital, yet despite our best efforts, their care was usually ineffective. As a medical educator, I wanted to find a classroom on the streets that would force us to work on their terms. In any other setting, those who were able to access our system would always be bending to our structure. I was seeking those who were not able to come to us. I would need to go to them. It soon became a very personal experience.

- Dr Jim Withers (2011)
Street Medicine

The outreach teams at OSN consist of an outreach specialist, support worker and clinical volunteer or medical student who operate a 5-day service, spending the majority of their time locating and building relationships with homeless people across the city of Pittsburgh. This can be by foot visiting people on the streets in the city centre or by car locating people who live in many of the camps in the woods and along the river banks that surround the city. They provide basic care to the people they work with in terms of providing food, water, socks, toiletries and basic medical care supplies. The outreach team report back to the medical team of OSN and they work together to prioritise patients who require medical input from one of the clinicians. The medical team carry first responder backpacks containing all equipment needed to carry out health assessments, wound care supplies and additional medications for physical health conditions. Common health conditions treated by the team include: diabetes, hypertension, COPD, wounds, and asthma.

To ensure consistency in the delivery of healthcare by OSN the equipment and supplies available are the same whether the patient is being seen on the street, in a clinic or in the mobile medical van.

Low-threshold Clinics

In addition to street-based work the OSN team also deliver care at low-threshold clinics such as the Wellspring Centre. The Wellspring Centre is a day centre for homeless adults providing drop in services 5 days a week. From the clinical rooms provided, OSN medical staff provide regular drop in sessions for patients to access physical health services. The Wellspring Centre is also one of the delivery locations for Healthy Housing Outreach (H2O) which is a three year health and social care initiative. The aim is to provide services to help homeless individuals, families, young people, or veterans to access housing, stabilise health conditions and maintain permanent housing. Referrals receive a comprehensive assessment from a network of providers and if accepted are provided with a range of support options to meet their individual needs. Services available include: mental health, physical health, peer support, accommodation support, substance misuse, and benefits support. Services are fully integrated to meet the needs of the client and commit to working together to provide an intensive and assertive response to individual needs with the aim of engaging the client with mainstream services and successfully moving them out of homelessness.

Mobile Medical Clinic

The OSN mobile medical unit is a large van with two clinical rooms and a reception area that provides drop in services to homeless people at set locations across Pittsburgh throughout the week (photo 4.3-4.6). Healthcare provided includes: health checks, vaccinations, wound care, foot care, skin care, and chronic disease management. Staff also complete referrals to other healthcare providers such as mental health, substance misuse, and dental services. Health promotion advice is given and tools to enable self-care such as socks, clothing, toiletries, and sanitary products. Patients who attend can also be linked in with social support services such as housing.

In 2017 OSN worked with over 1,600 people and supported 579 people into accommodation.
4.3 Homeless Healthcare: Lehigh Valley

Lehigh Valley in Eastern Pennsylvania is located an hour north of Philadelphia and an hour and a half west of New York. The three main cities in the region are Allentown, Bethlehem and Easton which cross 2 counties. In 2017 there were an estimated 1,380 homeless people in the region. Increasingly advertised as a commuter area the population of Lehigh Valley has increased significantly over the last few years, this in turn has increased the price of accommodation in the region which has led to an increase in homelessness. With limited shelter beds and poor treatment of rough sleepers in urban areas many of the homeless population are living in secluded woodland areas across the region. This can make it very difficult to access healthcare due to travel distances and the costs associated with this. Research by Lehigh Valley Health Network, one of the main providers of healthcare in the region, identified that between 5-16% of all patients across their 3 hospital sites were homeless.

The Feldmans

Brett and Corinne Feldman, both Physician Assistants, moved to Lehigh Valley in 2005. Aspiring to use their skills to provide care to homeless people in the area they established low-threshold clinics in shelters and soup kitchens across the region in conjunction with DeSales University and run by clinical volunteers. However, they realised that even with this additional provision many homeless people were still facing barriers accessing healthcare. Through a homeless health conference, they learned about the street medicine model of delivery and were put in touch with Dr Jim Withers and the team at Operation Safety Net who provided invaluable advice in supporting them to develop a proposal for a street medicine programme. A successful grant from a local philanthropic trust enabled Brett to spend one day a week implanting the street medicine programme. The success of the programme has led to expansion of the service which now delivers care 5 days a week to the homeless population of Lehigh Valley on the streets; in shelters and soup kitchens; and in hospital through a hospital consult service.

Street Medicine

Since 2014 the Lehigh Valley Street Medicine Program has been a fully integrated service provided by Lehigh Valley Health Network (LVHN). The team consists of a Physician Assistant, a Nurse and an outreach worker who all work full time supported by sessional nurses employed as required. Their ethos is to deliver care where the patient feels comfortable so in addition to the 8 low-threshold clinics they run in soup kitchens and shelters they also provide healthcare directly to patients in camps across the valley (photo 4.7 and 4.8). The outreach worker aims to visit all the main camps on a weekly basis as well as investigating reports of any new encampments. He then directs the clinical staff to patients most in need of their support. To promote access to healthcare the team try to ensure that all patients are supported to gain medical insurance, since 2015 the number of homeless patients with insurance has risen from 24% to 74%. Even for patients without medical insurance LVHN ensure that any patients registered with the street medicine service have their fees waived if they attend one of their hospitals, medication costs for patients are paid for directly by the Street Medicine Program through fundraising and donations to the service. The medical staff undertake health checks using mobile technology such as a pulse reader that connects to a smart phone; provide medication; give health promotion advice; arrange for follow up appointments at local hospitals and provide travel warrants; and use telemedicine to connect patients with specialist healthcare providers which serves to improve patient outcomes and reduces the risk of missed appointments. The Street Medicine Program currently has 1,600 registered patients and works with approximately 1,000 patients each year. Between 2016 and 2017 the team reported a reduction of 45% in emergency department visits from street medicine patients and a 25% decrease in admissions.

Street Medicine Program strongly advocates for the use of the street as a classroom and has developed a strong link with DeSales University Physician Assistant (PA) Program. Students can volunteer at the shelter-based DeSales free clinic which are entirely run by the
students with the support of the Street Medicine Program and financed through their fundraising activities. Students on the PA Program also have the opportunity to join the Street Medicine Team on outreach and can apply to become a regular volunteer.

Street medicine is not intended to be a long-term primary care support. The goal for patients who receive care on the street is to be encouraged to access healthcare at one of the shelter clinics and ultimately transferred to a local primary care provider. There are limited resources on the street to fully meet the needs of the patient, also once a patient has moved out of homelessness it is important to move them out of homeless health services to prevent practitioners from overreaching and to ensure the move out of homelessness is successful. To support this transition the Street Medicine Team work closely with local primary care providers delivering training on the homelessness, homeless health and access to services, along with providing practical advice to enable this to be done effectively. The Street Medicine Team continue to support both the patient and the new provider through the transition by attending appointments with the patient, locating the patient and passing on messages.

In addition to providing primary care service to homeless people, the Street Medicine Program also provide a hospital consult service for patients admitted to local LVHN hospitals. Patients are referred to the team via a pager and a member of the team visits the patient in hospital to complete an assessment. Patient discharge is facilitated and the Street Medicine Team follow up the patient up in the community to ensure healthcare is continued. One of the strengths of the service is that that all LVHN services use the same electronic medical record and have access to all patient notes ensuring consistency of care between the community and hospital services. Between 2016 and 2017 the program reported a 55% decrease in emergency department presentations for hospital consult patients and a 33% decrease in hospital admissions.

4.4 Homeless Healthcare: Boston

According to the 2017 Homeless census the homeless population of Boston was 6,327, the number of homeless individuals was 2,397 of which 186 were unsheltered. The population of homeless individuals had decreased by 29% since the 2016 census. In 2014 Boston’s Way Home was launched, a strategy to reduce homelessness particularly targeted towards chronic homeless individuals and homeless veterans. The strategy has focused on providing additional housing options with resources to support people to access and maintain accommodation. There has also been a focus on coordinating the work of all homeless partner agencies to share resources and prevent duplication of work.

Boston arguably has the most comprehensive healthcare system for homeless people in the world. Boston Health Care for the Homeless Program (BHCHP) was established in 1985 to provide high quality medical care to the homeless population of Boston, originally employing 7 staff BHCHP now employs nearly 500 staff and delivers healthcare to over 12,000 homeless people annually. Under the ethos of ‘Medicine Where it Matters’ BHCHP deliver health services at over 60 low-threshold clinics in shelters and soup kitchens; in a 7 day, drop-in health centre; across 2 hospital sites; through an outreach street team; and in a 104 bed respite facility (Fig. 1).

Dr James O’Connell

Dr James O’Connell joined BHCHP in 1985 as the first full-time Physician and has been instrumental in developing BHCHP into the impressive service it is today. With his guidance medical respite provision has increased from 25 beds in a shelter in 1985 to the current provision of a 104-bed medical respite facility with an additional 20 beds in a step-down respite facility. Working with Massachusetts General Hospital, Dr Jim designed an electronic medical record for BHCHP providing immediate access to the patient care records across all sites ensuring continuity of care to improve patient outcomes and providing one of the largest data resources on homeless health and utilisation of healthcare by this population which has allowed invaluable research to be conducted. Since 1986 he has spent 2 nights a week on a van that travels around the city from 9pm-5am providing food and clothing to homeless people. Rather than directly delivering healthcare this is a way of getting to know the people on the streets, talking to them about their health and engaging with them with the healthcare available to them in the city. In 2015 he published a book Stories from the Shadows: Reflections of a Street Doctor ab-out his experiences working as a Street Doctor for 30 years. He still undertakes weekly street rounds, visiting the patients he has been supporting for years. It is evident that they hold him in the highest regard, speaking to many they all say that they would have died on the street without the support of Dr Jim and his team and commonly refer to him as their friend.

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49 https://harvardmagazine.com/2016/01/street-doctor
Street Medicine

Based at the main BHCHP building (photo 4.9) and co-located with the primary care centre and the medical respite facility, the BHCHP Street Team is comprised of 3 Physicians, 1 Nurse, 1 Case Manager, 1 Recovery Coach, 2 part-time Psychiatrists and 1 Administrator. The team operate a 5-day service with 24 hour out of hours support to patients and health professionals provided by an on call team physician. Although called the Street Team they actually work with a caseload of 900 patients at various stages of homelessness. At any given time they are commonly working with 100 rough sleepers and 800 people with some form of shelter. Homeless people who have complex health needs and are not engaging with other healthcare provision can be referred to the team from a range of providers that BHCHP have developed strong working relationships with over time. Regular weekly outreach sessions conducted by a combination of clinical and non-clinical staff also help to identify new patients. Patients have the flexibility to stay under the care of the team for as long as they feel is necessary regardless of accommodation status.

The aim of outreach is not necessarily to deliver care directly on the streets rather to engage people with their health and the healthcare provision available (Photo 4.30). Patients are encouraged to visit one of the low-threshold clinics and can be provided with travel warrants to enable this; they can be linked into other services to address different health and social care needs; and can be admitted to the medical respite facility if necessary. In addition to street outreach all members of the team make house calls to their patients in more settled accommodation such as Permanent Supportive Housing and Housing First properties. The team all carry laptops which can access the electronic medical record system remotely allowing them to view and update records and provide medication via electronic prescribing.

The Street Team are part of a network of providers that support homeless people in Boston. Each week they attend a number of multi-provider meetings to discuss any issues, create plans for specific patients and share information. In response to the current opiate crisis and the increasing number of overdoses experienced by the homeless population the Street
Team have established a multi-agency working group to coordinate outreach activities, share information, collect data, develop processes and materials for educating homeless patients about the crisis and to offer harm minimisation advice as well as promoting use of narcan (naloxone).

Medical Respite

Barbara McInnis house in Boston’s South End is a 104-bed medical respite facility with 2 wards. Street Team patients are usually referred in following hospital discharge; for stabilisation prior to planned hospital admission; as a result of significant changes in health; or due to frequent presentations at emergency departments. Care across the 2 wards is delivered by 8 teams and each team is comprised of a Physician (MD), a Nurse Practitioner (NP) or Physician Assistant (PA), a Behaviour Worker, a Case Manager and a Pharmacist. One of the teams is led by a Physician from the Street Team and all Street Team patients are placed under the care of this team during admission. The NP or PA is responsible for the care of the patient Monday-Friday with input from the MD on a weekly basis through ward rounds. Ward rounds are used to work with the patient to treat medical conditions by ensuring the patient understands what is going on with regards to their health and their treatment and a plan is formulated to access follow up care in the community post discharge. It is also an opportunity to facilitate a safe discharge by finding out what the patient wants and trying to find appropriate options depending on need and eligibility. The Case Manager puts in applications for long-term options such as accommodation and rehab and tries to find suitable short-term options accessible on discharge. Length of admission is usually 2 weeks although Street Team patients often require a longer admission due to their complex health conditions and social situations. Barbara McInnis house also has capacity to provide palliative care for any homeless patient who need this service.

Mobile Medical Clinic

Bridge Over Troubled Water (BOTW) are a partner of BHCHP and deliver a range of service to homeless young people. In addition to emergency accommodation and a drop-in centre they also have a mobile van with a clinical room (photos 4.11 and 4.12). The van is taken out 5 days a week and used as a means of providing a safe space for homeless young people to access advice and support. Young people are encouraged to engage with the triage healthcare services that are delivered by BHCHP and clinical volunteers.
4.5 Homeless Healthcare: New York City

In 2017 New York City had the highest homeless population of all cities in the United States with a population of 76,501\(^{50}\). Of this 75% were members of homeless families living in homeless shelters where the average length of stay was 429 days. In December 2017 the total number of homeless individuals living in shelters was 16,259, 74% of which were male and 26% female\(^{51}\). Official statistics report the unsheltered population of New York City is 5% of the total homeless population (AHAR 2017).

To access the shelter system in New York a person or family must present at the assessment centre that corresponds with their situation. They will stay there for up to 72 hours at which point they are transferred to an assessment shelter where they are commonly accommodated for 6 months before moving to a

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**Photo 4.11** (BOTW van on Boston Common)

**Photo 4.12** (clinical room in the van)

**Fig. 2** map detailing CFHNY service locations (CFHNY 2016)
next step shelter. Due to the scale of the homeless population and the size of the city there are multiple providers of healthcare to homeless people. Care for the Homeless New York (CFHNY) are the largest provider of healthcare services to homeless people in New York, they deliver care to approximately 8,000 homeless people each year across 5 of the 4 New York boroughs. Established in 1985 services provided include: primary healthcare; shelter accommodation; behavioural health; dental care; substance misuse services; mobile medical clinic; specialist services for HIV and Hepatitis C; health education; and peer support (fig. 2).

Low-threshold Clinics

Working on the Patient Centred Medical Home model, where services are coordinated by the health centre to address the health needs of the person in a timely manner and in a way that they understand, CFHNY has health centres at 25 locations in New York. Clinical and non-clinical staff provide services at different sites which operate from 1-5 days per week. The majority of clinics can be divided into 2 categories, open access health centres or shelter-based health centres.

Open Access Health Centre

Part of the Solution (POTS): is a drop-in centre providing support to local people living in poverty. The health centre located in the basement has 7 clinical rooms and is open from 8am-4pm Monday-Friday. Primary care services provided by CFHNY include: full health assessments, wound care, vaccinations, screening, dispensing prescriptions, chronic health care, first aid, and medication compliance monitoring. They can also store medication for rough sleepers. 3 of the clinical rooms are dental suites utilised by the New York University Dental School who provide care to patients and use the clinic as a teaching opportunity not only to provide students with examples of extreme dental conditions but also to help them to gain skills in engaging patients to complete treatment plans and empathetic care.

St John’s: is a large day centre in Brooklyn that provides 1,000 meals per day to people from the centre and through a mobile soup kitchen as well as a wide range of advice and support services. CFHNY provide primary healthcare 3 days per week from 2 clinical rooms. In addition to the standard primary care services they also provide substance misuse treatment, rapid HIV and Hepatitis C testing and mental health services.

Shelter-based Health Centre

Susan's Place: is a 200-bed shelter located in The Bronx for women with mental health issues. Residents are encouraged to register with the health centre and can access clinical services 5 days a week delivered by a team which includes: Physician; Nurse; Medical Assistant; Case Manager; and Health Educator. Patients receive a full range of primary care health services and can be linked into specialist services at the local hospital.

Peter Jay Sharp residence: is a 74-bed shelter run by the Doe Foundation for men who have recently been incarcerated. The shelter offers vocational and training programmes which hopefully lead to full time work. Ready, Willing and Able is the programme. The CFHNY clinic is open 5 days a week to deliver primary care and psychiatric services to residents. In addition, they also provide substance misuse treatment and HIV and hepatitis C treatment.

All health centres are additionally resourced by members of the Health Education team and the CFHNY Peer-to-Peer Outreach Program.

Health Educators: plan and deliver a range of health promotion events across the CFHNY sites to engage homeless people with healthcare, provide information on how to improve health and manage certain conditions and empower people to take control of their health. At Susan’s Place they ran a day session for the women on breast cancer screening. The day started with a health education session in the shelter living room informing women of the importance of checking breasts, how to do it properly using a model and myth busting. Health Educators encouraged women to sign up for appointments at the clinic where a Nurse and MD were conducting health checks and breast exams and referring women to mammogram services at the local hospital.

Peer-to-Peer Outreach Program (PPOP): Peers are people who are either currently a CFHNY service users or have been in the last 12 months. Launched in 2015 the program aims to recruit, train and employ peers, once employed they receive a weekly stipend and a monthly metrocard which doesn’t affect their welfare entitlement. Peers are based at all CFHNY services and work to build relationships with homeless people and engage them with healthcare by promoting the services provided, accompanying to appointments and following up with patients who miss appointments.

Mobile Medical Clinic

CFHNY have a large medical van (photo 4.13) which has 2 clinical rooms, a reception and a small waiting area that provides MDT drop-in health services at a variety of locations across the city. 4 days a week from 8am-4pm. The van is equipped with a computer which has remote access to the electronic medical record system so patients can be registered and seen immediately. The van is often located in areas of high homelessness such as outside hostels and PPOP peers work to engage homeless people with the healthcare on offer.
Street Medicine

The Centre for Urban and Community Services (CUCS) is part of a coalition of 3 organisations who provide homeless services in Manhattan over 3 distinct catchment areas. As part of the many services provided by CUCS their medical program, Janian Medical Care, delivers psychiatric and medical services to sheltered homeless people and vulnerable people in permanent housing. In 2016 they expanded their offer of healthcare to include the delivery of healthcare at street level. A Nurse and a Nurse Practitioner work with a caseload of 100 unsheltered people who are referred by Case Managers across all 3 catchment areas. These are typically patients with a high level of physical and mental health need who predominantly access healthcare through the emergency room. Common health conditions treated by the team include: wound care, diabetes, hypertension, cellulitis, and COPD. The role of the service is to build relationships with the patients, conduct a full assessment of health need, engage the patient with a medical treatment plan and link the patient into community services.

4.6 Lessons from the USA

- High quality healthcare to homeless people can be delivered in a variety of community-based settings and street medicine services can be implemented as a legitimate healthcare delivery model. Consistency in healthcare can be maintained through establishment of clear protocols that ensure that healthcare delivered is standardised irrelevant of the setting.

- Street Medicine is not just about delivering healthcare to homeless people on the street. Central to the model is providing the opportunity for clinicians to engage with homeless people where they are and where they feel comfortable to build trust and form effective therapeutic relationships.

- Although assertive healthcare provision to homeless people can demonstrate clear benefits, the aim should be to transition homeless people to mainstream healthcare settings for the benefit of the patient and to prevent overburdening services. Establishing relationships with mainstream healthcare providers and delivering training in homeless health can ensure a successful transfer of care between providers and maintain patient engagement.

- Electronic medical records can provide a wealth of data on the health needs of homeless people and their utilisation of health services. This information can be used to improve service delivery and identify gaps in healthcare. Integration between primary and secondary care electronic medical records can improve patient safety through continuity of care. This can be particularly beneficial for people with complex health needs who struggle to communicate effectively with healthcare providers.

- Promoting student involvement in the delivery of healthcare to homeless people provides a unique opportunity for students to not only experience first-hand extremes of poor health but also develop skills in the activation of patients who find it difficult to engage with healthcare. Building relationships with homeless patients promotes compassionate care which is essential learning experience for students no matter what field they enter in to.
Conclusion

Through my Fellowship I discovered that the health needs of homeless people and the barriers they face accessing healthcare were similar in all the areas I visited. All of the services I had the opportunity to visit had established models of delivery for healthcare to homeless people that met at least one, if not all of the aims set out at the beginning of this report. The most effective services I observed during my Fellowship were those that provided as many opportunities for homeless people to access healthcare as possible and had developed services responsive to the specific needs of their homeless population. While the experience of homelessness and healthcare structures differed in each of the areas I visited there were some common principles that can be transferred to the delivery of healthcare to homeless people in the UK:

- Homeless healthcare requires a specialised approach that is proportionate to the level of need within the population.

- Where healthcare services are not engaging with homeless people that is a failure of the healthcare system and innovative ways of providing healthcare must be sought.

- Any delivery of homeless healthcare should sit within mainstream healthcare services.

In addition to health and social care skills there are specific values that underpin effective delivery of homeless healthcare, in particular commitment to reducing health inequalities, compassion, and advocacy. The Fellowship provided me with the opportunity to spend quality time with inspiring individuals and organisations who have fought for access to healthcare for homeless people, while all demonstrated incredible passion for the work they do they also all acknowledge that this is incredibly difficult and challenging work. While healthcare delivery may not always relieve homelessness the driving force behind their ongoing effort is that without access to quality healthcare their patients would die so they do the best they can to support homeless people to live longer and healthier lives.

“Don’t worry about the people in the waiting room, worry about the people who aren’t”

- Dr Jim Withers
Recommendations

1. Bring healthcare to homeless people: In order to effectively engage homeless people with healthcare and reduce health inequalities healthcare should be delivered by mainstream providers but in a setting where the patient feels comfortable. This can be achieved through implementation of street medicine teams, mobile health clinics and low-threshold healthcare services co-located with other services for homeless people. In order to maximise resources services should be should be developed and delivered in partnership with other organisations. Barriers to creating innovation in healthcare delivery should be minimised through support of the NHS, the Care Quality Commission and healthcare commissioners. Building on the learning from the recent article: What works in inclusion health: overview of effective interventions for marginalised and excluded populations\(^2\) as well as the latest version of the Homeless and Inclusion Health Standards for Commissioners and Service Providers\(^3\) homeless healthcare delivery would benefit from the production of NICE guidelines using evidence based medicine from homeless healthcare services in the UK and overseas.

2. Transition to mainstream healthcare settings: Although outreach and low-threshold services are a useful tool to engage homeless people with healthcare the goal should always be to link patients in with mainstream services. A clear pathway for homeless people should be created where both patients and new healthcare providers are supported by homeless healthcare services. Co-management of patients should be encouraged between healthcare providers to fully support the patient during the period of transition.

3. Ensure healthcare professionals have access to training in homeless health: For the transition of care for a patient with experience of homelessness to be effective healthcare providers should receive training in the complex nature of homelessness and specific health needs of the population. Training in early identification of risk factors associated with homelessness can also help health professionals to develop homeless prevention strategies for their patients.

4. Increase involvement of students in homeless healthcare: Meaningful opportunities for health and social care students to work with homeless patients should be established. As future health and social care providers this experience can ensure they have a clear understanding of the complex nature of homelessness and imbed in them the principle of compassionate care. While bespoke placements provide students with the chance to observe good practice, opportunities where students are able to directly apply the skills they are developing to the care of homeless patients can be hugely beneficial.

5. Use peers to promote engagement with healthcare services: The use of people with lived experience of homelessness is common in service across the UK; However, there are few examples of their application in a healthcare setting. If developed and manged appropriately peers have the capacity to use their unique perspective to build trust between patients and healthcare providers. This is also an opportunity for peers to develop skills and experience that can help them to move on and can serve as positive role models for the patients they support.

6. Utilising the potential of electronic medical records: As opposed to many other countries the standardisation of the use of electronic medical records in primary care in the UK provides the potential to effectively report on the health needs of the population. With correct use of coding the UK has the capacity to one of the richest data sets of homeless health in the world. Anonymisation of this data could be used in research to report on health needs, mortality trends and utilisation of healthcare services in the homeless population which could be used to inform healthcare strategy. Correct coding of risk factors associated with homelessness can ensure patients are provided with support in a timely manner which could prevent homelessness in the future. Integration of medical records between primary and secondary care has the potential to benefit all patients through continuity of care to improve patient safety. As high users of secondary care services this would be particularly beneficial for homeless patients and would identify gaps in community provision.

7. Expansion of medical respite services: the provision of step-up (from the community) and step-down (from hospital) respite services for homeless individuals would have a positive impact in reducing A&E attendances, unscheduled hospital admissions, number of bed days and hospital readmission rates within this population. Models of medical respite differ in scope and cost and options should be considered based on the level of need within the population determined by hospital data on the utilisation of acute services by homeless people. In addition to improving health outcomes for homeless people medical respite services also provide a platform for patient-centred integration of health and social care services.

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\(^2\) https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31959-1/fulltext?code=lancet-site

Appendix: Full itinerary

Oslo
12/06/17 — 18/06/17
Services visited:
- Frelsesarmeen Gatehospitallet
  Borggata 2 (Medical Respite)
- Frelsesarmeen Feltpleien
  Urtegata 16a (Low-threshold clinic)
- Fransiskushjelpen
  Enerhauggata 4 (Mobile health centre)
- Kirkens Bymisjon 24/7
  Tollbugata 3 (Low-threshold clinic)
- Prinsen mottakssenter
  Storgata 36c (supervised consumption room and Low-threshold clinic)
- Frelsesarmeen Jobben
  Heimdalsgata 27 (work experience centre for people with substance misuse)

Copenhagen
18/06/16 — 25/06/16
Services visited:
- Sundhedsteam, Sundholmsvej 18
  Street Team base
- Sundholm, Sundholmsvej 18
  Low-threshold clinic
- H17, Halmtorvet 17
  Supervised consumption room and low-threshold clinic
- Sundhedsrummet, Halmtorvet 9D
  Low-threshold clinic
- Thorsgade Centre, Thorsgade 61
  Medical Respite
- Hillerødsgade, Hillerødsgade 64
  Low-threshold clinic
- Kofoeds Kælder, Frederiksberggade 1A
  Drop-in centre for young homeless people
- Hellebro, Haydansvej 2
  Drop-in centre for young homeless people with low-threshold clinic
- WeShelter, Gl. Køge Landevej 137A
  Men’s hostel
- Fedtekælder, Øvengaden oven Vandet 6A
  Homeless daycentre
- Hus Forbi, Bragesgade 108
  Homeless Newspaper office with low-threshold clinic
- Skæve Boliger
  accommodation for people who do not fit mainstream housing environments

Pittsburgh
24/09/17 — 27/09/17
Services visited:
- Operation Safety Net, 249 South 9th Street
  Low-threshold clinic and Street Team base
- Wellspring drop in centre, 903 Watson Street
  Low-threshold clinic
- Mobile Medical Unit, 202 Stanwix street
  Mobile health centre

Lehigh Valley:
27/09/17—30/09/17
Services visited:
- Lehigh Valley Health Network Street Medicine Team,
  1628 West Chew Street
  Street Team base
- Lehigh Valley hospital
  1200 south cedar crest boulevard
  (Hospital consult service)

Boston
30/09/17 — 8/10/17
Services visited:
- Boston Health Care for the Homeless Program, 780 Albany street
  Low-threshold clinic and Street Team Base
- Barbara McInnis House, 780 Albany Street
  Medical Respite
- Massachusetts General Hospital, 55 Fruit Street
  Low-threshold clinic

New York
8/10/17 — 17/10/17
Services visited:
- Care for the Homeless New York, 30 East 33rd Street, NY
  Organisation HQ
- Susan’s Place, 1911-21 Jerome Avenue
  Low-threshold clinic
- POTS Health Centre, 2759 Webster Avenue, Bronx
  Low-threshold clinic
- Nelson Health Centre, 1605-11 Nelson Avenue, Bronx
  Low-threshold clinic
- St John’s Health Centre, 795 Lexington Avenue, Brooklyn
  Low-threshold clinic
- Peter Jay Sharp, 89-111 Porter Avenue, Brooklyn
  Low-threshold clinic
- Living Room Health Centre, 800 Barretto street, Bronx
  Low-threshold clinic
- Wards Island Health Centre, 1 Wards Island, New York
  Low-threshold clinic
- Manhattan Outreach Consortium, 593 Columbus Avenue, Manhattan
  Street Team base