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Homeless healthcare: a missing component in medical training?

Medics should be equipped with knowledge and skills that can help them provide equitable care to homeless people, writes Lydia Shackshaft

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Homelessness is rising in the UK and hospital attendances by people experiencing homelessness are increasing correspondingly.[1 2] Yet medical education currently leaves junior doctors feeling uninformed and underprepared to care for this group of people, raising the question of whether it's time for homeless healthcare, or the broader field of inclusion health, to become a core component of medical training.

Crisis, a UK homelessness charity, estimated that 242 000 people in England experienced the most acute forms of homelessness in 2022, reflecting a 17% increase in 10 years.[1] These trends are mirrored in hospitals: emergency department attendances by homeless people trebled in seven years, from 11 305 people in 2010-11 to 31 924 people in 2017-18.[2]

Newly graduated doctors will increasingly encounter patients who are homeless during their careers and will need an informed understanding of the health problems this group faces disproportionately. People who are homeless are more likely to experience systemic barriers to accessing healthcare, such as GP practices incorrectly refusing their registration because they lack a permanent address, inflexible appointments, digital exclusion, healthcare systems that are difficult to navigate, and embarrassment or fear of health settings after negative experiences of stigma and discrimination.[3 4] This adds to practical, individual barriers such as travel costs, poor mobility, and the need to prioritise sourcing food, money, and shelter over health. These health inequalities contribute to homeless men having a mean age of death of just 45.4 years and women 43.2 years.[5] Medics have a duty to equip themselves with this knowledge so that they can do more to provide equitable care.

In my experience, however, medical students in the UK receive a somewhat "superficial" education on social determinants of health. My peers and I at medical school knew that socioeconomic deprivation affected health in several ways, were familiar with the concept of "adverse childhood experiences," and could recite that Westminster and Canning Town—separated by just eight stops on the Jubilee Line— have a seven year disparity in life expectancy.[6] But with medical students disproportionately coming from affluent backgrounds,[7] I question whether our limited academic knowledge is sufficient to facilitate any meaningful level of understanding, which I'd argue is key to compassionate care.

Shattered prejudices

I had elective placements in two primary care centres for homeless people that emphasised how limited my understanding of this patient group was. Unlike my other clinical rotations, where the interactions I had with homeless patients were cursory and brief, these placements allowed me to purposefully engage with this population. Every story shared with me deepened my understanding of how intricately linked experiences of early life trauma, involvement with the criminal justice system, childhoods spent in care, or relationship breakdown were to homelessness. And every individual that I met shattered prejudices that I wasn't previously aware I'd even held.

"Trauma informed care" has become a buzzword in healthcare, but the phrase took on new meaning for me during these placements. The difficulties homeless people would have in forming trusting relationships with healthcare professionals, their limited access to and engagement with healthcare services, and cycles of frequent attendances at emergency departments, commonly related to drug and alcohol use,[8] made sense in the context of their lived realities. Medical students are in the privileged position of having the time to listen to patients' stories and gain their trust. If we are to tackle the stigma that homeless people experience trying to access healthcare, then providing all students with the opportunities in their clinical placements to have more meaningful interactions with this patient group is a logical first step.

Understanding the biopsychosocial model of health

Clinical placements in homeless healthcare can equip doctors with the understanding to provide empathic and non-judgmental care, but they can also help students to identify practical ways they can minimise inequalities in their future practice. This might include ensuring that patients receive safe discharge planning, with feasible follow-up care that takes into account their psychosocial context. It also cements students' knowledge of their responsibilities to support the social care and accommodation needs of homeless patients,[9] including their "duty to refer" someone who is homeless or threatened with homelessness to a local housing authority for assistance under the Homelessness Reduction Act 2017.[10 11]

More broadly, the skills that medical students gain from working in inclusion healthcare settings

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(healthcare services for socially excluded groups who face multiple risk factors for poor health, stigma, and discrimination)[4] are also widely applicable to all specialties and settings. This branch of medicine offers students deeper insight into the interactions between healthcare, social care, and the law; helps them identify their legal and moral responsibilities as clinicians to support patients' social wellbeing; and develops students' confidence in advocating for patients. Experiences in inclusion healthcare can also help students to develop a deeper comprehension of the biopsychosocial model of health, highlighting how social factors can be central to someone's illness or recovery.

The NHS is founded on the principle of providing healthcare that is universally available to all, free at the point of delivery, and based on clinical need.[12] Can we claim to be providing truly equitable care when so many barriers to accessing healthcare remain for people without a permanent home? Improving access to care for this group requires systemic and attitudinal change. For this change to be meaningful and sustainable, it needs the understanding, enthusiasm, and commitment of those entering the profession. This begins with education: it is time that homeless healthcare became a core component of medical training.

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1 Fitzpatrick S, Bramley G, McMordie L, et al. The homelessness monitor: England 2023. Crisis. July 2023. https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/homelessness-monitor/england/the-homelessness-monitor-england-2023/

2 Iacobucci G. Homeless people's A&E visits treble in seven years. *BMJ* 2019;364:. doi: 10.1136/bmj.l323. pmid: 30665940

3 Gulland A. "I didn't want to be known": finding healthcare when you are homeless. *BMJ* 2016;355:. doi: 10.1136/bmj.i6511. pmid: 27932320

4 NHS England. A national framework for NHS—action on inclusion health. October 2023. https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

5 Breen P, Butt A. Deaths of homeless people in England and Wales: 2021 registrations. Office for National Statistics. November 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations

6 Nuffield Trust. Health for London. Framework for Action. 2007. https://www.nuffieldtrust.org.uk/sites/default/files/2019-11/1575037889_darzilondon.pdf

7 Steven K, Dowell J, Jackson C, Guthrie B. Fair access to medicine? Retrospective analysis of UK medical schools application data 2009-2012 using three measures of socioeconomic status. *BMC Med Educ* 2016;16:. doi: 10.1186/s12909-016-0536-1. pmid: 26759058

8 Paudyal V, Ghani A, Shafi T, etal. Clinical characteristics, attendance outcomes and deaths of homeless persons in the emergency department: implications for primary health care and community prevention programmes. *Public Health* 2021;196:-23. doi: 10.1016/j.puhe.2021.05.007. pmid: 34182257

9 National Institute for Health and Care Excellence. Integrated health and social care for people experiencing homelessness: NICE guideline [NG214]. March 2022. https://www.nice.org.uk/guidance/ng214

10 Homelessness Reduction Act. 2017. UK Public General Acts 2017. https://www.legislation.gov.uk/ukpga/2017/13/contents

11 UK Government. A guide to the duty to refer. 2018. https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer

12 Delamothe T. Founding principles. *BMJ* 2008;336:-8. doi: 10.1136/bmj.39582.501192.94. pmid: 18511796

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