

# Meeting the healthcare needs of people experiencing homelessness and accessing healthcare services

## Abstract

People experiencing homelessness have unique health promotion and healthcare needs. This article allows nurses working with this client group, or who access their services, to understand the needs faced by homeless people and to recognise how best to meet these. A number of key projects in the UK are highlighted, as examples of how nurse-led models and innovative practice can improve the healthcare experience of this client group, through a sensitive, partnership approach.

## Introduction

This article has been written to help nurses and other healthcare professionals understand the complex backgrounds and support needs of people experiencing homelessness and who may access their services. It also profiles the highly specialist role played by physical health nurse practitioners that provide assertive outreach to street homeless individuals, and uses their experience to explain how to work effectively with individuals that may at first seem 'hard to engage'.

## Increasing homelessness in the UK

Homelessness in the UK has consistently increased since 2010. As an example, the number of people seen rough sleeping in London increased 136% from 3,673 in 2009-2010 to 8,096 in 2015-2016, and during the same period the number of national Local Authority statutory homelessness cases increased from 89,120 to 114,780 (Crisis, 2017). Reasons for this are complicated but include changes in welfare reform, hostel closures, a lack of housing stock, and increasing numbers of people with immigration issues.

Local authority monetary cuts have also played a part in making 'Housing Options' departments (the local government services that newly homeless people will be directed to) less responsive. A mystery shopper exercise (Crisis, 2014) illustrated the problems homeless people have accessing accommodation. Actors were asked to present at local authorities with one of 4 typical homeless stories, to try to make a homelessness application. In 50 out of 87 cases the person received little or no help. This included a domestic violence victim directed to a phone that did not work, and a person with learning disabilities and mental health problems being told to fill in form even though he told them he couldn't read and write. Nevertheless, it is important to understand that Local Authorities face huge challenges with a real terms budget cuts of 26% since 2010 (IFS, 2016), and 1,155,285 people on LA housing lists in the UK in 2017 – with some local areas having over 25,000 households on their lists (data.gov.uk accessed 2017).

A new Homelessness Reduction Act will become law in April 2018. This Act will convey new duties on Local Authorities to give advice to all people experiencing homelessness, regardless of whether they can prove a 'local connection'. (A person has a 'local connection', if they can evidence that they have lived in the area for a certain period of time. Local Authorities only

have a 'relief duty' or housing duty for people that can prove a local connection.). It is hoped that this Act will help bolster the support that is currently available from Local Authorities.

However additionally, the new Act conveys a duty to certain health services (e.g. inpatient services and A&E) to refer homeless patients for appropriate advice on their housing situation. Many services are currently unaware of this, and it is hoped that this article will help practitioners to assist their organisations in meeting this challenge.

### **Identifying people experiencing homelessness in health care environments**

When people are asked to consider the plight of individuals or families that are homeless they often think immediately of people sleeping rough on the streets, or of families living in bed and breakfast or hotels. However, many more types of people are 'homeless', and some of these are described as 'hidden homeless', largely because they are not counted in government statistics. (see Box 1).

#### **Box 1: Who is homeless?**

- People sleeping rough
- Single homeless people living in hostels, shelters and temporary supported accommodation
- Statutorily homeless households / families – households who have had housing assistance from a local authority due to having no accommodation. These families will be living in some form of temporary accommodation
- 'Hidden homeless' individuals and households – a wide variety of people who do not get counted in government statistics. This includes people living in severely overcrowded conditions, squatters, people 'sofa-surfing' with friends, family or acquaintances, boat dwellers without permanent moorings, people who sleep on buses, or spend their nights in 24-hour fast food restaurants, gypsies and Travellers who are not on designated sites, and people living in non-residential buildings like sheds, and factories.

In health care environments, staff will often not know whether a patient is homeless, unless that person has actively chosen to disclose this, or has no address that they can provide, so they need to register as "No Fixed Abode". People experiencing homelessness often try not to disclose their homelessness in health care, because they think it will affect their rights to access to care. An example of this is evidence that many GP practices will not allow patients without address ID to register, despite the fact that lack of ID should not be a barrier to GP

registration (Doctors of the World, 2015). Patients may often be embarrassed regarding their homeless status.

Indeed, as noted from Box 1, many currently homeless people will actually have a current address, and some others will have made arrangements for care of addresses. This combined with the fact that some patients actively hide their homelessness, means that healthcare staff often miss an opportunity to signpost individuals to where they can receive housing and welfare advice, social support, and healthcare.

### TIME OUT EXERCISES

1. Imagine for a moment that you have become a 'hidden' homeless person. Would you feel embarrassed? Who would you tell? List all the things that might be difficult e.g. storing belongings, washing, receiving mail, charging a mobile etc.
2. Think of the service that you currently work in. Do you think you know how many people experiencing all types of homelessness your service currently sees? Would it be possible to find this out? Who would you ask?
3. NHS London has currently brought out 'My rights to Registration' cards to distribute to homeless people to help them with GP registration which say 'I have a right to register and receive treatment from a GP practice. I **do not** need a fixed address. I **do not** need identification. My immigration status **does not** matter.' Does this surprise you? Research the guidance that supports these cards.

### Homelessness is bad for your health

Homeless people present health management challenges that relate to tri-morbidity – the co-concurrence of physical health care, mental health care and addictions problems (Hewett et al, 2012). Homeless Link (2014) reported that 80% of homeless people self-reported a mental health condition (although only 45% had been diagnosed with one), and 36% reported taking illicit drugs in the last month compared to 5% of the general population. The existence of addictions and mental health problems can often have a dramatic effect on outcomes. For example, a large-scale study of the death certificates of homeless people (Crisis, 2011) calculated the average age of death of homeless men to be 47 years of age, and homeless women to be 43 years of age. In this study, a third of deaths were caused by drug and alcohol abuse, and the study showed that homeless people are 9 times more likely to commit suicide than in general population.

However physical health care problems are still a key cause of morbidity and mortality - which can be partly attributed to so called 'lifestyle factors'. For example, one survey (Homeless Link, 2014) suggested that 77% of homeless people smoke. Poor nutrition is also a contributing factor, with high carbohydrate, high fat food being cheap and commonly available. Alcohol and drugs also seriously affect physical health. As a result, homeless people are 2.5 times more likely to have asthma, 5 times more likely to have a stroke, 6 times more likely to have heart disease, and 12 times more likely to have epilepsy than the general population. They are also more likely to have co-morbidity - more than one condition. (Story, 2013).

Infectious diseases are also common. In the UK, the prevalence of tuberculosis (TB) is reported to be 34 times greater in homeless people than in the general population, and the prevalence of hepatitis C viral infection is reported to be approximately 50 times greater. HIV prevalence has been found to be 1-20 times higher in homeless populations in the US than in the general population, but there are no UK studies. (Beijer, U et al, 2012).

As a result of tri-morbidity people experiencing homelessness often need high levels of support. Homeless people are also often very transient (in many cases not of their own volition), and this can add to this challenge of managing their health. However, for a variety of reasons homeless people access treatment less. For example, it is estimated that only 3% of homeless people with Hepatitis C receive treatment. (Story, 2013) Obviously in the case of Hepatitis C, not providing adequate screening and management services presents a real public health risk.

A recent article published in the medical journal The Lancet, built on previous work and concluded that homeless individuals, prisoners, sex workers, and individuals with substance use disorders have significantly worse health outcomes, and conclude that women have an all case standardised mortality ratio of 11.86 and men of 7.88 (Aldridge et al, 2018). A partner article outlines evidence of which health interventions work and are recommended for these types of patients (Luchenski et al, 2018).

### **TIME OUT EXERCISES**

1. Think of your current service. Would you be able to assess all the health needs that a homeless person might currently be struggling with? If not, how would you ensure that their needs were being met?
2. Are there any specialist homeless health services in your area? If so, find out where they are, and what services they provide.
3. Many people on low incomes who are not entitled to benefits, are still entitled to an HC2 card which entitles them to free NHS prescriptions, dental treatment and opticians care etc. Research how to support a patient to get an HC2 card on the NHS Low Income Scheme.

### **Homelessness and mental capacity**

Practitioners working with people experiencing homelessness have to be experts in assessing mental capacity. A person lacks mental capacity if they are unable to make or communicate a decision because of an 'impairment of, or a disturbance in the functioning of mind or brain'. The 'impairment' or 'disturbance' may be caused by a variety of factors, including mental illness, learning disability, dementia, brain damage or intoxication. (Mental Capacity Act, 2015). Mental capacity decisions are situation specific, and in homelessness often relate to a person's decision not to seek treatment, or leaving a health care environment before completing treatment.

In homelessness a number of factors may be affecting an individual's mental capacity. Diagnosed or undiagnosed mental illness is common, and a particular challenge may be the incidence of personality disorder - it is estimated that 70% of single homeless people suffer from personality disorder (more recently called complex trauma), versus about 4% in the general population (Maguire, 2009). Individuals with personality disorder may be totally unwilling to engage in mental capacity assessments, largely due to mistrust (which is frequently a result of genuine repeated 'let downs' both as a child, and in adulthood).

Traumatic and/or acquired brain injury is also common, and in one recent study 45% of homeless people had a traumatic brain injury (Topolovec-Vranic, J et al, 2014). Brain injury may occur as a result of trauma, or as a result of chronic alcohol consumption, but is often a combination of both. Brain injury generates cognitive deficits, but these often go undocumented if a patient is often under the influence of alcohol – making cognitive deficits harder to assess.

### **Box 2: The Mental Capacity Act**

The Mental Capacity Act (2015) contains a two-stage test of capacity:

1. Is there an impairment of, or disturbance in the functioning of, the person's mind or brain?

And then question 2...

2. Is the impairment or disturbance sufficient that the person is unable to make that particular decision?

Under this test, a person is regarded as being able to make a decision if they are able:

- to understand the information relevant to the decision;
- to retain the information relevant to the decision;
- to use or weight the information; and/or
- to communicate the decision (by any means).

Specialist guidance on undertaking mental capacity assessments with rough sleepers is available:

<http://www.pathway.org.uk/services/mental-health-guidance-advice/>

Educational factors may also contribute. A St Mungo's study in 2014 showed that 51% of homeless people lacked the basic English skills needed for everyday life, compared to 15% of the general population in England. St Mungo's is a UK based charity and housing association working with homeless people and those at risk of homelessness. A prior Thames reach study in 2010 identified that dyslexia and other mild learning difficulties were common, with 10%

of clients being totally illiterate. Thames Reach works directly in the UK with homeless people on the streets and in hostels. Undiagnosed learning difficulties are common in this population. They have often gone unidentified as these individuals have often been out of school from an early age, and have sometimes had mental health difficulties and substance misuse conditions that have complicated the picture.

### **TIME OUT EXERCISES**

1. Are you familiar with the Mental Capacity Act? If not, find out more about this generally. E.g. do you know who can undertake a Mental Capacity Act assessment?
2. Think about how you would effectively document a mental capacity act assessment in your clinical notes. Find examples of Mental Capacity Act screening tools that could help you.

### **Homeless health services**

Given the information above it is unsurprising that many specialist homeless health services exist, particularly in city areas. Specialist services including NHS commissioned 'homeless' GP services, homeless physical health community nursing teams, homeless community mental health teams, homeless hospital discharge teams, health visitor services for homeless families, homeless medical respite and 'end of life' care services, services provided in Home Office accommodation, and 'lone worker' posts that have developed in response to local need. There are also a small number of non-commissioned voluntary sector posts.

Many homeless health services are delivered in partnership with local voluntary sector providers of day centres, hostels, and street outreach services on non-NHS sites. This generally requires the writing of Service Level Agreements, and detailed consideration regarding the responsibilities of both partners, however it allows greater access to populations that are 'harder to reach', and enables better relationships between health care and support staff.

For more information on careers in homeless healthcare please contact: [www.pathway.org.uk](http://www.pathway.org.uk)

### **TIME OUT EXERCISE**

1. In general, it is known that people who are currently rough sleeping prefer to access specialist services, but there is an argument that mainstream services should be able to meet the needs of people experiencing homelessness. Do you think that specialist services are needed now? What about in a future NHS?

### **Physical health care outreach**

Several physical health care outreach services have recently been developed in response to local need in London. Examples of three services are described by their Service Leads in the service description boxes to help readers conceptualise what this work involves, and one case study of the type of work undertaken is provided.

## **SERVICE 1**

*Westminster Homeless Health Service by Nicky Tanner, Lead Nurse*

Westminster Homeless Health Team is a community healthcare team that provides nurse practitioner led primary health care clinics in day centres and hostels in Westminster. The team extended their remit to include street outreach work in 2014. There are two street outreach shifts, both delivered in partnership with Westminster City council outreach workers. One shift is delivered weekly at 6am - walking together to either the north or south locality of the borough to do opportunistic outreach. The other shift is provided fortnightly, around and inside the church of St Martin in the Fields in Trafalgar Square. This is a mid-morning shift outreaching homeless people with apparent health issues, who are not currently accessing homeless day centres or health services. As well as being paired with the outreach worker, nurses wear 'Skyguard' alarms, and carry work mobile phones. Outreach intelligence on current and known clients displaying difficult or dangerous behaviour is available at the beginning of shifts. The teams see 14 people per week on average on early shifts, and 2-5 on church shifts, although these clients often take longer to work with.

Nurses give out information sheets and contact cards (providing addresses and maps of outreach clinics in day centres), and introduced 'health packs' in 2016 for both humanitarian and engagement reasons. Packs contain space blankets, a toothbrush and toothpaste, soap, a notepad and pen, condoms and sanitary towels for women. In the summer water bottles and sunblock are also provided. Nurses don't carry clinical equipment, other than a small selection of emergency dressings.

Health packs are used to start a conversation. Nurses use "Language Line", an interpretation service, on their mobile phones where needed – in central London sometimes three quarters of rough sleepers that the team approaches are of non-UK origin. The team starts from the client's perspective, and tries to let clients lead the conversation and voice their own concerns. However, core questions are asked where possible. Does the person have current GP? How do they currently use health services, and do they know where outreach clinics are provided? What would help them access services? Do they have any serious concerns now?

Clients are escorted directly to day centre clinic sites if this is needed, and they are willing. Previously this was difficult (when day centres with local authority funding were unable to allow homeless people through their doors who did not have a local housing connection), but this restriction has eased off in recent times.

Documenting outreach contacts can be difficult. Some people seen on outreach will be already known to the team, but others won't and this can be a challenge. Some people on the streets are totally unwilling to give any details, and may be documented by the outreach team as 'older lady with trolley on the corner of Duke Street' or similar. In this case paper notes are kept until details are discovered.

Outreach is felt to be important because it shows an approachable face of the NHS to many people who have often had bad experiences. Anecdotally the team knows that these shifts bring many people into the service, and help get people engaged with healthcare.

## **SERVICE 2**

### *Great Chapel Street Medical Centre by Maxine Radcliffe, Lead Nurse*

Great Chapel Street Medical Centre has been undertaking street outreach in central London since the early 1980's. Since 2012 this has been nurse-led.

On opportunistic outreach visits, the nurse accompanies local authority outreach or outreach mental health teams on their street outreach rounds to chat to people experiencing street homelessness about healthcare, and encouraging them to register with the practice. This street contact encourages some people to attend the practice who otherwise wouldn't. It is very common for people to later attend the practice, but then wait for the practitioner they met on the street to see them, demonstrating that these initial street contacts can have a huge impact. The nurse gives out small access cards to patients, that mean they don't have to explain anything when they get to reception - they just get booked in with the right clinician.

Nurses also go out on targeted visits looking for specific people who are unwell, at the request of other clinicians or local authority outreach teams, who are worried that a person has a serious physical health problem. Some treatments can be given on the streets if necessary. Some cases involve safeguarding e.g. a recent case where a heavily pregnant woman remained on the streets for a variety of complex reasons, and was refusing treatment for a sexually transmitted infection that was transmissible to the foetus. Medication for the STI was able to be prescribed and administered by the nurse on outreach, and a relationship built to enable the woman to engage with a specialist midwife.

In response to a practice concern about the lack of pick-up of homeless women, the practice undertakes nurse outreach into a homeless women's day centre with a high number of vulnerable migrant women. GP registration, health screening and treatment for minor illness and injuries are all offered at the site as a 'welcome' into the practice. This has significantly changed the demographic of the practice from roughly 10% of the practice population previously, to 30% being female now.

### **SERVICE 3**

*Guys and St Thomas' Health Inclusion Team HITPlus service by Kendra Schneller and Serina Aboim, Nurse Practitioners*

The Health Inclusion Team is a community healthcare team that provides nurse practitioner led primary health care clinics in homeless day centres and hostels across Lambeth, Southwark and Lewisham. Street outreach is still in its infancy, takes place in Southwark only, and started in 2016. Outreach takes place on the 2nd Friday of every month, in partnership with the Southwark council commissioned Southwark Population Outreach Team. Target clients are identified at a meeting earlier in the week, where specific target outcomes are agreed. Outreach is undertaken in a car, and starts between 6.30 and 8.00am. Initially outreach was started with the intention of providing clinical interventions to clients from an outreach van, but it was quickly decided that this was unrealistic for a variety of reasons, and that practical alternatives existed (see later).

Contacts start with a general conversation with clients - getting to know their personality/likes/dislikes etc. It is also useful to examine client's expectations when they find out they are being visited by a nurse – being clear about what can and cannot be done. Nurses provide on-the-spot triage and immediate signposting into services, general health service information, health education and promotion. Nurses also carry a rucksack with a limited supply of equipment/stock. Basic observations can be undertaken, and clients can be provided with prescriptions by nurse prescribers or medication via PGD's if necessary.

Clients of concern can be conveyed immediately by car to a hub (one of the Health Inclusion Team hostel clinic rooms) by prior agreement with those hostels (clients do not have to have a prior relationship with the hostel) - health assessments, venepuncture, and wound care can be undertaken, and vaccinations administered.

Alternatively, agreement with a local interested GP practice (Melbourne Grove Medical Centre) has allowed any client perceived to have acute medical needs to be seen immediately in one of two pre-booked 30-minute appointments. Outcomes include appropriate engagement with primary care, and acute admission avoidance.

The team nurses see between 2-11 clients per outreach shift. Usually between 1-5 clients have their specific outcomes achieved on each shift.

This project has recently received a small amount of innovation funding from the Queens Nursing Initiative Homeless Health Initiative: <https://www.qni.org.uk/explore-qni/nurse-led-projects/homeless-health/>

## **INDIVIDUAL CASE STUDY:**

Mary was an older lady with a past complex history of abuse and trauma, and no family. As a result, she had come to feel that she “did not deserve to be inside”.

When the street outreach nurse first made contact with Mary, she had already spent 9 years living on a bench by the Thames in all weathers. She collected anything she could find on the streets to assist her, and had numerous bags and packages with her. The local street outreach team had raised concerns regarding both her physical and mental health.

On the first of many nurse outreach visits, Mary she said didn't want any help at all, but was happy to chat. At this stage she was judged to have mental capacity, but concerns regarding her vulnerability were evident. As a result, after this first contact, the nurse gradually developed a relationship with Mary based largely on the provision of hand creams (which Mary was happy to accept) and drinking cups of tea together. Over time it was established that the nurse would visit for a chat, bring some 'nice hand cream', and then check her pulse and hydration levels.

Gradually the nurse built up a picture of Mary's key physical and mental health concerns, which included incontinence, suspected pressure sores on her buttocks, and possible schizophrenia, presenting with negative symptoms, as well as a clear evidence of self-neglect.

Eventually Mary deteriorated, and clear concerns regarding her mental capacity were evident. By this time a relationship of trust had been built, and a joint visit to the bench was arranged with the specialist outreach Psychiatrist. Mary was admitted via Mental Capacity Act assessment to a physical health hospital (supported by the nurse), and after this went to mental health hospital on a Section 2 (and later Section 3). Mary was found to have extensive gynaecological issues and anaemia on admission, as well as an underlying urinary tract infection. She was doubly incontinent and had extensive tissue damage from years of sitting wet in the cold wind. She was later diagnosed with a severe and enduring mental illness (schizophrenia with negative symptoms).

Mary now resides on a community treatment order in a supported housing setting.

## **Networking to improve practice - what has been learnt?**

The London Network of Nurses, Midwives and Health Visitors Homelessness Group is a voluntary group of inclusion health practitioners that meet bi-monthly in London to support each other and share best practice ([www.homeleshealthnetwork.net](http://www.homeleshealthnetwork.net)).

This group recently met in late 2017 to discuss effective street outreach service strategies and develop guidelines for other practitioners planning to develop similar services. The guidance is split into 3 areas: Planning services, Engaging clients and Maintaining Safety.

### *Planning services:*

Effective planning is the key to success. It is important to learn from others, and to clearly understand the need that is presenting. Activities to undertake in the planning stage are:

- Visit other outreach services to understand different types of delivery
- Ensure the organisation's Lone Working Policy is up to date and covers outreach
- Ensure the organisation's insurance covers outreach, and be clear about what activities this includes
- Establish clear partnerships for service delivery e.g. with the Local Authority and voluntary sector
- Try to understand the need in depth. Why is the need for outreach arising? Do other services need to change? What are you hoping to achieve by delivering outreach services?
- Being clear about the outcomes of your service, and whether the primary aim is opportunistic contacts (to bring people into services) or targeted work (to individuals that are known not to engage with services)
- Try to have access to a clinic room or GP practice to be able to bring people into if necessary
- Ensure staff have a strong understanding of the mental capacity act, and are able to apply it autonomously
- Consider who the service might need to refer to, or get on the spot advice from, and ensure this contact information is available to all staff
- Think clearly about how you will document opportunistic encounters, and encounters with clients with no name / those who do not want to give a name
- Have strategies in place to avoid duplication of services, and maximise communication with other outreach services
- Contingency plan for the unpredictable (i.e. do not plan for heavy clinics in a service immediately after an outreach shift without adequate staffing available)

### *Engaging clients:*

Outreach services could also be called engagement services, in that this is their core purpose. As such staff need to be expert engagers. Strategies for staff to adopt in order to develop their engagement skills might include:

- Discuss target clients with partners in advance where possible to understand the particular concerns / issues the client may have, and to agree an approach that might work
- Be prepared to experience hostility and not personalise this – clients may be very mistrustful, and be used to being ‘let down’ by others, or meeting workers that can do nothing for them - be prepared to leave if the client does not want to engage, but if you plan to return to try again, let them know this.
- If a client is bedded down and asleep consider the options (preferably discuss the response in this eventuality beforehand). Depending on the history for some people it may be better to respect a clients’ personal space and return another time. Consider leaving written notes if this is possible. If the plan is to wake someone engage verbally and gently and watch someone’s body language carefully as they wake.
- Allow conversations to start with the client’s agenda, establishing what is important to them first. This is probably the most important strategy, and is evidence based (Luchenski et al, 2017)
- Have something to give if possible (e.g. cups of tea, toothbrushes, hand creams, health packs etc). This also helps to build relationships.
- Be prepared to accept hospitality, if it is safe to do so. Be prepared to ‘take a seat’ down on someone’s level, and accept e.g. a drawing or a wrapped sweet if they want to give you one (the sweet can always go in your pocket for ‘later’).
- Ensure a consistency of approach between staff – any lack of consistency and clients will very quickly only engage with the workers who they believe are better or who will give more
- Be clear about expectations on both sides from an early stage, and be clear about the limits of what the service can do
- Make sure staff do what they say they are going to do
- Make sure staff don’t make promises they can’t keep
- Remember it takes time to build rapport and results may not come quickly

#### *Maintaining safety:*

Outreach work can be a daunting prospect, and it is vital that staff feel safe, and understand how to maintain their boundaries.

- Ensure staff fully understand the Lone Working policy and are adequately insured for the work they will undertake.
- Ensure that staff and partners have an agreed method of assessing risk - preferably using an agreed risk assessment checklist – and that consequent decision making is documented.
- Ensure staff always go accompanied and never deviate from this
- Staff should carry both a phone and personal alarm. Ensure phones are fully charged. Staff should risk assess going into areas without a phone reception.
- Have adequate support / supervision available allow for reflection and learning and prevent burn out / exhaustion in staff
- Consider rotation of staff to prevent burnout

A final consideration when setting up an outreach service regards recruitment. This comment from outreach Nurse Practitioner Kendra Schneller sums up the type of nurse that might be needed to do outreach work.

‘You need to be resilient, innovative, creative, and be able to not take things personally. It is an emotional job, but there needs to be an ability to not become emotionally involved. This type of nursing is not black and white, and you have to often think outside of the box as long as you remain within ethical and moral guidelines.’

## **TIME OUT EXERCISES**

1. Think about the case study profiled. Do you think street outreach was needed, and what do you think it achieved?
2. Consider the section on ‘Engaging clients’ above. Think of a patient you may have had that had been labelled difficult. They do not have to have been homeless. Is there anything you think you could now do differently?

## **Summary and final thoughts**

People experiencing homelessness often experience barriers to health care and complex health needs which means they may benefit from specialist health care services. Specialist health services need thought to design and deliver, but can be extremely rewarding if delivered sensitively and thoughtfully.

However, homelessness is increasing throughout the UK, and people experiencing homelessness need mainstream services, so the Time Out exercises in this article are relevant to nurses working in all settings. It is often felt that people experiencing homelessness are actually a test of well-functioning health system i.e. if a mainstream health service is meeting the needs of homeless clients it is working.

The new Homelessness Reduction Act will convey health services to refer homeless patients for appropriate advice on their housing situation. This will hopefully enable more people to find routes out of homelessness. It is hoped that this article has started preparing you to think about the changes this might mean for your service and how they can be met.

### **Important websites**

**Streetlink** – use the Streetlink website to refer a rough sleeper in your area to your nearest outreach team. Homeless people can also self-refer <https://www.streetlink.org.uk/>

**Homeless UK** – use the Homeless UK website to find services which support homeless people in your local postcode area <https://www.homeless.org.uk/>

### **TIME OUT EXERCISES**

1. The Homelessness Reduction Act is due to become law. What could you do to help your service ensure it will be able to refer homeless people for advice appropriately.

### **What if I want to know more?**

The London Network of Nurses, Midwives and Health Visitors Homelessness Group meets bi-monthly in London, holds an annual conference, and welcomes specialist and non-specialist practitioners including students.

<http://homeleshealthnetwork.net>

The Queens Nursing Initiative Homeless Health Initiative hosts lots of resources and has national teaching events <https://www.qni.org.uk/explore-qni/homeless-health-programme/>

The London Homeless Health Program hosts useful resources on-line:

<https://www.healthylondon.org/homeless/our-work>

The Faculty of Homeless and Inclusion Health is free to join a multi-disciplinary clinical network that sends out inclusion health updates including alerts about publications / new evidence in the sector:

<http://www.pathway.org.uk/faculty/join/>

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