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Homelessness and Healthcare

There was a silver lining of the Covid-19 lockdown in the UK, for homeless people, with the implementation of the "Everyone in scheme" in March 2020. The scheme offered unconditional housing for homeless individuals and people sleeping rough. While effective for some - with 37,000 people given emergency accommodation - the scheme failed to support people's healthcare needs and ostracised the most vulnerable.

As our understanding of medicine has grown, healthcare systems have become focused on managing individual organ systems rather than treating the patients holistically. For patients with complex needs, defined by NICE as "people needing a high level of support with many aspects of their daily life and relying on a range of health and social care services", navigating an ever-specialising healthcare service becomes even more challenging.

While it is recognised that these patients are the majority rather than the exception in primary care settings, currently there is very little research on how best to support these individuals. Often, patients are managed on a case-by-case basis, leading to fragmented care and many individuals left "falling through the cracks". People experiencing homelessness often fall in this category of complex needs. It is well established that homeless individuals are at a greater risk of negative health and social outcomes, with an average life expectancy of 45 years for men and 43 for women (according to the study conducted by the UK national office of statistics in 2018), due to disproportionally high levels of chronic conditions (cardiac problems, long-standing TB and hepatitis) as well as severe mental health problems. In addition to the pitfalls encountered by patients with complex needs, people experiencing homelessness face the discrimination and the burden associated with having a dual diagnosis (defined as concurrent drug use and mental health problems).

With the onset of Covid-19, the already atomised and hard-to-access resources for people experiencing homelessness and struggling with complex needs in the UK have been stretched to breaking point. While funding for housing was increased (at least during the periods of lockdown), funding for (healthcare) support was not managed in the same way. Many services implemented strict eligibility criteria for treatment or moved online. To access mental health support, for instance, patients are often required to remain clean (off drugs); to access drug and alcohol services their mental health must be stable.

During periods of Covid-stress, without sufficient external support, many individuals relied on drugs or prescription medication as a coping strategy for managing their mental health -leading them into the same vicious cycle.

Additionally, with strict quarantine orders, streets were empty, meaning individuals were no longer able to supplement their income with begging to obtain the drugs they needed. This often lead to more desperate behaviour (and crime). As a result of "disobedience" or "misbehaviour" vis-à-vis institutional lockdown rules, people were evicted altogether from support institutions to protect "the majority" inside. The consequence? Many of the most vulnerable patients were back on the street and further marginalised from healthcare (and housing) provision.

For those who were able to access services, shifting from face-to-face consultations to digital platforms has left many feeling alienated, unable to use the digital services and concerned for their privacy. While the service benefited a small proportion of individuals who would otherwise not engage, the lack of suitable technology and inadequate training made it impossible for a big group to access the support they required, leaving underfunded non-profit organisations to fill in the gaps.