



The
HEALTH CARE
experiences of
**HOMELESS
PEOPLE**
in Essex

healthwatch
Essex



EXECUTIVE SUMMARY

Across the UK, it is estimated that more than 250,000 people are homeless or lack a permanent place to live. From 2010 to 2016 rough sleeping has increased by 134% (from 1,768 to 4,134 people). It is estimated that there are approximately 3,000 homeless people in Essex.

Background

Evidence shows that homeless people are far more likely to experience poor health and die younger compared to the general population. Previous research on homeless people's lived experiences of interacting with health care services and professionals describes significant challenges with accessing care service. Discrimination, poor previous experiences with services and professionals (including being disrespected, stigmatized, invisible and labelled) and lack of compassion on behalf of professionals resulted in loss of confidence in services and withdrawal from society.

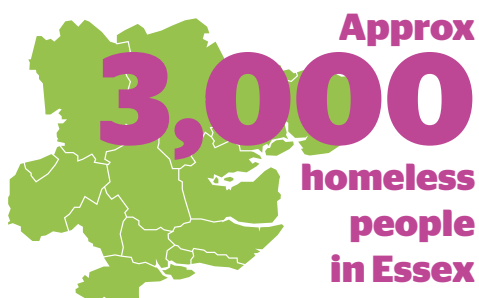
Homelessness services provide much needed support and shelter to homeless people; they also often encourage engagement with public services. However, there has been very little research into how homeless people experience the care they receive from mainstream NHS health care services in Essex, and whether being in contact with homelessness services affects the care they receive from mainstream NHS services.

Methods

We recruited 22 individuals who were in contact with homelessness services in Chelmsford (CHESS) and Colchester (Beacon House) and asked them to complete a Pictorial Technique of Care (PTC) to identify the range of services and professionals that participants were involved with. Participants were then asked to take part in one semi-structured interview which focused on their views and experiences of interacting with mainstream health care services. The average age of participants was 39.4 years (age range 24-61). All participants but one reported their ethnicity as white British.



250,000
homeless in the UK





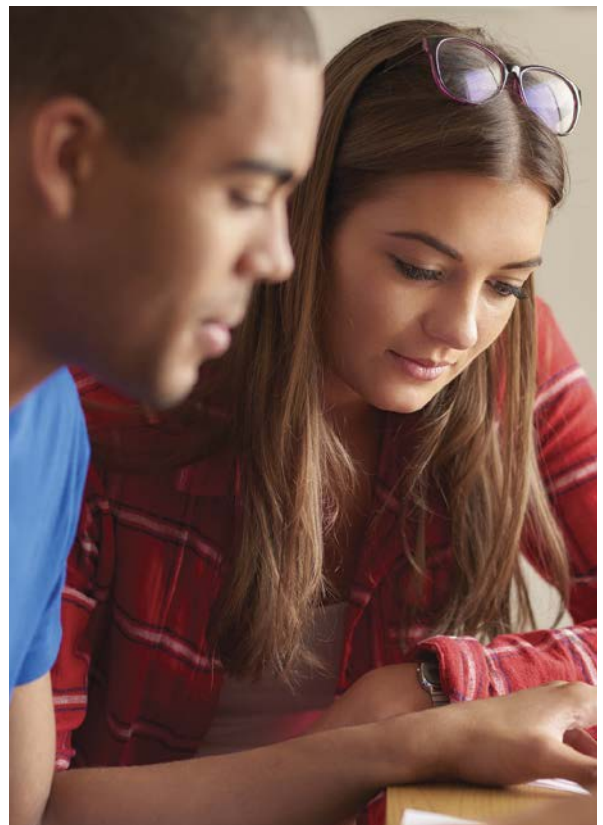
Findings

Participants' self-reported interactions with health care organisations indicated that they were satisfied with their interactions with health professionals when they had visited them for a physical health problem. Over the 6-months that the PTC covered, participants' rates of contact with mental health services were non-existent, with the in-house counsellors and GPs providing the majority of mental health care.

Participants talked about a range of physical and mental health problems affecting their health and overall well-being. Whereas the majority of participants reported that it was easy to access services for physical health problems, a large proportion of participants reported difficulties with accessing mental health care. A few participants reported that they had not received any mental health care despite experiencing serious mental health problems. Participants talked favourably and were more likely to visit health care professionals who were non-judgemental, were willing to listen to their concerns, offered practical advice and made onward referrals to specialist services. Participants valued relational continuity, however only a small proportion reported that they had been able to see the same GP. Continuity of care was particularly problematic for people who moved across different levels (e.g. from GP to specialist care) and locations of care (from prison to community care).

Conclusion

Our participants appeared to prefer services that were tailored to homelessness; those which have a flexible structure, provide longer consultations and offer drop-in sessions. They also talked favourably about professionals who were non-judgemental, listened and acknowledged their concerns and showed empathy. Healthcare professionals, service providers and NHS commissioners need to take into account such characteristics when they design services in order to make them accessible to homeless individuals. ■



“ A few participants reported that they had not received any mental health care despite experiencing serious mental health problems. ”

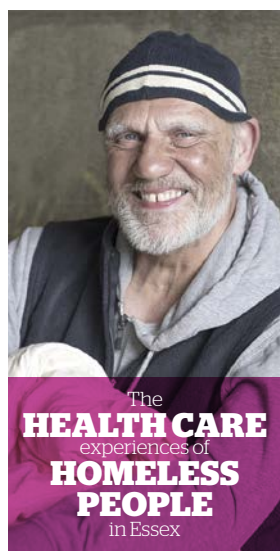
Recommendations for GPs interacting with homeless individuals

- 1.** During your clinical encounter with a homeless individual use your everyday human skills; listen and acknowledge what they have brought to you, show them that you have heard their concerns by explaining to them any actions that you intend to make or not.
- 2.** Do not assume, but ask how they experience their lives. It is very likely they have experienced several personal and social problems which could negatively impact their physical and mental health and psychological well-being. Explore together which of these problems you can treat and which you need to make onward referrals for.
- 3.** While exploring their concerns, avoid making assumptions about the roots of their concerns. Instead, ask open questions. Use expressions that will permit them to talk about themselves. This will allow rapport and trust to develop between you. Make sure that they are comfortable discussing these issues.
- 4.** Rather than viewing homeless people as having multi-morbidity, view them as having complex experiences and behaviours that are not well described by the diagnostic manuals (for mental health).

Recommendations for NHS commissioners and service providers commissioning and delivering services respectively for homeless individuals

- 1.** Support and promote the delivery of flexible services for homeless individuals. Flexibility around opening hours and length of the clinical consultation are important elements that facilitate access to services.
- 2.** Increase the availability and facilitate access to primary care mental health services (e.g. Improving Access to Psychological Therapies) for homeless people.
- 3.** Strengthen the primary and secondary care interface; many participants experienced poor continuity of care, particularly those participants who required specialist care from mental health services.
- 4.** Homelessness services positively affect homeless peoples' contact with mainstream NHS services. We therefore recommend providing practical and financial support to these services to assist them with continuing their important work.
- 5.** Develop and support systems that promote the integration of services (e.g. health, social care, drug and alcohol, housing, and criminal justice) for homeless people.

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1. THE RESEARCH STUDY

This report presents a research study that is focused on service users' experiences; the study examined how people who use homelessness services in Essex experience the care they receive from mainstream NHS services, and whether the care they have received is well-coordinated or not. Additionally, we set out to explore whether contact with homelessness services affects the healthcare that service users receive from mainstream NHS services.

Across the UK, it is estimated that more than 250,000 people are homeless or lack a permanent place to live. In Essex, it is estimated that there are approximately 3,000 homeless people (based on information from local authorities, number of places available in night shelters, refuges, and floating support). The number of hidden homeless, such as sofa surfers or squatters, is hard to estimate, but it's estimated to be high. National and local evidence shows that compared to the general population, homeless people have significant and complex physical and mental health needs, and report high rates of substance use. Despite their significant health and care needs, homeless people experience challenges in accessing and receiving high quality care.

While evidence exists for the high rates of physical and mental illness in the homeless population in Essex, there has been very little research into how homeless people perceive the care they receive from mainstream NHS health care services. Identifying and gaining an in-depth understanding of the issues and factors that affect access, quality and the co-ordination of care that homeless people receive, can provide valuable insights to health and social care commissioners, as well

as service managers to develop and design more appropriate and responsive mainstream services. Within this context, Healthwatch Essex's research team turned its focus on the health and care experiences of the homeless people in Essex in order to assist clinical commissioners and service managers with developing services tailored to the needs of homeless people.

Examining peoples' views, identifying the actions they take and exploring their views of services and professionals can also provide valuable insights for health policy makers and clinical commissioners into peoples' experiences of health, illness and care. In this study, we carried out interviews to collect peoples' views and experiences of accessing and interacting with homelessness and mainstream health care services, as it allowed for the exploration of personal meanings and the capturing of multiple realities that may exist for people.

The study, which was conducted between May - June 2017, was carried out in two homelessness services. One in Chelmsford (CHESS) and the other in Colchester (Beacon House). ■

2. HEALTHWATCH ESSEX: WHO WE ARE AND WHAT WE DO

This research project has been conducted by Healthwatch Essex (HWE), an independent charity with responsibilities under the Health and Social Care Act (2012) to provide a voice to the people of Essex regarding health and social care services. The research team conducts high quality academic research on the “lived experience” of patients, social care users, and citizens, to inform improvements in local health and social care commissioning and provision.

Health policy makers and clinical commissioners plan and fund services using information from a range of sources, such as clinical knowledge (e.g. what health professionals know about diseases), experimental evidence (e.g. what is the best medicine for a particular disease), and public and patient feedback and choice (e.g. how people experience an illness and the care they receive from services). The role of Healthwatch Essex is to assist both local government and NHS commissioners to develop and improve services (including primary and secondary health services as well as social care services) by investigating how the people in Essex understand illness, how they interpret their experiences, and whether the care they receive meets their needs. To gain an insight in peoples' experiences of health, illness and care, we use a range of methods: for example, we distribute questionnaires, we carry out individual interviews, and/or organise discussions with groups of people (e.g. focus groups). However, care is not delivered in a

vacuum; healthcare professionals and the wider system of care (e.g. emergency and community hospitals, health policy) play a vital role in how care is planned and delivered, and therefore, they influence how patients and service users experience care. Hence, our focus is also placed on services; we explore what professionals think about the care they deliver, which and how different factors affect care quality, and how health and social care professionals believe that services could be improved to meet service users' care needs. ■



3. BACKGROUND

3.1. Defining homelessness

Defining homelessness is not straightforward. There is some confusion about the matter, as people can be considered homeless even if they have a place to live. Initially, homelessness was conceptualized on a continuum, from sleeping rough at one extreme to living in insecure accommodation at the other. More recent definitions have identified four broad conceptual categories: rooflessness, houselessness, living in insecure accommodation, and living in inadequate accommodation. In 2004, the European Typology on Homelessness and Housing Exclusion (ETHOS) developed a comprehensive typology, which illustrates that rooflessness, the category that attracts the most media and political attention, is only the 'the tip of the iceberg' (**Table 1**).



Living in insecure accommodation

In England, the statutory definition of a homeless person has been set out in Part VII of the Housing Act 1996, which states that a person is homeless if the following conditions are met:

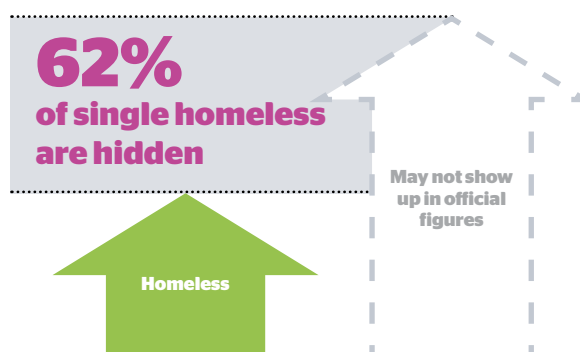
- 1. A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he:**
 - a. is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,
 - b. has an express or implied license to occupy, or
 - c. occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession.
- 2. A person is also homeless if he has accommodation but:**
 - a. he cannot secure entry to it, or
 - b. it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it.
- 3. A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy.**

“ In this report, we use Essex County Council’s definition of homelessness, which is closely aligned to ETHOS and to the national definition of homelessness. ”

Table 1. ETHOS - European typology on homelessness and housing exclusion

Conceptual category	Operational category		Living situation	
Roofless	1	People living rough	1.1	Public or external space
	2	People staying in a night shelter	2.1	Night shelter
Houseless	3	People in accommodation for the homeless	3.1	Homeless hostel
			3.2	Temporary accommodation
			3.3	Transitional supported accommodation
	4	People in women’s shelter	4.1	Women’s shelter accommodation
	5	People in accommodation for immigrants	5.1	Temporary accommodation, reception centres
			5.2	Migrant workers’ accommodation
	6	People due to be released from institutions	6.1	Penal institutions
			6.2	Medical institutions
			6.3	Children’s institutions/homes
	7	People receiving longer-term support (due to homelessness)	7.1	Residential care for older homeless people Supported accommodation for formerly homeless people
Insecure	8	People living in insecure accommodation	8.1	Temporarily with family/friends
			8.2	No legal (sub)tenancy
			8.3	Illegal occupation of land
	9	People living under threat of eviction	9.1	Legal orders enforced (rented)
			9.2	Repossession orders (owned)
	10	People living under threat of violence	10.1	Police recorded incidents
Inadequate	11	People living in temporary/ non-conventional structures	11.1	Mobile homes
			11.2	Non-conventional building
			11.3	Temporary structure
	12	People living in unfit housing	12.1	Occupies dwelling unfit for habitation
	13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding

Source: Amore, Baker, & Howden-Chapman, 2011, p.28



In this report, we use Essex County Council's definition of homelessness, which is closely aligned to ETHOS and to the national definition of homelessness: "A household either lacking accessible, physically available accommodation that the householder is entitled to occupy; or a household with accommodation that is unreasonable to continue to occupy" (Joint Strategic Needs Assessment, 2014, p. 10).

The definitions presented above show that there is a broad consensus that the term 'homelessness' includes more living situations than a person not having a roof over their head. It also includes people who, even though they live in a house, have accommodation which is not safe or adequate to occupy. Hidden homelessness is the concept used to describe people who are homeless but they do not show up in official figures, because they find temporary living accommodation by staying with family members or friends, or squatting.

In England, local councils have a statutory responsibility to help people who are homeless or threatened with homelessness. However, not everyone who becomes homeless or is threatened with homelessness is entitled to be housed. Certain conditions need to be met before a council can help an individual/family to find somewhere to live. These are: 1) that they meet the immigration status requirements, 2) are accepted as homeless, that is they meet the statutory definition of homelessness, 3) that they are in a 'priority need' category, and 4) they have not become homeless intentionally.

In this study, we recruited and talked to people who were in contact with homelessness services, and therefore, likely

to experience different living situations (e.g. roofless, houseless, or living in insecure accommodation). In sub-section 4.3 we present a more detailed picture of our participants' living arrangements.

3.2. A national picture on homelessness

As previously mentioned, across the UK, it is estimated that more than 250,000 people are homeless or lack a permanent place to live (Shelter, 2016). National statistics estimate that from 2010 to 2016 rough sleeping has increased by 134% (from 1,768 to 4,134 people) (Homeless Link, 2017). Levels of rough sleeping vary by region, with Westminster reporting the highest levels in 2016. According to Homeless Link,¹ approximately 4,100 people are estimated to be sleeping rough on any one night. Statutory homelessness has also increased over the last six years. From 2010 to 2016, statutory homelessness increased by 20% (from 97,000 in 2010 to 116,000 homeless applications in 2016) (Homeless Link, 2017). In 2016, local councils accepted less than 50% of the homeless applications they received (from 116,000 they accepted 56,000 applications). More than half of the homeless applications were rejected because applicants (households) were not deemed to be homeless. Hidden homelessness is much harder to estimate, though in 2004, it was estimated that there were as many as 380,000 hidden homeless people in Great Britain (Reeve & Coward, 2004). A recent survey carried out by Homeless Link (2017) indicates that about 62% of single homeless are hidden and therefore may not show up in official figures.

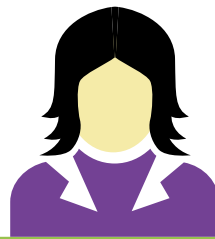
¹ Homeless Link is a national membership charity for organisations working directly with people who become homeless in England.

Is John counted as homeless?

Is Monica counted as homeless?



or



= No

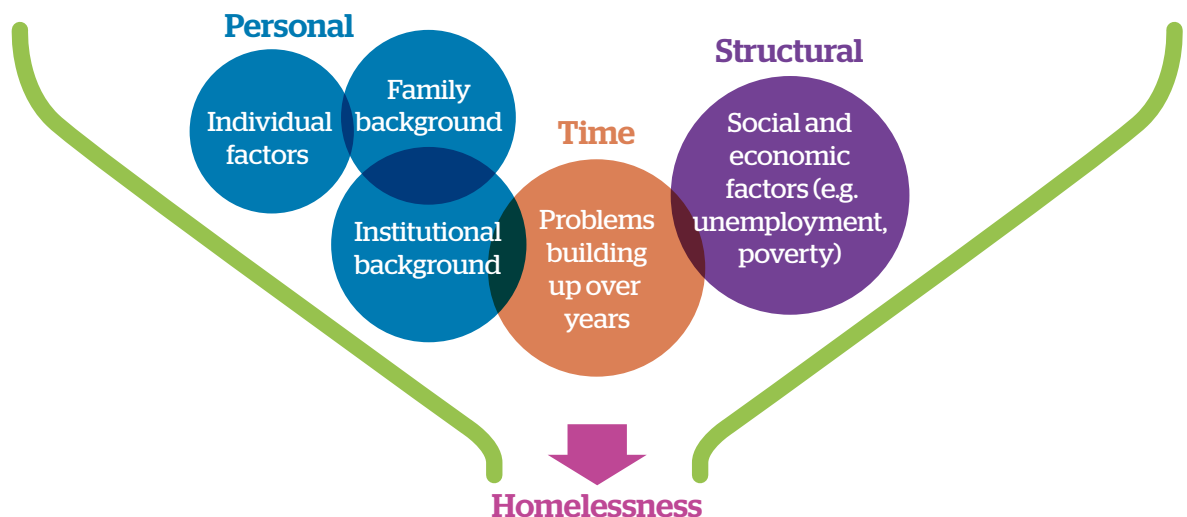
For example, take John, 16 years old; kicked out by his parents, he has been sofa surfing and relying on favours to find a bed to sleep for the last three years. Does he count? Or Monica, 26 years old; her local authority turned her application away as she has no kids. Is she counted? In all these circumstances, the answer is no. Neither John nor Monica are counted, and, therefore, they will not show up on official statistics (and therefore, they are not included in the total presented in the beginning of this paragraph).

3.3. What causes homelessness?

Homelessness is a complex issue. The cause cannot be easily reduced to single events or distinct factors; it should also not be considered the result of personal failings, and therefore, we should not think that if the economy is doing well then people should be able to find employment and get on with their lives

(Homeless Link, 2017a). Rather, homelessness often results from the complex interplay between individual personal circumstances and different 'structural' factors that are often outside of one's direct control (**Figure 1**). Examples of individual factors include lack of qualifications, lack of social support, debts, and poor physical and mental health. Examples of family factors include sexual and physical abuse, family breakdown and disputes, having parents with drug and alcohol problems, and previous experience of family homelessness. Finally, being in care, the armed forces or prison increases the risk of homelessness. Examples of structural factors include unemployment, poverty, housing policies, and a lack of affordable housing. These factors, however, are not considered as the underlying causes of homelessness; instead, they are often considered catalysts that trigger people to seek support from local councils and other related services.

Figure 1: Factors that can lead to homelessness



“ Evidence from national sources shows that homeless people are far more likely to experience poor health and die younger compared to the general population. ”

3.4. The health and well-being of homeless people

Evidence from national sources shows that homeless people are far more likely to experience poor health and die younger compared to the general population (National Housing Federation, 2017). A recent survey among 2,590 homeless people carried out by Homeless Link (2014), showed that more than 70% of the participants had at least one physical health problem, and that more than 80% had some form of a mental health issue (diagnosed or undiagnosed). From those who reported mental health issues, 45% had received a diagnosis, compared to 25% of the general population. Long-term physical health problems are more prevalent in the homeless rather than the general population. For instance, in the Homeless Link survey, the authors report that 22.1% of their sample reported joints and muscular problems (13.9%),² 15.2% chest and breathing problems (5.8%), 10.4% stomach problems (2.6%), and 14.2% eye problems (1.4%). The report draws a similar picture with regards to the mental health of the homeless population. For instance, as the within brackets comparisons indicate, the incidence of bipolar disorder (**6%** vs 1-3%), schizophrenia (**6%** vs 1-3%),³ personality disorder (**7%** vs 3-5%), and in particular, depression (**36%** vs 3%), is much higher in the homeless population. Other surveys show a similar trend particularly for depression and schizophrenia (30% compared to 1-4% in the general population), and personality disorders (60% compared to 5-15% in the general population). Homeless people are also more

likely to commit suicide, compared to the general population (42% compared to 1.5% in the general population). Homeless people are also more likely to experience multiple and co-occurring physical and mental health problems alongside substance use.

Drug and alcohol problems often develop to cope with past trauma (e.g. physical and/or sexual abuse, neglect, emotional abuse) as well as to cope with the difficulties of homeless life. Problems with drugs and alcohol may contribute to someone's spiral into homelessness; this however, does not mean that everyone with problematic drug and/or alcohol use becomes homeless or that every homeless person has substance use problems (Crisis, 2017). Nevertheless, national evidence shows that homeless people report higher rates of problematic drug and alcohol use compared to the general population (Crisis, 2017). For instance, in the Homeless Link Health Needs Audit (2014), it is reported that 39% of the participants said that they take drugs or are recovering from a drug problem, and 27% had or were recovering from an alcohol problem. Estimating the number of people who misuse substances, and more specifically the number of people who misuse substances and are homeless is complicated, as national statistics report data on people presenting for treatment and those in treatment. Therefore, it is hard to get a clear picture on the scale of problematic substance use in the homeless population. Homeless people are at high risk of experiencing tri-morbidity, that is the co-occurrence of physical health and mental health problems as well as

² Comparable rate in the general population.

³ Rate for homeless population highlighted.

“ In addition to their experience of being homeless, many homeless individuals have been exposed to other forms of trauma, such as, physical, sexual, emotional abuse and neglect during childhood, domestic violence, accidents, and combat-related trauma. ”

problematic substance use, which results in the development of complex problems. Recent research on emergency hospital admissions has shown that hospitalised homeless people are more likely to experience premature onset of multi-morbidity, associated with increased use of unscheduled healthcare. By contrast, housed patients are more likely to experience multi-morbidity due to ageing (Cheallaigh et al., 2016).

Evidence also indicates that homeless people are more likely, compared to the general population, to practice unhealthy lifestyles (e.g. smoke, not eat at least two meals per day, drink more than the recommended amount of alcohol, get regular exercise), which often have a negative impact on their health and well-being (Homeless Link, 2017).

3.5. Trauma and homelessness

Being homeless is a traumatic experience. Accounts of homelessness demonstrate the constant pressure that homeless people and families experience, unsure of their ability to sleep in a safe environment or obtain a decent meal (Goodman, Saxe, & Harvey, 1991). Many homeless people live precarious and stress-filled lives, characterized by frequent episodes of violence and housing instability. In addition to their experience of being homeless, many homeless individuals have been exposed to other forms of trauma, such as, physical, sexual, emotional abuse and neglect during

childhood, domestic violence, accidents, and combat-related trauma (Buhrich, Hodder, & Teeson, 2000), which can lead to experiencing complex trauma⁴ (Homeless Link, 2017b).

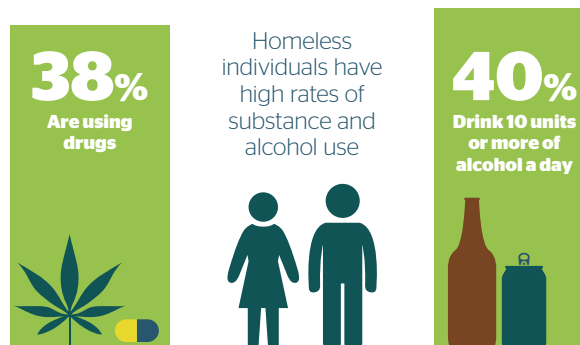
Traumatic events⁵ are frequently recognised as external events that occur in people's lives, and they are frequently experiences that create a sense of helplessness, fear, horror and overwhelm an individual's ability to cope (Keyes et al., 2013). The age at which people experience the abuse plays a significant role in the ways in which people express and cope with trauma (Harms, 2015). Experiencing trauma as a child can potentially influence and distort several aspects of a person's life (Rademaker, Vermetten, Geuze, Muilwijk and Kleber, 2008; Carvalho et al., 2014) and contribute to psychiatric morbidity including mood disorders (Weiss, Longhurst, and Masure, 1999; Widon, Bumont and Czaja, 2007), substance abuse (Tucci, Kerr-Correa and Souza-Formigoni, 2010), Post Traumatic Stress Disorder (PTSD) (Vranceanu, Nobfoll and Johnson, 2007), personality disorders (Afifi et al., 2011), and decreased uptake of pharmacological interventions (Nemeroff et al. 2003).

3.6. The healthcare experiences of homeless people

In 2012, the Health and Social Care Act introduced statutory duties on NHS commissioning organisations to reduce

4 "The term complex trauma describes both children's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually begin early in life and can disrupt many aspects of the child's development and the very formation of a self. Since they often occur in the context of the child's relationship with a caregiver, they interfere with the child's ability to form a secure attachment bond. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability." (source: The National Child Traumatic Stress Network).

5 Recently, the term 'potentially traumatic events' has been developed to avoid the assumption that an event is traumatic *per se* (Keyes et al. 2013). In addition, there are some 'internal experiences that have been described as traumatic, for instance, the experience of a psychotic episode' (Harms, 2015).



health inequalities in access and outcomes achieved by services. Among other groups, such as migrants, sex workers, Gypsies and travellers, homeless people are described as particularly subject to health inequalities. However, previous research on homeless people's lived experiences of interacting with health care services and professionals describes significant challenges with accessing care service. Discrimination, poor previous experiences with services and professionals (including being disrespected, stigmatized, invisible and labelled) and lack of compassion on behalf of professionals resulted in a loss of confidence in services and withdrawal from society (Daiski, 2007; Lamb et al., 2011; Rae & Rees, 2015). By contrast, evidence shows that services and professionals who are respectful, non-judgemental, flexible, and provide practical help and advice are more likely to engage with homeless people and therefore, have a positive impact on their health (Neale & Kennedy, 2002; Tweed et al., 2012; Williams & Stickley, 2010).

3.7. Homelessness in Essex

It is estimated that there are approximately 3,000 homeless people in Essex (based on information from local authorities, number of places available in night shelters, refuges, and floating support. Numbers of hidden homeless people, such as sofa surfers or squatters, is hard to estimate, but are estimated to be high. (Joint Strategic Needs Assessment, 2014). The most recent joint strategic needs assessment on homeless health shows that homeless individuals report high rates of physical health problems, (with muscular and joint related pains being the most common issue affecting the homeless), mental health problems (84% of the sample experienced either stress, anxiety

and/or depression with 64% experiencing all three), and problematic substance use (38% of the sample report that they were using drugs, with cannabis, cocaine and prescription drugs being the most popular in the homeless community, and roughly 40% of the sample drank about 10 units of alcohol on a typical day of drinking).

3.8. Key issues

Even though there is much evidence about the high rates of physical and mental illness in the homeless population in Essex, there has been very little research into how homeless people experience the care they receive from mainstream NHS health care services. Identifying and gaining an in-depth understanding of the issues that affect access, and the quality and co-ordination of care that homeless people receive, can provide valuable insights to NHS commissioners and service managers. The information could prove useful for developing and designing more appropriate and responsive mainstream services, capable of addressing the health and care needs of homeless individuals.

The aim of this research project was to explore how people who received support from two homelessness services in Essex viewed and experienced the care that they received from mainstream health care services (including physical and mental health) and whether the care they received was well coordinated. Additionally, the study examined whether contact with homelessness services affected the care that homeless people received from mainstream NHS services. ■

4. METHODOLOGY

4.1. Ethical concerns

All health-related research is reviewed in advance by an independent group of people called a Research Ethics Committee to protect the safety, rights, wellbeing and dignity of the participants. Essex County Council's research ethics committee reviewed and gave a favourable opinion to this study.

4.2. How did we approach and select participants?

Recruitment took place in two organisations that provide care and support services for homeless people in Essex, Beacon House Ministries (Colchester) and Churches Homeless Emergency Support Scheme (CHES, in Chelmsford). Beacon House is a Christian charity that has been established to help homeless people, those in insecure accommodation and those at high risk of homelessness. It offers a wide range of onsite drop-in support services, including showering facilities, laundry, clothing and toiletries, and operates a café open from 10am to 1.30pm offering hot food and drinks. Additionally, it offers life skills classes including computer IT, CV writing, support around cooking, budgeting, counselling, an IT suite, an art and crafts room, games and drop-in support from other agencies. Beacon House also provides primary healthcare services (through an in-house registered nurse trained and able to prescribe medicines), including access to health services, physical health, mental health, drugs and alcohol support, vaccination and screening. The healthcare team also undertakes health and well-being assessments for all new clients.



CHES seeks to relieve homelessness and related hardship and distress amongst single adults in Chelmsford and Essex, through the provision of support services and temporary accommodation that helps them move on with their lives. CHES has a number of properties that offer shelter to those who are homeless. CHES also operates a night shelter (staffed with support workers) capable of accommodating 7 people every night. CHES provides a counselling service and has strong links with local General Practitioners (GPs). It also encourages service users to access specialist providers, such as Open Road (substance misuse service), GP and health services, Citizens Advice Bureau, Job Centre Plus, Debt Advice Services, and opportunities for volunteering.

The recruitment sites provide different types of support to homeless people, with the main difference being that Beacon House is a drop-in centre whereas CHES is not. Therefore, we employed different recruitment methods at each site to ensure that we collected the views and experiences of a diverse range of people, irrespective of their age, gender, and ethnic background. We developed a set of inclusion and exclusion criteria to ensure that we selected the right sample of people to participate in the individual interviews (**Table 2**).

“ Participants’ meaning-making processes make up their view of reality and the basis upon which they define their actions/behaviours, for example whether to seek professional help and access services. ”

Table 2.
Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
1 18 years of age or older	1 Below 18 years old
	2 Unable to give informed consent
	3 Unable to understand or speak English
	4 Presents a threat to the safety of the researcher

At Beacon House the researcher visited the service 10 times and spent time talking to service users in the café and in the main area. During these visits, the researcher explained his role and the purpose of visit to the service users. The researcher approached potential participants individually within the Beacon House premises, and explained the aim of the research project. If the potential participant agreed to participate, the researcher and the potential participant went to a private room within Beacon House to carry out the interview. Potential participants were given the option of participating immediately after being approached. The reason for interviewing people so shortly after the initial approach was because of participants’ chaotic lifestyles and housing problems which do not permit a lot of flexibility. Therefore, to secure engagement they were given the option of participating immediately. By contrast, at CHESS, the researcher worked collaboratively with the support workers to identify potential participants. In the beginning of the study, the researcher met with CHESS support workers, where he explained the aims of the project and made explicit the inclusion and exclusion criteria. The support workers agreed to present the study to potential

participants (using the study’s information sheet) and ask them whether they wanted to be interviewed. Potential participants who answered positively were assigned a slot to have an interview with the researcher on a pre-determined date and time.

4.3. How did we collect participants’ views and experiences of care?

The focus of qualitative methodologies on the meaning and meaning-making processes of social phenomena and events resonates with the aim of the study - to gain an in-depth understanding of the meanings that homeless people attach to their experiences of interacting with healthcare services and professionals. Participants’ meaning-making processes make up their view of reality and the basis upon which they define their actions/behaviours, for example whether to seek professional help and access services.

Qualitative research aims to understand the complex world of human experiences and actions through the viewpoint of those involved in the situation of interest. This emic perspective - that is, from the participants’ point of view - requires researchers to avoid making any prior assumptions about the phenomenon under investigation; these should emerge through interaction with the participant (Ezzy, 2002; Bowling, 2009). By being attentive and getting closer to participants’ personal narratives of social phenomena, the researcher develops an understanding of participants’ experiences and behaviours (Flick, 2009). Capturing and understanding participants’ viewpoints of a phenomenon includes a close exploration of the meaning(s) that they attach to such points of view.



The meaning-orientated focus of qualitative methodologies is inextricably linked to the methods that describe – primarily in words – the qualities of social phenomena through observation, interviews (unstructured, semi-structured, partially structured and structured), focus groups, diary methods and analysis of documents and cultural products (Britten, 1995). For the present research, semi-structured interviews were the preferred source of data collection as they allowed the researcher to gain an insider perspective of the social phenomenon under investigation.

Participants were asked to take part in one semi-structured interview which lasted up to 30 minutes and took place within the homelessness service premises. The interview focused on participants’ views and experiences of interacting with mainstream health care services, and whether the care they had received was well co-ordinated or not. During the interview, the researcher also explored how participants’ contact with homelessness services affected the healthcare they receive. The interviews were digitally audio-recorded and transcribed by a professional transcriber.

The researcher used the Pictorial Technique of Care (PTC) method to identify the range of services and professionals that participants were involved with (see Appendix 1). This method allowed the researcher to collect initial data regarding the types of healthcare services that participants had accessed over the previous 6 months. This method has been previously proved to be an easy way to represent the number and quality of peoples’ interactions with healthcare professionals and

Table 3. Participants’ housing arrangements

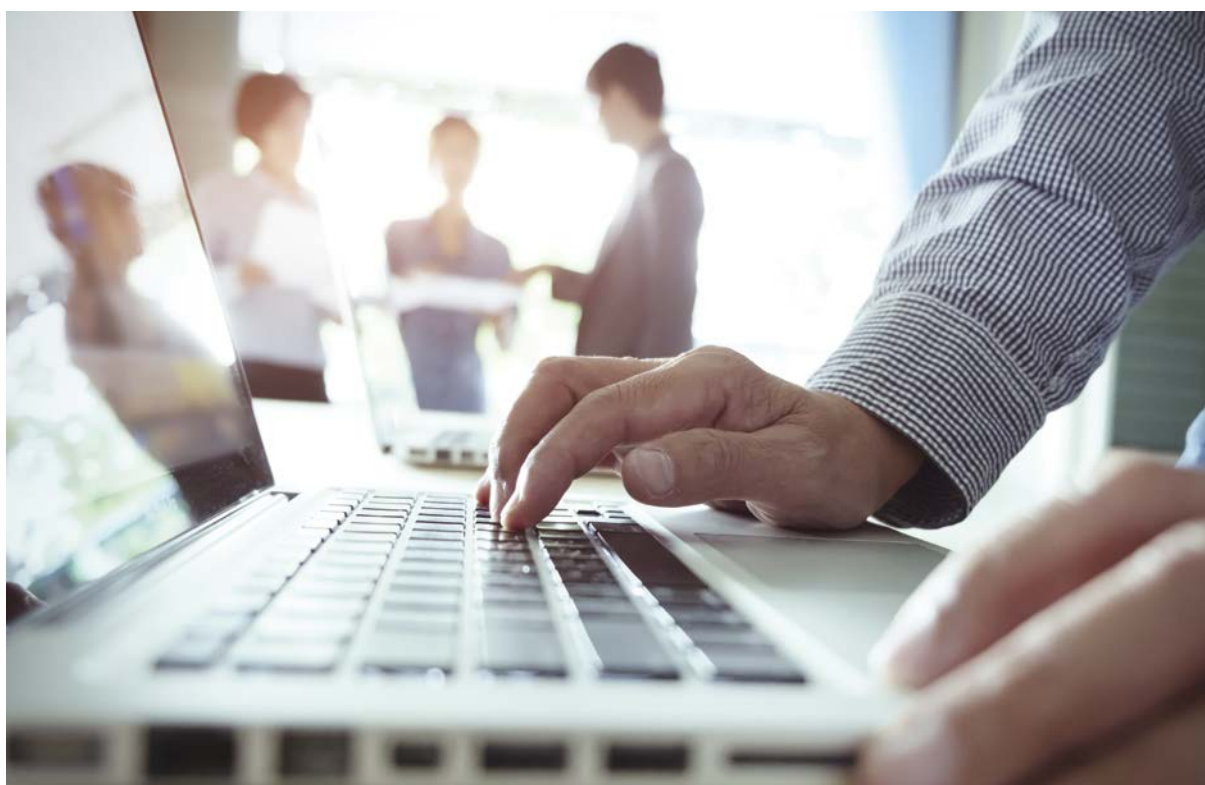
Type of accommodation	Number of participants
House or flat rented from a housing association/local authority	0
House or flat rented from a private landlord	4
Residential home or sheltered housing	13
Hostel	1
Homeless or living on the street	3
Staying with a friend or family but have their own room	0
Sofa surfing (staying with friends or family but not on a bed)	1
Other	0
Total	22

services (Byng et al. 2012). This technique aims at building up an initial, self-reported picture of the healthcare services that participants had accessed while being in contact, or not, with a homeless service, the reasons for accessing it, and information about the quality of the interaction with the professionals.

Across the two research sites, 22 people took part in the interviews (20 male and 2 female). The average age of participants was 39.4 years (age range 24-61). All but one participants reported their ethnicity as white British.

Table 3 presents participants’ living arrangements. Participants received a £15 voucher as a thank you for taking part in the research study. ■

5. ANALYSIS



We performed quantitative descriptive statistical analyses to build up a description of the types of healthcare services that participants had accessed over the last six months. The quantitative analysis of the collected data was carried out using a computer software program called SPSS v23.

We analysed the collected individual interview data using a qualitative method of analysis called 'qualitative summative content analysis' (Hsieh & Shannon, 2005). The analysis of the interview data resulted in the development of 3 categories that describe participants' views and experiences regarding interacting with health care services and professionals in Essex. ■



6. FINDINGS

6.1. Receipt of care

The objective of the pictorial technique of care (PTC) was to get a snapshot of the care that participants had accessed over the last 6 months, and to serve as a framework to discuss their experiences of interacting with healthcare services. The purpose of retrieving this data was to get a brief picture of the type of services that participants accessed, how often they visited them, and whether they were satisfied from their interaction with services.

The 22 participants reported 152 contacts with a range of health care services over the 6-month period covered. Participants reported 44 physical health-related contacts, the majority of which were with General Practitioners (GPs). Joint and respiratory problems were the most frequently mentioned physical health category. On average, for those participants who had accessed services for a physical health related issue, they rated their quality as almost always 'excellent'. With regards to mental health care, participants reported 99 contacts, the majority of which were with an in-house counsellor (75), whereas 25 contacts were with GPs. Depression was the most frequently mentioned mental health category (77/99). The majority of the contacts were reported by three participants (65/99). Over the 6-month period, 2 participants did not access any type of health care service for their mental health needs. For the other 17 participants there were 34 contacts, which gives an average of 1.88 mental health contacts per participant over the 6-month period. Noticeably only one of our participants (from the 13 who reported that they experienced anxiety and/or depression) had been offered and accessed IAPT services (e.g. Cognitive Behavioural Therapy). On average, for those

participants who had accessed services for a mental health related issue, they rated their quality as 'excellent.'

Participants' self-reported interactions with health care organisations indicate that participants were not very satisfied with their interactions with health professionals when they had visited them for a physical health problem. Over the 6-month period that the PTC covered, participants' rates of contact with mental health services were almost non-existent, with the in-house counsellors and GPs providing the majority of mental health care.

6.2 Experiences of health, illness and care

Participants talked about a range of physical and mental health problems affecting their health and overall well-being. Whereas the majority of participants reported that it was easy to access primary care services for physical health problems, a large proportion of participants reported difficulties with accessing mental health care. A few participants reported that they had not received any mental health care despite experiencing serious mental health problems. Participants talked favourably about and were more likely to visit health care professionals who were non-judgemental, were willing to listen to their concerns, offered practical advice and made onward referrals to specialist services. Participants valued relational continuity, however only a small proportion reported that they had been able to see the same GP. Continuity of care was particularly problematic for people who moved across different levels (e.g. from GP to specialist care) and locations of care (from prison to community care).



“ For the majority of participants, accessing primary care services was reported to be easier than accessing secondary care, and in particular specialist mental health care services. ”

6.2.1. Accessing primary care services

For the majority of participants, accessing primary care services was reported to be easier than accessing secondary care, and in particular specialist mental health care services. However, with regard to primary care, a large proportion of participants reported problems with accessing mental health services.

The majority of participants reported that they were registered with a local surgery, with a few reporting problems related to the cost of transport.

Alex: *How easy was it for you to access this healthcare service?*

Participant: *Pretty easy. The only thing is it is in [name of location], so it is quite a distance to travel. Where I am homeless I am finding it hard to get a different doctor, so I have kept that doctor.*

Alex: *You are not registered with someone?*

Participant: *No. I have tried, but they won't accept me. It is where I am homeless as well.*

(Participant 21)

Many participants reported that they had difficulties with finding a surgery that would accept them.

“Two (GP practices) were in [name of location] and one was in [name of location], which I am now registered with. Because it was quite difficult to get registered, just to get a script...It took me about two months to get registered and I actually went into the surgeries and some of them couldn't even offer me an appointment to register. So, it was quite difficult, yes...Yes, it was the fourth surgery that I tried and I managed to register. So, for that I was glad, you know.”

(Participant 14)

These participants reported that they had to turn to and seek support from the homelessness service they were in contact with to help them find a surgery that they could register with.

Alex: *So, have any of these contacts with your GP been initiated by your involvement with [name of homelessness service]?*

Participant: *Yes, exactly. The first time I came here, they signed me to the GP, they gave me just basically, instead of registering, they just give you a form to basically go over there, it's like a quick acceptance, they accept you more quickly.*

(Participant 16)

Similarly, another participant commented:

“They've told me to register at [name of GP surgery] and get my medication so that I don't run out. [name of support worker] told me that I needed a medication review because I wasn't sleeping. So yes, [name of organisation] have helped quite a bit.”

(Participant 6)

A few participants commented that, because they did not possess photographic identification, they could not register with a surgery. These participants had to turn to the homelessness services to seek support or, where available, access the in-house health care service.

“And then also, the situation is that you need photographic ID now, to go into Doctor's Surgeries and that, which I haven't got at the moment. So, I've got the nurse downstairs, that I was speaking to, and she helps me. So for people who don't have identification, or have missed appointments, and can't get a booking until a later date, it's quite handy that [name of organisation] have a health care service downstairs.”

(Participant 18)

“ Homelessness services became a space where participants could seek practical advice and support for accessing care from mainstream health care services. ”



Within this context, homelessness services became a space where participants could seek practical advice and support for accessing care from mainstream health care services. Once they had managed to register with a surgery, many participants reported that it was easy to see a GP. Almost all participants talked favourably about surgeries that were running morning drop-in sessions (e.g. from 08.00am to 10.00am) or surgeries where they could call or visit the surgery and make an emergency appointment.

“To be honest with you I have not gone to any health service in [name of city]. I have been told it is very good and you can just walk in. There are clinics down there, there is one down in [name of road] and I have been told you can walk in there and get help.”

(Participant 17)

Similarly, other participants commented:

Alex: *Was it easy for you to access this GP?*

Participant: *Yes. I went in at 8 o'clock in the morning of the day of the appointment and I received an appointment for 10 o'clock in the morning.*

(Participant 2)

Alex: *How easy has it been for you to access the health service?*

Participant: *Not as bad as I thought. If you try to get an appointment, an appointment would be a week or two weeks, whereas if I can get up at eight o'clock in the morning I can go in and I can get an emergency appointment. The emergency appointment time is from eight to ten. Yes, I do, I get an appointment. Yes, it's quite good. It's not like that back home. Emergency service or emergency appointments, it's an hour and it's late in the day. It's between five o'clock and six o'clock. If you're there and if you don't get to- you have to come back the next day to try again,*

try again. Over here, yes, I seem to get it every time. Yes, it's very good.

(Participant 20)

A few participants however did not talk favourably about making emergency appointments; instead they reported that they wanted to be able to plan their appointments.

“The only thing that is a bit hard is trying to make an appointment. You can't phone up and say, “Can I book an appointment for next week?” You have to phone up on the day at eight o'clock and make an appointment for that day...You can't really book advance appointments, that's the only thing that- You've got to wake up early to make a doctor's appointment.”

(Participant 9)

The configuration of services was not the only reason that affected participants' ability to access services. Psychological factors were also reported to influence access; for example, a participant talked about his struggle to visit a GP.

“If I get too panicked, or I suffer from anxiety quite quick, so if I get worried I won't go at all, and I'm quite a thingy person that doesn't really like doctors, police, stuff like that.”

(Participant 13)

Similarly, another participant reported that he was intentionally avoiding visiting doctors because he did not like them.

Participant: *I am one of these people who don't go and see a doctor. I am one of these ones who don't like doctors.*

Alex: *You don't like doctors.*

Participant: *It is just something I don't do. I did it three years ago when my daughters tried to help me and they got me a doctor. I went and saw her and I had the same thing, blood tests and everything else. They wanted to take blood and I couldn't do it.*

Alex: So, you avoid them.

Participant: I do avoid them. I know they are there to help. As I said, it is just one of those things with me.

(Participant 17)

Despite psychologically related factors influencing access to services, many participants valued surgeries that offered flexible appointments and had the capacity to see them at short notice. However, the situation was different for many participants who had tried to access primary care mental health services. These participants talked about the long waiting periods they had to endure while in a state of crisis to meet with a mental health professional, and in particular accessing Improving Access to Psychological Therapies services. These participants had to rely on anti-depressant medication and practice self-care until they had seen a mental health professional.

“From the point of self-referral I’d gone through a crisis at that point, which I went to my doctors and they gave me antidepressants. I was given the form for self-referral and I’d done that and I had a telephone assessment and they said I wasn’t a priority to be seen quickly...Every couple of months, I had a letter coming through asking if I still wished to be on the waiting list and that went on for 14 months.”

(Participant 2)

Even though pharmacological interventions are the last intervention in the IAPT stepped-care model (Richards, Bower, & Gilbody, 2009), for many participants such interventions were the first line of treatment. Other participants reported that, even though they were experiencing anxiety and/or depression, they had not been referred to receive talking therapies.



Alex: So, have you been referred to IAPT services, like counselling? Or anything like that?

Participant: No, not really.

Alex: No, nothing like that. Okay.

Participant: They give me, he printed off some information, off the internet, a little bit of information, and that was it really.

(Participant 16)

It is noteworthy to underline the difficulties that many participants had to overcome to access mental health care compared to accessing care for physical health problems. Another participant was critical of having to accept a mental health diagnosis to access mental health services.

“I have got depressive tendencies. I’m not lying because I do. Once I remember these memories, I slip into a lower form field of emotional state. I shut down a bit because, you know, these are horrific memories I’ve gone through. I get there but when I go to get help, you’ve got to say you’re an alcoholic or a drug addict and depressed to get help in the system. Otherwise, they start going, “Well, if you haven’t got any mental health problems, then you’re not vulnerable so you don’t get any help.”

(Participant 19)

The fact that the mental health system is not structured to provide care to people who do not necessarily conform to the diagnostic-based classification system prevented this participant from receiving mental health care from mainstream services.

“ He listened. Listened to my actual problem instead of ticking the boxes. I explained sufficiently to say, “This is the problem, my friend. This is what’s going on. ”

(Participant 19)



6.2.2. Interacting with healthcare professionals

Individual personalities and social dynamics, both established and emerging, played important roles in participants’ relationships with healthcare professionals. These dynamic relationships mostly involved acceptance, trust, empathy, a non-judgemental attitude and support. The presence and the combination of these elements allowed positive working relationships to form, and therefore, caring to occur. Almost all participants rated as excellent the healthcare professionals who presented with such characteristics.

Many participants reported that interacting with health care staff who were willing to listen and acknowledge their concerns was key in seeking professional help for their issues.

Alex: *What did you find the most useful part of this meeting when you went to your GP?*

Participant: *He listened. Listened to my actual problem instead of ticking the boxes. I explained sufficiently to say, “This is the problem, my friend. This is what’s going on.*

(Participant 19)

Similarly, another participant commented:

Alex: *How would you rate your interaction with your GP?*

Participant: *I get quite good service. It’s excellent.*

Alex: *Excellent?*

Participant: *Yes. Number one, because he understands.*

(Participant 20)

Asking questions and showing an interest in their lives was another characteristic of healthcare professionals that assisted the participants with developing positive working relationships.

Participant: *There was something that I had forgotten about, and all of the other doctors had forgotten to give me, some vitamin tablets, because of my drinking. It is Vitamin B and Vitamin D, I think...That, I didn’t ask. She volunteered them for me. That was something that she was thinking, because she looked, and told me, “Yes. You need some of that”. Yes. I mean, like I say, she was doing what she could. She wasn’t completely ignoring me.*

Alex: *Okay. It sounds like when they suggest things, when they give you advice, when they take an interest in your life.*

Participant: *Yes. I will get more done when they do that.*

(Participant 3)

For a few participants, the fact that their health care professional was willing to listen and assist them with their problems was an indication that they could be trusted.

Alex: *What do these things mean to you, if people listen and ask questions? Do they mean anything?*

Participant: *It means that you can rely on them. You can trust them. They’re not just going to fob you off and brush you aside. They generally care for you and your problems and they want to help you as best that they possibly can.*

(Participant 12)

“ Just the fact that it was such a professional service and the fact that they got me in the same day.”

(Participant 6)

Giving advice and making onward referrals to services was another characteristic that participants linked with healthcare professionals with whom they trusted and therefore they had established positive working relationships. Participants valued services and professionals who approached and treated them as individuals and valued their experiences.

Alex: *What was the most useful part of your appointment?*

Participant: *Just the fact that it was such a professional service and the fact that they got me in the same day. Like my appointment before the last one, they called me up and said that the GP wanted to see me, as opposed to just giving me a prescription. It was like a more personal service. He actually called me into the surgery.*

(Participant 6)

Some participants said that it was more likely that they would be understood by healthcare professionals who had experience in interacting with and treating homeless people.

“Because [name of surgery], [name of homelessness service] uses those doctors. I think I would probably get more of an understanding from the doctors that deal with [name of homelessness service]. Does that make sense?”

(Participant 3)

As this participant continued in the interview, he explained how other health care professionals had judged him because of his lifestyle choices.

Alex: *Do you feel they listened to what you had to say?*

Participant: *No. No, I don't.*

Alex: *Why is that?*

Participant: *I think that's because I drink and I smoke.*

Alex: *Okay.*

Participant: *It's a bit stereotypical, you know. It is like if I gave up drinking and smoking, I would all of a sudden be cured.*

Alex: *That's what they say?*

Participant: *I get the impression.*

Alex: *That's what you get?*

Participant: *Yes. I'd get more empathy if I didn't drink or smoke.*

(Participant 3)

All participants praised the level and quality of support that they had received from the health care and homelessness services. They talked about the encouragement they had received from these professionals as well as the flexibility that the service had shown to accommodate and address their physical and mental health needs.

Alex: *What do you think of counselling? Do you find it helpful?*

Participant: *I find it quite good...She is understanding and all that. She is very clever. She knows her job.*

(Participant 1)

Participants talked favourably about the time that the in-house health care professionals had spent talking and giving advice about their health concerns.

Alex: *The fact that she showed an interest, and she gave you advice, you felt it was these actions that made you feel she had acknowledged what you were coming for?*

Participant: *Yes. She wasn't in a rush or anything...She gave me quite a while, you know.*

(Participant 7)

“I wanted to tell him a little bit more about myself. But, I think he was a little bit pushed for time and all that.”

(Participant 1)



By contrast participants criticized GPs, who did not allow them or give them time to talk about their concerns, and in particular, mental health concerns.

“I wanted to tell him a little bit more about myself. But, I think he was a little bit pushed for time and all that. The surgery was getting quite packed and all that.”

(Participant 1)

Similarly, other participants commented:

Alex: *And if you remember, how long do you remember talking about your low mood?*

Participant: *Like I say, it was a very brief discussion, maybe because it's just like his time is very valuable, he's got to see a lot of people in a day. So, he sort of gets to the point quickly, and doesn't spend a lot of time talking about everything, he just helps you to say as much as he can, with the time that he has, do you know?*

(Participant 16)

Alex: *Do you think you have any time (to talk about his low mood)?*

Participant: *No.*

Alex: *No. Okay. So, he didn't ask any questions about this?*

Participant: *No.*

Alex: *Okay. Would you have liked him to ask you these kinds of questions?*

Participant: *Yes.*

Alex: *Yes. Why do you think he didn't ask you?*

Participant: *Not sure. Maybe not enough time.*

(Participant 5)

Many participants reported that they had to postpone talking about their health problems until their next appointment with a GP because of the restricted consultation time they had with their health care professional.

“Because my old support worker, which was [name of support worker], she thought that I might have IBS instead of just the sickness and diarrhoea. And I didn't manage to talk to him (GP) about that, but obviously if I'm having a full medication review I can talk to him about everything then.”

(Participant 6)

A few participants reported that, even though they had discussed some of their mental health concerns with their GPs, they did not consider them as the most appropriate health care professionals to discuss in length their mental health concerns. These participants reported that psychiatrists were the most appropriate source of support and care for their mental health concerns.

“Yes. My doctor was working with me but I don't think he had very much of an understanding because he wasn't a psychiatrist, he was a doctor. Because they can only refer you to these people, can't they?”

(Participant 4)

“I'd like to talk to someone more like a psychiatrist or someone...See someone, yes, but I never really got that option, I just got given medication really.”

(Participant 16)

Irrespective of the organisational context in which they occurred, participants described their interactions and relationships with healthcare professionals as cooperative and warm, filled with encouragement, support and trust. In these relationships, participants could explore, discuss and understand, make sense, and question their experiences of illness. Many participants were experiencing complex physical and mental health issues and needed time to discuss and explore their situation with their GPs; however, the limited time of the

“ A few participants talked negatively about the lack of relational continuity they had experienced within primary care settings from seeing different health care professionals each time they visited their surgery ”

clinical consultation did not allow them to raise, let alone, discuss their concerns. As a result, many participants did not manage to receive timely care and support for both their physical and mental health concerns.

6.2.3 Care continuity and coordination

The majority of participants reported that they were satisfied with how their care had been coordinated as they received care mainly from primary care services. However, a few participants talked negatively about the lack of relational continuity they had experienced within primary care settings from seeing different health care professionals each time they visited their surgery. Almost all participants whose care had been transferred between different locations (e.g. from prison to community or from hospital to community) and levels of care (e.g. the hospital setting) reported difficulties with care continuity and coordination.

Almost all participants reported that they had to see different doctors every time they had visited their surgery. While many of them did not talk negatively about this, there were a few participants who criticized the lack of relational continuity. These participants valued seeing a doctor who was familiar with their personal and medical history, and knowing they would not have to repeat their concerns.

“Somebody who actually does have your history, knows your history, possibly even like a family doctor. They know the intrinsic run-ins of the families. I think that would be nice. I don't know...I was a scaffolder. I got silly money, so I did certain things. I decided to go home to [name of

city], which is where I am from, got back to my doctors, obviously gave up the coke, but I felt listened to. I felt special, because again it was just a small, three doctors in the surgery, and you got the same doctor every time. They were more empathetic, more sympathetic to your plight. I felt, I gave up coke quite easily knowing that they were helping me. I felt really confident, because I had the same doctor.”

(Participant 3)

Similarly, another participant commented that he would have preferred seeing the same doctor if he had to disclose and discuss personal issues with them.

Alex: *Is it the same GP or are they different people every month?*

Participant: *It's a different doctor every month.*

Alex: *Do you like that?*

Participant: *It doesn't really bother me. If I had a reoccurring, like, something personal- But I don't really think it's an issue seeing other doctors. If it was something personal, if I trusted a doctor with this issue then yes, I would want to stick to that doctor, but I'm just going there for a repeat prescription.*

(Participant 9)

Another participant commented on the fact that she had to repeat her physical and mental health concerns every time she visited the surgery which she described as frustrating.

“Sometimes it does feel as if I do repeat myself and that's quite frustrating because I would expect healthcare services to talk to each other, if it's concerning my health and my medication and things like that.”

(Participant 6)

“ Another participant reported that he was unhappy for having to repeat his personal stories. ”



Similarly, another participant reported that he was unhappy for having to repeat his personal stories.

“I think the assessment and the waiting time needs to be addressed. At the point of my self-referral I was in the middle of a crisis and there was no support for me through it at that point, so I had to wait 14 months and by that point everything had finished, the crisis was over but then who wants to review that again? I was almost reliving the same problem twice.”

(Participant 2)

Participants whose care needs required support from non-primary care services or had been transferred between different locations of care, reported poor care continuity.

“The place I worked at are very good but in the night time, I was on my own. I was completely left after all this. Once you get help, it’s like, “You’re better now. See you later.”

(Participant 19)

Another participant reported that he had received no mental health care in prison even though he was scheduled to see a psychiatrist before he was incarcerated.

“No, the one just before prison was the only referral I had actually got to, but then I went to prison so that cancelled that.”

(Participant 21)

Although the majority of participants did not report challenges with care continuity and coordination, there were a few participants who required a more personalised and consistent approach to help them access and trust health care professionals and services: these participants criticized the poor care continuity and coordination they had experienced.



A few participants reported having been in contact with specialist care services. These participants experienced a few problems accessing specialist services for physical health problems, but overall, reported that access to such services was easy. By contrast, a large proportion of these participants reported difficulties with accessing specialist mental health care (e.g. psychiatrists).

Participants reported that they had experienced long waiting periods to access a specialist service which had negative effects on their condition.

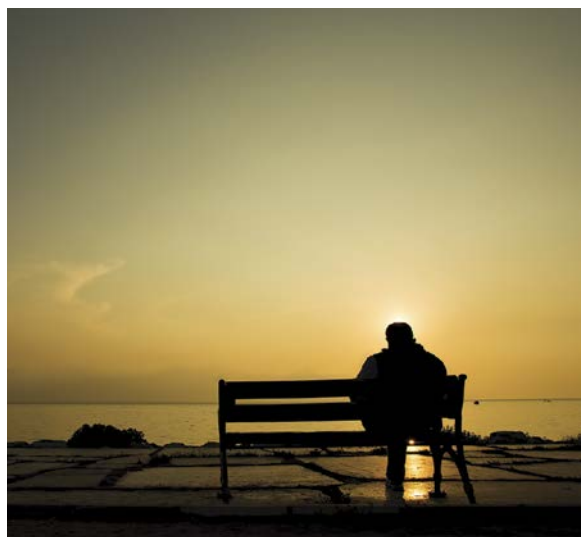
“No, not from the GP, from the hospital, it’s been a bit different, I’ve had a long waiting list for the hospital, to see a consultant, I’ve been waiting months and things, yes, that’s the only down point is the hospital.”

(Participant 16)

Although participants had to wait for long periods to access specialist care, when they had accessed it they valued the care and support they had received from healthcare professionals. By contrast, accessing specialist mental health care was described as more problematic by almost all participants who had been referred to such services. These participants reported that, even though their GP had made a referral to the specialist service, they had never heard back from them.

“I don’t know, maybe by getting me certain appointments with the people I need to speak to. My doctor says psychiatrist, then I need to see the psychiatrist. These things seem to take... I have been trying to access them for years and it hasn’t really...”

(Participant 21)



Similarly, another participant talked about the hurdles he had experienced in trying to access specialist mental health care.

Participant: *Well I’m still, it’s awkward. I’m going to have to go and see my doctor and say, “Where’s this psychiatrist?”*

Alex: *Psychiatrist appointment.*

Participant: *Yes, I’ve been waiting for that since last year.*

Alex: *Since last year you are waiting for that?*

Participant: *Yes*

(Participant 8)

For another participant, the persistent failure of the mental health system to provide him with care and support had significant consequences to his health and well-being.

“I don’t know. I don’t really, like, I’ve been in and out of the mental health system for 18 years. At one point, a long time ago, I might say, I was taking antipsychotics and sleeping tablets, and I saved them up for months and months, and took a really bad overdose. Ended up in hospital, in a coma for God knows how long, and even after that, the mental health system just failed me. They were like, “Oh, you seem alright, on you go.” You don’t do stuff like that if you’re mentally well. So, yes, as I get older I’m just getting to the stage where I’d rather just get on with it myself.”

(Participant 11)

Participants who required specialist mental health care experienced several obstacles to accessing care, owing to poor continuity and problematic communication at the primary and secondary care interface. ■

7. CONCLUDING DISCUSSION

The aim of this research project was to explore and understand the health care experiences of homeless people in Essex accessing and interacting with mainstream NHS services and professionals.

Additionally, we aimed to examine whether the health care that our participants had received was well-coordinated or not, and whether being in contact with homelessness services affected the care they receive from mainstream NHS services. Our findings show that while the majority of our participants had accessed and received good care from mainstream NHS services, they had faced significant challenges to achieve this, particularly with mental health services. Within this context, participants' contact and engagement with the homelessness services played a key role in affecting the health care they received from mainstream NHS services. For example, many participants had turned to the homelessness service to receive support and assistance with registering with a surgery or receiving treatment and care. Owing to the limited support they had received from primary and secondary mental health services, many participants had turned to the counselling service offered by one of the participating homelessness services to receive emotional support and assistance. As a result, participants' contact with homelessness services assisted them with accessing NHS care; it also filled gaps in service delivery and provision, particularly around mental health care. However, it is important to underline that the participating homelessness services had forged strong links with local primary care services. Therefore, our findings should be interpreted cautiously as participants had

been in contact with healthcare professionals and services that had adjusted their service design and delivery in such a way to address the needs of homeless people. It is likely that homeless people who are not in contact with homelessness services experience difficulties in accessing and receiving high quality care.

Overall, participants appeared to prefer services that are tailored to homelessness; those which have a flexible structure, offer drop-in sessions and allow them to make emergency appointments at short notice. Our findings are in good agreement with other studies which have shown that organisations involved in delivering care to homeless people need to deliver services that are tailored to homelessness. For example, Chrystal et al. (2014) study into the experience of primary care among homeless people with mental health condition reports that specialized staff, special hours and locations of operations, and unique factors such as facilitated access to specialist care, food and shelter are factors that predict a positive experience across primary care settings for homeless people. The participating homelessness services (CHESS, Beacon House) are very good examples of tailored services to homelessness; they facilitate access to services (and often provide it), provide flexible operational structure and offer food and/or shelter. Similarly, participants talk favourably about NHS mainstream services who have similar characteristics (e.g. special hours). Long waiting times, lack of



care coordination, and alcohol and substance use are issues that both our participants and previous literature identified as barriers to care for homeless people (Canavan et al. 2012).

Our participants appeared to also prefer health care professionals who listened and showed empathy to their concerns and were non-judgemental. Participants also appreciated health care professionals who showed that they had acknowledged their concerns by questioning them, giving them the opportunity and encouraging them to talk more about the issues they had brought to the clinical encounters and making onward referrals to services. Participants felt valued by such health care professionals, and therefore, they were more likely to rate them as excellent and seek their professional advice for health and care issues. By contrast, participants criticized and were less likely to seek professional help from health care professionals by whom they felt stigmatized. Our findings are broadly consistent with previous research on homeless peoples' interactions with health care professionals which has shown that positive working relationships, based on equality, empathy, and a non-judgemental approach, are highly important (Neale & Kennedy, 2002; Tweed et al., 2012; Williams & Stickley, 2010).

For this group of participants, care was based upon the co-creation of a 'talking space' where they could explore and understand their symptoms and illnesses, and where they could receive emotional and/or practical support. These care practices may have subtly worked towards restoring participants' self-confidence and their ability to re-engage in relationships with others, as many of their relationships had been fractured due to family/relationship problems. The principle of equality was

mirrored in the talk of participants who had established a positive working relationship with their health care professionals. Participants reported that they were able to talk about their problems in an environment where they felt acknowledged and understood. Signposting to services, advice and practical tips on how to manage their symptoms were types of support that they appeared to value, and hence, such support made a positive contribution to their health and care. Implicit in these relationships was the sense of equality; participants were not shown any lack of respect, and the problems that they had brought to the encounter were not discarded. Health care professionals (either based in NHS mainstream services or homelessness services) recognised both as important and tried to support participants to address/resolve their problems. Participants trusted health care professionals who took them and their health concerns seriously.

However, it appeared that, implicitly, public discourses on the notions of deservedness and entitlement contributed to participants avoiding seeking professional support for either physical or mental health problems. Drug and/or alcohol addiction and lifestyle choices were the main factors that participants reported as influencing how a few health care professionals designated categories of deservedness and entitlement. The stigma that participants experienced had negative implications for the quality of care they received and the types of treatment they were offered, both having detrimental effects on the permeability of services and hence, participants' future utilisation of them. These healthcare professionals used their medical knowledge to sanction or not participants' behaviours.



These findings echo those of studies by Fitzgerald, McDonald and Klugman (2004), Simmonds and Coomber (2009), and Joseph (1995) on injecting drug users' (IDUs) experience of stigma. For instance, exploring how social stigma affects the identity of IDUs, Fitzgerald et al. (2004) illustrate how stigma increased the likelihood that IDUs would reject services. Similarly, in their study on how stigma both affects IDUs and operates within them and its consequences on harm reduction amongst IDUs, Simmonds and Coomber (2009) argue that some pharmacists and community members reported stigmatising attitudes towards IDUs. Further, Joseph (1995) argues that despite methadone maintenance being one of the most (or probably the most) widely accepted treatments of opiate dependence, there is a significant amount of social stigma attached to it. Finally, Lloyd (2010), reviewing the literature on health professionals' attitudes towards problematic drug users, argues that professionals working in primary care settings have more negative attitudes compared to professionals working within secondary care services towards people with problematic substance use.

Even though many participants valued the help and support they had received from mainstream NHS services and professionals, they talked negatively about the short length of their consultation with their GPs. Almost all participants cited their GP as their main care provider, and therefore they needed to be aware of and familiar with their health concerns and often the personal matters which could affect their health. However, many participants reported that owing to the short length of the

consultation time they had to be selective with regards to the health concerns they would talk about with their GP. This process of self-censorship did not appear to have immediate negative consequences to participants' health (as health emergencies were identified and treated in a timely fashion); however it appeared to have a negative impact on participants with long-term physical and mental health problems who needed time to explain how their symptoms, and often treatment, had affected their health and overall well-being.

Even though the average length of GP consultation has increased in the UK over the last 20 years (currently it is estimated to be 8-10 minutes), it is still considered to be the shortest compared to international standards⁶ (Triggle, 2017). While it has been suggested that short GP consultations, coupled with GPs' increased workloads, can increase the risk of harm for patients, particularly those with complex needs, such as homeless people (Topping, 2017), evidence also shows that longer consultation times do not improve patient experience (Elmore et al., 2016). A recent report by Healthwatch England (Healthwatch, 2015) cites short or rushed appointments as one of the issues. Among others these include: difficulties with booking appointments; frustration with appointment systems; lack of choice of GP; poor attitudes of staff (particularly reception staff) as affecting patient experience. It may be that patients, and particularly patients with complex needs, should be asked whether they need a longer consultation and offered the opportunity for such a consultation with their GPs systematically.

⁶ Although GP practices collect huge amounts of data, there is no systematic data collection that present the number or nature of consultations and who undertakes them (National Audit Office, 2015).

8. THE IMPORTANCE OF IN-DEPTH NARRATIVE DATA

Finally, participants criticized the poor relational continuity they experienced from their GP practices. Many of them had hardly ever seen the same GP, which meant they had health concerns every time they saw a new GP. Our findings echo those presented by the national GP survey (conducted by Ipsos Mori on behalf of the Department of Health) which reports that fewer people were always or almost always able to see their preferred GP (Ipsos Mori, 2016). Continuity in primary care denotes a sense of affiliation between health care professionals and patients (e.g. my patient my doctor), “often expressed in terms of an implicit contract of loyalty by the patient and clinical responsibility by the provider...the affiliation...fosters improved communication, trust, and a sustained sense of responsibility” (Haggerty et al., 2003, p. 1219).



Participants appeared to value seeing health care professionals with whom they had managed to build up positive and trusting working relationships and were familiar with their personal and social context. ■



Compared to research studies that have exclusively relied upon surveys to examine peoples’ experiences of interacting with homelessness and mainstream NHS services, this study, by employing the method of individual interviews, has generated deeper insights into peoples’ lived experience of health care and experiences of healthcare professionals and services. This focus helped us explore the meanings that people attach to these social phenomena as well as their views on how health care services could better support them in seeking and accessing professional help. ■

9. RECOMMENDATIONS

The following recommendations aim to inform GPs and local NHS commissioners and service providers about how primary and secondary care services could be improved to address the health care needs of homeless individuals. The recommendations presented below should not be considered definitive or comprehensive, but they are a start. Therefore, Healthwatch Essex welcomes comments, constructive feedback and suggestions relating to the recommendations presented below.

9.1. Recommendations for GPs interacting with homeless individuals

1. During your clinical encounter with a homeless individual use your everyday human skills; listen and acknowledge what they have brought to you, show them that you have heard their concerns by explaining to them any actions that you intend to make or not.
2. Do not assume, but ask how they experience their lives. It is very likely they have experienced several personal and social problems which could negatively impact their physical and mental health and psychological well-being. Explore together which of these problems you can treat and which you need to make onward referrals for.
3. While exploring their concerns, avoid making assumptions about the roots of their concerns. Instead, ask open questions. Use expressions that will permit them to talk about themselves. This will allow rapport and trust to develop between you. Make sure that they are comfortable discussing these issues.

4. Rather than viewing homeless people as having multi-morbidity, view them as having complex experiences and behaviours that are not well described by the diagnostic manuals (for mental health).

9.2. Recommendations for NHS commissioners and service providers commissioning and delivering services respectively for homeless individuals

1. Support and promote the delivery of flexible services for homeless individuals. Flexibility around opening hours and length of the clinical consultation are important elements that facilitate access to services.
2. Increase the availability and facilitate access to primary care mental health services (e.g. Improving Access to Psychological Therapies) for homeless people.
3. Strengthen the primary and secondary care interface; many participants experienced poor continuity of care, particularly those participants who required specialist care from mental health services.
4. Homelessness services positively affect homeless peoples' contact with mainstream NHS services. We therefore recommend providing practical and financial support to these services to assist them with continuing their important work.
5. Develop and support systems that promote the integration of services (e.g. health, social care, drug and alcohol, housing, and criminal justice) for homeless people. ■

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APPENDIX 1: PICTORIAL TECHNIQUE OF CARE

Participant ID: _____ Date: _____ Recruitment site: _____

A. Demographic questions

1. How old are you? _____
2. Gender: _____
3. Marital status: _____
4. Ethnicity: _____
5. Where are you currently living? (put a tick in the box)
 - House or flat rented from a housing association/local authority
 - House, flat or room rented from a private landlord
 - Residential home or sheltered housing
 - Hostel
 - Homeless or living on the street
 - Staying with a friend or family but have my own room
 - Sofa surfing (staying with friends or family but no bed)
 - Other (please specify)

B. How would you say you have been feeling recently?

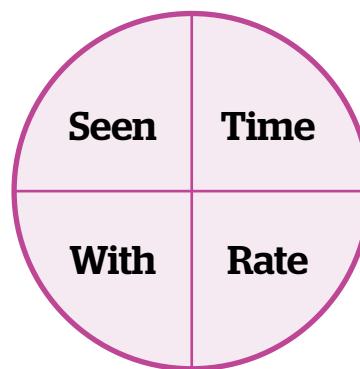
C. Pictorial Technique of Care

(Prior to interview researcher will have filled in months (for last six months) across first row)

Now, I'd like to ask you about the health services you have used in the last six months. We are interested in how contact with different services for homeless people affects the health care you receive. We are also interested in what you think about the care that you receive, and whether you think that it is well co-ordinated or not. It's important for us to understand when things have gone well and when not so well.

First of all, if you're happy to tell me, we'd like to know when you have been in contact with services for homeless people in the last six months (Also include Criminal Justice related systems such as bail hostels, drugs and alcohol rehab etc..)

- Researcher marks on these contacts as 'x' for short one off contact, or '_' for sustained period of contact across the appropriate months, across the second row. The name of the part of the CJS they were in contact with should be written next to the contact mark.



Thank you. Now I'd like us to think about your health problems. Can you tell me the health problems (including physical and mental health) that you experience?

- Researcher marks down each health problem in a separate box in first column under 'Health problems'
- If there are more than four health problems, the researcher will decide whether to use additional sheets and/or prioritise the health problems that seem most important to the person being interviewed.

I'd now like us to think about each of those problems in turn. Thinking about* (*name first health problem listed), when have you seen somebody about that in the last six months? (Prompt Card 4).

- For each contact the researcher marks a circle (split into quarters) across this problem's row, under correct month (and if judged necessary - particularly in the case of multiple contacts within one month) in the appropriate third of the month.

For each contact researcher then asks:	For each contact researcher marks on grid:
Which organisation/ service/ professional did you see? (Use Prompt Card).	Put code for who seen for contact in top left-hand corner of contact circle. (Use Prompt Card).
How long in minutes did you see someone for?	Number of minutes in top right-hand quarter of circle.
How would you rate the quality of the contact? (Use Prompt Card).	Quality rating number in bottom right-hand quarter of circle. (Use Prompt Card).
Who went with you? Did any of the following prompt or suggest you should go?	Write 'FAM' or 'FRE' in bottom left-hand quarter of circle where family or a friend had a direct positive influence on the person accessing contact and/or accompanied them. AND/OR Where a homeless service contact had a direct influence on person accessing contact draw a dotted line between the healthcare contact being discussed and the relevant homeless service contact in the top row. Arrow heads should be drawn to indicate direction of influence. If there is additional information that the researcher feels is significant about the interaction between health and homeless service this can be recorded in the further comments box.

Researcher then repeats this process for each of the health problems identified.

N.B. If there is a single contact which was about more than one health issue researcher should record one large circle, with one set of information across both health issues.

When all Health and Homeless Service contacts have been recorded please remember to ask about links between the two.

Contacts with services in the last six months

Months ▶						
Homeless service contacts ▶						
Health Problems ▼						

Prompt Card

Types of services you might have used in the last six months

Local doctor/ GP practice – GP	GP	Prison Healthcare Primary Care – GP	PHCGP
Local doctor/ GP practice – nurse	PCN	Prison Healthcare Primary Care – Nurse	PHCN
Other health professionals (Physio, OT)	OHP	Prison Healthcare – Inpatient	PHCI
Hospital (Out patient, In patient)	HO or HI	Prison Mental Health In-reach	PMH
Drug Service	DS	Prison Drug and Alcohol In-reach	PDA
Community Mental Health Service	CMH	Voluntary sector (e.g. support group) (AA, NA or VS)	AA/NA/VS
Self-care	SC	Social Services	SS
Alternative therapies/practitioner	AT	Chemist	CH
Any other services (<i>please specify</i>)	OS		

Quality of your contact with healthcare

1	Excellent
2	Quite Good
3	So-So (neither good or bad)
4	Quite Bad
5	Really Bad

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