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Provision and accessibility of primary healthcare services for people who are homeless

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Perspectives of homeless individuals on the provision and accessibility of primary healthcare services: A qualitative study

Background: Anecdotal reports of homeless people being denied access and facing negative experiences of primary healthcare have often come to light. However, there is a dearth of research exploring homeless people's views and experiences of such services.

Aim: This study aims to explore the perspectives of homeless individuals on the provision and accessibility of primary healthcare services.

Design and setting: A qualitative study with homeless people recruited from three homeless shelters and a specialist primary healthcare centre for the homeless in West Midlands of England.

Methods: Semi-structured interviews were audio recorded, transcribed verbatim and analysed using a thematic framework approach. Theoretical Domains Framework (TDF) was used to map the identified barriers in framework analysis.

Results: A total of 22 homeless were recruited. While some participants described facing no barriers, accounts of being denied registration at general practices and being discharged from hospital on to the streets with no access or referral to primary care providers were described. Services around substance misuse and mental health were deemed to be excluding those with the greatest need. Participants described committing crimes with the intention of going to prison to access healthcare. High satisfaction was expressed by participants about their experiences at the specialist centre.

Conclusions: The homeless participants of this study perceived inequality in access and mostly faced negative experiences in their use of mainstream services. Changes are imperative to facilitate access to primary healthcare, improve patient experiences of mainstream services and to share best practices identified by participants at the specialist centre.

How this fits in

Anecdotal reports of homeless people being denied access to general practices and primary healthcare services struggling to fulfil their complex healthcare needs have often come to light. However, there is a dearth of research exploring homeless people's views and experiences of such services. By exploring the perspectives of homeless individuals on the provision and

accessibility of primary healthcare services, this study shows that key barriers exist for homeless people in registering with a mainstream general practice and their awareness of services available for the homeless. There is scope for facilitating better access to services, improving patient experiences at mainstream general practices and replicating best practices experienced by patients at the specialist centre.

Introduction

Homelessness manifests itself in many forms including rough sleeping, squatting, sofa surfing and residing in hostels or council housing.[1] Homelessness is a national concern in the United Kingdom (UK). More than 112,000 homeless applications were submitted to local authorities in England during 2017.[2] The number sleeping rough in some urban areas has doubled in the last six years.[3]

Significant healthcare disparities remain for the homeless community; standardised mortality ratios for homeless females and males are reported to be 11.9 and 7.9 respectively, compared to the general population.[4] The Inverse Care Law, i.e. 'the availability of healthcare is inverse to the health needs of the population',[5] is often applicable to the homeless population as there is a cognizance that homeless individuals face barriers when accessing mainstream primary healthcare services.

Homeless people are known to be 40 times less likely to be registered with a mainstream general practice compared to the general population.[6] In an attempt to address such disparities, specialist primary healthcare centres for the homeless have been established. Specialist primary healthcare centres for the homeless provide multiple services including general practitioners (GPs), dentists, specialist nurses and psychotherapy counselling services usually under one roof.[7] Homeless patients are expected to relocate from the centre to mainstream primary care providers once permanently housed.[8]

Barriers to accessing healthcare can contribute to the worsening of health issues experienced by the homeless due to delayed diagnosis and treatment. It is known that the homeless population is up to 60 times more likely than the general population to attend an Accident and Emergency (A&E) Department,[9] with substance and alcohol misuse commonly linked to such visits. This may indicate points of weakness in the primary healthcare system for the homeless.

Exploring reasons for underutilisation or non-access to primary care services, experiences that deter or facilitate such use, and potential reasons for frequent A&E visits by the homeless population are imperative to improve the health of the homeless population. Use of primary care

services is particularly important as seeing a trusted healthcare professional (HCP) is essential to ensure continuity of care.[10] Standards for service providers and commissioners have been published by the Faculty for Homeless Health that focus on the need for cross-sector collaboration, including outreach where facilitated access to the sites are not practical or successful.[11] However, implementation remains poorly understood.

This study aimed to explore the perspectives of the homeless population around their access to and use of primary healthcare services, including mainstream general practices and a specialist centre.

Methods

A qualitative study using face-to-face, semi-structured interviews was conducted which allowed for a naturalistic enquiry of participants' perspectives and experiences.[12] Homeless participants aged ≥18 years with capacity to provide informed consent and communicate in English (or otherwise who had access to an interpreter on site) were recruited from three diverse homeless shelters and a specialist primary health centre for the homeless in the West Midlands region of England (table 1). A convenience sampling method was used based on the availability of participants at each site during data collection. Posters were made available in the public areas of the shelters to advertise the researchers' visit. Owing to variable literacy levels amongst the homeless population, staff at the study sites also verbally communicated details of the project to potential participants. Individuals were approached by staff at the study sites and referred to the research team if they expressed an interest to participate. At the specialist centre, participants were referred to the research team following their consultation with a healthcare practitioner. The interviews took place in private rooms to maintain confidentiality, with the exception of two interviews which were conducted in communal areas at the participants' request.

Informed consent, both signed and verbal, was obtained from the participants and interpreter (when used) by researchers operating in pairs. The interpreter was working in a professional capacity and accompanied patients in their medical consultation and hence participants expressed comfort in taking part with them. Prior to data collection, the researchers attended a street banquet for the homeless and accompanied a street outreach team for several hours to familiarise and build rapport with the homeless population. However, the research team had no links with the study sites or participants.

An interview schedule was developed based on the limited existing literature, discussion amongst the research team, input from HCPs at the specialist centre and use of the Theoretical Domains Framework (TDF). The interview schedule was piloted with a participant at each site.

TDF outlines 14 domains of behavioural determinants, each embodying individual constructs and representing a synthesis of 33 behaviour change theories.[13] These include knowledge, skills, resources, social influences and intentions. TDF enables the identification of appropriate components of planned behavioural interventions, the barriers and enablers which need to be addressed, and the way behaviour changes brought through the interventions can be measured and understood.[14] The researchers have utilised TDF previously in research involving homeless participants.[8,15]

Interviews were audio recorded, transcribed verbatim and analysed through a thematic framework approach[16] by two researchers (EG, SC) and checked by the third researcher (VP) prior to discussion in the team. The first four transcripts were analysed initially to develop a pool of subthemes, in addition to those identified from the topic guides. Interrelated subthemes were then categorised into main themes through inductive coding. This provided a working framework. Each transcript was manually annotated after being read line-by-line. Facilitators and barriers to access and use of services were mapped into the domains relevant to the TDF.

Ethical approval was issued by University of Birmingham. Approval was also gained from Birmingham and Solihull Mental Health NHS Foundations Trust for research within the specialist centre, including the issuance of research passports to the researchers involved. Anonymity was established by coding the setting and participant so that both were unidentifiable. Audio recordings of the interview were uploaded onto encrypted files before being deleted from the recording device. Consent forms were stored in a locked filing cabinet at the University and were accessed only by the lead researcher.

Results

Demographic characteristics
A total of 22 interviews were conducted by two researchers across the four sites. Participant ages ranged from 24 to 70 years. Participants had faced homelessness for less than six months to more than 5 years. A range of routes to homelessness were described by the participants including immigration, loss and bereavement, substance misuse and violence. Most suffered from chronic health conditions and co-morbidities such as epilepsy, diabetes and infectious diseases including HIV and hepatitis C (table 2).

Key themes
Key themes in relation to participant views around their access and experiences of the use of primary care and community services are presented here and summarised in table 3. The

facilitators and barriers identified across these themes from the data are mapped in table 4 against TDF domains.

A. Organisation and delivery of services

i. Patient registration at general practices

Most participants identified the absence of a 'fixed abode' as the biggest barrier to registering at a mainstream general practice where both proof of address and photo identification were often requested by the frontline staff. Those using mainstream practices were either registered prior to becoming homeless or through a mutual agreement between the shelter and the local general practice. Some participants relied upon help from friends or relatives to assist with supplying proof of address by allowing utility bills to come to their names. Some mentioned that there was 'no way' of getting a general practice registration when sleeping rough.

> "getting proof of address when you're on the streets you don't have an address so it does get quite difficult and like I managed to get erm my uncle to let me stay with him for a while, get some bills sent there er like my bank statements stuff like that so I could actually get a GP…I know several people who have been coughing up blood and all that kinda stuff but they can't get in to see a GP coz they can't register". (24-year-old male, shelter A).

> "Since we've come [here], I'm not registered, she's [daughter] not registered [because]' I can't find [a] GP". (32-year-old female, shelter B).

ii. Integration of services

Integration of services was described in the context of signposting, and patient use of mental health and substance misuse services in the community.

Signposting to services

Participants described a lack of signposting to appropriate services. Despite participants being refused registration at local mainstream practices, they mentioned that they were not signposted to alternative services such as specialist primary healthcare centres for the homeless. This resulted in a patient having no access to a general practice for several months. Instead, participants at the specialist centre recalled being signposted to such service by police officers or charity staff.

"I found out about this [specialist centre] from a street warden, err like a police officer, not the doctors that I first went to, the other GPs when I tried to sign up to go to them. I went to about four or five in my postcode. Err all of them says that I couldn't sign up because I had no fixed abode, but none of them give me the details about this [specialist centre]". (43-year-old male, specialist centre).

Integration of services-for mental health and substance misuse

The lack of service integration was also described in the context of mental health and substance misuse services which were deemed to exclude those with the greatest need. Entry thresholds to such services were said to actively obstruct those patients who were self-harming, including those with recent suicide attempts, despite these issues often being precipitated by ill mental health. One participant described such practice as being responsible for many suicide attempts and illicit drug use.

> "…I self-harm a lot right I've had a lot of suicide attempts but what [the mental health services] …if you've self-harmed within the last six months they won't touch you as well as if you're on the alcohol or drugs as well they won't touch you because they think you're too high of a risk…you shouldn't be using [recreational drugs] to self-medicate but when you don't have access to the services what else are you meant to do?". (24-year-old male, shelter A).

Some participants with mental health conditions and concomitant substance misuse mentioned not being able to receive mental health support until they addressed their substance misuse issue despite their perception that these were interrelated, thus placing them in a vicious cycle. A participant described committing crimes with the intention of going to prison in order to access healthcare.

> "I wanted to come off alcohol that bad they said it was killing me- but they couldn't have no funding until April… I got self-sent to prison for three weeks so they could help detox me". (34-year-old male, shelter A).

iii) Continuity of care

Themes around continuity of care were identified in the context of transition of care across services and sharing of patient medical records.

Transition of care across services

Transition of care between secondary and primary healthcare and onto social services were often deemed to be suboptimal in practice. Variation in hospital discharge pathways for homeless patients was reported by those who had been admitted to hospital whilst homeless. One hospital was aware of the participant's homeless status and discharged him only once accommodation had been arranged. However, the accommodation was unsuitable as it had no

fridge to store his insulin. Alternatively, another participant was discharged onto the streets despite making staff aware of his living circumstances.

> "they knew full well I didn't have anywhere to go once they discharged me but they discharged me anyways". (24-year-old male, shelter A).

Participants also gave accounts of how poor transition of care between health and social services can perpetuate the cycle of homelessness. Failure of hospital staff to notify the city council regarding a participant's need for housing upon discharge led to a participant being refused accommodation upon arrival at the council despite his assumption of eligibility. Although the health of the participant had improved, he was forced to return to rough sleeping.

> "I went over to that council and they said that they had no information at all about me coming there so the hospital didn't communicate with them to say that I was going there which then left me on the streets". (24-year-old male, shelter A).

Some participants moved out of the catchment area of their practice and therefore needed to re-register at a new practice, whereas others described not 'bothering' to re-register for being unsure about the stability of their new accommodation.

Sharing of patient medical records

Participants recounted negative experiences of having to re-tell their medical and social history due to the perceived absence of a good system of handover between different services and deemed this to be frustrating given their complex life circumstances.

The participants mentioned that they could not trust HCPs with their health unless they saw them on a regular basis.

> "... you make a relationship with the doctor then the next week you come and it's a totally different doctor and you have to re-tell them your whole life's story…" (43-year-old male, specialist centre).

However, users of the specialist centre described continuity of care in this setting. Staff at the centre also undertook outreach services on the streets and at a local homeless shelter, used a patient's social network in order to contact the patient, provided opportunistic interventions and initiated follow-up. The sense of reliance upon the staff at the practice, however, posed a barrier to the patients relocating to a mainstream general practice.

iv. Waiting times and appointment lengths

Given the multitude of healthcare problems they were facing, several participants described the long waiting lists for an appointment as a barrier to accessing care. Participants explained that they often experienced a rushed appointment in mainstream practices which limited their opportunity to fully discuss the multiple health issues they faced. Participants alluded to the disservice the 'one appointment, one problem' policy was causing them.

> "…it seems like they just like have you in for five minutes…they have a quick chat with you, ask how you feel then like kick you out…like they spend less time with you". (43-year-old male, shelter A).

On the contrary, participants at the specialist centre praised the flexibility of appointments which enabled multiple issues to be addressed in one consultation. Provision of drop-in sessions at the centre was identified as a facilitator of primary care access.

> "most days at one o'clock it's a drop-in, ask for a nurse or a doctor [inaudible] other surgeries you've got to wait two to three weeks to get an appointment, that doesn't happen [at the specialist centre]". (64-year-old male, specialist centre).

Half of participants reported attending A&E in the 12 months preceding interviews and participants described long waiting times and difficulty travelling to the general practice as reasons for presentation at A&E. Long waiting times at A&E itself were also a barrier and led to non-use of 'any' healthcare services by some participants.

> "like I say I got mugged, beaten up right, broken nose, broken toe but I couldn't be bothered to go into A&E and just sit there for eight hours ya know not to mention the fact I would have had to walk all the way from Paignton to Torquay and that's about six miles… I haven't seen any healthcare person since that happened". (24-year-old male, shelter A).

B. Patient-related factors
i. Patient knowledge and awareness of primary healthcare services

Some participants mentioned that they were aware of the mainstream general practices that existed in their local area. A few, however, explained that finding a local practice was not easy given their lack of access to the internet and their unstable living arrangements. Most had attempted to register with a mainstream practice in the recent past, with varying degrees of success. The specialist centre was known only to those participants who were staying in a nearby hostel or who had been referred by personnel such as charity workers and police officers.

"No I don't know anything (about the specialist centre)". (32-year-old female, Shelter B)

ii. Patient skills and health literacy

Some participants felt confident in registering at a mainstream practice as they were able to complete application forms and understand the processes involved. However, others mentioned that they had struggled because of learning difficulties or being unable to comprehend the system.

> "People have dyslexia, people have any learning difficulties, people that maybe are on drugs or addictions will not be able to maybe erm get through so easy in signing up to a GP because of their mental state, personality disorder, erm also not understanding the waiting times and procedures, they get frustrated". (30-year-old male, shelter A).

iii. Patient resources

Some participants described having to walk to services which was restricted by existing health issues and disabilities. Upon becoming homeless, one participant was forced to stop attending counselling sessions for depression and anxiety as he could not afford to pay for transport. One participant explained how severe pain further restricted service access as, upon arrival at the practice, the participant no longer felt well enough to interact with staff.

> "I can't afford fares…by the time I get there and I'm walking, I'm in such a bad mood that I don't talk to nobody". (50-year-old male, shelter C).

Resources were also described in the context of managing prescribed medicines. Participants reported having a large pill burden. A former rough sleeper explained that shelter and food were prioritised above medication when living on the streets. Medicines were often distributed or stolen within social circles. One participant described the difficulty he faced in storing insulin as there was no fridge in the temporary accommodation.

iv. Patient emotions

A person's emotional state was identified as a barrier to accessing primary healthcare. Feelings of embarrassment and depression were examples of emotions which deterred homeless people from seeking healthcare.

"the pain I'm going through I just can't tell anyone about it coz I'm embarrassed". (50-year-old male, shelter C).

"I've not said anything I don't- I don't know if they [GP] could (help)… so I do blame myself… for not mentioning it [homelessness] but I think it's just better that way". (29-year-old female, shelter B).

C. Social exclusion and stigma

While accounts of good relationships between some participants and healthcare providers were described, others perceived being victims of discrimination and stigmatisation by HCPs due to their living circumstances, immigration status and health issues. Participants recounted mistrust between themselves and the HCPs.

"when you go back in and you say [to a GP] something like ya know [the medication has] been stolen, for example, half the time the GP's not going to believe you… they're just gonna think you want another script early because you're using it recreationally…". (24-year-old male, shelter A).

'When we go GP or like er healthcare, no matter dentist or anything, it's different. Some it's very good at treat(ing) like same (equally) but some we feel like (facing) racist (racism). We got problem(s), ill (ness), but you treat us like this. We're humans, we are human(s)". (35-year-old female, shelter B).

The influence of staff attitude on a patient's health-seeking behaviour was emphasised by several participants and said to be a 'decider between life and death' for some homeless patients.

"That could be the decision between him-you finding him alive with a smile on his face tomorrow or dead because of him just choosing to walk in that door because it was a nice nurse on or it was the horrible b*tch that's in on a Wednesday…especially with having HIV ya know…". (33-year-old male, specialist centre).

There was a general perception that good rapport and trust between patients and staff existed at the specialist centre which was found to motivate participants to seek care; the practice was described as 'a little close-knit family'. Staff members were also commended for their tolerance towards 'aggressive' patients and competency in managing co-morbidities.

Some participants also described the experience of facing stigma and exclusion from other service users at mainstream practices which led them to exhibit poor behaviour and be de-registered from services.

"when I've gone through certain circumstances erm I've felt a certain way, everyone's against you, the world's against you, so naturally you're gonna have this mentality and personality that you don't care and you're gonna come across quite abrupt so then… that person automatically knows or thinks that you're from a certain segmentation". (30-year-old male, shelter A).

D. GP awareness of the complex healthcare needs of homeless people

Participants reported diversity in the quality of care they had received. While some GPs would provide additional support to homeless patients, other GPs would 'fail to help'. Some mainstream GPs were also reported to lack awareness of the impact of homelessness on health. Further training for mainstream HCPs to raise awareness of such issues was suggested by several participants in order to improve primary care provision.

"I think they probably need to be made more aware of [homelessness] because there's a lot of erm things that you can face on the streets you can face a lot of illness more than you would do in like a house". (24-year-old male, shelter A).

Discussion

Summary

This study has reported the perspectives of homeless people on their access to and use of primary healthcare services. The homeless population perceived inequality in access and mostly faced negative experiences in their use of mainstream primary healthcare services. Changes are imperative to facilitate access and improve patient experiences of mainstream services. The service delivery model at the specialist centre was perceived by participants to be best practice and so implementing such practice in mainstream settings could help to bring about positive change. Key barriers to the access and use of primary healthcare services related to being denied registration at the mainstream general practices, lack of continuity of care due to unstable accommodation, fragmented services, lack of awareness by primary HCPs on the complexity of homeless people's healthcare needs, inadequate signposting and perceived stigma and discrimination from other patients and HCPs. A total of 12 TDF domains were identified in the data including knowledge; skills; social influences; beliefs about capabilities; beliefs about consequences; emotions; environmental context and resources; goals; intentions; memory, attention and decision processes; reinforcement; social influences; social/ professional role and identity. These domains can be targeted in future interventions. The barriers to primary

healthcare services identified in this study have the potential to widen existing health inequalities. Participants highly valued the provision of the specialist centre.

Strengths and limitations

In exploring the in-depth perspectives of the homeless population on their access to and use of primary healthcare services, this study recruited participants from multiple sites which provided a variety of experiences associated with homelessness and primary healthcare utilisation. The validation and piloting of the research materials, use of theory and subjection of data to rigorous framework analysis increased the trustworthiness of the findings.

This study has some limitations. The study findings may not be representative of the views and experiences of all homeless people. Some participants relayed experiences of their family and friends rather than personal accounts which may reduce reliability of the findings. However, social influences were deemed important in health-seeking behaviour by participants of this study and in our previous work with the homeless population.[9,15] Given the diverse nature of homelessness and participant experiences, data saturation was not achieved. Lastly, there is a potential risk of response bias as participants may have provided desirable answers for fear of repercussions on the care or treatment they receive. Researchers attempted to address this limitation in advance through information leaflets and verbal reassurances.

The participants of this study were mostly male and comprised people living in hostels who were registered with a primary healthcare provider and therefore our results need to be interpreted with caution. However, this compares well against the local demography of the homeless population in West Midlands.[17]

Comparison with existing literature

NHS England states that individuals can register with a general practice regardless of residential status,[18] however, there continues to be confusion at practice level as this study identified homeless people who have been denied registration with a mainstream practice. This study finding corroborates limited existing research and, in addition, provides in-depth patient experiences.[19]

Previous published research found mainstream GPs to report a perceived lack of competence when treating homeless patients owing to the lack of its coverage in the curriculum.[20] This was reflected in the responses of participants which suggested the skill set possessed by mainstream practitioners did not meet the complex needs of homeless patients, contrary to the care provided at the specialist centre. Positive experiences at the specialist centre have been

reported as a barrier to relocating to mainstream practices when patients move to permanent accommodation.[8] Outreach services were found to overcome multiple barriers experienced at mainstream settings.[21] Previous literature suggests that provision of a roof, regardless of accommodation quality, could improve a patient's access to primary care and subsequently their health.[22]

The findings of this study show that a potential barrier to accessing mainstream primary healthcare services by the homeless population could be the current service delivery model. This finding corroborates published literature[23] which indicates that the rigid appointment systems may be difficult to adhere to by homeless patients owing to their chaotic lifestyles.

Implications for research and practice

This study has highlighted the complex interplay of barriers which hinder homeless people's access and experiences of primary healthcare services. The model of service delivery at the specialist centre was regarded by the study participants to be best practice in overcoming many barriers. Whilst commissioning more specialist primary healthcare centres for the homeless would be an idealistic solution to improve their access to primary healthcare, the study findings also suggest that mainstream services need to be adapted to be inclusive of homeless patients. The following recommendations are grounded in the study findings and aim to address key points of weakness in the system in order to improve homeless people's access and experiences of primary healthcare services:

Short-term:
- Training and education of frontline staff at mainstream general practices to reinforce the registration guidelines; emphasising that being of no fixed abode is not a barrier to registering so as to avoid any confusion at practice level.
- National distribution of 'My right to access healthcare' cards to provide guidance to homeless individuals about registering at mainstream providers and facilitate self-advocacy. This scheme is currently limited to London.[24]
- Provision of information to staff at mainstream practices to facilitate signposting to additional health and homeless services; this aims to reduce fragmentation of services and improve continuity of care.
- Review of entry criteria to primary care mental health services for homeless people in order to increase accessibility. The homeless face additional stresses and risk factors compared to the housed population and should have a lower entry threshold to mental health services to improve timely access.

- Compliance with the homelessness reduction act*[25] to ensure healthcare settings proactively identify vulnerable people and work collaboratively with social services to offer support so that patients are no longer discharged to the streets and are referred to primary care services for seamless care .

* The Homelessness Reduction Act 2017[25] mandates local housing authorities and health service providers to provide anticipatory and corrective measures for the reduction of homelessness and came into force for health service providers in October 2018.

Long-term:
- Provision of a health needs assessment tool for use by primary care practitioners. This will support practitioners to feel more confident when addressing complex issues and ensure a holistic approach to the care of homeless patients.
- Incorporation of healthcare for the homeless into the standards for education of HCPs to increase understanding, improve quality of care and reduce perceived discrimination towards this marginalised community.
- Training of designated staff to deliver specialist care in those mainstream practices with a high homeless population and facilitating access to multiple services under the same roof within these practices, thus sharing good practice identified at the specialist centre

An inventory list of specialist services available for the homeless population has recently been developed[8] that can help commissioners undertake a local needs assessment of services. However, facilitating access to mainstream services also requires addressing wider barriers identified in this study. For example, anti-stigma intervention for HCPs such as the 'targeting the roots of healthcare provider stigma'[26] can be useful. This model requires improving: the ability of healthcare professionals to cope with the feelings and emotions when working with patients in challenging situations; improving competence and confidence of staff; and addressing the lack of awareness of one's own prejudices. The lack of understanding of homelessness by healthcare professionals may be responsible for the discrimination experienced by the participants. Previous research has linked low self-esteem and subsequent paranoia for such perceptions[23] but those suggestions are not consistent with the findings of this study.

Obtaining the views of wider stakeholders, such as mainstream primary care providers, would provide further insight into the barriers and facilitators to accessing primary healthcare services. Evaluation of various service delivery models, such as outreach programmes and non-medical prescribing, including their impact on homeless people's health and quality of life outcomes is warranted.

Additional information

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