Reference (Harvard)

Rae, B.E. & Rees, S. (2015) The perceptions of homeless people regarding their healthcare needs and experiences of receiving healthcare. *Journal of Advanced Nursing* Vol.71, Iss.9, pp 2096-2106

ABSTRACT

Aims. To understand the perspective of the homeless about their healthcare encounters and how their experiences of receiving healthcare influence their health seeking behaviour.

Background. A phenomenological study undertaken because of increasing levels of homelessness in the United Kingdom (UK). Most of the current literature is American or Canadian.

Design. An interpretive phenomenological inquiry.

Method. An opportunistic sample of fourteen single homeless adults was recruited from one male hostel and one non-residential day centre. Data collection was done in 2013. Semi-structured audio-recorded interviews were conducted one-to-one. Colaizzi's method for data analysis was used.

Findings. Three major themes emerged. Expressed Health Need, Healthcare Experiences and Attitudes to healthcare. Health problems are recognised by the homeless but the need for intervention is not always prioritised. Obstacles in access to healthcare in the UK are both perceived (attitudes towards the homeless; previous bad experience) and actual (difficulty in registering with a general practitioner, difficulty travelling to services, being forced to move to new area). Some homeless people feel they are treated with prejudice and receive substandard care. Positive healthcare experiences were also reported.

Conclusions. Positive and negative healthcare encounters can profoundly affect the homeless. Recommendations: Address apparent inconsistency of care; promote greater interdisciplinary communication and referrals to homeless services from prisons and hospitals; increase the availability of intermediate services; reduce obligation of homeless to move area; research experiences of homeless families.

Keywords.

Homelessness, healthcare, perceptions, phenomenology, lived experience, inconsistency, intermediate services, nursing.

Summary Statement

Why is this research needed?

- Very little current United Kingdom research that addresses the perspective of the homeless on their healthcare experiences.
- Understanding what influences the health seeking behaviour of the homeless as a population with substantial health care needs.
- Aim to improve engagement appropriately with the homeless in striving to deliver consistent healthcare.

What are the key findings?

- Poor level of communication between services, especially around discharge.
- Perceived (such as attitudes towards the homeless) and actual (such as inability to register with a general practitioner) difficulty in engaging with healthcare services.
- For the homeless who are motivated to seek help, positive and negative healthcare experiences have a profound effect on health seeking behaviour.

How should the findings be used to influence policy/practice/research/education?

- Further research/audit of healthcare provision and engagement of the homeless.
- Greater use of intermediate services to assist effective discharge from secondary care/prisons.

- Improved access to primary care services and communication between services, including referral to homeless service providers.

INTRODUCTION

Homelessness in the United Kingdom (UK) is, for the purposes of this research, those living on the street, using shelters, temporary accommodation or hostels. Shelters provide only a place to sleep, for a few nights and are council or charity run. Additional cold weather shelters are available from December to March and are mostly charity run. Temporary accommodation is a shared house that is council or charity owned. Hostels provide longer term accommodation where individuals or families have one room and shared community areas. Statutory homeless are given priority in finding accommodation, as are pregnant women, adults with dependent children, those vulnerable through old age, mental illness, disability or emergency such as fire or flood (UK Government 1996a). Ineligibility for support includes those who are deemed to be intentionally homeless (UK Government 1996a) and immigrants not habitually resident in the UK (UK Government 1996b). Those with priority now include those who had been in custody, in the Forces or at risk of violence (UK Government 2002, DCLG 2012).

The average age at death of a homeless adult in the UK is 47 years; 30 years younger than the average age at death of the domiciled population (Thomas 2012). The main causes of death are cardiovascular, drug or alcohol related. The overall causes of death reflect significantly more accidental or deliberate causes (suicide or undetermined intent) as opposed to disease (Thomas 2012). People with mental illness also have a younger than average age at death (Chang *et al.* 2011) and a high incidence of mental illness among the homeless contributes to morbidity and early mortality (Commander & Odell 2001, Woollcott 2008, Joyce & Limbos 2009, Kirkpatrick & Byrne 2009, Williams & Stickley 2010, Lamb *et al.* 2011). This is compounded by the Inverse Care Law which identifies that those most in need of care are least likely to receive it (Tudor Hart 1971, Fiscella & Shin 2005, Hill & Rimington 2010).

BACKGROUND

This phenomenological research was undertaken because the level of statutory homelessness in England has risen to 48,510 in the last quarter of 2011, an increase of 10% from the previous year; there were an additional 48,920 identified in temporary housing, three quarters of these are in London (DCLG 2012). The scale of hidden homeless, non-visible rough sleepers, squatters and 'sofa surfers' is, by definition, unknown. Visible rough sleeping in England is estimated by counts done by councils throughout the country on a single night and shows an increase of 23% from 2010 to 2012 (DCLG 2013).

The researcher, working clinically with the homeless, saw varied levels of engagement with healthcare, gaining some insight into the reasons for this may be a valuable step towards improving engagement and health-seeking behaviour. Moreover, understanding the health challenges faced by the homeless can potentially help inform services where gaps in provision or engagement exist. While current UK literature was insufficient to provide a rich reflection of the homeless using – or not using – the National Health Service (NHS), current phenomenological studies into the lived experience of the homeless in the USA and Canada is more abundant. The USA and Canada have different cultures and healthcare systems and some of the themes raised in their literature are unique to them, of the themes are echoed in UK literature and are relevant and applicable.

Daiski (2006) conducted a Canadian descriptive phenomenological study to understand perspectives about the healthcare needs of a sample of 24 men and women. Reported needs were repeated infections, addiction and injury. Physical and mental health was worsened by street and shelter living. Engaging with services was not straightforward; lack of money, transport and poor past experiences can limit access. While there may be recognition of health problems, priorities depend on their immediate situation (John & Law 2011, Bigelow & Stepka 2012) and healthcare may not be sought until the impact is severe (Cocozza-Martins 2008, Hill & Rimington 2011). Commander and Odell (2001) compared the needs of homeless and never-homeless patients with psychotic disorders in a study, including patient perception of their mental disorder. The perceived need for intervention in mental health was significantly lower than the domiciled patients. Swigart and Kolb (2004) found fear and apathy prevented engagement with mobile tuberculosis services in the USA.

Williams and Stickley (2010) stated a homeless person is 40% less likely to be registered with a General Practitioner (GP) in the UK than a domiciled person. Homeless individuals are entitled to register with a primary care service and can use the surgery's own address to enable this (Crisis 2002) but Woollcott (2008) indicates that there has been little improvement in access to primary care. Lamb *et al.* (2011), in reference to mental health in primary care, identified stigma, discrimination and poor experience of previous healthcare encounters resulting in loss of confidence in others and withdrawing from society.

Phenomenological studies have identified that being ignored by society, or in healthcare settings, does discourage health seeking behaviour (Daiski 2007, Nickash 2009, Wen, Hudak & Hwang 2007). Schmidt-Bunkers (2004) conducted a phenomenological-hermeneutic study in the USA to understand if homeless women feel other people care about them and their well-being. This research was not exclusively in the context of healthcare but one theme was positive healthcare encounters, which recognised the women as individuals, concern for their welfare and acknowledgment of their feelings.

Neale and Kennedy (2002) interviewed providers of drug addiction services (12 people) and 36 service users, exploring delivering good service in Scotland. Both groups identified being respectful and non-judgemental as highly important. Service users rated practical help higher than the service providers. Tweed, Biswas-Diener and Lehman (2012) in Canada and Williams and Stickley (2010) in the UK both recognised attitudes of positivity and hope important for engaging with an often hard to reach population.

THE STUDY

AIMS

To understand to understand the perspective of the homeless about their healthcare encounters and how their experiences of receiving healthcare influence their health seeking behaviour.

DESIGN

The hermeneutical, or interpretive, phenomenology was the approach adopted to present an accurate and trustworthy representation of the participants' experiences (Benner 1994, Grbich 2007, Cowan 2009, Parahoo 2006) through depth and richness of data (Thorne 2000). Working as an Advanced Nurse Practitioner (ANP) where 15% of the practice population is homeless, the researcher felt unable to authentically adopt bracketing, which requires the researcher to remove entirely their beliefs, experiences and attitudes from the research process (LeVasseur 2003, Dowling & Cooney 2012). Instead, a reflective diary was written, in keeping with Heidegger's idea of 'dasein', or self-awareness (Mackey 2004, Bulman & Schutz 2004). Burton (2000) questions the validity of reflective practice, stating there is a lack of empirical evidence to support it, but as a novice researcher this journal was helpful in maintaining clarity of personal values and maintaining objectivity (Jootun, McGhee & Marland 2009, Johns 2006).

Sample

The convenience sample was recruited from two local homeless services; one hostel for men and one non-residential facility for male and female homeless, providing drug and alcohol rehabilitation and structured programmes to return clients to domiciled status. The people using this facility were sleeping on the street, in shelters, hostels or temporary accommodation.

Twenty-seven people were approached and twenty agreed to participate. One changed his mind before signing the consent form. Another three, who were street-homeless, could not stay as they were informed emergency accommodation was available and therefore had to leave immediately. Another was approached by his key worker and agreed to meet the researcher. On introduction the researcher realised they had previously met in a clinical context and was therefore he was ineligible. Another agreed to be interviewed but could not be included as it transpired she had recently moved into permanent accommodation so was no longer homeless. Two women and twelve men were interviewed. The bias was due to who was opportunistically available and interviewing at a men's hostel. The inclusion criteria were: a) Homeless defined as living on the street; living in sheltered, temporary or hostel accommodation or sofa-surfing without knowledge of when or if permanent housing will be available; b) Willingness to participate and have their voices recorded; c) Ability to understand and speak English; d) Not previously known to the researcher; e) 18 years or older and f) Free from uncontrolled psychotic illness and not intoxicated during the interview.

Data Collection

The research was conducted over nine months between September 2012 and May 2013. The interviews were conducted over a three week period over January and February 2013. Once the individual was ready to start the interview, the researcher verbally announced switching on the audio-recorder. Although note-taking during the interview is advocated by other researchers even when recording (Rubin & Rubin 2005), the researcher felt this would be too distracting for both her and the interviewee. In the interests of veracity, audio-recording was used to avoid diverting the attention of the researcher, or accidental bias in note-taking and recall. Open ended questions were used in one-to-one semi-structured interviews, with prompt questions to explore what had been said or to encourage expansion (Table 1) (Doody & Noonan, 2013).

A £5 supermarket voucher was given to each participant to thank them for their time. There was no reference to this in the information sheet or pre-interview discussion to avoid unwitting coercion in the decision to participate. The vouchers were given to all 14 participants with 24 hours of the last interview being completed.

Ethical Considerations

This study was approved by a university Ethics Committee. The consent form was signed only after written information had been given and discussed. Verbal reiteration of right to withdraw consent at any time was given. All the participants were voluntary and had capacity to give consent. Confidentiality was assured verbally, in the information sheet and the consent form. While it is aimed this paper will add to current knowledge, it was explicit in the information sheet and in pre-interview discussion that the study would not directly benefit the participants. Aware that difficult memories and experiences could arise during the course of the interviews meant that it was important to be aware of appropriate support prior to beginning the interviews as it was incumbent on the researcher to do no harm and to actively support their wellbeing (RCN 2004, NMC 2008). An internal phone, silent to incoming calls, was in the interview room. In the event of any significant distress the researcher would have terminated the interview, contacted their keyworker and stayed with the participant. However, this did not arise.

Data Analysis

Colaizzi's (1978) eight-step method of analysis was selected for its suitability for this study (Table 2). It is relevant at every point, providing a sound framework where to answer the question (Sanders 2003, Loiselle *et al.* 2010). Conducting the interviews and transcribing them began the process of author immersion. All the audio-recorded interviews were downloaded and transcribed verbatim. Transcription was done as soon as possible after the interview; the longest completion time was eight days post-interview. All interviews were re-read while listening to the recordings to correct any errors. The procedure was repeated to ensure nothing had been overlooked and if an error was found, the procedure was repeated. The transcribed interviews were uploaded into NVivo10 to organise the significant statements into meaningful clusters. These were then compared with the original interviews to ensure the right statements had been captured and none omitted. Detailed descriptions of each statement were written to assist author immersion, before formulating succinct statements.

The final step was to verify the interpretation of the interviews. It was not possible to make verification part of the inclusion criteria, due to the transient population. It had been hoped that at least those living in the hostel would be available. However, two had been evicted, others were unavailable. Two people were willing to meet the researcher again to verify the interpretation and representation of their interviews. McConnell-Henry, Chapman and Francis (2011) criticise the use of member checking, arguing that it is an illogical step as qualitative research is not intended to be generalizable. Sale (2008) is also critical, stating researchers assume that different perspectives will define the same version of truth. They appear to assume the researcher interprets the meaningful statements in one theme as identical but this is not the case. In this study, member verification is used to verify the meaning of what was said, not to expand the data. If any disagreement had arisen, this would have been presented alongside the original interpretation (Ryan-Nicholls & Will 2009).

Rigour

Guba and Lincoln (1982) developed a four part test for rigour – credibility, applicability, dependability and confirmability - which was applied in this study. Credibility in results is achieved with transparency of methodology and analysis. Applicability addresses how far it is possible to generalise from the principles identified from the data which are relevant beyond the study. Dependability demands that the procedure should be reproducible in its entirety by another researcher. Finally, conformability is deemed to be the neutrality of the researcher and the effort to avoid bias, which has been addressed in 'design'.

FINDINGS

The demographic details of the sample are given in Table 3. Individuals are coded by gender and age, so M44b is one of two males aged 44. After thoroughly reading the interviews, 286 separate significant statements were extracted from the 14 interviews. These were reread and the formulated meanings (Table 4) were then clustered under provisional headings and deeper examination of the meaning allowed the researcher to find commonality in content, so defining three major themes. Theme one is expressed health need. Theme two is healthcare experiences. Theme three is attitudes; their own and attitudes towards them.

Theme One – Expressed Health Need

Priorities

Throughout the interviews it was explicit that the priorities of the homeless in their daily life altered the importance they attached to their health and well-being and therefore their healthcare seeking behaviour. When they had fewest resources (shelter, money, food) they frequently neglected themselves until crisis point. One man, referring to his time living on the street, explained:

> When people are homeless they don't really want to see doctors. It's only if they're really bad. Then they go to hospital. (M49).

One woman described the time she had been living on the street up to 8 months previously and addiction overruled all other considerations:

> There would be days I would be on a period, instead of buying tampons or towels, I'd use tissue because every penny I put together I'd use for alcohol and drugs. (F44).

She discussed how her priorities changed from the time she lived on the street:

> I haven't done any other sort of sexual examinations, which I know I should do. And I probably will, now I've been put in a hostel. All these things are a bit more concerning, … when I've been clean and been able to <u>think</u>. (F44).

A man described how he lost his home after falling behind with payments when his common-law wife of 20 years was diagnosed with cancer and died within three months. In his grief he lost the energy and will to appeal and did not value his own well-being:

> I just needed to clear my head, with my wife and everything, I just wanted to go to sleep. I didn't really care. I had nothing to give up. I had nothing. (M53c).

Their reasons for not prioritising health are multiple and are not just about *being* homeless; it is what effect that has, as well what has preceded the homelessness. One man commented on the fact that getting a roof after being street-homeless does not suddenly change the psychology or habits of the person overnight:

> It doesn't end there, you know, the living condition doesn't change you into being a hygienic person. (M50).

Safety

Several participants cited occasions they had been subjected to violence or felt threatened:

> I was attacked … when I was first kicked out of the hostel and I had nowhere to go, so obviously people recognise you in the street, especially if you're in the same place all the time. (F30).

> I've been hurt. I got punched in the face, so yeah, it's been difficult. (F44).

> There was a big safety issue [in a shelter]. That was in the sense of, you've got a lot of drugs there, a lot of people who are on cocaine, heroin. Like, the first night I was there I got into four arguments and I like to keep myself to myself. (M44b).

> I had quite a few hidings while I was on the street, people see you sleeping there, they thought it was a good idea to give me a kicking. I had both my shoulders broke, three broken ribs and a broken ankle after one attack, because I was in a sleeping bag. (M46).

Lack of resources

The interviews revealed how lack of resources, (money, shelter, food) influenced their health. This lady describes her poor diet. By stating she is 'subjected' to poor food it is clear that this is not through preference or laziness, but lack of choice:

> Not having money to support and that, you can only buy cheap food. So then you're subjected to eating junk 'cause it's the cheapest food. (F30).

> But anything's better than the streets. With me having a slipped disc previous and with me being out in the cold, it's got worse. (M44b).

> The weather and conditions that you live in, sometimes it means you don't even think about that side of your health. (M50).

After a life threatening episode of illness, one man was discharged back to sleeping on the street:

> I got trapped in [hospital] for weeks before the pneumonia went. When I came out of there, I was straight out on the streets. (M53c).

> My health's OK, but mental illness, I suffer from mental illness. It affects me quite a lot. I've been to A&E for drug overdoses and self-harming. (M34b).

> I went to the doctors, basically I had this sore foot, basically trench foot and it was painful. (M46).

This is a pertinent illustration of the necessity for healthcare providers to understand not just the health issues of their patient, but the context of their lives, problems and priorities to be able to foster trust and engagement.

Theme Two – Healthcare Experiences

Access to Healthcare

Having spoken about the priorities of the homeless and the circumstances under which they neglect their health, it would be a short but misplaced step to assume access to healthcare is not given only because it is not wanted. Six of the participants said they had been obliged to move to an area they didn't know, which meant losing their own GP and then having difficulty in registering elsewhere. Several participants had been refused registration with a practice because they had no fixed abode and none had been offered the surgery address as a 'care of' address (Crisis 2002). Some were able to use a day centre address as a 'care of' address and day centres know which GP practices will welcome homeless patients. None of the participants reported having zero healthcare encounters, needs, or not seeking healthcare:

> They want proof of address of where you live and stuff like that and that's what I didn't have. (M44b).

> 'cause I was homeless there were only certain doctors who would accept homeless people and most of them were up in the city. (M46).

> When you're homeless you can't really get healthcare because doctors need you to have an address for where you're staying and all that, so if you're staying nowhere and you ain't got a 'care of' address you don't get no healthcare. (M49).

Positive experiences

Flexibility from the GP was valued and helped to keep patient engagement. This was not about absolving the patient from responsibility, but understanding their circumstances:

> And they knew, right, because I was sleeping rough, I ain't going to get there at a certain time. I turn up and they say 'Yes, alright fair enough, sit down, you might be an hour. (M49).

> The drug and alcohol awareness team; I don't know… I've had amazing help through them. (F44).

> She took it upon herself to say you're OK in not being on the streets now, but what is the effect that you've had as a healthy person? What has changed about you?

And she sat down with me and said, I'm going to put some appointments together and every now and then I'll examine you. (M50).

My GP's very, very good. I've had psychiatric care and all of that from him. (M53b).

The day services, they turned me around. They helped a lot. They got me a doctor that I could see and who would see me for who I was, not what they thought I was. M46

Negative experiences

In this study being given technically correct but unrealistic advice made the participants feel unwelcome and uncared for:

I was weighed today and told I was morbidly obese by my doctor; that I need to go on a diet and that. Tch! *[Laughs.]* (F30).

I've always been susceptible to chest infections. So I had to go and see a doctor about that. And they'd say, 'Oh, there's nothing wrong with your lungs, you've just got a heavy cold, you've just got to relax and rest. [Raises his eyebrows.] That's kinda difficult when you're homeless. (M34a).

Five participants mentioned that they had been released from prison with no fixed abode; no contact had been made on their behalf with homeless services. In spite of the priority recognition to those leaving custody and domestic violence (DCLG 2012), in practice this made no difference to the participants in this study who became homeless after 2011 under those circumstances.

The responses to being asked how they feel about seeking medical help now were mixed. Some who currently had a GP and had felt they had received good care didn't foresee any problems asking for healthcare. Those who felt they had been treated badly and one was currently registered with a GP, said they did not trust they would be listened to and preferred to go to A&E if they felt they really had to. Poor discharge planning from hospital resulted in substandard care and highlights the lack of communication between services. Two participants mentioned that they had been given the details of night shelters by police while they were on the street, but none had been given such details in A&E:

> As for the hospitals, all they want to do is discharge you. I went straight back to where I'd been attacked which was the only place under shelter. They didn't care. (M46).

> I was 5 weeks in hospital, 'cause pneumonia – chronic pneumonia gets into the bones and that'll kill you quick time. They said, 'You got to be careful 'cause you can catch it again.' But I was still out there in the cold, outside. (M53c).

Theme Three - Attitudes

Across the interviews participants talked about how they felt about themselves and their situation and their values:

> She tells me things and then I try and do 'em. So then she knows I'm trying to help myself as well. In this life if you don't help yourself [other] people can't do it for you. (M49).

> I don't like being told what to do – you've got to do this, you've got to do that. If I wanna do it, I'll do it, I'll go along with it. My choices, not theirs. I wanted CBT. I wanted to come off drink. I knew what damage it was doing to me. (M46).

> Of my own accord I do AA meetings every day. (F44).

The sense of responsibility was an unlooked for response but clearly showed that there is a population in great need of health and social care that can respond to positive regard, being listened to and appropriate care. Not being listened to or treated as an individual also blocks engagement:

> There's a lot of prejudice against you. <u>A lot</u>. They seem to think all people on the streets are with drink and drug problems, but they're not. (M46).

> Because I'm homeless I'm not seen as a priority. I have problems just like everybody else but I'm not treated equally. I know that. 'Cause she goes, 'I've got patients waiting.' Am I not a patient? (F30)

> Sometimes it's hard to talk to a nurse. They don't listen sometimes. (M43).

> When you're in a shelter, the staff don't treat you as a person. They treat you as cattle. (M44b).

Finally, the participants also talked about their own feelings and their outlook:

> *My confidence level has gone down.* (M29).

> So when I see someone else in a worse situation than me, I wouldn't really blame them, I wouldn't really be negative to them because everyone's been through their dramas; everyone's got their own demons. (M34a).

> I find opening up about personal stuff difficult. (M44a).

> So thank God for the GPs and thank God for this place [day centre]. (M50).

DISCUSSION

Delay in health seeking behaviour by the homeless is recognised by Cocozza-Martins (2008) and Hill and Rimmington (2011). While the homeless recognise their health issues, their assessment of need for intervention varies from that of healthcare professionals much more than the domiciled patients (Commander & Odell 2001).

The participants in this study were consistent in how they discussed their priorities. Two key aspects consistent with other studies were survival – finding shelter, food and stability (Morell-Bellai *et al.* 2000, John & Law 2011, Bigelow & Stepka 2012) and escapism from the reality of their lives through alcoholism and drug addiction (Cocozza-Martins 2008, Pauly 2008, Williams & Stickley 2010).

In keeping with other literature, positive healthcare experiences have been with clinicians who listened, did not make assumptions and showed interest and concern (Schmidt-Bunkers 2004, Raven *et al.* 2011). Nickash (2009) also found the downward spiral effect of poverty and street-sleeping on the health of the homeless. Neale and Kennedy (2002) identified that follow-up care is valued, as reported in this study. When a homeless person seeks healthcare, it is important to them that the healthcare and advice is personally relevant and takes account of the impact of not being domiciled (Finfgeld-Connett 2010, Neale & Kennedy 2002, Billings & Kowalski 2008). Participants in this study felt discouraged from seeking healthcare when they had been given inappropriate or impractical advice.

The attitudes of society generally and healthcare professionals frequently can be difficult to deal with when people make assumptions because of their homeless status (Daiski 2007, Nickash 2009, Wen, Hudak & Hwang 2000, Williams & Stickley 2010).

The homeless can feel they are treated as though they are worthless, compounding loss of confidence and social isolation. Conversely, when someone is ready to seek healthcare they are very responsive when someone does listen, show concern and the professionalism to give non-judgemental and personalised healthcare (Schmidt-Bunkers 2004).

Limitations of this study

It is acknowledged that the sample was limited; no families or minors were interviewed for this study so their views and experiences are not represented. A further limitation is that those who were interviewed were ready to engage with services and had, at some point, sought help. This study does not represent those who do not wish to or do not know how to engage with healthcare. Finally, member verification was possible with only two participants, which was fewer than the researcher had hoped, which could arguably compromise the rigour.

CONCLUSION

This phenomenological framework has successfully addressed the question, with implications for current practice. This study offers an insight into the healthcare experiences of homeless people and the factors that influence their health and choices, addressing a gap in current UK literature. It has revealed gaps between services in terms of inadequate discharge planning. There are perceived and actual obstacles which both limit access to healthcare. While motivation in healthcare seeking behaviour is variable among the homeless, there were those who showed a strong sense of self-responsibility. This study highlights that when homeless individuals feel marginalised, when their problems are inadequately addressed or they experience difficulties accessing healthcare, this can have a profound negative impact on their health seeking behaviour and engagement. This was underlined by the positive encounters that helped the homeless individuals feel welcomed and supported and made a material difference to their well-being and life-style. The consequences of healthcare encounters can be profound for the homeless as a vulnerable population and opportunities to engage and give constructive assistance are valuable.

The inconsistency of services could be investigated; for example, the difficulty in registering with GP surgeries. No healthcare professionals were interviewed in this study, so reasons for reluctance to accept homeless patients are unclear and open to inquiry. More effective communication between prisons, A&E Departments, GP practices and homeless services could be investigated with the aim of reducing the incidence of being discharged back to the street with no information or referral to homeless services. Research into the experience of homeless families and minors would be valuable to understand how vulnerable children are having healthcare needs met. Intermediate services that liaise with primary and secondary services in managing discharge plans and patient care to reduce unnecessary admissions or A&E attendance have not been a part of this research question. They are not universally available and consideration of their effectiveness where they do exist would be a positive next step.

References

Benner, P. Ed. (1994) *Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness* Sage Publications, London.

Bigelow, A. and Stepka, D. (2012) Smoking cessation in adults who are homeless *Practice Nursing* 23(8), 406-412.

Billings, D.M. and Kowalski, K. (2008) Increasing Competency in the Care of Homeless Patients *The Journal of Continuing Education in Nursing* 39(4): 153-154.

Bulman, C. and Schutz, S. (2004) *Reflective Practice in Nursing* 3rd Edn. Blackwell Publishing, Oxford.

Burton,B.A. (2000) Reflection: Nursing's Practice and Education Panacea *Journal of Advanced Nursing* 31(5): 1009-1117.

Chang, C.K., Hayes, R.D., Perera, G., Broadbent, M.T.M., Fernandes, A.C., Lee, W.E., Hotopf, M. and Strewart, R. (2011) Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Healthcare Case Register in London *Plos One*
Available at:
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0019590
Accessed on 8th November 2012

Cocozza-Martins, D. (2008) Experiences of homeless people in the healthcare delivery system: A descriptive phenomenological study. *Public Health Nursing* 25(5), 420-430.

Colaizzi, P. (1978) Psychological research as a phenomenologist views it. In R. Valle & M. King,eds, *Existential-phenomenological alternatives for psychology.* Oxford University Press.

Commander, M.J. and Odell, S.M. (2001) A comparison of the needs of homeless and never homeless patients with psychotic disorders *Journal of Mental Health* 10(4), 449-456.

Cowan, D. (2009) *Research Issues in Health and Social Care* M&K Update Ltd, Cumbria.

Crisis (2002) *Policy Brief: Critical Condition: Vulnerable Single Homeless People and Access to GPs.*
Available at:
http://www.crisis.org.uk/data/files/publications/GP_policybrief[1].pdf
Accessed on 16th January 2013

Daiski, I. (2006) Perspectives of homeless people on their health and health needs priorities *Journal of Advanced Nursing* 58(3), 273-281.

Department for Communities and Local Government (2012) *Statutory Homelessness: October to December Quarter 2011 England.*
Available at:
http://www.communities.gov.uk/documents/statistics/pdf/2102020.pdf
Accessed on 17th October 2012.

Department for Communities and Local Government (2013) *Rough Sleeping Statistics England – Autumn 2012 Experimental Statistics*
Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/73200/Rough_Sleeping_Statistics_England_-_Autumn_2012.pdf
Accessed on 11th February 2013

Doody, O. and Noonan, M. (2013) Preparing and conducting interviews to collect data *Nurse Researcher* 20(5): 28-32

Dowling, M. and Cooney, A. (2012) Research approaches related to phenomenology: negotiating a complex landscape *Nurse Researcher* 20(2): 21-27

Finfgeld-Connett, D. (2010) Becoming Homeless, Being Homeless and Resolving Homelessness Among Women *Issues in Mental Health Nursing* 31: 461-469.

Fiscella, K. and Shin, P. (2005) The Inverse Care Law: Implications for Healthcare of Vulnerable Populations *Journal of Ambulatory Care Management* 28(4): 304-312

Grbich,C. (2007) *Qualitative data analysis, an introduction* Sage Publications, London.

Guba, E.G. and Lincoln, Y.S. (1982) *Effective Evaluation: Improving the Usefulness of Evaluation Results Through Responsive and Naturalistic Approaches* Jossey Bass Publishers, London.

Hill, K.B. and Rimmington, D. (2011) Investigation of the oral health needs for homeless people in specialist units in London, Cardiff, Glasgow and Birmingham *Primary Healthcare Research and Development* 12(2): 135-144

John, W. and Law, K. (2011) Addressing the health needs of the homeless *British Journal of Community Nursing,* 16 (3). pp. 134-139.

Johns, C. (2006) *Engaging Reflection in Practice: A Narrative Approach* Blackwell Publishing, Oxford.

Jootun, D., McGhee, G. and Marland, G.R. (2009) Reflexivity: promoting rigour in qualitative research *Nursing Standard* 23(23): 42-46

Joyce, D.P. and Limbos M. (2009) Identification of cognitive impairment and mental illness in elderly homeless men *Canadian Family Physician* 11(55):1110-1.e1-6
Available at:
http://www.cfp.ca/content/55/11/1110.full.pdf+html
Accessed on 10th October 2012

Kirkpatrick, H. and Byrne, C. (2009) A narrative inquiry: moving on from homelessness for individuals with a major mental illness *Journal of Psychiatric and Mental Health Nursing* 16: 68-75

Lamb, J., Bower, P., Rogers, A., Cowrick, C. and Gask,L. (2011) Access to mental health in primary care: A qualitative meta-synthesis of evidence from the experience of people from 'hard to reach' groups. *Health* 16(1): 76-104

LeVasseur, J.J. (2003) The Problem of Bracketing in Phenomenology *Qualitative Research* 13:408
Available at: http://qhr.sagepub.com/content/13/3/408
Accessed on 6th May2013

Loiselle, C.G.,Profetto-McGrath, J., Polit, D.F. and Tatano-Beck, C. (2010) *Canadian Essentials of Nursing Research* Lippincott and Williams, Canada.

Mackey, S. (2004) Phenomenological Nursing Research: methodological insights derived from Heidegger's interpretive phenomenology *International Journal of Nursing Studies* 42 pp 179-186.

McConnell-Henry, T., Chapman, Y. and Francis, K. (2011) Member checking and Heideggerian phenomenology: a redundant component *Nurse Researcher* 18(2): 28-37

Morrell-Bellai, T., Goering, P.N. and Boydell, K.M. (2000) Becoming and Remaining Homeless: A Qualitative Investigation *Issues in Mental Health Nursing* 21: 581-604.

Neale, J. and Kennedy, C. (2002) Good practice towards homeless drug users: research evidence from Scotland *Health and Social Care in the Community* 10(3) 196-205

Nickash, B. and Marnocha, S.K. (2009) Healthcare experiences of the homeless *Journal of the American Academy of Nurse Practitioners* 21, 39-46

NMC (2008) *The Code: Standards of conduct, performance and ethics for nurses and midwives.* Nursing and Midwifery Council, London.

Pauly, B. (2008) Shifting moral values to enhance access to healthcare: harm reduction as a conflict for ethical nursing practice *International Journal of Drug Policy* 19: 195-204.

Parahoo, K. (2006) *Nursing Research, Principles, Process and Issues* 2nd Edn. Palgrave Macmillan, Hampshire.

Raven, M.C., Doran, K.M., Kostrowski, S., Gillespie, C.C. and Elbel, B.D. (2011) An intervention to improve care and reduce costs for high-risk patients with frequent hospital admissions: a pilot study *Health Services Research* 11:270.

RCN (2004) *Research Ethics* Royal College of Nursing, London.

Rubin, H and Rubin, I. (2005) *Qualitative Interviewing: The Art of Hearing Data* 2nd Edn. Sage Publications, London.

Ryan-Nicholls, D. and Will, C.I. (2009) Rigour in qualitative research: mechanisms for control *Nurse Researcher* 16(3) 70-85

Sale, J.E.M. (2008) How to assess rigour…or not in qualitative papers *Journal of Evaluation in Clinical Practice* 14: 912-913

Sanders, C. (2003) Application of Colaizzi's method: Interpretation of an auditable decision trial by a novice researcher *Contemporary Nurse* 14 (3): 292-302.

Schmidt-Bunkers, S. (2004) The Lived Experience of Feeling Cared For: A Human becoming Perspective *Nursing Science Quarterly* 17(1), 63-71.

Swigart, V. and Kolb, R. (2004) Homeless Person's Decisions to Accept or Reject Public Health Disease-detection Services *Public Health Nursing* 21(2): 162-170.

Thomas, B. (2012) *Homelessness Kills* Published by Crisis, London.
Available at:
http://www.crisis.org.uk/data/files/publications/Homelessness%20kills%20-%20full%20report.pdf
Accessed on 17th October 2012

Thorne, S. (2000) Data analysis in qualitative research *BMJ Evidence Based Nursing* 3: 68-70
Available at:
http://ebn.bmj.com/content/3/3/68.full.html
Accessed on 13th February 2013

Tudor Hart, J. (1971) The inverse care law *The Lancet* i. 405-412.

Tweed, R.G., Biswas-Diener, R. and Lehman, D.R. (2012) Self-perceived strengths among people who are homeless *The Journal of Positive Psychology* 7(6): 481-492

UK Government (1996a) *Housing Act*
Available at:
http://www.legislation.gov.uk/ukpga/1996/52/contents
Accessed on 11th February 2013

UK Government (1996b) *Asylum and Immigration Act*
Available at:
http://www.legislation.gov.uk/ukpga/1996/49/contents
Accessed on 11th February 2013

UK Government (2002) *Homelessness Act*
Available at:
http://www.legislation.gov.uk/ukpga/2002/7/pdfs/ukpga_20020007_en.pdf
Accessed on 7th October 2012

Wen, C., Hudak, P. and Hwang, S. (2007) Homeless people's perceptions of the welcomeness and unwelcomeness in healthcare encounters *Journal of General Internal Medicine* 22(7), 1011-1017.

Williams, S. and Stickley, T. (2010) Stories from the streets: people's experiences of homelessness *Journal of Psychiatric and Mental Health Nursing* (18); 432-439

Woollcott, M. (2008) Access to primary care services for homeless mentally ill people *Nursing Standard* 22(35), 40-44.

Table 1 Interview Questions

The interviews began with demographic questions: 1) How old are you? 2) How long have you been homeless? 3) Have you ever lived on the street? For some people, these questions opened up the way to telling their stories and experiences.
Questions used in the semi-structured interviews: 1) Can you tell me about yourself and your health? 2) Can you tell me about any experiences that stand out in your mind? **3)** What are your priorities?
Prompt questions were used to expand something they had said : - How did that make you feel? - Can you tell me more about that? - Has that changed how you feel about asking for healthcare now? - During that time did you try and see a doctor? - Did they say why you couldn’t register at the practice?

Table 2 Colaizzi's eight step Framework

Colaizzi (1978)
Read all the statements carefully.
Re-read and identify and extract all significant statements.
Formulate meaning of all significant statements.
Identify the commonality between formulated meanings and form clusters.
Refer clusters to original statements Test - is anything left out? Anything included that was not implied in original statements?
Exhaustive description of everything learned.
Formulate into a succinct statement to identify the functional structure.
Return to the subjects for validation of interpretation.

Table 3 Demographic Details

Male	12
Female	2
Age range (years)	29 – 53
Ethnicity:	
Irish	1
Mixed British	2
White British	5
Asian	2
Afro-Caribbean	4
Time homeless range	8 weeks – 12 years
Current Accommodation:	
Street	2
Shelter	0
Temporary accommodation	3
Hostel	9
Previously street homeless	11

Table 3 Examples of Significant Statements and Formulated Meanings.

Significant Statements	Formulated Meaning
Because I'm homeless I'm not seen as a priority. 'OK, she's homeless, just get her out,' but I have problems just like everybody else but I 'm not treated equally. I know that. 'Cause she goes, 'I've got patients waiting.' Am I not a patient? (F30)	Because homeless, made to feel she is taking doctors time away from her patients when she deserves equal care.
I've always been susceptible to chest infections. So I had to go and see a doctor about that. And they'd say, 'Oh, there's nothing wrong with your lungs, you've just got a heavy cold, you've just got to relax and rest. [Raises his eyebrows.] That's kinda difficult…that's very difficult when you're homeless. (M34a)	Advice generic, not personal; does not take into consideration the fact he was living on the street.
When they put my name in, they said 'Oh yeah, you broke your ankle but we couldn't put a plaster cast on because where your shoulders were bad from living on the streets, because of your shoulders, we couldn't give you crutches. I turned straight round and said, 'It's lovely ain't it. You could have at least got somewhere.' ' Oh no, it's not our job, it's down to social services.' I said, 'You could have called social services.' 'Oh, that's not our job either.' (M49)	Because homeless received substandard care and no discharge planning.
I was attacked in [gives name of high road] when I first was kicked out the hostel and I had nowhere to, so obviously people recognise you in the street especially if you're in the same place all the time. (F30)	Targeted because she was homeless.
I had quite a few hidings while I was on the street, people see you sleeping there, they thought it was a good idea to give me a kicking. I had both my shoulders broke, three broken ribs and a broken ankle after one attack, because I was in a sleeping bag. I was in a bad way. (M49)	Targeted in violent attack because he was homeless.
When you're in a shelter it does affect how you're treated 'cause the staff don't treat you as a person. They treat you as cattle. (M44b)	In shelters homeless treated like cattle, not individuals, as people.
I probably wouldn't have worried about my health if it hadn't been made apparent to me. For example, the TB [tuberculosis] mobile x-ray van. I would never have thought of that in a million years that sharing a room every night with 20 other people, that that would be in any way an issue. And it wasn't, thank goodness, but they were also able to tell me I had an enlarged liver. (F44)	Outreach service alerted her to risk she had not been aware of and helped her to consider her health generally.
And they knew, right, because I was sleeping rough, I ain't going to get there at a certain time, I was going to fall asleep somewhere else because I would wake up at 6 o'clock, 5 o'clock in the morning so, you walk around, look around, go to the park and fall asleep. So if it's at 1 o'clock, I might fall asleep at 12 o'clock and forget. I'm asleep and then wake up and think, 'oh, the doctors' and then just turn up and they say 'Yes, alright [name] fair enough, sit down, you might be an hour.' (M49)	Flexibility from GP and understanding his situation and addiction.