Healthcare and housing provision for a UK homeless community: a qualitative service evaluation

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Abstract

Objectives: Homelessness is both a significant determinant and consequence of health and social inequalities. To better meet healthcare needs, dedicated mental health and general nurses were implemented to deliver outreach healthcare to people experiencing homelessness in one United Kingdom (UK) county. During COVID-19, the UK Government also instructed local authorities to accommodate individuals sleeping rough and have a national target to end rough sleeping. This qualitative study explored experiences of this nurse-let outreach service and housing journeys during and beyond COVID-19 among people experiencing homelessness.

Study design: Face-to-face, narrative storytelling interviews were conducted via opportunistic sampling in community settings. Individuals with recent or current experiences of homelessness were eligible.

Methods: Participants were informed about the study via known professionals and introduced to the researcher. Eighteen narrative interviews were conducted, transcribed, and analysed using reflective thematic analysis.

Results: Individuals described complex journeys in becoming and being homeless. The nurse-led outreach service provided integral support, with reported benefits to person-centred and accessible care and improved outcomes in health and wellbeing. After being housed, individuals valued housing necessities and described new responsibilities. However, some participants did not accept or stay in housing provisions where they perceived risks.

Conclusions: Interviewed participants perceived that the dedicated nurse-led outreach service improved their access to care and health outcomes.. In the absence of dedicated provisions, mainstream healthcare should ensure flexible processes and collaborative professional working. Local authorities must also be afforded increased resources for housing, as well as integrated support, to reduce social and health inequalities.

Keywords: Homeless, Housing, Health Inequalities, Healthcare Access, COVID-19, Narrative Interviews

Introduction

Homelessness is defined as the lack of a place someone can legally live or reasonably stay[1]. A more visible form of homelessness is rough sleeping, where individuals may live on the streets or in tents, with forms including sofa-surfing or squatting referred to as 'hidden homelessness'[2]. It is therefore challenging to confirm the extent of homelessness, but recent figures estimated 271,000 people were homeless in the United Kingdom (UK)[3], with 3069 individuals recorded as rough sleeping during an annual count in England[4]. Eligibility for housing is assessed by local authorities, who should accommodate individuals with a specified priority need[5]. Some individuals are ineligible, including those with no recourse to public funds[6].

As a health protection measure during COVID-19, the UK government instructed local authorities to accommodate individuals rough sleeping, termed 'Everyone In'[7]. Following the lockdown in March 2020, local authorities in England were required to accommodate homeless individuals not usually entitled to housing using hostels, hotels and other accommodations[8]. Criteria for priority need was also later extended to individuals deemed "extremely clinically vulnerable"[7]. However, after June 2020, eligibility for housing otherwise fluctuated alongside lockdowns[7,8]. Everyone In was reported to have offered accommodation to 90% of rough sleepers by April 2021[9]. However, one charity reported that more than three-quarters of those initially accommodated did not move into settled accommodation of at least six months[7]. The UK aims to end rough sleeping by 2027[5]. Therefore, it is crucial to understand and improve factors associated with accessing and maintaining housing following homelessness.

Homelessness is a significant consequence and determinant of social and health inequalities. Individuals experiencing homelessness are more likely to have experienced family instability, poverty, mental illness, substance misuse, abuse, incarceration, and be care experienced[10], and experience poorer health, unequal access to healthcare, and shorter life expectancies[11–14]. People experiencing homelessness have reported barriers to registering with primary care, stigma, and a lack of continued and integrated healthcare[15,16]. Such inequalities increase emergency care utilisation among homeless populations[17,18]. Dedicated healthcare provisions for homeless individuals have therefore been implemented[19], often adopting community-based and outreach approaches[20,21]. Services must also work collaboratively given the inter-relations between housing and health[1].

Local context

This study evaluates aspects of healthcare and housing provision in Warwickshire, a UK county. Warwickshire is a rural county with smaller and larger towns and increased rates of homelessness given the population[4]. Rural homelessness is associated with challenges in effective commissioning and delivering services across greater distances[22]. In Warwickshire, the local authority commissioned dedicated nurses to deliver outreach healthcare to individuals rough sleeping or vulnerable housed (e.g., in temporary accommodation). The service was co-produced and delivered in collaboration with the local health service and voluntary organisations, further described elsewhere[23]. Two senior mental health nurses deliver psychological therapies and motivational interviewing, and two senior general

nurses provide care for issues such as wounds and blood-borne viruses. Interviews conducted with involved professionals indicated that the service increased access to person-centred care. Further benefits were from mental health and general nurses working together, and with multidisciplinary partners to scaffold wider support[23]. The perspectives and experiences of homeless individuals eligible to access this service must also be understood. Given the interactions between housing and health, this evaluation aimed to explore homeless individuals' journeys with housing and health provisions alongside the novel context of COVID-19[24].

Methods

Design

This qualitative study involved face-to-face interviews with individuals with experience of homelessness. To improve appropriateness, the study was co-designed with stakeholders in the local authority, voluntary organisations, and the nurses. Coventry University Ethics Committee approved this study in February 2022 (P130453).

Eligibility and recruitment

Participants were adults with current or recent experience of homelessness. Participants were required to have sufficient English to talk about their experiences and provide verbal or written consent. Opportunity sampling was employed within community spaces (supported accommodations and voluntary and community organisations) across four towns. Recruitment was facilitated by co-located professionals, including the nurses. Professionals discussed the study with eligible individuals where appropriate (i.e., according to wellbeing on the day and ability to give informed consent), and then introduced the participant to the researcher who gained consent.

Data collection

Data were collected during March and April 2022. Participant information was read to, or by, all participants. Informed consent was collected via a written form or verbal transcript, to include individuals with impairments or limited reading or writing skills.
A verbal narrative, story-telling method was employed to collect data, previously used in research with people experiencing homelessness[25]. Storytelling interviews are characterised by unstructured formats, where the participant constructs their story with the interviewer[26]. Narrative inquiry enables participants to share their experiences in an order and manner that matters to them, and enables the researcher to hear about wider contexts[27,28]. Two broad questions invited participants to talk about their journey with housing, including during COVID-19, and their experiences of accessing healthcare, including the nurse-led outreach service. Prompts, reflections, and follow-up questions were asked to help participants move through their story and clarify events. Audio-recorded interviews were conducted with one trained researcher. Participants could have a professional present. Participants were offered a £5 supermarket/food outlet voucher to thank them for their time. Verbal and written debriefs were provided.

Analysis

Audio recordings were semi-auto-transcribed using Microsoft Word and corrected. Transcription was verbatim, including hesitations and repetitions. Analysis adopted a six-

stage reflexive thematic analysis[29], iteratively coding responses and organising codes into themes and subthemes. Analysis was underpinned by social constructionism, which assumes that meaning is constructed through social interactions[30]. For example, a participant's storytelling may be influenced by perceived power differences or previous experience in an interview situation. This lens aligned with the embeddedness of the study design, whereby professionals facilitated recruitment and the subjectivity of researchers is embraced[31].

Results

A total of 18 participants took part in interviews ranging from 8-27 minutes. No professionals remained closely present during interviews.

Demographics

Participants were aged 20 to 70 years and most often male (n=13/18; 72.2%) and White British (n=12/18; 66.7%). Most participants reported difficulties estimating how long they had been homeless, often with cycles of episodic homelessness.

Findings

Four overarching themes were interpreted from the narrative interviews, each capturing poignant experiences in participants' stories. These themes are discussed and presented with quotations.

Theme 1: Becoming homeless

Participants discussed the circumstances leading to becoming homeless, and some described cyclical patterns of homelessness. Though experiences varied, commonalities leading to homelessness included bereavements and relationship breakdowns.

> *"I lived with my mum… when she died I had to leave the house. Erm, so I got put in a... B&B [Bed and Breakfast]... I ended up … living on like the streets in [town] and sleeping in doorways. And then COVID had hit and during COVID they-I think they had to house people."* (P3)

> *"why we got evicted is 'cause I lost my children…they're in foster care…Ever since that, you know, just stopped paying everything."* (P4)

Participants faced complex issues including finances, mental and physical health problems, broken relationships, and isolation. When these issues compounded, cyclical patterns of homelessness were more apparent.

> "*When you're street homeless, everything just seems as worse as possible as it as it can be. There's no future. There's no respite from it there's no rest from it… it's ten times worse*." (P8)

Theme 2: Unable to escape a stigmatised identity

Participants described living a stigmatised identity through sharing experiences of discrimination and abuse. Participants often collectively referred to negative stereotypes held among the public, such as assumptions of drug and alcohol use, and lamented how little understanding of homelessness existed.

> "*People just look down at you… a fella come out and started on me and he said stop being a drug addict and like started on me…everyone thinks everyone's an alcoholic or drug addict when they're homeless, and I wasn't an addict.*" (P8)

Some participants felt discriminated against by national housing or organisational policies. Such processes may be necessary for the prioritisation of resources, but some participants expressed frustrations that this meant they stayed rough sleeping for longer. Some participants felt unheard by services.

> *"I didn't have a priority need then to help me get off the street, which means I have to remain on the street longer.*" (P2)

> *"I don't know, what's the point, they won't listen, they ain't bothered. That's how I feel."* (P13)

Experiences with inflexible systems were also reiterated. Participants described that not having resources like a smart phone restricted access to healthcare and other services.

> *"Unless you've got a smart phone, it's impossible. It's the same now with doctors …I tried to sort my electric out the other day, for this flat I've been given, and I said, look, can I send you proof of tenancy through the post, and they're like, "no it's gotta be done over smartphone", I says, "but I haven't got a smartphone!" So they won't let me put [the bill] in my name."* (P6)

Theme 3: Nurses are a crucial bridge connecting us to healthcare

The nurse-led outreach service was well-received, with participants collectively endorsing that this service should continue. Participants compared the nurses to family members and described receiving treatment and feeling cared for. The outreach service was contrasted with previous inflexible and unsupportive experiences with mainstream healthcare.

> "*Well the nurses are pretty good actually on the streets. If it wasn't for the nurses like going around the streets at the minute for the homeless, what would the homeless have, they'd have nothing.*" (P9)

> *"There's two professionals like representing for you, so. It's like a family member, you know, they said say you should always go to see a doctor with a family member so there's another pair of eyes and ears there so you wouldn't just get fobbed off, cause a lot of them do try and fob you off.*" (P1)

The outreach, relational and friendly approach of the nurses was crucial. Participants could choose whether they wanted to engage, and the nurses could identify changes in someone's health. Many participants described that accessing the dedicated-homeless nurses was easier than attending primary care settings, because the nurses visited them in situ rather than requiring travel to an appointment. Nurse-led drop-in sessions in community spaces also offered more direct access to healthcare.

> *"Instead of waiting to get through to your doctor…they ask what's wrong over the phone, you can just ask, like I asked [nurse] about my wrist the other day… it's really a lot easier having access to them in here*." (P3)

> *"It's been helpful, erm, they're much more approachable than the GP. Also, they'll come out to see me, which is a benefit it means I can plan my work." (P1)*

Participants perceived that their health had improved because of access to care and treatments, as well as the nurses supporting them to develop self-efficacy with managing their health.

> *"Like making sure I take my medication. I got antibiotics, blood thinners, erm, epilepsy tablets, and if I didn't come here and her [nurse] help me, I wouldn't take them." (P16)*

> *"[nurse] did me a prescription and she got my leg sorted and all sorts of things. So without [nurse] I would have been screwed really, to be honest."* (P6)

Theme 4: Being housed and beyond

Participants relayed their journeys to being housed, including the role of COVID-19 and moving between emergency or temporary accommodations. Participants described a range of feelings after being housed following rough sleeping. Participants expressed gratitude and needing to adjust to having amenities like a kitchen, television, and bed. Some questioned how they had ever slept rough. Participants also discussed additional responsibilities in managing their income and developing household skills.

> "*now, when I look at homeless people, I'm thinking "wow, how do they actually do that, how do they do that. I don't know how I was doing it with a little sleeping bag."* (P9)

> *"I have to like keep pride in it, make sure it's tidy, the bills are paid, make sure that I don't let certain people in now. You got a responsibility*." (P16)

Being housed also made logistically receiving and storing medical supplies feasible, benefitting health management.

> "*I think if I was homeless again, I would struggle. Because I have to have a lot of medical stuff sent to me like the pouches and the sprays and everything that's all sent to me, so I'd need some kind of address." (*P14)

Some participants were housed in areas or situations that posed risks to health, wellbeing and maintaining tenancies, such as via substance misuse by other tenants. This was sometimes linked to an insufficient supply of housing. Embedded support provisions were needed to reduce or respond to these risks.

> *"I wanted to get out of there cause there was one or two of them drinking a lot." (P7)*

As suggested here, maintaining housing, including following Everyone In, was often a greater challenge than being housed. Participants reflected that systems did not work with people. Specific accommodation policies, such as visiting policies intended to safeguard tenants, and availability of housing in preferred locations, meant some participants did not accept or stay in housing provisions.

> *"I let somebody in, and I got kicked out"*. (P11)

> "*They tried to send me off to [neighbouring local authority]. So, I went street homeless because like I said, my kids are in [current area], my parents are in [current area]*". (P7)

In addition, some participants reported not knowing when or where they would be moved until the time came, because of rapid rehousing needs, waiting lists or professionals bidding on their behalf.

> "*It's hard because we had to wait for the housing officer to say, "this is happening". And we didn't know where we were going until we was in a taxi. We would ask the taxi driver where we was going and he'd tell us."* (P5)

Discussion

Eighteen people described their stories of homelessness and healthcare during COVID-19 and beyond. The nurse-led outreach service was highly commended. Participants described the nurses akin to family members because of the care and advocacy they provided. The flexible service was contrasted with experiences of inaccessible mainstream care. Housing journeys were complex and non-linear. After being housed, including during COVID-19, participants valued housing necessities. Some expressed disbelief about how they had normalised life on the streets. However, some participants did not accept or stay in housing where they perceived risks.

This study follows an evaluation of the nurse-led service from the professionals' perspective[23]. The inter-relations between mental health, physical health, and housing were evidenced across both studies, with social exclusion of homeless individuals further depicted[32]. People experiencing homelessness face reduced access to mainstream healthcare because of inflexible systems, unaffordability, professional attitudes, and an individual's ability to access care[33]. Participants here reiterated these experiences and valued the friendly and dedicated approach of the dedicated nurses. Participants perceived that the nurses provided direct access to care and promoted self-efficacy in self-care, found to be low among people experiencing homelessness[34]. Participants linked having a secure

home with improved wellbeing and being able to store medical supplies, which can improve medication adherence[35]. Where dedicated healthcare provisions for homeless individuals are not commissioned, policymakers should ensure that mainstream healthcare is flexible and person-centred[33] and that providers work collaboratively[36]. For example, having an address is not legally required to register with a primary care provider, although some providers may request this and contribute to inequalities[9]. Further research investigating emergency care utilisation among individuals accessing nurse-led outreach services would develop understanding about the wider health and economic benefits[18].

COVID-19 brought additional complexities for local authorities needing to provide rapid housing. 'Housing First' models similarly prioritise providing rapid housing regardless of substance use, and have reported success for housing stability and health outcomes[37]. However, participants here highlighted that rapid housing must also integrate adequate support to ensure individuals maintain tenancies. Some participants described risks associated with other tenants misusing substances. Such experiences may pose health risks to peer-influenced substance use[38] and housing instability if individuals leave the accommodation. With evidence that initial reductions in homelessness during COVID-19 were not maintained nationally[7], sufficient resources must be available to local authorities to provide housing and integrated support.

Strengths and Limitations

Using narrative methodology, participants chose how to share their story. This approach meant participants were in greater control of their interview, especially as journeys were complex. Although, some participants may not have been aware of how their housing journey related to Everyone In, such as if their situation was managed by a professional. Participants were not directly asked about social care, and so any role of social care in a participant's story may not have been explored. The face-to-face approach meant that participants met the researcher in settings familiar to them and was facilitated by known professionals. However, individuals not accessing any health provisions or support services were not interviewed. This study also interviewed a male majority, though women told their stories. Women are more likely to fall into hidden homelessness, using informal support networks for longer before presenting to local authorities, and can experience gender-based discrimination[39]. Interviews were conducted only in English and with majority White British participants, with wider evidence advocating for improvements to anti-racist and culturally responsive provisions[6]. Some interviews were also short. Health problems and autism, found to be more common among people experiencing homelessness[40], may have also contributed to shorter lengths. Interpreting the findings alongside national and international evidence will also contribute to a fuller picture of the impact of COVID-19 on people experiencing homelessness[41,42].

Conclusion

This qualitative evaluation explored the stories of people who have experienced homelessness in one UK county. In telling their stories, participants highlighted the benefits of person-centred approaches to healthcare and housing provisions. Participants described

that the dedicated nurse-led outreach service made it easier to access healthcare, and self-reported improvements with their health and wellbeing. Furthermore, mainstream healthcare should improve inclusion through flexible processes and professional training about homelessness. COVID-19 posed challenges for local authorities who were instructed to house individuals rough sleeping. Stories from participants provided further evidence that local authorities must be afforded sufficient resources to end homelessness and help people maintain tenancies.

Author contributions

LB, MW, DL, EF, TKB, and RP contributed to research design. Interviews were conducted and transcribed by LB. Data analysis was conducted by RP. The manuscript was drafted by RP, MW, & LB. All authors critically reviewed the manuscript and approved the final version.

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Statement of ethical approval

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Competing Interest

The authors declare no competing interests.

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