BMJ Open

Working and living in a homeless hostel: the experiences of hostel staff and residents in UK hostels

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-053185
Article Type:	Original research
Date Submitted by the Author:	06-May-2021
Complete List of Authors:	Armstrong, Megan; UCL, Marie Curie Palliative Care Research Department Shulman, Caroline; Pathway charity; Marie Curie Palliative Care Research Department London, UCL Hudson, Briony; Marie Curie Stone, Patrick; University College London, Marie Curie Palliative Care Research Unit ; University College London (UCL) Hewett, Nigel; University College London, London Pathway homeless team
Keywords:	HEALTH SERVICES ADMINISTRATION & MANAGEMENT, QUALITATIVE RESEARCH, Substance misuse < PSYCHIATRY

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

Working and living in a homeless hostel: the experiences of hostel staff and residents in UK hostels

Megan Armstrong[1,2], Caroline Shulman[1,2], Briony Hudson[3], Patrick Stone[2] & Nigel Hewett[1]

1. Pathway Charity, 250 Euston road, London, UK
2. Marie Curie Palliative Care Research Department, Division of Psychiatry, UCL, 149 Tottenham Court road, London, UK
3. Marie Curie, 89 Albert Embankment, Vauxhall, London, UK

Corresponding Author

Megan Armstrong

Dept. Primary Care & Population Health

University College London (UCL)

Royal Free Campus

Rowland Hill St

London, NW3 2PF

Megan.armstrong@ucl.ac.uk

Abstract

Introduction: The number of people living in homeless hostels in the UK has steadily increased over the past decade. Despite people experiencing homelessness often having considerable health problems and a range of complex needs frequently in association with addictions, the experiences of hostel staff and residents in relation to accessing health and social care support has seldom been explored.

Design: Exploratory qualitative baseline data collected as part of an intervention to facilitate palliative care in-reach into hostels.

Setting/participants: Interviews were conducted with 33 participants; 18 homeless hostel managers/support staff and 15 people experiencing homelessness, from 6 homeless hostels in London and Kent

Results: Three themes were identified (1) Internal and external service barriers to health and social care access (2) The nature of hostel staff's role and (3) Staff and residents' needs

Discussion: Residents have multiple complex needs yet both hostel staff and residents face stigma and barriers accessing support from external services. Positive relationships were described between hostel residents and staff, which can be an essential step in engaging with other services. People experiencing homelessness urgently need better access to person-centred, trauma-informed support ideally via in-reach from people who understand the needs of the population.

Strengths and limitations

- The views of people experiencing homelessness are seldom heard in research. Due to the expertise of the team, including an inclusion health GP, we were able to sensitively explore this topic.
- The people experiencing homelessness recruited were suggested by staff or self-selected, so potentially there may have been bias towards including residents who were more positive about hostel staff or hostel life.
- Hostels vary greatly in terms of the support available to them (e.g., mental health services, in-reach primary care, in-reach addiction services etc). We cannot conclude the experiences would be the same in different hostels.
- Our topic guide was informed by an Expert by Experience and our interpretation of the findings was informed by a variety of professionals with expertise in this area.

Introduction

Prior to COVID, homelessness in Great Britain was increasing year on year, more than doubling since 2010 [1]. 'Homelessness' includes people without shelter of any kind ('rough sleeping'), those sleeping in temporary accommodation (such as hostels) and those living in insecure or inadequate housing [2]. In 2018, there were 35,727 bed-spaces in 1,185 accommodation hostels across England and it is suggested at least 75,000 different individuals use hostels over the course of a year [3]. The needs for health and social care support are high in this population, as evidenced by the high rates of premature ageing, frailty, multimorbidity, and mortality rates [4, 5]. The average age of death for people experiencing homelessness in England has been estimated to be 51.6 years old [6].

Hostels have been around since the 19th century, as a response to a need for shelter [7]. The remit of most hostels is to support people to 'recover' and move out of homelessness. This recovery focus may include an emphasis on supporting access to addiction services, training, and meaningful activities. However, residents in hostels often have severe and complex needs, with a combination of mental health difficulties, substance misuse and physical health problems [8]; therefore, the recovery focus of hostels may not always be appropriate. Furthermore, negative experiences, such as feelings of being infantilized, objectified and stigmatized often result in people experiencing homelessness not accessing health and social care support [9, 10].

Increasingly the burden of dealing with a severely unwell population, including people with palliative care needs, is falling on hostel staff, who often struggle to access adequate support from health and social care professionals for hostel residents [11, 12]. Working in a hostel has been described as potentially traumatizing [13, 14]. This lack of support is exacerbated by a lack of interventions aiming to support people experiencing homelessness manage their health and reduce unscheduled health care utilisation and mortality [15].

Limited research has explored the experiences of living and working in a homeless hostel. One study explored the relationship between hostel staff and residents, specifically in relation to those who misuse drugs, and found that people experiencing homelessness felt poorly treated by hostel staff, felt unheard and had no privacy [16]. Exploring the experiences of both residents and staff allows for a more complete picture of an issue or situation and enables all perspectives to be considered. This paper is based on analysis of baseline qualitative data collected as part of an intervention study evaluating the impact of twinning palliative care services with hostels [17], in which staff and residents expressed several challenges that went beyond those specifically related to palliative care. These

baseline interviews explored the health of residents, the support residents receive from hostel staff and external services and the views of staff and residents regarding what may improve care and support for the people that live within the hostels.

Method

Design

Exploratory qualitative baseline data collected as part of an intervention to facilitate palliative care in reach into hostels, guided by the Standards for Reporting Qualitative Research framework [18].

Participants and procedure

Hostel managers, hostel staff and residents were recruited for baseline interviews from six hostels as part of an intervention study of palliative care in-reach into hostels [17] between April 2019 and October 2019. The hostels provided for residents with medium to high support needs [3]. All staff and residents with capacity to consent were eligible. Residents were approached by a member of the hostel staff to see whether they were willing to talk to the researchers and were offered a £10 supermarket voucher as a mark of appreciation for their time. No participant declined to be interviewed. All interviews were conducted at the hostels and were conducted by two authors either together or separately (CA and MA). CS is an inclusion health General Practitioner (GP) and MA is a research fellow. Interviews took between 30-90 minutes and were audio recorded. A semi-structured topic guide informed by an expert-by-experience was used to guide the interviews. Interviews with residents explored their history of homelessness, their general health and health needs. Their experiences of accessing support from professionals, friends and hostel staff around those health needs were also explored alongside their views regarding information sharing. Interviews with staff explored the health needs and support received by unwell residents. Interviews covered the extent of any support that staff or their residents currently received from health and social care agencies including palliative care.

Public and patient involvement

An expert by experience sits on the advisory board of this project and has contributed to design of the wider project and the topic guide for the interviews in this paper. Experts by experience will contribute to the dissemination of these findings.

Ethics

Ethical approval for this research was provided by UCL Research Ethic Committee on 08/02/2019 [Project ID: 6927/002].

Analysis

Thematic analysis guided by Braun and Clarke's framework [19] was used to identify, analyse, and report themes. Line-by-line coding was undertaken by MA using NVIVO 12 [20] and consensus was achieved through discussion (MA, CS and BH). Higher level candidate themes and subthemes were developed and discussed with all authors.

Results

Characteristics of participants and hostels

Fifteen people experiencing homelessness who were residents, five hostel managers and 13 hostel staff from six hostels across London and Kent were interviewed. Residents had an average age of 45.7 years and 11/15 were male. All hostels were supporting people with medium or high support needs with the number of beds ranging from 23 to 60. Only one hostel had in-reach primary care. See Table 1 for participant characteristics and Table 2 for hostel characteristics.

Table 1: Participant characteristics

		Support workers/ managers (n=18)	Residents (n=15)
Gender	**Male**	5	11
	Female	13	4
	Mean age	38.8	45.7
Ethnicity	**White British**	11	13
	Black British	4	1
	South Asian	1	1
	White other	2	0

Table 2: Hostel characteristics

Hostel	Number of residents	Length of stay	Age range of residents	Level of need	Alcohol allowed on premises	Food provided	GP/nurse in reach	Mental health in reach	Drug and alcohol in reach
1	35	Up to two years	22 +	High support needs with alcohol use	Yes	Yes: three meals a day	In-reach GP who attends once a week	No	No but was aiming to organize this
2	58	Six to 15 months	18 +	Medium to high support	No	Breakfast and dinner; no meals for bedsits	No but good links with local homeless GP	No	No
3	60	6 months to two years	18 to 65	High complex needs	Yes (not in communal areas)	No	No	No	No
4	50	18 months - two years	18 - 65	Medium complex needs	Yes (not in communal areas)	No	No	No	Yes - was due to start shortly after interviews were conducted
5	23	Two years	18 +	High complex needs	Yes but was due to become no	None	No	Not at time of interview: one due to start.	Yes – comes once a week
6	42	Two years	16 +	High complex needs	No	None	No	Not at time of interview: one due to start.	Yes – comes once a week

Themes

Thematic analysis of semi-structured interviews exploring health and access to health and social care services for people living and working in homeless hostels identified three main themes (see Table 3).

Table 3: Experiences of hostel staff and residents in accessing support

Theme	Sub-theme
1. Internal and external service barriers to health and social care access	Misconception of the role of a hostel
	Lack of responsiveness from external health and social care services
	Stigma affecting quality of support
	Pressure to move on despite being unwell
	Lack of information sharing with health and social care services
	Assumptions regarding mental capacity
2. The nature of hostel staff's role	Going above and beyond
	Staff burnout
	Positive relationships with residents
3. Staff and residents' needs	Support from those that understand this population
	In-reach
	Staff training

1. Internal and external service barriers to health access

Misconception of the role of a hostel

Staff felt that there was a misconception from health and social care providers about the support they were able to provide within a hostel. A 'complex needs' hostel is not able to provide health or social care support. People discharging patients from hospitals along with other service providers often think that the presence of a member of staff in the hostel overnight equates to provision of 24-hour care, which is not the case. The overnight member of staff may, for instance, only be a concierge.

> *"I think because a lot of people presume because it's 24-hour manned project, they've got staff. They don't really realize that our job isn't to be carers…It's not always practical to see everybody every single day. What people see from the outside is 24-hour staff*" Support worker, hostel 5

Lack of responsiveness from external health and social care services

All hostel staff described struggling to get support from a range of external services for residents. Hostels that did not have regular GP in-reach described considerable barriers in accessing primary care, such as difficulty getting residents registered, inflexibility and lack of appointments. Staff described how some residents struggled to fit in with societal norms and that this hindered their ability to access the mainstream services they required.

> *"For me, she epitomizes…a Resident who doesn't fit in what I would term as the social norms of society, where society tries to shoehorn you into a box that says you will do this and this, and this is how society works and you must behave like this et cetera. When you're dealing with Residents like this they don't operate on that level."* Support worker, hostel 5

Staff also struggled to get adult social services to respond to referrals and to adequately undertake and / or act on Care Act Assessments. Referrals for care act assessments were often made to obtain help for people who were self-neglecting and needing help with tasks like washing and dressing. Getting this support was especially difficult for people with active addictions.

> "*There are some Residents here who not only don't self-care, but possibly don't know how to. That sounds silly, but there are a lot of Residents who don't wash or shower for days, and genuinely don't look after themselves...I think that is the main issue with our Residents, there is a lot of mental health, self-medicating and their mental health is interlinked, physical, mental health and substance use."* Support worker, hostel 5

Often hostel staff felt there was a lack of communication or responsibility from external services when hostel staff made referrals. This inaction left hostel staff feeling responsible for people who were unwell.

> *"There was no communication with us…[we don't know if] they've received it [the referral], that they're looking into it or it's gone to the wrong team or anything like that. It's only because we had to raise it [again that we heard anything]. You have to go that far until essential support is allocated to that person."* Manager, hostel 3

On occasions, hostel staff described resorting to extreme measures to get essential services involved:

> *""Someone will get back to you. Someone will get back to you," or "We'll get back to you," and they [external services] never do, and you can spend days chasing it. It's frustrating. On some occasions in recent times there was a staff member here who actually had to get the police*

involved and get the police to action the Community Mental Health team because the Mental Health team wouldn't come out to what was deemed a crisis and was a crisis. It took police intervention to actually get them on our doorstep, which is not ideal." Support worker, hostel 6

It was acknowledged by staff that many services are underfunded and overstretched.

"obviously, everyone's in the same boat and every service is flat out, understaffed, underpaid, under everything." Support worker, hostel 5

Stigma affecting quality of support

There were many suggestions of stigma towards residents from external services.

"*It's really difficult to get anyone to come in and do anything really. We've had district nurses come in to look and people's legs and things but trying to get them to understand our resident group. And they don't get it. They don't understand our resident group …they look at our resident group as if they don't count."* Support worker, hostel 1

Staff from one hostel described an insistence from their local GP practice that a member of staff attended every appointment with the resident regardless of the needs of the individual concerned.

"We have got one of the local GPs around here, they will not accept our Residents unless a keyworker is with them, and they have to attend all appointments with them and register with them. They won't accept them on their own." Support worker, hostel 3

This was echoed by residents who said they felt stigmatised, especially by GP receptionists who sometimes refused to register them.

"*You get the receptionist barrier, don't you? Very snooty, "Well no, we're not taking any new residents,*" Resident, hostel 6

Hostel staff themselves also described feeling marginalised, stigmatised, and disbelieved by some services:

"It's also being believed or trusted. When we are saying, "look, there's a problem here, they can't be struggling with this, they can't do it." Then they're not taking our word for it." Support worker, hostel 3

Pressure to move on despite being unwell

Given the recovery focused nature of hostels and the limited number of hostel beds available, staff reported feeling under pressure from local councils or commissioners to move residents on into less supported accommodation. The length of time for which hostels can house residents varies, but the longest was typically around two years for our sample. For many people, especially those whose health is poor, this can be challenging. There is often no suitable accommodation for people to move into, and residents may be too unwell to move into less supported accommodation. If residents were still at the hostel when they should be moving on, then staff often had no choice but to try to move the resident to another hostel or to less supported accommodation, despite a high level of support needs.

> "*The pressure is clearly high. We're feeling it to the point where we need to be able to move on Residents…we have to be explaining what we do and why they're here…Obviously, how do we move on someone when we feel the person perhaps may need more support to get all the valuable skills to be able to live independently."* Support worker, hostel 4

Residents feared the thought of moving on and worried about where they would go next.

> *"My key worker said they try to get you out of-- Not get you out, but they try to move you on within six months. You can stay up to a maximum of two years here and I think I'll be up by the end of the year. That's a realistic option. It's not something that I welcome."* Resident, hostel 3

Working with incomplete information

The lack of ease with which information flowed between hostel residents, staff and external agencies caused frustration and difficulties in providing person-centred care. Hostel staff were often not recognised by health services as being important for facilitating ongoing support for their residents. This meant that they often did not have access to the information that they needed to advocate for their residents.

> *"Then I've got the doctor refusing me because I haven't got resident consent. I have the resident consent, it's just a fact that they don't believe what I have. It is very to-ing and fro-ing with resident consent. This whole GDPR thing, I understand it. I know why it's there; I know it's important, but I do find that the hardest thing."* Support worker, hostel 6

Lack of information sharing was also frustrating and surprising for residents. Lack of continuity in care meant that residents found they had to retell their stories to different agencies involved in their care who were working with out-of-date information. This further eroded their trust in systems and services.

"I was that upset and annoyed that she's [social worker] not speaking to anyone else that I'm working with. I said, "It's not keeping you up to date." I speak to you once every three weeks, you don't know what's happening. So I could be going through a really difficult time and you're not aware of it and that something could trigger me to go back and you're not going to know until I've been arrested." Resident, hostel 6

In addition, some staff felt that residents were not always able or comfortable sharing information with external services about their health or symptoms. As a result, diagnoses could be missed.

"I find a lot of the time purely because maybe some of our residents aren't the most articulate. It's just- a lot of investigation work doesn't get taken place. I think that's the biggest challenge we face." Manager, hostel 4

High caseloads and pressures meant hostel staff did not have sufficient time to spend with residents to build trust. Without the development of trust, the sharing of information relating to health between residents and staff was limited and challenging.

"I'm still finding I'm having to learn to trust people. I don't always trust people now, and my confidence is not brilliant. Once I know someone [this is different]…., but I'm not very good coming forward at the beginning." Resident, hostel 1

Assumptions regarding mental capacity

When residents are self-neglecting or refusing to see a health care professional, this can be distressing for staff, as they are left feeling responsible. Concerns were raised by staff about the assumptions of external services regarding the capacity of residents to refuse treatment, often without assessing them. This means that hostel staff are often left to support people alone. Staff described the assessment of mental capacity as complex when people were self-neglecting or had significant health problems, on a background of substances misuse.

"The other thing is they feel that the Resident is able to make that judgment for themselves. That could be difficult even though we've said actually, "Please don't leave without even assessing them," because that would be a concern for us." Manager, hostel 3

2. The nature of hostel staff's role

Going above and beyond

Staff describe how the activities they undertake to support residents' health and wellbeing far exceed their job roles, which are to support people to move out of homelessness and engage with services.

They often ended up taking responsibility for medicines management and supporting people who are self-neglecting with multiple and complex needs. This was usually in the absence of sufficient training or support.

> *"That was always my grind that we are not trained but they expect you and the expectation is there for us to give them the support."* Support worker, hostel 1

> *"We also have to go and collect people's medications. We don't have to but we're doing that as well and liaising with GPs to put [medication] in dosette boxes and things like that."* Manager, hostel 3

Staff acknowledged that they all worked differently with some providing more support than others. Nonetheless, it was agreed that theirs was a demanding role and staff need to be robust, resilient, and dedicated.

> *"For one to be able to do a good job, you need to be robust, you need to be resilient."* Support worker, hostel 4

Staff burnout

Due to the challenging nature of their role, the demands placed upon them and low pay, turnover among hostel staff is high, often resulting in staff shortages. This places staff under further strain which can impact on their well-being.

> *"I don't really switch off. Even on my week on annual leave."* Support worker, hostel 4

Staff shortages can also negatively affect residents.

> *"Because of how understaffed we are at the moment, we're stretched. Things are getting missed that wouldn't have been missed a few months ago. Checks aren't getting done as often. Just because there's no staff and it's one of the biggest issues here at the minute."* Manager, Hostel 5

It can be extremely traumatic for staff when a resident dies, as highlighted by this quote following a sudden unexpected death of a resident.

> *"When he was standing along the walls and he was saying, "I'm feeling pain," and he just slid into the floor. It was during the night, early morning so there were only two staff. Staff were running up and down. It was quite a traumatic experience."* Manager, hostel 2

Positive relationships with residents

The residents that we interviewed were overwhelmingly positive about hostel staff, describing how they would be the first person they would talk to if they were concerned about something. They described how staff listened to them in a non-judgemental way and provided continuous care and support.

> *"It's pretty supportive. My key worker is great. They're people that don't come across as judgmental."* Resident, hostel 1

> *"Yes. I think she does care about me. I've never actually asked her, does she care? The staff here are alright, I like them. I like the staff here. I ain't got a bad word to say about them."* Resident, hostel 3

> *"Here the staff are brilliant. They're actually brilliant. They're available 24/7 which is good because sometimes I do feel that I do need to talk to someone, I need to get things out. They work with anyone outside that I want them to work with."* Resident, hostel 5

3. Staff and residents' needs

Support from those that understand this population

Staff reported feeling powerless. Their expertise and understanding of the population were often not appreciated, and they wanted and needed support from other agencies that understand this population. In the hostels with significant barriers in accessing primary care, when there is a health problem, all staff feel they can do is advise their residents to use emergency services. Staff felt they needed assistance and advice regarding how to get better support for their residents and how to build, maintain and benefit from relationships with other agencies.

> *"Sometimes it's about just general advice…. Say, "Okay, in future try and do X,Y,Z." Sometimes you're just trying to learn as new things happen and it's not a professional way of learning it's just your learning."* Manager, hostel 1

In-reach

In the hostels where it was in place, in-reach from GPs or nurses was felt to be extremely useful. Providing consistent support within the hostel eliminated key barriers to access and provided the opportunity for trusting relationships to be built.

> *"it's really invaluable because it then allows Residents to bypass the process of having to get past the gatekeeper or the receptionist. It takes away, in effect what is happening in that there are barriers being put in place between being able to access the services they want to access. If you take away that barrier, so the Residents know that a healthcare professional is coming here on a certain date, then they don't have to fight the system as it were, having to jump through hoops to get an appointment."* Support worker, hostel 6

Residents also felt that in-reach into hostels might improve engagement with other services. The following quotation came from a resident in a hostel where there was no primary care in-reach.

> *"I sometimes wonder. Again, it's so expensive to do it. Like if we had a doctor come on a regular basis. If someone from those services come, but it's not likely to happen, which I think it would help a lot of people, because they would then go in and talk to them. It might take a while initially"* Resident, hostel 5

One hostel described a good relationship with a specialist homelessness GP practice. Staff at the hostel with an in-reach GP also felt well supported. When talking about a particular resident of concern:

> *"We would raise the risk to the GP and other relevant bodies, people who are dealing with this particular individual…We are well supported in that area when it comes to the health care."* Support worker, hostel 1

More staff training

To be more equipped both in terms of knowledge and emotional capacity to support residents, staff highlighted training as something that would be useful. Training around recognising signs of deteriorating health, building and maintaining useful relationships with other local services and engaging residents that currently aren't accessing support were identified as key topics to be considered.

> *"It's the training that we lack on that side. Our resources don't stretch that far as to be trained in the physical side of things."* Support worker, hostel 4

Discussion

This paper has explored the experiences of hostel staff and residents in relation to accessing health and social care support. We identified three themes that summarised staff and residents' experiences and challenges. These included managing the barriers of access to internal and external services, the

nature of hostel staff's role as well as what staff and residents felt they needed to move forward in a positive way.

Experiencing stigma from health and social care services has been identified in previous research and has been recognised as a significant barrier for people experiencing homelessness [9]. However, this paper identified that staff themselves can also become stigmatised and not believed. Many of the barriers that staff described related to fragmentation and a lack of support from outside agencies, disagreements over whether residents have capacity or not (often resulting in a reason for not providing support), and a lack of information sharing. Previous research identified the need for multidisciplinary, joined up care in which services communicate effectively with each other for people experiencing homelessness [21]. This paper has also illuminated the pressure hostel staff face from commissioners to ensure residents move on, out of the hostel, within a specified time, irrespective of their needs.

Experiences of trauma are common among people experiencing homelessness. Homelessness itself is traumatic [22]. Within this study, previous traumas and negative experiences negatively influenced the development of trusting relationships with services. Issues relating to a lack of trust did not extend to hostel staff, with whom residents reported caring and supportive relationships. Although this is encouraging, it increases the pressure and responsibility felt by staff who are often the mediators in residents' contacts with external services. This sense of responsibility and isolation in combination with the complex needs of residents contribute to staff going 'above and beyond' their job role, sometimes contributing to staff burnout. Previous research identified how burnout can create a vicious cycle in which staff are too unwell to work, putting pressure on remaining staff, leading to further burnout [23].

Hostel staff wanted to be supported and believed by other services. They wanted support from services that understand the population and with whom they could build a relationship. In the absence of specialist inclusion health services, in-reach by GPs or nurses could help remove barriers and enable residents to build trusting relationships and access services. Hostel staff requested more resources and training to support and advocate for residents. Whilst training has been found to be beneficial, multi-disciplinary care is also necessary for lasting change and empowerment to take effect [24]. Ongoing support and training for staff should therefore be a priority for future research and service development.

Strengths and limitations

This study has explored the experiences of hostel staff, managers, and hostel residents in relation to accessing health and social care support and has captured a range of challenges and areas of need. The people experiencing homelessness recruited were suggested by staff or self-selected, so there was likely to have been bias towards including residents who were more positive about hostel staff or hostel life. Another limitation is that hostels vary greatly in terms of the support available to them (e.g., mental health services, in-reach primary care, in-reach addiction services etc). We explored six hostels here, but we cannot conclude the experiences would be the same in hostels with a higher level of support in place.

Implications for research and clinical practice

This research has highlighted how previous traumatic or negative experiences can influence how a person relates to others and accesses services and support. There is a recognition of the need for 'psychologically informed environments', in which the psychological and emotional needs of people experiencing homelessness and the needs of people who are supporting them, are met [25]. Some research has shown this can be challenging to embed in practice but is broadly meeting the aim of creating an improved environment [26]. The lack of understanding from some other agencies described by both staff and residents in this study posed additional barriers to accessing person-centred care and support. There is growing recognition of the value and need to include people with lived experience (experts by experience or peers) in the development and delivery of services, to ensure that they are accessible, inclusive, and designed with those with experience at their heart. *Groundswell* run a homeless health peer advocacy programme across several areas in England, whereby people with lived experience of homelessness are trained to support others to address barriers to accessing health services and support them to attend appointment and to address their physical and mental health needs [27]. Further work exploring the impact of peer navigators working within services in a psychological trauma informed framework (SHARPS) on harm reduction is also currently underway in Stirling, Scotland [28]. The focus of this project will be to facilitate the development of trusting, supportive relationships and providing practical elements of support such as access to primary care, treatment, and housing options.

Both staff and residents in this study called for greater in-reach from health and social care services into homeless hostels. GP practices in England are now grouped into primary care networks, which are expected to appoint an inclusion health lead. Hopefully this will result in more provision of in-reach support into complex need hostels [29]. A recently developed self-assessment tool can support

primary care networks around how to best meet the needs of inclusion health groups and interventions that may be helpful to consider [30]. Creating mechanisms for identifying and sharing examples of good practice would be helpful to share learning from services that are able to work in a holistic, multidisciplinary way to support people experiencing homelessness.

Conclusion

This paper explored the experiences of accessing health and social care support from the perspectives of staff and residents. Significant barriers were faced which increase the inequity experienced by some of the most marginalised and unwell people in society and contributes to staff burnout. Hostels urgently need additional support from health and social care providers, including in-reach to deliver care to people in an environment in which they feel comfortable. Support and services need to psychologically and trauma informed and could gain valuable insights and input from people with lived experience.

Acknowledgements

The authors would like to thank the hostel staff, managers and residents of the homelessness services. Many thanks also to Julian Daley, an Expert by Experience, for his valuable insights during the development of the study.

Funding

This project is funded by The Oak Foundation (OCAY-14-574). PS is supported by Marie Curie Chair's grant. BH was funded by Marie Curie.

References

1. Bramley, G., *Homelessness projections: core homelessness in great britain, summary report.* Crisis. Available here: https://www. crisis. org. uk/media/237582/crisis_homelessness_projections_2017. pdf, 2017.
2. Jacobs, K., J. Kemeny, and T. Manzi, *The struggle to define homelessness: a constructivist approach.* Homelessness: Public policies and private troubles, 1999: p. 11-28.
3. Link, H., *The Future Hostel: The Role of Hostels in Helping to End Homelessness*. 2018, London: Homeless Link.
4. Rogans-Watson, R., et al., *Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel.* Housing, Care and Support, 2020.
5. Palepu, A., et al., *Substance use and access to health care and addiction treatment among homeless and vulnerably housed persons in three Canadian cities.* PloS one, 2013. **8**(10): p. e75133.
6. Aldridge, R.W., et al., *Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England.* Wellcome open research, 2019. **4**.
7. Busch-Geertsema, V. and I. Sahlin, *The role of hostels and temporary accommodation.* European Journal of Homelessness _ Volume, 2007.
8. Hewett, N. and A. Halligan, *Homelessness is a healthcare issue*. 2010, SAGE Publications Sage UK: London, England.
9. Hoffman, L. and B. Coffey, *Dignity and indignation: How people experiencing homelessness view services and providers.* The Social Science Journal, 2008. **45**(2): p. 207-222.
10. Pendyal, A., et al., *"When you're homeless, they look down on you": A qualitative, community-based study of homeless individuals with heart failure.* Heart & Lung, 2021. **50**(1): p. 80-85.
11. Hudson, B.F., et al., *Challenges to access and provision of palliative care for people who are homeless: a systematic review of qualitative research.* BMC palliative care, 2016. **15**(1): p. 96.
12. Shulman, C., et al., *End-of-life care for homeless people: a qualitative analysis exploring the challenges to access and provision of palliative care.* Palliative medicine, 2018. **32**(1): p. 36-45.
13. Johnson, R., C. Scanlon, and J. Adlam, *The (dis) stressing effects of working in (dis) stressed homelessness organisations.* Housing, Care and Support, 2012.
14. Webb, W.A., *When dying at home is not an option: exploration of hostel staff views on palliative care for homeless people.* International journal of palliative nursing, 2015. **21**(5): p. 236-244.

15. Hanlon, P., et al., *A systematic review of interventions by healthcare professionals to improve management of non-communicable diseases and communicable diseases requiring long-term care in adults who are homeless.* BMJ open, 2018. **8**(4): p. e020161.
16. Stevenson, C., *A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation.* Journal of Substance Use, 2014. **19**(1-2): p. 134-140.
17. Armstrong, M., et al., *The benefits and challenges of embedding specialist palliative care teams within homeless hostels to enhance support and learning: Perspectives from palliative care teams and hostel staff.* Palliative Medicine, 2021: p. 02692163211006318.
18. Tong, A., P. Sainsbury, and J. Craig, *Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups.* International journal for quality in health care, 2007. **19**(6): p. 349-357.
19. Braun, V. and V. Clarke, *Using thematic analysis in psychology.* Qualitative research in psychology, 2006. **3**(2): p. 77-101.
20. Castleberry, A., *NVivo 10 [software program]. Version 10. QSR International; 2012.* American journal of pharmaceutical education, 2014. **78**(1).
21. Jego, M., et al., *Improving health care management in primary care for homeless people: a literature review.* International journal of environmental research and public health, 2018. **15**(2): p. 309.
22. K Hopper, E., E. L Bassuk, and J. Olivet, *Shelter from the storm: Trauma-informed care in homelessness services settings.* The open health services and policy journal, 2010. **3**(1).
23. Schiff, J.W. and A.M. Lane, *PTSD symptoms, vicarious traumatization, and burnout in front line workers in the homeless sector.* Community mental health journal, 2019. **55**(3): p. 454-462.
24. Shulman, C., et al., *Evaluation of training on palliative care for staff working within a homeless hostel.* Nurse education today, 2018. **71**: p. 135-144.
25. Haigh, R., et al., *Psychologically informed environments and the "Enabling Environments" initiative.* Housing, Care and Support, 2012.
26. Phipps, C., et al., *Psychologically informed environments for homeless people: resident and staff experiences.* Housing, Care and Support, 2017.
27. Groundswell, *Saving Lives, Saving Money*. 2015.
28. Parkes, T., et al., *Supporting Harm Reduction through Peer Support (SHARPS): testing the feasibility and acceptability of a peer-delivered, relational intervention for people with problem substance use who are homeless, to improve health outcomes, quality of life and social functioning and reduce harms: study protocol.* Pilot and feasibility studies, 2019. **5**(1): p. 1-15.
29. England, N. and N. Improvement, *Personalised care.* London: NHS, 2019.
30. Health and wellbeing alliance. *VCSE Inclusion Health Audit Tool*. 2019; Available from: https://www.inclusion-health.org/pcn/.

Manuscript: Working and living in a homeless hostel: the experiences of hostel staff and residents in UK hostels

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:
Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	Page 4 – MA and CS
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	Page 1
3. Occupation	What was their occupation at the time of the study?	Page 4
4. Gender	Was the researcher male or female?	N/A
5. Experience and training	What experience or training did the researcher have?	Page 1 and page 4
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Page 4 .
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Page 4
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Page 4

Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Page 4
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Page 4
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Page 4
12. Sample size	How many participants were in the study?	Page 5
13. Non-participation	How many people refused to participate or dropped out? Reasons?	Page 4
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Page 4 .
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	Page 4 - no
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Page 5
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Additional file and page 4
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	Not as part of this paper – these were baseline interviews – page 4
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Page 4
20. Field notes	Were field notes made during and/or after the inter view or focus group?	No

21. Duration	What was the duration of the inter views or focus group?	Page 4
22. Data saturation	Was data saturation discussed?	No
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	Page 4-5
25. Description of the coding tree	Did authors provide a description of the coding tree?	Page 4-5
26. Derivation of themes	Were themes identified in advance or derived from the data?	Page 7
27. Software	What software, if applicable, was used to manage the data?	Page 4
28. Participant checking	Did participants provide feedback on the findings?	No
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Page 7-14
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes, there was. Page 7-14
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes. they were. From page 7-14
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Discussion of major and minor themes From page 14

BMJ Open

Barriers and facilitators to accessing health and social care services for people living in homeless hostels: a qualitative study of the experiences of hostel staff and residents in UK hostels

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-053185.R1
Article Type:	Original research
Date Submitted by the Author:	23-Sep-2021
Complete List of Authors:	Armstrong, Megan; UCL, Marie Curie Palliative Care Research Department Shulman, Caroline; Pathway charity; Marie Curie Palliative Care Research Department London, UCL Hudson, Briony; Marie Curie Stone, Patrick; University College London, Marie Curie Palliative Care Research Unit ; University College London (UCL) Hewett, Nigel; University College London, London Pathway homeless team
Primary Subject Heading:	Public health
Secondary Subject Heading:	Qualitative research
Keywords:	HEALTH SERVICES ADMINISTRATION & MANAGEMENT, QUALITATIVE RESEARCH, Substance misuse < PSYCHIATRY

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

Barriers and facilitators to accessing health and social care services for people living in homeless hostels: a qualitative study of the experiences of hostel staff and residents in UK hostels

Megan Armstrong[1,2], Caroline Shulman[1,2], Briony Hudson[3], Patrick Stone[2] & Nigel Hewett[1]

1. Pathway Charity, 250 Euston road, London, UK
2. Marie Curie Palliative Care Research Department, Division of Psychiatry, UCL, 149 Tottenham Court road, London, UK
3. Marie Curie, 89 Albert Embankment, Vauxhall, London, UK

Corresponding Author

Megan Armstrong

Dept. Primary Care & Population Health

University College London (UCL)

Royal Free Campus

Rowland Hill St

London, NW3 2PF

Megan.armstrong@ucl.ac.uk

Abstract

Introduction: The number of people living in homeless hostels in the UK has steadily increased over the past decade. Despite people experiencing homelessness often having considerable health problems and a range of complex needs frequently in association with addictions, the experiences of hostel staff and residents especially in relation to accessing health and social care support has seldom been explored. The aim of this paper is to identify the barriers and facilitators to accessing health and social care services for people living in homeless hostels.

Design: Exploratory qualitative baseline data collected as part of an intervention to facilitate palliative care in-reach into hostels.

Setting/participants: Interviews were conducted with 33 participants; 18 homeless hostel managers/support staff and 15 people experiencing homelessness, from 6 homeless hostels in London and Kent

Results: Three themes were identified (1) Internal and external service barriers to health and social care access due to stigma, lack of communication and information sharing from services, and assumptions around capacity and the role of the hostel; (2) the impact of lack of health and social care support on hostel staff leading to burnout, staff going beyond their job role and continuous support given to residents (3) Potential facilitators to health and social care access such in-reach and support from those that understand this population and hostel staff training.

Discussion: Residents have multiple complex needs yet both hostel staff and residents face stigma and barriers accessing support from external services. Positive relationships were described between hostel residents and staff, which can be an essential step in engaging with other services. People experiencing homelessness urgently need better access to person-centred, trauma-informed support ideally via in-reach from people who understand the needs of the population.

Strengths and limitations

- The views of people experiencing homelessness are seldom heard in research. Due to the expertise of the team, including an inclusion health GP, we were able to sensitively explore this topic.
- The people experiencing homelessness recruited were suggested by staff or self-selected, so potentially there may have been bias towards including residents who were more positive about hostel staff or hostel life.

- Hostels vary greatly in terms of the support available to them (e.g., mental health services, in-reach primary care, in-reach addiction services etc). We cannot conclude the experiences would be the same in different hostels.
- Our topic guide was informed by an Expert by Experience and our interpretation of the findings was informed by a variety of professionals with expertise in this area.

Introduction

Prior to COVID, homelessness in Great Britain was increasing year on year, more than doubling since 2010 [1]. 'Homelessness' includes people without shelter of any kind ('rough sleeping'), those sleeping in temporary accommodation (such as hostels) and those living in insecure or inadequate housing [2]. In 2018, there were 35,727 bed-spaces in 1,185 accommodation hostels across England and it is suggested at least 75,000 different individuals use hostels over the course of a year [3]. The needs for health and social care support are high in this population, as evidenced by the high rates of premature ageing, frailty, multimorbidity, and mortality rates [4, 5]. The average age of death for people experiencing homelessness in England has been estimated to be 51.6 years old [6].

Hostels have been around since the 19th century, as a response to a need for shelter [7]. The remit of most hostels is to support people to 'recover' and move out of homelessness. This recovery focus may include an emphasis on supporting access to addiction services, training, and meaningful activities. However, residents in hostels often have severe and complex needs, with a combination of mental health difficulties, substance misuse and physical health problems [8]; therefore, the recovery focus of hostels may not always be appropriate. Furthermore, negative experiences, such as feelings of being infantilized, objectified and stigmatized often result in people experiencing homelessness not accessing health and social care support [9, 10].

Increasingly the burden of dealing with a severely unwell population, including people with palliative care needs, is falling on hostel staff, who often struggle to access adequate support from health and social care professionals for hostel residents [11, 12]. Working in a hostel has been described as potentially traumatizing [13, 14]. This lack of support is exacerbated by a lack of interventions aiming to support people experiencing homelessness manage their health and reduce unscheduled health care utilisation and mortality [15].

Limited research has explored the experiences of living and working in a homeless hostel. One study explored the relationship between hostel staff and residents, specifically in relation to those who misuse drugs, and found that people experiencing homelessness felt poorly treated by hostel staff, felt unheard and had no privacy [16]. Exploring the experiences of both residents and staff allows for a more complete picture of an issue or situation and enables all perspectives to be considered. This paper is based on analysis of baseline qualitative data collected as part of an intervention study evaluating the impact of twinning palliative care services with hostels [17], in which staff and residents expressed several challenges that went beyond those specifically related to palliative care. These

baseline interviews explored the support residents receive from hostel staff and external services, the impact this had on the hostel staff, and the views of staff and residents regarding what may improve health and social care access for the people that live within the hostels.

Method

Design

Exploratory qualitative baseline data collected as part of an intervention to facilitate palliative care in reach into hostels, guided by the Standards for Reporting Qualitative Research framework [18].

Participants and procedure

Hostel managers, hostel staff and residents were recruited for baseline interviews from six hostels as part of an intervention study of palliative care in-reach into hostels [17] between April 2019 and October 2019. The hostels provided for residents with medium to high support needs [3]. All staff and residents with capacity to consent were eligible. Residents were approached by a member of the hostel staff to see whether they were willing to talk to the researchers and were offered a £10 supermarket voucher as a mark of appreciation for their time. No participant declined to be interviewed. All interviews were conducted at the hostels and were conducted by two authors either together or separately (CA and MA). CS is an inclusion health General Practitioner (GP) and MA is a research fellow. Interviews took between 30-90 minutes and were audio recorded. A semi-structured topic guide informed by an expert-by-experience was used to guide the interviews. Interviews with residents explored their history of homelessness, general health and health needs, experiences of accessing support from external services and hostel staff. Interviews with staff explored the health needs of the residents, the extent of any support that staff or their residents currently received from health and social care agencies and the impact lack of support causes.

Public and patient involvement

An expert by experience, who has lived experience of being homeless, sits on the advisory board of this project and has contributed to design of the wider project and the topic guide for the interviews in this paper. The remaining advisory board is made up of researchers, clinicians, social care providers, and a hostel manager. Experts by experience will contribute to the dissemination of these findings.

Ethics

Ethical approval for this research was provided by UCL Research Ethic Committee on 08/02/2019 [Project ID: 6927/002]. Written consent was given from all participants. CS and MA are both trained in accessing capacity to ensure informed consent was given.

Analysis

Thematic analysis guided by Braun and Clarke's framework [19] was used to identify, analyse, and report themes. Line-by-line coding was undertaken by MA using NVIVO 12 [20] and consensus was achieved through discussion (MA, CS and BH). Higher level candidate themes and subthemes were developed and discussed with all authors.

Results

Characteristics of participants and hostels

Fifteen people experiencing homelessness who were residents, five hostel managers and 13 hostel staff from six hostels across London and Kent were interviewed. Residents had an average age of 45.7 years and 11/15 were male. All hostels were supporting people with medium or high support needs with the number of beds ranging from 23 to 60. Only one hostel had in-reach primary care. See Table 1 for participant characteristics and Table 2 for hostel characteristics.

Table 1: Participant characteristics

		Support workers/ managers (n=18)	Residents (n=15)
Gender	**Male**	5	11
	Female	13	4
	Mean age	38.8	45.7
Ethnicity	**White British**	11	13
	Black British	4	1
	South Asian	1	1
	White other	2	0

Table 2: Hostel characteristics

Hostel	Number of residents	Length of stay	Age range of residents	Level of need	Alcohol allowed on premises	Food provided	GP/nurse in reach	Mental health in reach	Drug and alcohol in reach
1	35	Up to two years	22 +	High support needs with alcohol use	Yes	Yes: three meals a day	In-reach GP who attends once a week	No	No but was aiming to organize this
2	58	Six to 15 months	18 +	Medium to high support	No	Breakfast and dinner; no meals for bedsits	No but good links with local homeless GP	No	No
3	60	6 months to two years	18 to 65	High complex needs	Yes (not in communal areas)	No	No	No	No
4	50	18 months - two years	18 - 65	Medium complex needs	Yes (not in communal areas)	No	No	No	Yes - was due to start shortly after interviews were conducted
5	23	Two years	18 +	High complex needs	Yes but was due to become no	None	No	Not at time of interview: one due to start.	Yes – comes once a week
6	42	Two years	16 +	High complex needs	No	None	No	Not at time of interview: one due to start.	Yes – comes once a week

Themes

Thematic analysis of semi-structured interviews exploring health and access to health and social care services for people living and working in homeless hostels identified three main themes (see Table 3).

Table 3: Themes and sub-themes on the experiences of accessing health and social care support for residents living in UK hostels

Theme	Sub-theme
Internal and external service barriers to health and social care access	Misconception of the role of a hostel
	Lack of responsiveness from external health and social care services
	Stigma affecting quality of support
	Pressure to move on despite being unwell
	Lack of information sharing with health and social care services
	Assumptions regarding mental capacity
Impact of lack of health and social care support on hostel staff	Going above and beyond
	Burnout
	Continuous support given to residents
Potential facilitators to health and social care access	Support from those that understand this population
	In-reach
	Staff training

1. Internal and external service barriers to health and social care access

Misconception of the role of a hostel

Staff felt that there was a misconception from health and social care providers about the support they were able to provide within a hostel. A 'complex needs' hostel is not able to provide health or social care support. People discharging patients from hospitals along with other service providers often think that the presence of a member of staff in the hostel overnight equates to provision of 24-hour care, which is not the case. The overnight member of staff may, for instance, only be a concierge.

> *"I think because a lot of people presume because it's 24-hour manned project, they've got staff. They don't really realize that our job isn't to be carers…It's not always practical to see everybody every single day. What people see from the outside is 24-hour staff"* Support worker, hostel 5

Lack of responsiveness from external health and social care services

All hostel staff described struggling to get support from a range of external services for residents. Hostels that did not have regular GP in-reach described considerable barriers in accessing primary care, such as difficulty getting residents registered, inflexibility and lack of appointments. Staff described how some residents struggled to fit in with societal norms and that this hindered their ability to access the mainstream services they required.

> *"For me, she epitomizes…a Resident who doesn't fit in what I would term as the social norms of society, where society tries to shoehorn you into a box that says you will do this and this, and this is how society works and you must behave like this et cetera. When you're dealing with Residents like this they don't operate on that level."* Support worker, hostel 5

Staff also struggled to get adult social services to respond to referrals and to adequately undertake and / or act on Care Act Assessments. Referrals for care act assessments were often made to obtain help for people who were self-neglecting and needing help with tasks like washing and dressing. Getting this support was especially difficult for people with active addictions.

> "*There are some Residents here who not only don't self-care, but possibly don't know how to. That sounds silly, but there are a lot of Residents who don't wash or shower for days, and genuinely don't look after themselves...I think that is the main issue with our Residents, there is a lot of mental health, self-medicating and their mental health is interlinked, physical, mental health and substance use."* Support worker, hostel 5

Often hostel staff felt there was a lack of communication or responsibility from external services when hostel staff made referrals. This inaction left hostel staff feeling responsible for people who were unwell.

> *"There was no communication with us…[we don't know if] they've received it [the referral], that they're looking into it or it's gone to the wrong team or anything like that. It's only because we had to raise it [again that we heard anything]. You have to go that far until essential support is allocated to that person."* Manager, hostel 3

On occasions, hostel staff described resorting to extreme measures to get essential services involved:

> *""Someone will get back to you. Someone will get back to you," or "We'll get back to you," and they [external services] never do, and you can spend days chasing it. It's frustrating. On some occasions in recent times there was a staff member here who actually had to get the police involved and get the police to action the Community Mental Health team because the Mental*

Health team wouldn't come out to what was deemed a crisis and was a crisis. It took police intervention to actually get them on our doorstep, which is not ideal." Support worker, hostel 6

It was acknowledged by staff that many services are underfunded and overstretched.

"obviously, everyone's in the same boat and every service is flat out, understaffed, underpaid, under everything." Support worker, hostel 5

Stigma affecting quality of support

There were many suggestions of stigma towards residents from external services.

"*It's really difficult to get anyone to come in and do anything really. We've had district nurses come in to look and people's legs and things but trying to get them to understand our resident group. And they don't get it. They don't understand our resident group …they look at our resident group as if they don't count."* Support worker, hostel 1

Staff from one hostel described an insistence from their local GP practice that a member of staff attended every appointment with the resident regardless of the needs of the individual concerned.

"We have got one of the local GPs around here, they will not accept our Residents unless a keyworker is with them, and they have to attend all appointments with them and register with them. They won't accept them on their own." Support worker, hostel 3

This was echoed by residents who said they felt stigmatised, especially by GP receptionists who sometimes refused to register them.

"*You get the receptionist barrier, don't you? Very snooty, "Well no, we're not taking any new residents,*" Resident, hostel 6

Hostel staff themselves also described feeling marginalised, stigmatised, and disbelieved by some services:

"It's also being believed or trusted. When we are saying, "look, there's a problem here, they can't be struggling with this, they can't do it." Then they're not taking our word for it." Support worker, hostel 3

Pressure to move on despite being unwell

Given the recovery focused nature of hostels and the limited number of hostel beds available, staff reported feeling under pressure from local councils or commissioners to move residents on into less supported accommodation. The length of time for which hostels can house residents varies, but the longest was typically around two years for our sample. For many people, especially those whose health is poor, this can be challenging. There is often no suitable accommodation for people to move into, and residents may be too unwell to move into less supported accommodation. If residents were still at the hostel when they should be moving on, then staff often had no choice but to try to move the resident to another hostel or to less supported accommodation, despite a high level of support needs.

> "*The pressure is clearly high. We're feeling it to the point where we need to be able to move on Residents…we have to be explaining what we do and why they're here…Obviously, how do we move on someone when we feel the person perhaps may need more support to get all the valuable skills to be able to live independently."* Support worker, hostel 4

Residents feared the thought of moving on and worried about where they would go next.

> *"My key worker said they try to get you out of-- Not get you out, but they try to move you on within six months. You can stay up to a maximum of two years here and I think I'll be up by the end of the year. That's a realistic option. It's not something that I welcome."* Resident, hostel 3

Working with incomplete information

The lack of ease with which information flowed between hostel residents, staff and external agencies caused frustration and difficulties in providing person-centred care. Hostel staff were often not recognised by health services as being important for facilitating ongoing support for their residents. This meant that they often did not have access to the information that they needed to advocate for their residents.

> *"Then I've got the doctor refusing me because I haven't got resident consent. I have the resident consent, it's just a fact that they don't believe what I have. It is very to-ing and fro-ing with resident consent. This whole GDPR thing, I understand it. I know why it's there; I know it's important, but I do find that the hardest thing."* Support worker, hostel 6

Lack of information sharing was also frustrating and surprising for residents. Lack of continuity in care meant that residents found they had to retell their stories to different agencies involved in their care

who were working with out-of-date information. This further eroded their trust in systems and services.

> *"I was that upset and annoyed that she's [social worker] not speaking to anyone else that I'm working with. I said, "It's not keeping you up to date." I speak to you once every three weeks, you don't know what's happening. So I could be going through a really difficult time and you're not aware of it and that something could trigger me to go back and you're not going to know until I've been arrested."* Resident, hostel 6

In addition, some staff felt that residents were not always able or comfortable sharing information with external services about their health or symptoms. As a result, diagnoses could be missed.

> *"I find a lot of the time purely because maybe some of our residents aren't the most articulate. It's just- a lot of investigation work doesn't get taken place. I think that's the biggest challenge we face."* Manager, hostel 4

High caseloads and pressures meant hostel staff did not have sufficient time to spend with residents to build trust. Without the development of trust, the sharing of information relating to health between residents and staff was limited and challenging.

> *"I'm still finding I'm having to learn to trust people. I don't always trust people now, and my confidence is not brilliant. Once I know someone [this is different]…., but I'm not very good coming forward at the beginning."* Resident, hostel 1

Assumptions regarding mental capacity

When residents are self-neglecting or refusing to see a health care professional, this can be distressing for staff, as they are left feeling responsible. Concerns were raised by staff about the assumptions of external services regarding the capacity of residents to refuse treatment, often without assessing them. This means that hostel staff are often left to support people alone. Staff described the assessment of mental capacity as complex when people were self-neglecting or had significant health problems, on a background of substances misuse.

> *"The other thing is they feel that the Resident is able to make that judgment for themselves. That could be difficult even though we've said actually, "Please don't leave without even assessing them," because that would be a concern for us."* Manager, hostel 3

2. Impact of lack of health and social care support on hostel staff

Going above and beyond

Staff describe how the activities they undertake to support residents' health and wellbeing far exceed their job roles, which are to support people to move out of homelessness and engage with services. They often ended up taking responsibility for medicines management and supporting people who are self-neglecting with multiple and complex needs. This was usually in the absence of sufficient training or support.

> *"That was always my grind that we are not trained but they expect you and the expectation is there for us to give them the support."* Support worker, hostel 1

> *"We also have to go and collect people's medications. We don't have to but we're doing that as well and liaising with GPs to put [medication] in dosette boxes and things like that."* Manager, hostel 3

Staff acknowledged that they all worked differently with some providing more support than others. Nonetheless, it was agreed that theirs was a demanding role and staff need to be robust, resilient, and dedicated.

> *"For one to be able to do a good job, you need to be robust, you need to be resilient."* Support worker, hostel 4

Burnout

Due to the challenging nature of their role, the demands placed upon them and low pay, turnover among hostel staff is high, often resulting in staff shortages. This places staff under further strain which can impact on their well-being.

> *"I don't really switch off. Even on my week on annual leave."* Support worker, hostel 4

Staff shortages can also negatively affect residents.

> *"Because of how understaffed we are at the moment, we're stretched. Things are getting missed that wouldn't have been missed a few months ago. Checks aren't getting done as often. Just because there's no staff and it's one of the biggest issues here at the minute."* Manager, Hostel 5

It can be extremely traumatic for staff when a resident dies, as highlighted by this quote following a sudden unexpected death of a resident.

> *"When he was standing along the walls and he was saying, "I'm feeling pain," and he just slid into the floor. It was during the night, early morning so there were only two staff. Staff were running up and down. It was quite a traumatic experience."* Manager, hostel 2

Continuous support given to residents

The residents were overwhelmingly positive about hostel staff partly due to the support they gave them when other services failed to. Residents described how the staff would be the first person they would talk to if they were concerned about something. The staff then listened to them in a non-judgemental way and provided continuous care and support.

> *"It's pretty supportive. My key worker is great. They're people that don't come across as judgmental."* Resident, hostel 1

> *"Yes. I think she does care about me. I've never actually asked her, does she care? The staff here are alright, I like them. I like the staff here. I ain't got a bad word to say about them."* Resident, hostel 3

> *"Here the staff are brilliant. They're actually brilliant. They're available 24/7 which is good because sometimes I do feel that I do need to talk to someone, I need to get things out. They work with anyone outside that I want them to work with."* Resident, hostel 5

Potential facilitators to health and social care access *Support from those that understand this population*

Staff reported feeling powerless. Their expertise and understanding of the population were often not appreciated, and they wanted and needed support from other agencies that understand this population. In the hostels with significant barriers in accessing primary care, when there is a health problem, all staff feel they can do is advise their residents to use emergency services. Staff felt they needed assistance and advice regarding how to get better support for their residents and how to build, maintain and benefit from relationships with other agencies.

> *"Sometimes it's about just general advice…. Say, "Okay, in future try and do X,Y,Z." Sometimes you're just trying to learn as new things happen and it's not a professional way of learning it's just your learning."* Manager, hostel 1

In-reach

In the hostels where it was in place, in-reach from GPs or nurses was felt to be extremely useful. Providing consistent support within the hostel eliminated key barriers to access and provided the opportunity for trusting relationships to be built.

> *"it's really invaluable because it then allows Residents to bypass the process of having to get past the gatekeeper or the receptionist. It takes away, in effect what is happening in that there are barriers being put in place between being able to access the services they want to access. If you take away that barrier, so the Residents know that a healthcare professional is coming here on a certain date, then they don't have to fight the system as it were, having to jump through hoops to get an appointment."* Support worker, hostel 6

Residents also felt that in-reach into hostels might improve engagement with other services. The following quotation came from a resident in a hostel where there was no primary care in-reach.

> *"I sometimes wonder. Again, it's so expensive to do it. Like if we had a doctor come on a regular basis. If someone from those services come, but it's not likely to happen, which I think it would help a lot of people, because they would then go in and talk to them. It might take a while initially"* Resident, hostel 5

One hostel described a good relationship with a specialist homelessness GP practice. Staff at the hostel with an in-reach GP also felt well supported. When talking about a particular resident of concern:

> *"We would raise the risk to the GP and other relevant bodies, people who are dealing with this particular individual…We are well supported in that area when it comes to the health care."* Support worker, hostel 1

More staff training

To be more equipped both in terms of knowledge and emotional capacity to support residents, staff highlighted training as something that would be useful. Training around recognising signs of deteriorating health, building and maintaining useful relationships with other local services and engaging residents that currently aren't accessing support were identified as key topics to be considered.

> *"It's the training that we lack on that side. Our resources don't stretch that far as to be trained in the physical side of things."* Support worker, hostel 4

Discussion

This paper has explored the experiences of hostel staff and residents in relation to accessing health and social care support. We identified three themes that summarised staff and residents' experiences and challenges. These included managing the barriers of access to internal and external services, the impact of lack of external support on hostel staff and potential facilitators in supporting hostel staff and residents to access health and social care support.

Experiencing stigma from health and social care services has been identified in previous research and has been recognised as a significant barrier for people experiencing homelessness [9]. However, this paper identified that staff themselves can also become stigmatised and not believed. Many of the barriers that staff described related to fragmentation and a lack of support from outside agencies, disagreements over whether residents have capacity or not (often resulting in a reason for not providing support), and a lack of information sharing. Previous research identified the need for multidisciplinary, joined up care in which services communicate effectively with each other for people experiencing homelessness [21]. This paper has also illuminated the pressure hostel staff face from commissioners to ensure residents move on, out of the hostel, within a specified time, irrespective of their needs. The barriers to health and social care combined with the stigma and lack of understanding around the needs of people experiencing homelessness highlights an urgent need for more training, support and dedicated funded inclusion health in this area for more equitable access.

Experiences of trauma are common among people experiencing homelessness and homelessness itself is traumatic [22]. Within this study, previous traumas and negative experiences adversely influenced the development of trusting relationships with services. Issues relating to a lack of trust did not extend to hostel staff, with whom residents reported caring and supportive relationships. People experiencing homelessness often have a limited social network with many estranged from their family [23]. This social isolation can lead to the hostel staff taking on a more familial role by emotionally supporting residents and visiting them in hospital in their free time, as well as even arranging funerals and vigils [14, 17]. This study echoes those findings by highlighting how the hostel staff go above and beyond their job role consistently to try to meet the residents' needs. This sense of responsibility and isolation in combination with the complex needs of residents can contribute to staff burnout. Previous research identified how burnout can create a vicious cycle in which staff are too unwell to work, putting pressure on remaining staff, leading to further burnout [24].

Hostel staff wanted to be supported and believed by services that understand the population and with whom they could build a relationship. In the absence of specialist inclusion health services, in-reach by GPs or nurses could help remove barriers and enable residents to build trusting relationships and access services. Hostel staff requested more resources and training for themselves to increase their knowledge and confidence in supporting and advocating for residents. Training for hostel staff has been found to be beneficial, but multi-disciplinary care is also necessary for lasting change and empowerment to take effect [25]. Ongoing support and training for staff should therefore be a priority for future research and service development.

Strengths and limitations

This study has explored the experiences of hostel staff, managers, and hostel residents in relation to accessing health and social care support and has captured a range of challenges and areas of need. The people experiencing homelessness recruited were suggested by staff or self-selected, so there was likely to have been bias towards including residents who were more positive about hostel staff or hostel life. Another limitation is that hostels vary greatly in terms of the support available to them (e.g., mental health services, in-reach primary care, in-reach addiction services etc). We explored six hostels here, but we cannot conclude the experiences would be the same in hostels with a higher level of support in place.

Implications for research and clinical practice

This research has highlighted how previous traumatic or negative experiences can influence how a person relates to others and accesses services and support. There is a recognition of the need for 'psychologically informed environments', in which the psychological and emotional needs of people experiencing homelessness and the needs of people who are supporting them, are met [26]. Some research has shown this can be challenging to embed in practice but is broadly meeting the aim of creating an improved environment [27]. The lack of understanding from some other agencies described by both staff and residents in this study posed additional barriers to accessing person-centred care and support. There is growing recognition of the value and need to include people with lived experience (experts by experience or peers) in the development and delivery of services, to ensure that they are accessible, inclusive, and designed with those with experience at their heart. *Groundswell* run a homeless health peer advocacy programme across several areas in England, whereby people with lived experience of homelessness are trained to support others to address barriers to accessing health services and support them to attend appointment and to address their physical and mental health needs [28]. Further work exploring the impact of peer navigators working

within services in a psychological trauma informed framework (SHARPS) on harm reduction is also currently underway in Stirling, Scotland [29]. The focus of this project will be to facilitate the development of trusting, supportive relationships and providing practical elements of support such as access to primary care, treatment, and housing options.

Both staff and residents in this study called for greater in-reach from health and social care services into homeless hostels. GP practices in England are now grouped into primary care networks, which are expected to appoint an inclusion health lead. Hopefully this will result in more provision of in-reach support into complex need hostels [30]. A recently developed self-assessment tool can support primary care networks around how to best meet the needs of inclusion health groups and interventions that may be helpful to consider [31]. Creating mechanisms for identifying and sharing examples of good practice would be helpful to share learning from services that are able to work in a holistic, multidisciplinary way to support people experiencing homelessness.

Conclusion

This paper explored the experiences of accessing health and social care support from the perspectives of staff and residents. Significant barriers were faced which increase the inequity experienced by some of the most marginalised and unwell people in society and contributes to staff burnout. Hostels urgently need additional support from health and social care providers, including in-reach to deliver care to people in an environment in which they feel comfortable. Support and services need to psychologically and trauma informed and could gain valuable insights and input from people with lived experience.

Author contribution

CS is the principal investigator of this project. CS and MA carried out the data collection and alongside BH analysed the data. MA drafted the first version of the paper. MA, CS, BH, PS, and NH contributed to the interpretation of the data and the final draft.

Competing interests

The authors report no competing interests.

Funding

This project is funded by The Oak Foundation (OCAY-14-574). PS is supported by Marie Curie Chair's grant. BH was funded by Marie Curie.

Data sharing

Data are available upon reasonable request

Acknowledgements

The authors would like to thank the hostel staff, managers and residents of the homelessness services. Many thanks also to Julian Daley, an Expert by Experience, for his valuable insights during the development of the study.

References

1. Bramley, G., *Homelessness projections: core homelessness in great britain, summary report.* Crisis. Available here: https://www. crisis. org. uk/media/237582/crisis_homelessness_projections_2017. pdf, 2017.
2. Jacobs, K., J. Kemeny, and T. Manzi, *The struggle to define homelessness: a constructivist approach.* Homelessness: Public policies and private troubles, 1999: p. 11-28.
3. Link, H., *The Future Hostel: The Role of Hostels in Helping to End Homelessness*. 2018, London: Homeless Link.
4. Rogans-Watson, R., et al., *Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel.* Housing, Care and Support, 2020.
5. Palepu, A., et al., *Substance use and access to health care and addiction treatment among homeless and vulnerably housed persons in three Canadian cities.* PloS one, 2013. **8**(10): p. e75133.
6. Aldridge, R.W., et al., *Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England.* Wellcome open research, 2019. **4**.
7. Busch-Geertsema, V. and I. Sahlin, *The role of hostels and temporary accommodation.* European Journal of Homelessness _ Volume, 2007.
8. Hewett, N. and A. Halligan, *Homelessness is a healthcare issue*. 2010, SAGE Publications Sage UK: London, England.

9. Hoffman, L. and B. Coffey, *Dignity and indignation: How people experiencing homelessness view services and providers.* The Social Science Journal, 2008. **45**(2): p. 207-222.
10. Pendyal, A., et al., *"When you're homeless, they look down on you": A qualitative, community-based study of homeless individuals with heart failure.* Heart & Lung, 2021. **50**(1): p. 80-85.
11. Hudson, B.F., et al., *Challenges to access and provision of palliative care for people who are homeless: a systematic review of qualitative research.* BMC palliative care, 2016. **15**(1): p. 96.
12. Shulman, C., et al., *End-of-life care for homeless people: a qualitative analysis exploring the challenges to access and provision of palliative care.* Palliative medicine, 2018. **32**(1): p. 36-45.
13. Johnson, R., C. Scanlon, and J. Adlam, *The (dis) stressing effects of working in (dis) stressed homelessness organisations.* Housing, Care and Support, 2012.
14. Webb, W.A., *When dying at home is not an option: exploration of hostel staff views on palliative care for homeless people.* International journal of palliative nursing, 2015. **21**(5): p. 236-244.
15. Hanlon, P., et al., *A systematic review of interventions by healthcare professionals to improve management of non-communicable diseases and communicable diseases requiring long-term care in adults who are homeless.* BMJ open, 2018. **8**(4): p. e020161.
16. Stevenson, C., *A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation.* Journal of Substance Use, 2014. **19**(1-2): p. 134-140.
17. Armstrong, M., et al., *The benefits and challenges of embedding specialist palliative care teams within homeless hostels to enhance support and learning: Perspectives from palliative care teams and hostel staff.* Palliative Medicine, 2021: p. 02692163211006318.
18. Tong, A., P. Sainsbury, and J. Craig, *Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups.* International journal for quality in health care, 2007. **19**(6): p. 349-357.
19. Braun, V. and V. Clarke, *Using thematic analysis in psychology.* Qualitative research in psychology, 2006. **3**(2): p. 77-101.
20. Castleberry, A., *NVivo 10 [software program]. Version 10. QSR International; 2012.* American journal of pharmaceutical education, 2014. **78**(1).
21. Jego, M., et al., *Improving health care management in primary care for homeless people: a literature review.* International journal of environmental research and public health, 2018. **15**(2): p. 309.
22. K Hopper, E., E. L Bassuk, and J. Olivet, *Shelter from the storm: Trauma-informed care in homelessness services settings.* The open health services and policy journal, 2010. **3**(1).
23. Sanders, B. and B. Brown, *I was all on my own': experiences of loneliness and isolation amongst homeless people.* Crisis, 2015: p. 1-9.
24. Schiff, J.W. and A.M. Lane, *PTSD symptoms, vicarious traumatization, and burnout in front line workers in the homeless sector.* Community mental health journal, 2019. **55**(3): p. 454-462.
25. Shulman, C., et al., *Evaluation of training on palliative care for staff working within a homeless hostel.* Nurse education today, 2018. **71**: p. 135-144.
26. Haigh, R., et al., *Psychologically informed environments and the "Enabling Environments" initiative.* Housing, Care and Support, 2012.
27. Phipps, C., et al., *Psychologically informed environments for homeless people: resident and staff experiences.* Housing, Care and Support, 2017.
28. Groundswell, *Saving Lives, Saving Money*. 2015.
29. Parkes, T., et al., *Supporting Harm Reduction through Peer Support (SHARPS): testing the feasibility and acceptability of a peer-delivered, relational intervention for people with problem substance use who are homeless, to improve health outcomes, quality of life and*

social functioning and reduce harms: study protocol. Pilot and feasibility studies, 2019. **5**(1): p. 1-15.
30. England, N. and N. Improvement, *Personalised care.* London: NHS, 2019.
31. Health and wellbeing alliance. *VCSE Inclusion Health Audit Tool*. 2019; Available from: https://www.inclusion-health.org/pcn/.

Manuscript: Working and living in a homeless hostel: the experiences of hostel staff and residents in UK hostels

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:
Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	Page 4 – MA and CS
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	Page 1
3. Occupation	What was their occupation at the time of the study?	Page 4
4. Gender	Was the researcher male or female?	N/A
5. Experience and training	What experience or training did the researcher have?	Page 1 and page 4
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Page 4 .
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Page 4
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Page 4

Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Page 4
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Page 4
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Page 4
12. Sample size	How many participants were in the study?	Page 5
13. Non-participation	How many people refused to participate or dropped out? Reasons?	Page 4
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Page 4 .
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	Page 4 - no
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Page 5
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Additional file and page 4
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	Not as part of this paper – these were baseline interviews – page 4
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Page 4
20. Field notes	Were field notes made during and/or after the inter view or focus group?	No

21. Duration	What was the duration of the inter views or focus group?	Page 4
22. Data saturation	Was data saturation discussed?	No
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	Page 4-5
25. Description of the coding tree	Did authors provide a description of the coding tree?	Page 4-5
26. Derivation of themes	Were themes identified in advance or derived from the data?	Page 7
27. Software	What software, if applicable, was used to manage the data?	Page 4
28. Participant checking	Did participants provide feedback on the findings?	No
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Page 7-14
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes, there was. Page 7-14
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes. they were. From page 7-14
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Discussion of major and minor themes From page 14