A general practice street health service

Patient and allied service provider perspectives

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Background and objective

People who are homeless or marginalised have poor engagement with mainstream healthcare services. The aim of this study was to explore patient and staff perspectives of a street-based, primary health service, to help identify factors influencing patient access and management.

Methods

A qualitative study was undertaken from April to September 2016. Interviews (n = 27) explored patients' experiences of accessing healthcare services. Interviews with allied service staff (n = 5) explored referral pathways and patients' access to healthcare.

Results

Factors influencing patients' willingness to access primary healthcare through the street health service were identified as doctor–patient empathy, better understanding of patient circumstances, fostering of social capital, facilitating referral pathways and supporting the transition to mainstream general practice as circumstances improve. Hospital discharge planning and follow-up management were identified as gaps in the continuity of service.

Discussion

Ease of access provided by a street-based health service facilitates access to the healthcare system for homeless and marginalised patients.

PATIENTS WHO ACCESS street doctor health services are predominantly homeless and marginalised.[1] Such patients have a higher prevalence of multimorbidity and disease severity than mainstream populations,[2] and tend to be frequent users of hospital emergency departments but poor users of mainstream primary healthcare.[1,3]

Within the Australian context, homelessness means either an inadequate dwelling or lack of tenure or control over one's living space for social relations.[4] The definition is broad, reflecting a common cycle of living on the street or in temporary accommodation.[5] The term 'homeless' creates self-devaluation, stigma and discrimination.[6–8] An Australian study[5] found that many residents in temporary accommodation do not identify themselves as homeless, and those who reject the self-categorisation report greater wellbeing and lower negative mood.

People who are homeless or marginalised have multiple risk factors and health problems[2,3,9–11] as well as higher premature mortality, compared with the general population.[3,12] Health problems may be the cause or result of being homeless.[9] A large proportion of those who are homeless have mental illness, and misuse of alcohol and/or drugs.[3] These problems result in greater difficulty in accessing healthcare and social services, and retaining accommodation.[9] The spillover extends across several social determinants of health, including housing, income, employment, education, safety, security and healthcare access.[1,13] Although mental health problems are prevalent, people who are homeless often place more priority on their physical health and practical circumstances than on their mental health.[14]

Established in 2005, the Freo Street Doctor (FSD) service is an accredited, mobile, open-access general practice service to improve primary healthcare for people who are homeless and marginalised in Fremantle and the surrounding suburbs. Community-based allied service providers work closely with staff at this service. The FSD clinics are held in locations such as community centres for homeless and marginalised people, transition housing and parks. In this way, potential stigma is removed and a culturally safe place provided to access primary healthcare.

The aim of this study was to explore patient and allied service provider perspectives of this unique service, to identify factors influencing access and health management.

Methods

A generic qualitative study using semi-structured interviews was undertaken.[15] Open-ended questions prompted participants to describe experiences and perspectives. Purposeful sampling provided a range of different ages, gender, cultural background, housing status and length of attendance at the FSD service. Interviews with patients (n = 27) explored their experiences of healthcare services, the impact of personal circumstances on accessing primary healthcare (street-based and mainstream), and their capacity to seek alternative options to the FSD service. Interviews with allied service staff (n = 5) from housing, mental health and Aboriginal and Torres Strait Islander health support explored referral pathways and access to street-based and mainstream healthcare. Ethics approval was obtained from the University of Notre Dame Human Research Ethics Committee (Project ID: 015154F).

Recruitment of patients was assisted by an outreach worker to help broker transfer of trust.[9] Interviews were undertaken

from April 2016 to September 2016. The researcher determined when data saturation was achieved. Interviews were audio-recorded and transcribed verbatim. Analysis of the interview transcripts was assisted by NVivo. A thematic analysis was undertaken using Braun and Clarke's[16] six phases. Two authors (CS, CF) identified themes and patterns independently for cross-validation. Findings were reviewed by all authors.

Results

Table 1 shows the characteristics of patients who participated in the study. Thirteen participants disclosed having a combination of mental health problems and alcohol and drug dependency; 10 participants disclosed having neither of these problems. The frequency of patients' visits ranged from once a week to once every three months. An environment of homelessness and unstable housing, with poor family or social support, was a recurring scenario for many participants. Several participants who are now in state-funded housing had a prior history of living on the street. Thematic analysis identified five main factors influencing patient willingness to access primary healthcare.

1. Doctor–patient empathy

An FSD team included a general practitioner (GP), nurse and outreach worker, who also drove the van, managed reception and triaged patients in an outdoor 'waiting room'. Patients valued their relationship with team members, describing them as friendly, caring, non-judgemental, respectful, and interested in helping improve their health and circumstances.

Many of the interviewees had long, complex social and medical histories and valued the ability of the FSD team to understand and prioritise their most immediate social or medical problems. Attending mainstream general practice usually meant repeating their history and social circumstances with GPs who tried to address everything at once and left patients feeling overwhelmed. Some patients described feeling rejected from

Table 1. Patient characteristics

Patient characteristics	n
Sex	
Female	7
Male	20
Age group	
23–45 years	12
46–84 years	15
Ethnicity	
Aboriginal and Torres Strait Islander	5
Non-Indigenous	22
Current living arrangements	
Living rough (on the street or 'couch surfing')	6
Living in a refuge or boarding/transition housing	10
State or shared housing	11
Length of time attending FSD service	
Less than one year	11
One year to 15 years	15
Missing	1
Conditions disclosed	
Alcohol and/or drug dependency	16
Mental health disorders (anxiety, depression, PTSD, psychosis and schizophrenia)	14
Obesity, diabetes, hypertension, stroke and heart disease	12
Arthritis, orthopaedic conditions and/or surgery	9
Mental and/or physical trauma from violence	8
GIT and/or liver conditions (hepatitis C, cirrhosis)	7
Asthma, emphysema, pneumonia and chest infections	6
Physical disability, accidental and/or workplace trauma	6
Abscesses and other skin conditions	4
Menopause or prostate conditions	3

FSD, Freo Street Doctor; GIT, gastrointestinal tract; PTSD, post-traumatic stress disorder

the broader community and alienated from mainstream healthcare services.

> *… that feeling too when you are homeless … it's very hard … you feel isolated and you feel … that you are not part of the community anymore. So going to a normal GP … it's a very difficult thing to do. Because it's [homelessness] not something that you can just get out of straight away. It takes time to get housing … and the FSD sympathetic to that … and safe and there's*

understanding … because you do … you feel rejected … rejected by society … by the community. (Female, aged 32 years, living in a refuge)

Allied service providers also reported disconnection between patients and the community, which made attendance at mainstream primary healthcare difficult.

> *Overwhelmingly, with most [FSD patients] … there's an underlying sense*

of shame about their life circumstances and they feel that they've failed or they don't fit into society. So, people in that situation … in my experience … they underuse medical services relative to their needs. (Service provider)

Although some mainstream GPs empathised well with people who were homeless and marginalised, some patients reported feeling stigma from reception staff and other patients in practice waiting rooms.

2. Better understanding of patient circumstances

Patients stated that the FSD team understood their special circumstances and needs because '… they're dealing with a lot of the same issues' (male, aged 47 years, living in a squat). A few participants described how homelessness and marginal circumstances had directly affected their physical and mental health. Patients and service providers talked about how homelessness and mental ill health impaired their ability to do practical and simple things, such as attend appointments, complete forms or apply for a Health Care Card. Normally, they would have done these themselves when their circumstances and health were better.

Because you know … when you've got all this going on … you haven't got access to your paperwork … you haven't got the same mental capacity when you are in that emotional turmoil … to do these things. It all sounds very simple. I was a manager you know … so I was really able to fill paperwork out and be organised. But then yeah … but after … [in these circumstances] it's too much … (female, aged 41 years, with domestic violence history relocated to hostel from the street)

I went to the hospital … they basically said there's nothing they can do … they sent me away. So that's why I'm saying the FSD was very helpful for me … because they're the only people that seem to be able to do anything. [At that time, you were seeking help for?] Umm … I just needed somewhere where I could stay first of all … because I

was in … not in a very good mental state … I couldn't really do much for myself and I had nowhere to go. (Male, aged 30 years, living rough)

Service providers reported how patients were often unable to produce Medicare and Health Care Cards when needed for mainstream services. By contrast, the drop-in, relaxed triage system of the FSD service suited their health issues and informal and often chaotic nature of their lives. The FSD clinic locations were convenient for patients as they often co-located with other services, such as food and laundry programs, housing and mental health services (www.blackswanhealth.com.au/services/primary-health-services/freo-street-doctor). The rotation of street health clinics to different sites improved potential access and helped to link patients to services.

3. Fostering of social capital

Many of the participants had limited social support and the FSD clinics formed a vital resource of social capital, fostered through interacting with others with shared norms, trust and reciprocity. The FSD 'waiting room' was described as a positive and safe environment where patients could talk to each other and share information to help each other's circumstances. This was particularly so for those living on the street who felt vulnerable and at risk of assault and theft.

It's a lot of safety issues … because once you're known to not having anyone around you … you're vulnerable to everything. So, under the FSD umbrella … it's a safe environment to interact with other people. We tend to help each other (at the FSD waiting room). With our food … where to get different services and when you are sleeping rough … you tend to be by yourself … a lot of the time isolated. And you know most … a lot of people haven't been on the streets before. So, you don't know where those services are … you don't know … where you can get help a lot of the time. (Female, aged 32 years, living in a refuge)

The FSD waiting room provided an opportunity for the outreach worker to talk to patients about their social problems

informally, thus helping the FSD team to work with them to address their difficulties. The social capital fostered between the FSD service and patients helped engender trust with other services and encouraged patients to look out for each other.

And everyone knows everyone … even the ones on the street … so and so is looking for you … you know that and FSD wants to see you … ok. They're like they've got their own family. That's their family the street people … a little community. (Service provider)

4. Facilitating referral pathways

Patients described experiences where the FSD service either prevented or managed a health crisis by arranging hospital admissions, while others occasionally self-referred to emergency departments when the FSD service was not available.

Yes, it is good service and easy. They look at your problem straight away and get me to the hospital if I need to go to hospital. (How many times?) Ooh probably about five or six … [in] the last two years … yep. (Male, aged 44 years, with chronic gastrointestinal condition previously living rough – now in hostel)

Hospital discharge planning and management were difficult for FSD patients as many had no support network, no GP and no fixed address. Patients who had been hospitalised in the previous 12 months were often unclear about post-discharge communication from the hospital. The FSD staff and allied health professionals reported commonly having to contact hospitals to find out details of admissions and discharge management plans. Patients often did not have the capacity to manage their ongoing health problems post-discharge.

The client might have been given it [discharge letter] but has no intention of following up with the GP … because they don't actually have one … or they're so unwell that they have no idea what's on the paper … or they can't read … so they don't know what this piece of paper is. (Service provider)

Referral pathways between community services, such as mental health and Aboriginal and Torres Strait Islander services, were reciprocal with the consent of patients. The service providers viewed this as a strength in the management of ongoing patient care and contributed to improving patient health outcomes. They reported many patients having long histories of disengagement, distrust and poor experiences in the public healthcare system. A trusting relationship with the patient took time to build but once established enabled a transfer of trust to other services.

> Within homelessness a subculture exists ... word by mouth travels there as fast as in other areas of other culture and society. That service [FSD] provides an empathic, non-judgemental approach to their needs and so a lot of people will gravitate to it. It builds it [trust] ... makes it easier to transfer onto another appropriate service because we don't have an integrated health system. We've got a lot of services but not integrated. And FSD especially helps to integrate some of those services for this populace. (Service provider)

5. Supporting the transition to mainstream general practice

Service providers and some patients were aware of demands and limited resources of the FSD service and the need to free up space for those most in need. The transition to a mainstream general practice bulk-billing service usually occurred once a patient's circumstances improved, such as stable housing, and was patient-led and service-led. Those transitioning began visiting the FSD much less frequently with the view to moving to the local general practice bulkbilling service.

> ... if someone's got some structure in their lives [named GP] is a better option. Because it's a bulk-billing medical practice ... nearby ... you can make appointments ... and it takes the pressure off the FSD a bit because they're dealing with so much urgent care.' (Service provider)

> ... and I think part of my reasoning for doing that [transitioning from FSD to mainstream] I thought it would look better on my medical records ... because I've got a few issues ... hep C and my heart condition. So I sort of thought it would be better for me to have a proper GP base ... The medical centre has more facilities at its disposal. (Male, aged 59 years, in state housing – lived rough previously)

Some patients of the FSD service distrust mainstream health services and find it difficult to transition, preferring instead the 'drop-in' FSD clinic. Such patients tend to have a longstanding, trusting relationship with the FSD team and prefer to rely on their help when needed. Only two patients reported occasional dissatisfaction when a consultation with the doctor was delayed because the clinics were full.

Most patients said they would have to find an alternative doctor if there were no FSD. Although some would be able to find timely alternative healthcare, others – those with less stable housing, in particular – felt they would struggle and be unable to get assistance, especially in a crisis. Four of the patients stated they 'would be dead' if not for the help received from the FSD service when they had a health crisis. Several now in stable housing and transitioning to mainstream general practice had histories of living rough and availing of the FSD service when their circumstances precluded regular healthcare.

Discussion

Maintaining a good relationship between patient and doctor/healthcare team is recognised as important and universal.[17] For people who are homeless, this is pivotal to accessing primary healthcare[14,18] and is supported by our findings. Furthermore, disconnect from the broader community makes it difficult for FSD patients to attend mainstream GPs but more comfortable with FSD clinics that are more welcoming to those who are homeless. O'Campo et al[18] include empathy, respect and dignity for the individual as relationship factors in their synthesis of effective services for homeless people. Furthermore, 'acts of kindness', such as advocating on their behalf or assisting in a practical way, helps to build doctor–patient empathic relationships.[18] The FSD service advocates for and connects patients to housing programs and other services.

The FSD service was acknowledged as important for hospital and service referral, and to help integrate community services for patients. However, the communication nexus between hospital discharge planning and primary healthcare services is weak and needs improving, especially in the area of integrated support networks to ensure discharge management is followed through in an effective manner. This recommendation is supported by current research.[2,14,19–21] The circumstances of homelessness can exacerbate health problems and make health recovery difficult, especially following hospitalisation and the ongoing, heightened risk of re-admission.[9,14] Therefore, collaboration between community and hospital teams is likely to improve health outcomes and reduce re-admissions.[20,21] Currently, a promising 'in-reach' GP program is being piloted in Perth.[22] This program involves overlapping of primary and tertiary healthcare services. The GP runs a weekly clinic at the hospital and attends ward rounds specifically for inpatients who are homeless or at risk of becoming homeless. The 'in-reach' staff assist with patient discharge and ongoing care in the community.

Some patients attending the FSD service for several years reflect the revolving poor circumstances of homeless and marginalised people.[9] The allied service providers described how improvements in circumstances and health occur in small increments for this population. Although the transition to mainstream primary healthcare is both service-led and patient-led, some patients continue to use both FSD and mainstream GPs, reflecting the long-term trust and social capital fostered at the FSD clinic.

Social capital[23] at the FSD clinic has a positive effect on the wellbeing of the attendees as people talk and share information to help each other's circumstances. Outside the FSD clinic 'life on the street' can be isolating, which supports earlier research.[24] The positive

relationship between social capital and improved mental and physical health has been well documented.[25,26] The potential benefits for people who are homeless to connect with others at the street-based clinic should not be underestimated.

The strength in this study lies in the heterogeneous nature of the patient sample and the services that work closely with FSD. A limitation is that there are smaller proportions of females (26%) and Aboriginal and Torres Strait Islander (19%) participants, compared with those known to the FSD service (43% and 30% respectively).[2] Patients' perceptions are restricted to those well enough to participate, acknowledging that FSD works with people at crisis points in their lives on an ongoing basis.

Conclusion

Our study contributes to a deeper understanding as to why and how a primary care–based, street health primary care service is pivotal in facilitating access for homeless and marginalised individuals to the healthcare system. Our research highlights the open access, non-judgemental nature of the service as well as the psychosocial supports that it offers to this vulnerable population.

Implications for general practice

People who are homeless and marginalised can be challenging for primary care teams in mainstream general practices. The FSD service is an accredited, street-based general practice service that seeks to meet many of the health needs of these patients. Our research shows that patients attending the service appreciate the open access nature of the clinic, the focus on psycho-social as well as medical needs and the empathy and understanding shown by the GPs, nurses and outreach services who deliver the service. Provider preparedness to meet the altered needs of marginalised patients is a key factor in engagement. Mainstream general practice would do well to recognise and adopt strategies that recognise the special needs and social circumstances of these patients.

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