

# Health Needs, Experiences and Expectations of Homeless Individuals in the Canton of Vaud

MD Candidate: Luana Schaad    Supervisors: Véronique Grazioli & Patrick Bodenmann

## Background

Homelessness is the most extreme manifestation of poverty and social exclusion. A recent report by the European Social Policy Network indicates that the number of people experiencing homelessness (PEH) has increased drastically over the last decade in most European countries<sup>1</sup>. Various sources indicate that Switzerland is not spared from this situation, although statistics are lacking. Recent data from the Federal Housing Office (FHO) surveying homelessness in 616 municipalities in Switzerland (28% of all municipalities) reported a total of 2200 PEH<sup>2</sup>. However, those data seem to be underestimated. A study conducted in Geneva reported 730 homeless people<sup>3</sup>. In the canton of Vaud, the activity report of the *Sleep In* (one of the four emergency shelters in Lausanne) reported that 1551 different people found shelter in their structure alone in 2020<sup>4</sup>.

Homelessness has a major impact on health. French data report a life expectancy of 49 years for PEH compared to 79 years for the general population<sup>5</sup>. Despite the increasing number of PEH in Switzerland, few studies explored these individuals' health-related problems and needs. A cross-sectional study conducted in Zürich reported that after assessment of the mental health and self-reported health (SRH) of 338 PEH, 96% of them suffered from at least one mental health problem and had a worse SRH than the general population<sup>6</sup>. In addition to the mental health problems reported in numerous studies<sup>7-9</sup> including some conducted in Switzerland<sup>10,11</sup>, PEH are also disproportionately affected by infectious<sup>10-13</sup> and dermatological<sup>14,15</sup> diseases, physical injuries<sup>16,17</sup>, metabolic diseases<sup>18,19</sup> and substance misuse<sup>20,21</sup>. In Lausanne, the Report on the Trajectory of Emergency Shelters Beneficiaries conducted by the General Health Directorate reports that 14% of the 149 PEH surveyed reported poor to very poor state of health and 53.3% say that they do not eat for 24 hours frequently or sometimes. In addition, 60% of the PEH surveyed reported smoking<sup>22</sup>. Moreover, the homeless population is aging with a current average age of 50 years<sup>7</sup>, leading to a need to address geriatric and end-of-life health issues as well as chronic diseases<sup>7,23,24</sup>. These illnesses require complex care as most of the population do not have a primary care physician or medical follow-up<sup>25</sup>. PEH favor using emergency rooms in order to seek care, which means that some of them become frequent users of emergency department, *i.e.* >5 visits/ 12 months<sup>26-28</sup>. Finally, the health costs associated with PEH have been described in the literature as significantly higher than those of the general population<sup>29</sup>.

Despite their important health-related needs, homeless individuals typically have a limited access to the healthcare system and often focus on their primary needs (e.g. finding shelter, food) rather than their health<sup>30-36</sup>. Previous international research documented that they frequently face a wide range of barriers limiting their access to the health care system (e.g. lack of resources, organizational, health insurance)<sup>30,34-40</sup>. Beyond these financial and logistic barriers, they have difficulty navigating the health care system (e.g., due to low health literacy, complexity of the system)<sup>30,33,36,37</sup>. Furthermore, PEH often experienced discrimination in healthcare, resulting in negative perceptions of care, which typically reinforces the limited access to care<sup>30,32-38,41,42</sup>. As a result of these often cumulated barriers, their care is often discontinuous<sup>43</sup> and there is a mismatch between their health problems and their use of the healthcare system<sup>44</sup>.

Improving access to healthcare is therefore critical to help address health inequities in this population. To contribute to this agenda, the first important step consists of improving our knowledge of the health needs, experiences, and expectations among these individuals in Switzerland. To the best of our knowledge, there is a dearth of research exploring these themes in Switzerland. Most studies which investigated these issues were conducted in English-speaking countries (United States, Canada, and the United Kingdom). In addition, very few qualitative studies were conducted in Europe. Such research is yet critical to reach a deep understanding of the needs, experiences, and expectations of PEH. We found only one Swedish study that explored the specific needs of homeless women and one Spanish study that

examined access to care for PEH in Barcelona. Finally, we found one Dutch qualitative study that evaluated the avoidance of care for PEH as perceived by social workers and spiritual advisors<sup>30-36,38,41</sup>. These studies provide some first insight into the health needs, expectations, and experiences of PEH. However, it is important to examine to what extent these results are transferable to the Swiss health and social system in which data concerning PEH are very limited. In response, this study aims to explore the needs, expectations, and healthcare experiences of PEH in the Canton of Vaud. By using a mixed-method approach combining perspectives of the PEHs with those of involved professionals, this study will provide a broader and deeper understanding of the needs, expectations, and health experiences of the homeless population in Vaud.

This doctoral work is part of a parent study that aims to explore the feasibility and desirability of implementing integrative medical approaches in the homeless population of the Canton of Vaud. Using parts of the data from the parent study, the present study will have the following objectives:

- (1) To explore quantitatively the health needs of PEH in the canton of Vaud, as well as their use of the conventional Swiss health system.
- (2) To explore quantitatively the PEH's intention and barriers to seek care when needed.
- (3) To explore qualitatively what the experiences of the PEH in the conventional health system, as well as their needs, and expectations in the canton of Vaud.
- (4) To explore qualitatively the perceptions of professionals working with PEH of the health needs, experience, and expectations of this population.

## Methods

### Participants

In total, 123 homeless individuals thorough the Canton of Vaud (Lausanne, Yverdon-les-Bains, Vevey and Nyon) completed a paper-pencil questionnaire assessing their health-related needs, experience, and expectations. Parts of the participants ( $n= 18$ ) took part in semi-structured interviews exploring the same dimensions. These themes were also explored among professionals involved with the target population ( $n=13$ ; social workers, emergency shelter supervisors and nurses) through semi-structured interviews.

### Measures

To meet these objectives, we will use data collected from PEH in different cities of the canton. We will use a mixed method, combining both quantitative and qualitative assessments. Specifically, we will use the following measures of the questionnaire:

- The demographics of the participants
- Participants' intentions to use the health care system when necessary and their attitudes towards seeking care, i.e., how easy, or difficult it is for them to seek somatic or psychiatric care. Those measures are based on the Theory of Planned Behavior.<sup>45</sup>
- Participants' quality of life (QoL): assessed with the WHOQOL-BREF scale, a validated 26-item questionnaire<sup>46</sup>.
- Their psychological health status: assessed with the validated Kessler scale (K6) to estimate psychological distress over the past 30 days<sup>47</sup>.
- Their use of the health care system: assessed by open-ended questions about their main health problem, how they sought care for that problem, and their use of different health care services in the past 6 months.

We describe the quantitative data that will be use for the analyses in this paper in Table 1 (see appendix). Furthermore, we will use qualitative data from the semi-structured interviews among PEH and involved professionals exploring health-related needs, experience, and expectations to complement quantitative data.

### Data analysis

**Quantitative analysis.** We collected quantitative data via hetero administration of questionnaires by the research team. The questionnaire data were recorded in RedCap<sup>®</sup>. A 2<sup>nd</sup> researcher double checked

the data to avoid errors. The data will be pre-cleaned (checked for extremes, outliers, missing data). Next, descriptive statistics will be used to summarize the data (e.g., proportions, means, standard deviations if normal distribution). Descriptive statistics will be performed using SPSS 27.

Finally, to explore the intention to seek care when needed, we will evaluate the relationships of the intention and attitudes towards seeking care with healthcare use and health-related quality of life. Depending on the distribution shapes of these variables (normally vs. non-normally distributed), we will use linear or Poisson/negative binomial count regressions to examine these associations.

**Qualitative analysis.** The data will be analyzed using a conventional inductive content analysis with a comparative process<sup>48,49</sup>. Qualitative interviews were conducted using an interview guide with open-ended questions and probes to explore the experiences and health needs of PEH. The interviews were recorded and then transcribed verbatim, making them completely anonymous. Regarding the analysis, two researchers will do the initial coding independently. The researchers will pool their codes to reduce redundant, idiosyncratic, or common codes to elaborate a codebook. A third researcher will test the codebook to provide feedback. Then, three researchers will double-code 10% of the interviews until an inter-judge agreement of at least 80% is achieved. The three researchers will then independently code different parts and explore the different themes using Atlas.ti.

For the needs analysis of professionals working with PEH, the process will be the same, the interviews will be transcribed and anonymized. Two researchers will carry out the initial coding independently. They will pool their codes to reduce redundant, idiosyncratic, or common codes. A third researcher will test the codebook to provide feedback. The three researchers will double-code 10% of the interviews to obtain at least 80% inter-judge agreement. The researchers will then independently code different parts (complementary medicine, participatory research, and conventional health care system respectively) and explore the different themes using Atlas.ti.

## Calendar

|                        |  |
|------------------------|--|
| November-December 2022 | <ul style="list-style-type: none"> <li>- Study protocol</li> <li>- PEH codebook's elaboration for qualitative interviews</li> <li>- Beginning of the quantitative analysis</li> </ul>                          |
| January-February 2023  | <ul style="list-style-type: none"> <li>- Professional's codebook's elaboration for qualitative interviews</li> <li>- Beginning of qualitative analysis</li> <li>- End of the quantitative analysis.</li> </ul> |
| March-April 2023       | <ul style="list-style-type: none"> <li>- End of qualitative analysis</li> <li>- Article redaction</li> </ul>   |
| May-November 2023      | <ul style="list-style-type: none"> <li>- Dissemination of data</li> </ul>  |

## Expected results

Several studies have explored the PEH's needs. However, the vast majority of the studies retrieved were conducted in Anglo-Saxon countries (United Kingdom, Canada and the United States)<sup>30-33,35,38</sup>. Outside the UK, we found only three qualitative studies exploring the needs and experiences of PEH in the health care system in Europe, two through interviews with PEH and one through interviews with professionals<sup>34,36,41</sup>. More studies were conducted in the United Kingdom, whose health system differs from the Swiss system in several aspects (e.g., free health care, gate keeping by the general practitioners, etc.). In addition, there has been a political will to reduce homelessness, with the implementation of the Homeless Reduction Act in 2017, a law that commits health professionals not to take leave of PEH without referring them to a competent authority in order for them to obtain housing assistance<sup>50</sup>.

To identify how improving access to healthcare and quality of care in the Canton of Vaud, it is crucial to gain a better knowledge of the experiences, needs and health expectations of these patients. However,

in Switzerland, we are only at the beginning of research on the health of PEH, with a considerable lack of research. Furthermore, it is important to know whether the results concerning the health needs, expectations, and experiences of PEH that were reported elsewhere are reproducible in a different social, health and cultural setting. Using a mixed quantitative and qualitative approach that considers the point of view of both PEH and professionals, this doctoral work will provide a broader perspective of the health needs, expectations, and experiences of PEH in the Canton of Vaud. To the best of our knowledge, this study will be the first to explore PEH's health in French-Speaking Switzerland. The results of this work will provide a solid foundation for future work aiming to develop and implement targeted interventions for PEH in French-speaking Switzerland to help engage them in healthcare care and respond more adequately to their specific needs.

## Appendix

Table 1: Use of quantitative data

| Use of quantitative data  |  |
|---|--|
| Demographics  | Gender   |
|   | Age  |
|   | Nationality  |
|   | How long has the person been in Switzerland  |
|   | Residence permit   |
|   | Migration's Situation  |
|   | Education  |
|   | Health insurance   |
|   | How long has the person been homeless  |
|   | Most frequent accommodation over the last 2 weeks  |
|   | Priority for emergency accommodation   |
|   | Access to treatment, intentions, and attitude  |
| Intention: Likelihood of seeking help for psychological health problem (using a scale from 1 = likely, to 7 = unlikely) |  |
| Attitude: assessment of difficulty in seeking help for somatic health (using a scale from 1 = easy, to 7 = difficult)   |  |
| Attitude: assessment of difficulty in seeking psychiatric help (using a scale from 1 = easy, to 7 = difficult)          |  |
| Quality of life (WHOQOLBREF)  | Assessment of quality of life in terms of physical health (e.g., pain, fatigue, mobility, energy, ...), psychological health (e.g., positive feelings, self-esteem, ...), social relationships (e.g., personal relationships, social support, ...) and environmental quality (e.g., financial resources, housing environment, ...).  |
|   | According to the score instructions, the data will be classified in each domain and scored according to a range from 0 (lowest QoL) to 100 (highest QoL).  |
| Psychological health status (Kessler K6)  | Assessment of psychological distress over the past 30 days. The score is composed of 6 items to assess the frequency of feelings and experiences (e.g., anxiety, hopelessness, hopelessness to the point of no hope, agitation, ...) on a scale of 0 to 4 (0=never to 4=all the time). The scores will be added up to give results between 0 and 24. Based on the literature, the scores will correspond to low (0 to 7), moderate (8 to 12) and high (13 to 24) psychological distress. |
| Use of the health system  | Open-ended question: What is your main health problem?   |
|   | Open-ended question: Which health service would you prefer to contact to treat this health problem?  |
|   | In the last 6 months, which health care service did you use?   |

## References

1. COMMISSION STAFF WORKING DOCUMENT *Confronting Homelessness in the European Union Accompanying the Document COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS Towards Social Investment for Growth and Cohesion - Including Implementing the European Social Fund 2014-2020.*; 2013. Accessed November 9, 2022. <https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=celex%3A52013SC0042>
2. OFL O fédéral du logement. Le sans-abrisme en Suisse. Accessed November 7, 2022. <https://www.bwo.admin.ch/bwo/fr/home/wie-wir-wohnen/wohnen-und-armut/publikationen-bwo/obdachlosigkeit.html>
3. Bonvin JM, Waltz O, Vogel T. Besoins en matière d'hébergement d'urgence à Genève - Communiqués de presse - UNIGE. Published September 21, 2021. Accessed November 14, 2022. <https://www.unige.ch/communication/communiqués/2021/etude-des-besoins-en-matiere-dhebergement-durgence-a-geneve>
4. Association *Le Sleep-In Rapport d'activité 2020*.
5. Observatoire national de la pauvreté et de l'exclusion. La Mortalité des personnes sans domicile en France entre 2008 et 2010. Published online 2013.
6. Briner D, Jäger M, Kawohl W, Baumgartner-Nietlisbach G. [Mental Disorder and Self-Rated Health Among Homeless People in Zurich - First Epidemiological Data from Switzerland]. *Psychiatr Prax*. 2017;44(6):339-347. doi:10.1055/s-0042-111742
7. Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*. 2014;384(9953):1529-1540. doi:10.1016/S0140-6736(14)61132-6
8. Nielsen SF, Hjorthøj CR, Erlangsen A, Nordentoft M. Psychiatric disorders and mortality among people in homeless shelters in Denmark: a nationwide register-based cohort study. *Lancet*. 2011;377(9784):2205-2214. doi:10.1016/S0140-6736(11)60747-2
9. Knörle U, Gutwinski S, Willich SN, Berghöfer A. [Associations of mental illness and homelessness: results of a secondary data analysis at a Berlin health center for the homeless]. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz*. 2022;65(6):677-687. doi:10.1007/s00103-022-03536-9
10. Lauber C, Lay B, Rössler W. Homeless people at disadvantage in mental health services. *Eur Arch Psychiatry Clin Neurosci*. 2006;256(3):138-145. doi:10.1007/s00406-005-0616-4
11. Lauber C, Lay B. Homelessness among people with severe mental illness in Switzerland. *Swiss Med Wkly*. Published online January 29, 2005. doi:10.4414/smw.2005.10815
12. Beijer U, Wolf A, Fazel S. Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. *Lancet Infect Dis*. 2012;12(11):859-870. doi:10.1016/S1473-3099(12)70177-9
13. Raoult D, Foucault C, Brouqui P. Infections in the homeless. *The Lancet Infectious Diseases*. 2001;1(2):77-84. doi:10.1016/S1473-3099(01)00062-7
14. Moretti DF, Dory É, Favrat PB, Winterton DN, Berger Jé. Précarité et problèmes cutanés. *REVUE MÉDICALE SUISSE*. Published online 2015:5.
15. Brouqui P, Stein A, Dupont HT, et al. Ectoparasitism and Vector-Borne Diseases in 930 Homeless People From Marseilles. *Medicine*. 2005;84(1):61-68. doi:10.1097/01.md.0000152373.07500.6e
16. Topolovec-Vranic J, Ennis N, Colantonio A, et al. Traumatic brain injury among people who are homeless: a systematic review. *BMC Public Health*. 2012;12(1):1059. doi:10.1186/1471-2458-12-1059
17. Frencher SK, Benedicto CMB, Kendig TD, Herman D, Barlow B, Pressley JC. A comparative analysis of serious injury and illness among homeless and housed low income residents of New York City. *J Trauma*. 2010;69(4 Suppl):S191-199. doi:10.1097/TA.0b013e3181f1d31e
18. Bernstein RS, Meurer LN, Plumb EJ, Jackson JL. Diabetes and Hypertension Prevalence in Homeless Adults in the United States: A Systematic Review and Meta-Analysis. *Am J Public Health*. 2015;105(2):e46-e60. doi:10.2105/AJPH.2014.302330
19. Lee TC, Hanlon JG, Ben-David J, et al. Risk Factors for Cardiovascular Disease in Homeless Adults. *Circulation*. 2005;111(20):2629-2635. doi:10.1161/CIRCULATIONAHA.104.510826
20. Baggett TP, Chang Y, Porneala BC, Bharel M, Singer DE, Rigotti NA. Disparities in Cancer Incidence, Stage, and Mortality at Boston Health Care for the Homeless Program. *Am J Prev Med*. 2015;49(5):694-702. doi:10.1016/j.amepre.2015.03.038
21. Baggett TP, Chang Y, Singer DE, et al. Tobacco-, Alcohol-, and Drug-Attributable Deaths and Their Contribution to Mortality Disparities in a Cohort of Homeless Adults in Boston. *Am J Public Health*. 2015;105(6):1189-1197. doi:10.2105/AJPH.2014.302248
22. Stadelmann S, Debons J, Samitca S. *Profils et trajectoires des bénéficiaires des hébergements d'urgence dans le canton de Vaud en 2021*. Centre universitaire de médecine générale et santé publique (Unisanté); 2022. doi:10.16908/ISSN.1660-7104/338
23. Brown RT, Kiely DK, Bharel M, Mitchell SL. Geriatric Syndromes in Older Homeless Adults. *J GEN INTERN MED*. 2012;27(1):16-22. doi:10.1007/s11606-011-1848-9
24. McDonald L, Dergal J, Cleghorn L. Living on the Margins. *Journal of Gerontological Social Work*. 2007;49(1-2):19-46. doi:10.1300/J083v49n01\_02
25. Khandor E, Mason K, Chambers C, Rossiter K, Cowan L, Hwang SW. Access to primary health care among homeless adults in Toronto, Canada: results from the Street Health survey. *Open Med*. 2011;5(2):e94-e103.
26. Capp R, Rosenthal MS, Desai MM, et al. Characteristics of Medicaid enrollees with frequent ED use. *Am J Emerg*

- Med.* 2013;31(9):1333-1337. doi:10.1016/j.ajem.2013.05.050
27. Lindamer LA, Liu L, Sommerfeld DH, et al. Predisposing, Enabling, and Need Factors Associated with High Service Use in a Public Mental Health System. *Adm Policy Ment Health.* 2012;39(3):200-209. doi:10.1007/s10488-011-0350-3
  28. Abramson TM, Sanko S, Eckstein M. Emergency Medical Services Utilization by Homeless Patients. *Prehospital Emergency Care.* 2021;25(3):333-340. doi:10.1080/10903127.2020.1777234
  29. Salit SA, Kuhn EM, Hartz AJ, Vu JM, Mosso AL. Hospitalization Costs Associated with Homelessness in New York City. *N Engl J Med.* 1998;338(24):1734-1740. doi:10.1056/NEJM199806113382406
  30. Omerov P, Craftman ÅG, Mattsson E, Klarare A. Homeless persons' experiences of health- and social care: A systematic integrative review. *Health & Social Care in the Community.* 2020;28(1):1-11. doi:10.1111/hsc.12857
  31. Paudyal V, MacLure K, Buchanan C, Wilson L, Macleod J, Stewart D. 'When you are homeless, you are not thinking about your medication, but your food, shelter or heat for the night': behavioural determinants of homeless patients' adherence to prescribed medicines. *Public Health.* 2017;148:1-8. doi:10.1016/j.puhe.2017.03.002
  32. Pendyal A, Rosenthal MS, Spatz ES, Cunningham A, Bliesener D, Keene DE. "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):80-85. doi:10.1016/j.hrtlng.2020.08.001
  33. McNeill S, O'Donovan D, Hart N. Access to healthcare for people experiencing homelessness in the UK and Ireland: a scoping review. *BMC Health Services Research.* 2022;22(1):910. doi:10.1186/s12913-022-08265-y
  34. Klop HT, Evenblij K, Gootjes JRG, de Veer AJE, Onwuteaka-Philipsen BD. Care avoidance among homeless people and access to care: an interview study among spiritual caregivers, street pastors, homeless outreach workers and formerly homeless people. *BMC Public Health.* 2018;18(1):1095. doi:10.1186/s12889-018-5989-1
  35. Heaslip V, Green S, Simkhada B, Dogan H, Richer S. How Do People Who Are Homeless Find Out about Local Health and Social Care Services: A Mixed Method Study. *International Journal of Environmental Research and Public Health.* 2022;19(1):46. doi:10.3390/ijerph19010046
  36. Cernadas A, Fernández Á. Healthcare inequities and barriers to access for homeless individuals: a qualitative study in Barcelona (Spain). *Int J Equity Health.* 2021;20(1):84. doi:10.1186/s12939-021-01409-2
  37. Canavan R, Barry MM, Matanov A, et al. Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities. *BMC Health Serv Res.* 2012;12(1):222. doi:10.1186/1472-6963-12-222
  38. Bell L, Whelan M, Fernandez E, Lycett D. Nurse-led mental and physical healthcare for the homeless community: A qualitative evaluation. *Health & Social Care in the Community.* n/a(n/a). doi:10.1111/hsc.13778
  39. Vuillermoz C, Vandentorren S, Brondeel R, Chauvin P. Unmet healthcare needs in homeless women with children in the Greater Paris area in France. *PLOS ONE.* 2017;12(9):e0184138. doi:10.1371/journal.pone.0184138
  40. Salize HJ, Horst A, Dillmann-Lange C, et al. Needs for mental health care and service provision in single homeless people. *Soc Psychiatry Psychiatr Epidemiol.* 2001;36(4):207-216. doi:10.1007/s001270170065
  41. Kneck Å, Mattsson E, Salzman-Erikson M, Klarare A. "Stripped of dignity" – Women in homelessness and their perspectives of healthcare services: A qualitative study. *International Journal of Nursing Studies.* 2021;120:103974. doi:10.1016/j.ijnurstu.2021.103974
  42. Irestig R, Burström K, Wessel M, Lynöe N. How are homeless people treated in the healthcare system and other societal institutions? Study of their experiences and trust. *Scand J Public Health.* 2010;38(3):225-231. doi:10.1177/1403494809357102
  43. Dauriac-Le Masson V, Mercuel A, Guedj MJ, Douay C, Chauvin P, Laporte A. Mental Healthcare Utilization among Homeless People in the Greater Paris Area. *International Journal of Environmental Research and Public Health.* 2020;17(21):8144. doi:10.3390/ijerph17218144
  44. van Dongen SI, van Straaten B, Wolf JRLM, et al. Self-reported health, healthcare service use and health-related needs: A comparison of older and younger homeless people. *Health & Social Care in the Community.* 2019;27(4):e379-e388. doi:10.1111/hsc.12739
  45. Ajzen I. The theory of planned behaviour: Reactions and reflections. *Psychology & Health.* 2011;26(9):1113-1127. doi:10.1080/08870446.2011.613995
  46. Skevington SM, Lotfy M, O'Connell KA. The World Health Organization's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. A Report from the WHOQOL Group. *Qual Life Res.* 2004;13(2):299-310. doi:10.1023/B:QURE.0000018486.91360.00
  47. Furukawa TA, Kessler RC, Slade T, Andrews G. The performance of the K6 and K10 screening scales for psychological distress in the Australian National Survey of Mental Health and Well-Being. *Psychological Medicine.* 2003;33(2):357-362. doi:10.1017/S0033291702006700
  48. Chamaz K. Coding in Grounded Theory Practice. In: *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis.* Sage Publications; 2006.
  49. Hsieh HF, Shannon SE. Three Approaches to Qualitative Content Analysis. *Qual Health Res.* 2005;15(9):1277-1288. doi:10.1177/1049732305276687
  50. Paudyal V, Saunders K. Homeless reduction act in England: impact on health services. *The Lancet.* 2018;392(10143):195-197. doi:10.1016/S0140-6736(18)31383-7