



Perceptions of Service Use Among Currently and Formerly Homeless Adults with Mental Health Problems

Nick Kerman¹ · Sophia Gran-Ruaz¹ · Madalynne Lawrence¹ · John Sylvestre¹

Received: 11 October 2018 / Accepted: 15 February 2019 / Published online: 23 February 2019
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Abstract

This qualitative study used in-depth interviews to examine the service experiences of 52 currently and formerly homeless people with mental health problems. Thematic analysis identified five themes associated with positive and negative service experiences: (1) accessibility of services, (2) humanity in approach to care, (3) perceptions and relationships with other service users, (4) physical space and environment, and (5) outcomes of service use. Overall, minimal differences were found between currently and formerly homeless people with mental health problems, suggesting that both groups have the same wants and needs related to service use, including to be treated fairly and without judgment, receive needed support and assistance, and feel good following their service experience. However, both groups also described encountering barriers to accessing programs and navigating service systems; using services where they felt judged, unsafe, or uncared for; and having unmet needs following service use.

Introduction

Homelessness can have deleterious effects on health and well-being. People experiencing homelessness are at greater risk of developing chronic medical conditions, being sexually assaulted, experiencing substance use problems, becoming socially isolated, attempting suicide, and dying at a younger age than the non-homeless population (Desai et al. 2003; Grigsby et al. 1990; Hwang 2000, 2001; Kushel et al. 2003). Health and social services are critical to preventing the exacerbation of health problems and maintaining the connections that people need to exit homelessness. Yet, people who are homeless often encounter barriers to using services, such as fragmented service systems, inadequate continuity of care, and competing needs (Gelberg et al. 1997; Jago et al. 2016; Lamanna et al. 2018; Padgett et al. 2016). In addition, experiences of stigma and discrimination can lead to mistrust of service providers and avoidance of service systems (Patterson et al. 2015; Wen et al. 2007). Given the many challenges associated with accessing and using services, engagement and retention of people experiencing homelessness is a key challenge (Padgett et al. 2008).

Studies examining the perspectives of people with histories of homelessness offer key insights into the aspects of health and social services that are associated with positive or negative experiences. Interactions with service providers have consistently been identified as an important part of service use experiences. Relationships characterized by encouragement, positive attitudes, and provision of support are instrumental in helping people to exit homelessness (Thompson et al. 2004). Service providers who are perceived as being warm and willing to go the extra mile can also have a positive effect on involvement in treatment services (Padgett et al. 2008). In contrast, feeling stigmatized and discriminated against by health and social service professionals may lead to distrust and avoidance of services (Patterson et al. 2015). Lack of service availability or poor responsiveness during crises can also be detrimental to perceived adequacy of care (Bhui et al. 2006). Beyond the human element of service provision, perceiving that service use could lead to acquiring housing has been linked to positive service experiences (Padgett et al. 2008). In emergency shelters, thefts, restrictive rules, long waiting times, lack of direct communication with staff, and unsafe locations are associated with negative experiences that can lead to future avoidance and further complicate effective outreach intervention (Brown et al. 2017; Donley and Wright 2012; Thompson et al. 2004).

Although patterns of service use change following exits from homelessness (Kerman et al. 2018), the actual services

✉ Nick Kerman
nkerm094@uottawa.ca

¹ School of Psychology, University of Ottawa, Ottawa, ON K1N 6N5, Canada

people use may remain the same as many continue to live in the same communities after becoming housed with access to the same service systems (Henwood et al. 2013; Iaquina 2016). Because of this, perceptions of services used during homelessness may have implications for how and what services people use once housed. However, studies examining the service experiences of people who are formerly homeless have primarily focused on supportive housing (for a review, see Krotofil et al. 2018). Less is known about experiences with other services for people with mental health and substance use problems who may continue to live in poverty after exiting homelessness. Thus, the similarities and differences in perceptions of service experiences between currently and formerly homeless people are unknown. Moreover, given the consequences associated with negative service experiences when people are homeless, it is necessary to also understand the factors that contribute to positive and negative service experiences for formerly homeless people, as these will have implications for improving service delivery and preventing recurrent homelessness.

This qualitative study used in-depth interviews to examine the service experiences of currently and formerly homeless people with mental health and substance use problems. Two research questions were explored: (1) What are the factors associated with positive and negative experiences when using health, social, and community services? and (2) How do the service use perspectives of people currently experiencing homelessness differ from those who are housed and have histories of homelessness?

Method

Sample

Individuals were eligible to participate in the study if they: (a) were either currently or formerly homeless (i.e., one or more nights spent on their own in an emergency shelter or on the street), (b) self-reported having a mental illness or substance use problem, (c) were 18 years or age or older, and (d) spoke English. This study involved a convenience sample of participants who were recruited through three service agencies (an emergency shelter, a supportive housing program, and an intensive case management team) in a mid-sized Canadian city. Prospective participants were screened either in-person or by telephone to determine if they met the inclusion criteria. Of the 61 individuals who were screened for the study, two were ineligible and five were lost prior to being interviewed. A total of 54 participants took part in the study. One participant withdrew from the study and one other participant was excluded from analysis due to unreliable and poor-quality data. Data from 52 participants—half of whom were currently homeless and the other half of whom

were currently housed with a history of homelessness—were analyzed for this study. All participants provided written consent to take part in this study and received a \$25 honorarium for their time.

Procedure

Semi-structured, audio-recorded interviews were conducted in-person with each participant. Prior to the interview, a short questionnaire was completed that collected demographic, health, housing, and service use information. Interviews began with the intention of building rapport and exploring memorable past experiences using services. Prompts were used to encourage participants to continue their narrative or to provide more depth, as well as to focus on key factors associated with use of the service. The interview then transitioned to discussion of participants' use of social, community, and health services in the past year. Guided by participants' identification of the services they used on the questionnaire, they were asked how helpful or unhelpful each service was and why. The interviews lasted approximately 75 min, on average.

Data collection was carried out in two phases. First, 15 initial interviews were conducted. The transcripts were then reviewed to determine whether the interview guide and quality of data were adequate for achieving the study objectives, as well as to identify emergent topics that lacked clarity or required further exploration. Minor revisions were then made to the interview guide and the second phase of data collection began. Summaries were completed following all interviews. The interview summaries identified participants' reported positive and negative service experiences, as well as any other salient details that might be relevant to the analysis.

Data Analysis

Audio recordings of the interviews were transcribed verbatim. Data were analyzed using thematic analysis (Braun and Clarke 2006). The first phase involved a review of transcripts to generate initial codes. Line-by-line coding was then performed by the lead author. This consisted of applying descriptive codes to segments of the data where participants discussed positive, negative, and mixed service experiences. The coding of the data was assisted through the use of NVivo 12. Next, coded data were collated separately by the first three authors into potential themes. The authors then independently developed thematic maps of the analysis to lay out the properties and the relationships between potential themes. The results were then reviewed as a team to identify similarities and discrepancies, with any disagreements being resolved through consensus. Finally, themes were verified by comparing them to the interview summaries. This process

ensured that the findings were reflective of the individual interview narratives. Comparisons of demographic information and self-reported health problems between currently and formerly homeless participants were performed using Chi square and independent samples *t*-tests.

Results

Of the 52 participants, 53.8% identified as female and 44.2% identified as male. One participant identified as transgender female. On average, formerly homeless participants were 47.62 years of age ($SD = 10.73$) and had been housed for 5.44 years ($SD = 4.39$). Currently homeless participants were younger ($M = 41.85$, $SD = 8.80$) and had been without housing for 2.43 years ($SD = 3.26$). Almost all participants had one or more mental health problems (96.2%) and the majority also reported having a substance use problem (61.5%). All currently homeless participants were staying in emergency shelters, whereas the housing of the 26 formerly homeless participants varied (supported housing: 34.6%, social housing: 30.8%, market rent housing: 11.5%, supportive housing: 11.5%, living with family or friends: 7.7%, and rooming house: 3.8%). The only significant difference between current and formerly homeless participants was in their age ($t = 2.12$, $df = 50$, $p = 0.04$).

Thematic analysis identified five dimensional themes associated with positive and negative service experiences, each of which is described below (subthemes are italicized).

Accessibility of Services

Currently and formerly homeless participants' experiences with services and service systems were often shaped by their perceptions of accessibility, which included service eligibility, information and direction, program capacity, proximity, and affordability. *Eligibility* was the most prominent subtheme of accessibility, with service bans and refusals being a common negative experience. Decisions to ban or refuse service to participants were often seen as one-sided, unfair, or discriminatory. Though both groups described being refused or banned from services, currently homeless participants were most concerned as it left them few to no options of where else to go to meet their basic needs (i.e., shelter, food, healthcare). Service refusals could also yield a sense of hopelessness, abandonment, and other negative internalizations. Said one currently homeless woman, "You feel like you have nobody and nobody wants to help you. That's why I just kept going on like, 'What is wrong with me that the shelter can't even take me?'" Another eligibility barrier, especially among currently homeless participants, was a lack of proper identification. Several participants described this as creating a catch-22 situation: "I don't have

a family doctor so I can't get the forms done through [social assistance] and I don't have identification so I can't get a family doctor." In contrast, participants viewed services that helped them despite intoxication or being at full capacity as compassionate and understanding.

Services that offered *information and direction* about other services increased accessibility and helped to reduce feelings of being "lost" within service systems. This required service providers who were not only knowledgeable about their own programs but other available services as well. Assistance with referrals and completing paperwork to access services also reflected helpful direction. Although the subtheme of information and direction was discussed by both groups, formerly homeless participants emphasized the importance of having information about existing services, whereas currently homeless participants focused more on the value of receiving direction and assistance to access services.

Program capacity was another subtheme of service accessibility. Wait times affected participants' perceptions of treatment and care for better or worse. Further, actions taken by service providers to expedite care were seen positively: "The receptionist ... will know that it's me crying and literally just transfer me right through to [the counsellor] rather than waiting on hold." Participants also appreciated service providers who provided sufficient face-to-face time to discuss problems, efficiently responded to meet needs, and followed-up as needed. However, comparisons with other service users appeared to affect participants' perceptions of service providers: "My housing worker should have been able to find me a place within a couple months because there were plenty other people getting places. It made me feel like they were leaving me out for some reason."

With regard to *proximity*, services that were nearby or would physically come to service users (e.g., outreach programs, community-based mental health teams) were perceived positively, especially by currently homeless participants. Similarly, many participants appreciated when service providers would coordinate and accompany them to programs as it reduced the likelihood of missed appointments or not seeking needed treatment and care. *Affordability* was also identified by participants, with services that were free or covered by provincial health insurance being described positively and services that were unaffordable being discussed unfavourably.

Humanity in Approach to Care

Participants placed great emphasis on their perceptions of services' approach to care. Many currently and formerly homeless participants shared their views of the *organizational rules and policies* guiding service provision. Service rigidity was identified as contributing to negative

experiences. This included inflexible prescribing practices by physicians, strict rest times within the shelter system, organizational prioritization of the views of service providers over service users in response to disagreements, and lack of integration of service users' feedback into service delivery. Other rules and policies described by participants that could lead to a negative experience included: lack of confidentiality; insufficient training of staff, especially in conflict resolution; and a general inconsistent application of the rules between staff members. In contrast, when programs had qualified, "specialized" staff; "reasonable policies"; and minimal hierarchies, these contributed to a positive service experience.

The *characteristics and approach of service providers* was also widely discussed by participants. Participants described their interactions, observations, and views of the individuals involved in the delivery of services. Service providers who were "disrespectful", "judgmental", "impersonal", "unapproachable", and "lacking compassion" were perceived negatively, whereas participants described more positive experiences and relationships with providers who were "considerate", "nonjudgmental", "friendly", "welcoming", "smiling", "caring", and "understanding". Service providers who were perceived to be dependable, responsive, and action-oriented were seen favourably and could reduce feelings of being alone: "I know I got somebody on my side". In contrast, some participants discussed feelings of frustration when service providers exhibited unethical or unfair behaviours, such as abusing their power or displaying favouritism.

A comment sentiment expressed by currently and formerly homeless participants was that some service providers were employed in their roles "for the paycheck" and not to help service users. In contrast, service providers who went "above and beyond" for service users were described as good-hearted and as facilitating trusting relationships: "It's like it goes a bit beyond his pay level, that it's actually a career that he chose because he was passionate about and actually wants to help us."

Perceptions and Relationships with Other Service Users

Participants described how their service experiences were influenced by others who were also using the services. Other service users affected participants' perceptions of *safety and security*. Female participants felt safer in women only groups and programs. Conflict among service users led to participants feeling unsafe. Reports of conflict included: bullying, arguments, physical altercations, being "ripped off" financially, and thefts of personal possessions. Moreover, for participants who did not use substances, including those in recovery, interactions with other service users who were

using substances or intoxicated could be triggering and make them feel unsafe.

Relatability was characterized by participants having an 'us' or 'them' mindset. Participants described a sense of solidarity and connection with other service users who had similar backgrounds, traits, and experiences ('us'). The relatedness led to friendships and a sense of belonging: "They were all having the same issues that I have in life. I wasn't no different than anybody else." In contrast, participants avoided or negatively judged other service users who they viewed as being dissimilar ('them'). Other service users could be perceived as dissimilar due to mental health or substance use problems, even when participants themselves shared these challenges. For example, one currently homeless participant described not wanting a dormitory room at an emergency shelter because that was where the "crazies" stayed. Said another formerly homeless participant of the service users at an emergency shelter, "You're just surrounded by junkies who scream and yell and throw things all night ... the people there are just out of control." Some currently homeless participants also described themselves as being different from other emergency shelter users who had poor hygiene, which contributed to a negative experience.

Physical Space and Environment

The physical space of a service, including the quality and atmosphere, impacted participants' experiences. *Quality* was most frequently discussed in the context of living in social housing or staying in the shelter system. Contributing to a negative experience was a lack of cleanliness in sleeping spaces and communal washrooms. Specifically, bed bugs and cockroaches, the presence of used syringes, neglected housing repairs, and general dirtiness were highlighted. Some participants shared diminished feelings of self-worth as a result of their poor living conditions: "There is still cockroaches everywhere. Nobody says anything, we don't matter." The *atmosphere* of the service environment also emerged in participants' descriptions. Service atmospheres that were described as "chaotic" and "uncomfortable" were perceived negatively. In contrast, spaces that were "calm", "safe", and "quiet", and had elements of privacy and greenery were seen positively.

Outcomes of Service Use

Appraisals of service experiences often involved consideration of outcomes. *Feelings* were one type of outcome discussed by participants. Feelings of distrust and helplessness following service use were notable negative outcomes: "I didn't feel like I could trust many of the staff members. I didn't feel like they had my best interests in mind and it's like I kind of had a mistrust of the [emergency shelter] ever

since.” In contrast, service experiences that left participants feeling good about themselves were described positively.

Another outcome subtheme was *met or unmet basic needs*. Formerly homeless participants described having basic needs met in terms of acquiring or keeping their housing, which could also provide a sense of security: “[A housing support program] got me off the street, it got me to where I feel safe about myself, where I don’t have to worry about my neighbors.” Services that helped to stabilize or alleviate physical health, mental health, or substance use problems were also viewed positively by participants in both groups. However, negative perceptions arose when services did not provide sufficient treatment and care, leading to worsening health, service discontinuation, and future avoidance. For example, one currently homeless participant had sought help for suicidal ideation but was denied service, leading to severe consequences: “Drove me to a suicide attempt and it drove me out of my sobriety. Nine months gone.” Said another participant who had not received effective pain management from a walk-in clinic visit, “I ended up going on the street, that’s when I started getting my drugs off the street.”

Discussion

Perceptions of service use among currently and formerly homeless people with mental health problems in this study were shaped by experiences before, during, and after use of services. The theme of accessibility highlighted that a common experience for this vulnerable population was ineligibility for services as a result of being refused or banned from services, or lacking required documentation. In some cases, this led to a negative experience before any services had been used and subsequent avoidance of the services thereafter. As programs that were able to accommodate participants despite intoxication or capacity issues were seen favourably, low-barrier services are a key component of health and social care systems for this population. Scaling up low-barrier services, including emergency shelters, to prevent access barriers is needed along with sufficient development of harm reduction supports to reduce risks associated with overdose that can be traumatic for service users (Wallace et al. 2018). In conjunction with the findings on inflexible organizational rules and policies, reducing requirements to accessing or maintaining an emergency shelter bed may yield positive experiences that are helpful to preventing service disengagement. As for health services, consistent with past research (Lamanna et al. 2018), participants discussed the important role of service proximity. Thus, enhancing system capacity to provide mobile and outreach-based health services may further reduce barriers to accessing services and increase utilization.

The impact of services’ approach to care on experiences, as found in this study, is consistent with past research showing that people with histories of homelessness value supportive relationships with service providers and recognize efforts by staff who go above and beyond job requirements (Krotofil et al. 2018; Padgett et al. 2008; Thompson et al. 2004). The findings underscore a primary need to be treated fairly and with respect by providers when using services. The interactions and relationships with other service users were also found to greatly affect service experiences for better or worse. With regard to the latter, this included stigmatization among service users. Because participants also described feeling stigmatized and discriminated against by service systems, observations and judgments that other individuals accessing services are different in some way may foster stigma among the stigmatized. For those experiencing homelessness, given that communal programs (e.g., emergency shelters, soup kitchens, drop-in programs) form the basis of their service networks, offering groups and programming that are intended to bring people together to bond over shared experiences and interests may be helpful for reducing stigma and enhancing sense of safety. Further, implementing anti-stigma campaigns within homeless-serving agencies may be beneficial for changing judgmental attitudes held by some service users toward other, outgroup service users.

Consistent with previous research on supportive housing programs (Krotofil et al. 2018), the quality and atmosphere of services affected participants’ service use experiences. This was not limited to housing and shelter services as participants also described the effects of design and atmosphere in the context of community health centres, hospitals, and libraries. Given that environmental factors, such as poor living conditions and neglected repairs, could negatively impact well-being, it is important to recognize the impacts of place on health within service systems. Housing support and case management teams can help people exiting homelessness to consider environment-related issues by sharing information about the role of landlords in completing needed repairs and discussing the suitability of shared bedroom accommodations and their potential health impacts.

Outcomes of service use, such as how participants felt and if their basic needs were met, also shaped experiences. The emotional outcomes are important given the long waiting lists for affordable housing and some healthcare services often prevent people from having their needs met immediately. Because of this, positive emotional experiences are a relevant and measurable outcome that programs can target when serving people with mental health problems and histories of homelessness, especially those in states of limbo. Affordable counselling and self-help groups may also provide opportunities for service users to form connections and have compassionate experiences. However, any changes to improve outcomes at the service delivery level must be an

adjunct to systemic changes to reduce affordable housing shortages and wait times for recovery-oriented mental health services.

There were few differences in the findings between currently and formerly homeless participants. Given this, the findings suggest that formerly homeless participants continue to encounter barriers to accessing programs and navigating service systems; use some services where they feel judged, unsafe, or uncared for; and may leave services with unmet needs. The similarities between the two groups may be partially the result of many formerly homeless participants continuing to live in poverty and use some of the same services that they did prior to obtaining their housing (e.g., social assistance, community health centres, drop-in and meal programs). As such, there may be few experiential changes when using these services (i.e., same objectives, interactions with service providers and other service users, outcomes). Another consideration for the similarities in the findings between the two groups is that the factors found to impact service experiences are commonly desired and sought by service users; people want to access services in a timely manner, be treated fairly and respectfully, feel safe and supported when using services, and achieve positive and helpful outcomes. These are experiences that have been widely identified as desirable when using healthcare services (Coulter 2005; Gilbert et al. 2008; Jenkinson et al. 2002), suggesting that currently and formerly homeless participants with mental health problems want the same experiences as anyone else but do not consistently have them.

There were several limitations to the study design. First, participants were recruited from several service agencies. As such, people experiencing homelessness who are disconnected from service systems were not included in the study's convenience sample. Second, given that interviews were, on average, 75 min in length, participants with higher functioning were likely overrepresented. Third, only a single interview was held with participants so comparisons of service use experiences from homelessness-to-housing and vice versa were not feasible. A longitudinal study may have revealed more differences related to housing status.

Conclusion

This study explored the positive and negative service experiences of currently and formerly homeless adults with mental health problems to achieve a greater understanding of the service delivery needs of this population. Findings showed that relationships and communication were often at the centre of service experiences, with supportive service providers having the potential to reduce aloneness. Differences were few between currently and formerly homeless people with mental health problems, indicating that both groups are

looking to be treated fairly and without judgment, receive needed support and assistance, and feel good following their service experiences. However, both groups also described past experiences in which they encountered barriers to accessing programs and navigating service systems; used services where they felt judged, unsafe, or uncared for; and had unmet needs following service use, suggesting that the needs and wants of currently and formerly homeless people with mental health problems when using services are not consistently being achieved.

Acknowledgements Financial support for this study was provided to the lead author by Mental Health Research Canada (MHRC). The MHRC did not have any role in the development of the study, analysis or interpretation of the data, or in the preparation of the manuscript. All authors contributed meaningfully to the completion of the study and certify responsibility for the manuscript.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval The study was approved by the Research Ethics Board of the authors' institution (Reference Number: #H06-16-06). All procedures performed in this study were in accordance with the ethical standards of the *Tri-council Policy Statement 2: Ethical Conduct for Research Involving Humans* by the Panel on Research Ethics of the Government of Canada.

Informed Consent Written consent was obtained from all participants prior to their commencement in the study.

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