Author’s response to reviews

Title: Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities

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Author’s response to reviews: see over
Dear editorial board of BMC Health Services Research,

Please find enclosed the revised manuscript ‘Service provision and barriers to care for Homeless people with mental health problems across 14 European capital cities’ as requested. We have provided a point-by-point response to the concerns raised and have made the necessary changes to the manuscript.

Sincerely yours,

Mr. Réamonn Canavan and Professor Margaret Barry.

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Section 1: Major Compulsory Revisions

1. The methods utilized to determine whether services were deemed homeless-specific are described in the second paragraph of the ?Assessment of services? section. This is confusing and appears very arbitrary. The authors should explain what they mean by, ?if necessary, the proportion of clients who were homeless.? When was this necessary?

The coding of services as being homeless specific or generic was based on service self-definition. Each service was coded by the researchers who carried out the interviews in their capital city. In a small number of cases it was not clear which marginalised group the service was aimed at or whether the service was group specific or generic. In such cases if 50% or more of the clients were estimated to be homeless (and these figures were available – see section 3, point 4) the service was designated as a homeless service. Where the figures were not available, the coding of such services was left to the discretion of the researchers in that particular capital city as they had the best insight into the service. The coding process was not as clear cut as desired but the system used was designed to ensure that any services which predominately served homeless people, but which were not specifically defined as a homeless service, were included in the analysis.
Services were also classified as either mental health, social care or general health services. This distinction was once again based on service self-definition. In cases where it was not clear whether a service was mental health specific or generic, once again if 50% of clients were estimated to have a mental health problem the service was classified as a mental health service.

This information has been updated on page 7/8 of the manuscript.

2. What is the rationale for identifying ?Homeless-specific? services as opposed to services with 49% or less of its clientele being homeless? If homelessness is not an exclusionary criterion, then a service can serve homeless individuals. Any service serving homeless individuals is a resource for these individuals, whether the service is ?homeless-specific? or not. The services that an agency can provide are typically based on issues like licensing, staffing, and resources, not the client’s condition. The authors need to justify this important methodological and analytical decision.

Any service which serves homeless people may potentially be a resource for these individuals. However, with the exception of Accident and Emergency services, homeless people don’t tend to access general health services for reasons outlined in the introduction e.g. accessibility, lack of health insurance, provision of outreach services etc. This study aimed to focus the analysis on services which were directed at homeless people or which served predominately homeless people.

However, data relating to the generic services are also presented in the paper, particularly in relation to aspects of service provision which have most relevance to homeless people with mental health problems. While some Accident and Emergency services were assessed as part of the study, they were not assessed in sufficient numbers across countries to include in the main analysis. This is a potential limitation of the study and commentary on this has now been included in the Discussion under the limitations section of the paper.

The authors are of the view that if all services were analysed together i.e. homeless specific and generic, it would be difficult to extract useful data specific to the homeless population. One of the strengths of the study was the ability to distinguish between homeless specific and generic services and to then analyse the differences in provision between these services. More general results relating to the assessment of services are available at:

Priebe et al (2012) ‘Mental health-care provision for marginalized groups across Europe: findings from the PROMO study’ Available at: http://eurpub.oxfordjournals.org/content/early/2012/02/06/eurpub.ckr214

The rationale for focussing the assessment of services on homeless-specific services is now outlined more clearly on page 7.
3. The procedures used to code and analyze interviews are described in the Data Analysis section. Data from the initial 12 transcripts were coded line by line to develop a coding frame, and researchers from multiple centres were involved. The authors should clarify whether any/all of the initial 12 transcripts were coded independently by more than one researcher to examine inter-rater reliability, or if several researchers coded each transcript together as a group utilizing consensus scoring. The authors should also clarify if each of the last 16 transcripts was coded by only one researcher with no inter-rater reliability checks.

The initial 12 manuscripts were coded independently by two researchers from different centres and following discussion a consensus-based coding frame was produced. This frame was then used by the researcher from the project co-ordinating centre to code the remaining 16 manuscripts.

This data analysis procedure has now been clarified on page 11.

4. The authors should specify the recruitment procedures used to identify the PROMO projects participating services. Were similar recruitment efforts utilized in each capital city? Are we to assume that the capital cities with fewer participating services actually have fewer services? Should there be a relationship between each capital cities population size (Table 1) and number of services assessed (Figure 1)?

Services were identified according to available directories of services and information from relevant local practitioners. Information gathered during the interviews was used to consistently update the list of services. For example, services provided by NGOs were often not included in the directories of services. While every effort was made to ensure consistency of recruitment across capital cities, this was difficult to ensure in such a large multi-centre study. Also, it was not possible to impose too rigid a set of criteria for selection of services due to the diversity of health and social care systems across the 14 countries. The service lists were continuously updated according to the findings from fieldwork, in order to ensure that they were as comprehensive as possible.

The recruitment procedures have now been detailed more clearly on page 8/9.

We cannot assume that capital cities with fewer participating services actually have fewer services overall, nor can we necessarily assume that there should be a relationship between the population size and the number of services in each capital city assessed. Due to the differences in the overall level of provision of mental health care in general across the participating countries in this study, the level of service provision for homeless people also shows great variability which is not necessarily linked to the population size. Also, in some capital cities services relating to homeless people tend to be more centralised (e.g. Stockholm) and in other cities more dispersed (e.g. Dublin).
The variability across capital cities may also be related to the characteristics of the research areas selected in each city. The data from Dublin is a good example of this and is discussed in the paper on page 20. In Dublin all of the 19 homeless services assessed were located in one area as this area incorporated an area of the inner city where homeless people tend to congregate. No homeless services were identified in the second research area. It is important to note that the research areas in the study were identified in order to maximise the number of services catering for all assessed marginalised groups, and not specifically homeless people.

Selected areas had to adhere to certain rules regarding population size. However, the identification of two distinct marginalised areas with relatively large populations was more appropriate for the larger capital cities. In the smaller capital cities there was some overlap of research areas, as in some cases a service identified may have been relevant to both areas rather than being distinct to one particular area which may have reduced the numbers overall.

Considering the points raised here, it is difficult to make direct comparisons of service provision across the capital cities. The aim of the quantitative section of the paper is to give a general overview of service provision for homeless people with mental health problems across 14 capital cities in Europe. Considering that data were collected from each of the 14 capital cities across Europe, it was deemed important to include information on all homeless services assessed in order to get the best overview. This was done while taking into consideration the variability in the numbers of services assessed across the cities, whether real or a result of other factors.
Section 2: Minor Essential Revisions

1. The Methods section on ?Identification of research areas? indicates that the population size of each area was between 80,000 and 150,000 inhabitants. This does not match the corresponding Table 1 that suggests the range to be 73,207 to 202,824. This should be fixed.

The population size of each research area was originally intended to be between 80,000 and 150,000 inhabitants, however, the actual range reported was between 73,207 and 202,824. Some flexibility in the population size of selected areas was deemed necessary in order to accommodate different local contexts relating to administrative boundaries and service catchment areas e.g. London and Warsaw. Also, in some cases one or more areas were combined to achieve the target size.

Clarification of this point had been included on page 6/7.

2. In the Assessment of Services area, the first paragraph describes ?general health services,? whereas the next paragraph refers to these as ?physical health services.? The term should be kept consistent throughout the manuscript.

‘General health services’ is now used throughout the manuscript.

3. The statistical significance level is specified as .05, but the authors should also clarify whether the Chi-Square and Mann-Whitney tests were one-tailed or two-tailed.

Statistical tests were two-tailed. This has now been documented on page 10.

4. The results indicate that 84 services were described as homeless-specific social care services. The breakdown of these does not add up to 84 (i.e., 30 accommodation + 17 day centres + 13 social support + 5 outreach = 65). Seven of the eight homeless-specific physical health services were described as primary care. The authors should specify the eighth one.

The remaining 19 social care services were difficult to classify as they provided a variety of social care type services e.g., accommodation plus outreach, rather than focussing on the provision of one specific type. The breakdown of the 65 services was intended to give an overview of the type of services being provided rather than being a definitive categorisation. This has now been clarified on page 12.

The eight homeless specific general health service is a co-ordinating service which helps link homeless people to appropriate primary care services. We have now classified this service as a primary care service.
5. The results indicate that countries exhibited a high level of variability with regard to provision of outreach services. Were there other areas in which countries exhibited a high degree of variability? If not, this should be stated.

Other areas where countries indicated a high level of variability were the reported provision of internal supervision for staff and whether aggressive behaviour on the part of homeless people was a reason for exclusion from the service.

This has now been stated on page 13.

6. The results indicate that generic services reported having a higher number of paid staff. The statistics should be reported.

This statistic has now been included in the results section on page 14.

7. Page 19: This may just be an "American" English thing - but we spell it "focused."

Yes, this is a European - American distinction although many people in Europe also spell it ‘focused’. We have now spelt it ‘focused’.
Section 3: Discretionary Revisions

1. While the scope is broad by inclusion of 14 European capital cities, limited methods were utilized to gather information from only two highly deprived areas in each city. The authors should explain why only two areas were selected and why only highly deprived areas were selected. For instance, might a deprived area in one capital city actually have more resources than a non-deprived area in another capital?

Highly deprived areas of capital cities were chosen for this study due to the tendency of marginalised groups to be concentrated in these areas. While this paper focuses specifically on the homeless population, the overall PROMO study included six different marginalised groups and therefore, had to concentrate on highly deprived areas in order to include relevant services for all these groups. Only two areas were chosen as this was deemed manageable in terms of the financial and time resources of the project.

Whether a deprived area in one capital city has more resources in general than a non-deprived area in that city or another city is a question which is beyond the scope of this study. A deprived area is more likely to have larger populations of marginalised groups and is, therefore, more likely to provide services specific to such groups. Also, it should be noted that services located outside of the selected research areas that were reported as being accessed by marginalised groups from within the research areas, were also assessed as part of the study.

This information has now been updated on Page 6.

2. The second paragraph of the Background section points out that a permanent residence still represents one of the main requirements for registering with the health care system. The authors should indicate which health care system(s) this refers to (e.g., some/all European systems, United States)?

Although the entitlement to free health care for those in social exclusion is in principle guaranteed by most of the countries investigated, the administrative barriers prove particularly high for the homeless population. While difficulties for the homeless population in accessing mental health care services have been recognized by social exclusion policies in many European countries, a permanent residence still represents one of the main requirements for registering with a number of the health care systems in Europe including the UK, Ireland, Belgium, Germany, Italy, Poland, Portugal, Hungary and Spain. This either manifests itself with the requirement of a de-facto ‘proof of address’ (e.g. United Kingdom) or proof of being ‘a legal residence of the country’. In Germany, for example, reimbursement for the insurance premium is dependent on the reception of welfare benefits. The issue of registering for these rights starts with the fact that most administrations are organised per catchment area and require a permanent address. In Spain and Portugal you...
need to be registered with municipality to get a health card, and to register with the municipality you need an address.

This point has been clarified on page 5 as follows: ‘A permanent residence still represents one of the main requirements for registering with the health care systems in a number of European countries’.

3. Although acknowledged by the authors, a significant limitation of the study is that ?experts? were not selected to include representation from homeless or formerly homeless individuals.

This point is acknowledged under discussion of the study limitations on page 21.

4. Some services likely serve a larger number of individuals than other services at any given time. It is a limitation of this study that all services were equally weighted in the analyses, with no consideration of their size. Interviewees may have been able to provide a reasonable estimate on the number of individuals they serve. Some descriptive statistics to this effect would be helpful, particularly alongside each country’s Table 1 population size.

Interviewees were asked to provide a figure for how many individuals they served in the previous 12 months. However, there were some difficulties with analysing the results of this question. Figures given were combinations of real data and estimates. Interviewees also gave answers for different time periods, as services tended to operate different reporting periods. We asked interviewees for figures relating to the number of clients they serve from the two research areas. In capital cities with less sectorised health systems interviewees found it difficult to answer this question as clients may have come from any area. Similarly, if services provided care for a few areas they also found it difficult to answer these questions. Many of the services assessed were NGOs who often did not have such figures available.

5. Results are structured around three types of services: mental health, social care, and physical health. It would be helpful if Table 2 organized relevant results in this fashion.

This option was explored but such a table including a large amount of data was considered to be too unwieldy and too complex for inclusion.

6. On page 5, it is noted that "the more severe the level of homelessness the poorer the level of mental health." As a reader I am curious to know what the varying levels of homelessness are, and how people are assigned to each severity.

The varying levels of homelessness are related to the ETHOS typology of homelessness as referenced on page 6. The main categories are roofless, houseless, insecure and inadequate. People are assigned to each level of severity according to their current housing situation.

(http://www.feantsa.org/files/freshstart/Toolkits/Ethos/Leaflet/EN.pdf)
7. Also on page 5, you note that "less than a third of single homeless people with mental health problems receive treatment." It is unclear why this was relevant, as the study itself did not focus solely on single homeless people, and it left me wondering how families compare statistically.

The study that this statistic is taken from is based on a national survey of single homeless people carried out in the UK. As the study only focussed on single homeless people we felt we should report it as such. We did not find any comparable statistics in relation to how families compare. This statistic is relevant as it gives an indication of the numbers of homeless people with mental health problems who actually receive treatment. As the majority of homeless people are single it gives an accurate representation of the situation.

We have now inserted the following statement in the first paragraph of the background to the study (page 5) – ‘Comparable statistics in relation to homeless families are not available’.

8. Page 7, it is noted that "Only services which provide care specifically for homeless people were included in the analysis for this paper." Is this because these are the services that homeless individuals access most often? In my own community, homeless individuals are most likely to access emergency room services for care - it seems that to be so exclusive in analysis may in fact be not examining where individuals are actually going for care most frequently.

In many areas, homeless people will often go to Accident and Emergency services when attempting to access care. This fact is highlighted in the background section of the paper. However, for a variety of reasons the care homeless people receive there is often inappropriate to their needs. As mentioned previously, although some Accident and Emergency services were assessed as part of the study, they were not assessed in sufficient numbers to include in the main analysis and were, therefore, defined as a generic general health service for the purposes of this paper.

9. Page 8, the identification of "experts" is of concern. How was the quality of the "expert" ensured, particularly since only one was interviewed in each area? How did the authors account for the potential bias of this one individual?

The criterion for inclusion as ‘expert’ was good knowledge of local service provision and experience of providing or facilitating access to mental health care for people from the six groups. The experts were identified during the assessment of services phase of the study where service managers were asked to identify potential and suitable interviewees in the area. If such an expert could not be found in the area, they were recruited from other areas in the same city. Participants were employees of a wide range of services in the not-for-profit and state sector.

We did not impose strict criteria in relation to identifying experts as we realised that there was a possibility of a dearth of people with the knowledge and experience of providing
mental health care to marginalised groups in some contexts e.g. undocumented migrants, travellers. We were also working across 14 countries and across six marginalised groups. It is difficult in any study such as this totally remove the potential bias of any one individual. However, the fact that we found commonalities across countries suggests a strong level of validity in the findings. Also, the experts who participated in the homeless interviews came from a variety of professional backgrounds and worked in both the state and not for profit sectors.

10. Page 9 - the phrase "semi-structured interview" makes me as a reader question the reliability of the method utilized.

Using semi-structured interviews to collect qualitative data is common practice. The interviews were guided by a set of questions which the interviewer had to follow sequentially. Within this process there was freedom for the interviewee to express their own views and speak about topics relating to the questions which they felt pertinent. Using thematic analysis in the context of semi-structured interviews is also standard practice.

11. Page 12, it is interesting that the majority of services do not employ any professionally qualified mental health staff. Given the high prevalence of mental health disorders among homeless individuals, it would be helpful to know why the entities are not hiring mental health qualified staff. What are the barriers or biases? How can they not see this as a need?

We can only speculate why this is as we didn’t ask this question in the study. It may be related to funding, service size, number of staff employed overall or that mental health may not be perceived as a priority.

12. Page 14, it was noted that a barrier relating to health insurance was "not being registered with a GP." What is a GP? Is this defined anywhere in the paper?

A GP is a general practitioner. This has now been defined in the paper on page 15.

13. Page 16, the statistic that "20% of homeless people with mental health problems are also diagnosed as having substance dependence problems" seems very, very low. In the United States we would estimate that as many as 80% of said individuals would have co-occurring disorders. I would recommend comparing and contrasting with other sources. Also - in this same area, what defines a substance "misuse" disorder - Is this dependence? Abuse? Could the phrasing be used consistently with DSM-IV diagnostics for purposes of clarity?

From looking at other sources we can see that the numbers of homeless people with co-occurring disorders varies widely – from 10%-20% (Wright and Tompkins, 2007; Drake et al,
1991) to 50% (SAMHSA, 2002). The paper has been changed to reflect the variety of statistics available (Page 17).

There are a variety of reasons why such statistics may differ e.g. characteristics of samples selected (age, location) diagnostic criteria used (abuse or dependence, severity of mental illness), study type etc.

The term substance abuse in line with DSM-IV diagnostics is now used consistently throughout the article.

14. Also on page 16, it is noted "The issue of substance misuse as a barrier to care was again highlighted." I would contend that the problem someone has as a result of their illness/disability is not the barrier; the system’s inability to effectively address it is the problem. We must use caution in blaming individuals for their illnesses, and this language could be construed as such.

The issue of substance abuse was highlighted by experts in the study in terms of the difficult and chaotic life circumstances which homeless people tend to have, often as a result of substance misuse problems. This was perceived by service providers as being a barrier to care in terms of inability to keep appointments and difficulties with medication compliance. On the other hand, there are problems inherent in health care systems, both homeless specific and generic, in dealing with homeless people diagnosed with both mental health and substance abuse issues.

This point has been revised as follows on page 17: ‘The issue of substance abuse amongst homeless people was highlighted by experts in this study’.

15. Page 18, excellent point that the interpretation of some of the questions may have differed across countries. You give some examples - more would be welcome.

As per Section 2 (5) – interpretation of the questions related to aggressive behaviour, and internal supervision.