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## The views of homeless people and healthcare professionals on palliative care and the desirability of setting up a consultation service: a focus group study

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### ABSTRACT

#### Context.

Palliative care for homeless people is often given late, if at all. Professionals in both palliative care and shelter care are often insufficiently equipped to provide this complex care.

#### Objectives

To provide insights into the palliative care experiences of professionals and homeless people., including barriers and facilitators to care, and to investigate whether a consultative function can help improve palliative care for homeless people.

#### Methods

Six focus groups; four with professionals (n=19) and two with severely ill homeless people (n=15). Professionals were sampled purposively in organizations providing (palliative) care to the homeless. Homeless people were recruited by opportunity sampling.

#### Results

Palliative care for homeless people is especially complex and differs substantially from regular palliative care. It differs greatly between professionals, institutions and cities. Homeless people get less autonomy than they would like. Homeless people and professionals have different perceptions of the care provided. Trusting relationships between professionals and homeless

people are essential, and easily accessible, and flexible care is needed. Consultation, in particular involving exchange of expertise between professionals, can provide added value to professionals. Homeless people consider consultation primarily as an opportunity to train professionals to show more understanding, provide tailored palliative care and enhance professional collaboration. The local situation, characteristics of a consultant and role of a consultant in providing information and education must be considered when developing the consultation process.

#### Conclusion

Consultation can play an important role in improving palliative care by linking disciplines, providing support to professionals and providing appropriate palliative care to homeless people.

## BACKGROUND

People who are homeless often have psychiatric disorders and alcohol and drug dependency, as well as intellectual disorders (1), (2). Their lifestyles and living conditions are accompanied by multiple comorbidities and a significantly lower life expectancy than the non-homeless population (2), (3), (4), (5). Defining homeless people as those known to the Dutch social shelter system, about 30,000 people in the Netherlands are currently estimated to use that, and this number is thought to be growing (6), (7). Almost 80% are male, 16% are aged between 50 and 65, and they mainly live in the four major cities<sup>7</sup>. Due to the low life expectancy and multiple comorbidities at the end of life, palliative care is often needed<sup>8</sup>. However, more and more international studies are showing that homeless people's access to palliative care is still minimal for several reasons. Firstly, there are factors related to the homeless themselves, e.g. competing priorities and not complying with procedures. Secondly, there are factors related to the healthcare professionals caring for them, e.g. limited knowledge of the specific needs of homeless people. Finally, there are factors related to the organization of services such as the system's non-adherence to harm reduction strategies (4), (9), (10), (11), (12), (13), (14), (15), (16), (17). When looking for strategies to overcome the problems mentioned above, many studies recommend multidisciplinary collaboration between professionals and staff training to improve the access and quality of palliative care for homeless individuals (4), (9), (11), (18), (19). Because consultation proved to be an effective way of getting different disciplines working together and increasing knowledge of palliative care in the Netherlands<sup>20</sup>, consultation might also be effective in homelessness and palliative care. We define consultation as the process in which healthcare professionals can consult somebody with more expertise in a particular field or situation, with the aim of providing appropriate care. This consultation approach largely corresponds to a multiagency approach as mentioned by Hudson et al.<sup>21</sup>, where meetings are arranged in which professionals with different expertise get together to consider the care of a homeless individual with advanced ill health and work together to form care plans for that patient that meet both their immediate, and potentially future care needs and wishes. In addition, our approach to consultation specifically concerns professionals in social care who consult palliative care experts (e.g. hospice nurses) and vice versa. In practice, this implies that when a social worker suspects or knows that a homeless person is nearing the end of life, a hospice

nurse or another palliative care expert is approached for palliative care advice when the homeless person stays in the shelter. Where the homeless person later requires admission to a palliative setting, the social worker can give advice on treatment, challenging behaviour and contact with the patient. In order to understand whether reciprocal consultation between social workers and palliative care experts would be helpful in providing appropriate and timely palliative care to the homeless, more insights are also needed into current care and the problems experienced by both professionals and homeless individuals. Our study therefore aimed:

1. To explore the experiences and perceptions of professionals and severely ill homeless people regarding care and support provided to such people, including barriers and facilitators within that care
2. To explore whether reciprocal consultations between professionals in social and palliative care would be appropriate for improving palliative care for homeless people.

## METHODS

### Design and participants

We held four multidisciplinary focus groups with professionals working with homeless people needing palliative care and two focus groups with severely ill homeless people. Professionals were recruited by telephone and e-mail using purposive sampling, ensuring as much variation as possible in characteristics, such as organization (homeless shelter for day care, respite care, night shelters, nursing home wards, or palliative care facilities), city, and profession (physicians, nurses, social workers, policy makers). Inclusion and exclusion criteria are shown in Figure 1. Recruitment was through relevant healthcare organizations and existing professional networks of the project team using the snowball method. Of all professionals approached for participation, 31 agreed to participate in one of the four focus groups. Finally 19 professionals participated. Participants who failed to take part mostly did so at short notice, due to illness, work-related emergencies and public transport problems. As a consequence, two focus groups with professionals were smaller than expected (both  $n=3$ ). Homeless people were recruited using opportunity sampling. In a specialized nursing home for homeless people and a homeless shelter providing medical respite care, staff were asked to distribute an information letter to all homeless residents who were admitted in the nursing home and the homeless shelter, or being cared for by outreach home care provided by the nursing home because of severe illness (defined as having one or more life-limiting illnesses, such as COPD, cancer, liver problems and infections). Severe illness and the corresponding definition were chosen because a recent systematic review showed that determining whether a patient is nearing the dying phase and observing palliative care needs is very difficult for healthcare providers, particularly in this target group<sup>22</sup>. Residents who did not respond (e.g. low-literacy people or non-native speakers) received explanations from staff or were asked later on by staff whether they were willing to participate; no pressure was exerted. Of 70 homeless people approached, eight agreed to participate in advance, ten agreed as a result of last-minute recruitment, and 15 actually participated. Not wanting to take part was mostly at very short notice and due to not wanting to talk in a group or sudden other

activities. We followed the consolidated criteria for reporting qualitative studies (COREQ) guidelines<sup>23</sup>.

[FIGURE 1.]

### **ETHICS**

Both homeless participants and professionals provided written informed consent prior to the focus groups. All participants received a gift voucher for their participation. Transcripts were anonymized to ensure the participants' anonymity. Access to the data was limited to three researchers. On 27 July 2016 the Ethics Review Committee of VU University Medical Center provided a waiver as ethical approval was not needed under Dutch law.

### **DATA COLLECTION AND TOPICS**

Data was collected from 11 October to 30 November 2016. All focus groups were conducted and moderated by the same female researcher, trained in both qualitative and quantitative research. She was assisted by another female researcher who also made field notes. Focus groups (duration: 1.5 hours) with professionals were held at a central location. Focus groups with (duration: 1 hour) homeless people were conducted in the nursing homes where they were staying at that time. Well-being of the homeless participants was ensured by the availability of a staff member who was informed about the research and was willing to assist the homeless participants during or after the focus group. An interview guide was developed for the focus groups (Figure 2). When talking about care needs, some homeless participants recognized that they might be at the end of life, others discussed experiences of other homeless people with advanced ill health. Demographic data as shown in Table 1 was collected by brief paper questionnaires prior to the focus group. Data saturation was discussed frequently. All focus groups were audio recorded and transcribed verbatim.

[FIGURE 2. ][TABLE 1]

### **Analysis**

Data from the first two focus groups was discussed by two researchers, who decided that the interview guide worked well and needed no adjustment for the remaining focus groups. Transcripts were analysed following the principles of thematic analysis<sup>24</sup>. Before analysing, the transcripts were read and reread by two researchers for familiarization with the data. Codes were assigned to meaningful text and then grouped into themes by one researcher and checked by a second, using Atlas.ti 7. The codes and themes were discussed with three researchers after initially coding five transcripts and then after coding all transcripts. In addition, themes and interpretations were regularly discussed in the project team.

### **RESULTS**

Experiences and perceptions of care and support for severely ill homeless people Characteristics of the participants are shown in Table 1. Several themes emerged from the data that gave insights into how severely ill homeless people and

professionals experience the care given. A brief overview of these themes is provided in Figure 3

[FIGURE 3.]

**Palliative care for homeless people is especially complex**

According to both the professionals and homeless people interviewed, needs of homeless people who may benefit from palliative care differ greatly from those of regular palliative patients (Table 2, Q1). The disease course is often unpredictable, making it difficult to recognize the palliative phase and address problems adequately. This is largely related to the frequent (somatic and psychiatric) multi-morbidity, often combined with addiction to alcohol and/or drugs and intellectual disabilities. Related to this, services are often unable to meet the homeless person's needs. According to homeless participants, palliative care in nursing home departments now focuses mainly on providing physical care, whereas social and psychosocial care is very important to them. In concrete terms, psychosocial care, e.g. taking time for small talk, attention to the life story and building trust is essential for the target group. Additionally, the challenging behaviour of homeless people can be distressing to the healthcare providers, which complicates the care (Table 2, Q2). Given the various problems homeless people experience, it is almost impossible for professionals or even specialists to have sufficient expertise in all aspects. Both professionals (Table 2, Q3) and homeless people (Table 2, Q4) brought this up. Professionals also expressed a desire to share existing knowledge with professionals from different disciplines and cities (Table 2, Q5). This was a recurring theme in all focus groups.

**Palliative care varies widely between professionals, institutions and cities**

Although participants indicated that palliative care for homeless people has received more attention during the last few years, a majority pointed out that the quality and knowledge of palliative care still varies greatly between professionals, organizations and cities (Table 2, Q6). Opportunities for professionals to consult someone often appear to depend on available knowledge, experience and funding regarding palliative care for homeless people (Table 2, Q7).

**Homeless people get to determine less than they would like**

Both homeless participants and professionals saw self-determination as an important need of homeless people, especially in palliative care (Table 2, Q8). They also identified tension between homeless people's wishes when it comes to self-determination in care (e.g. wanting to be more autonomous) and the role of the professional regarding decisions about care (e.g. wanting to be more involved). Homeless participants wanted to become more involved in decisions about health or treatment, even in cases of limited mental capacity (Table 2, Q9). This tension often creates conflicts between professionals and homeless individuals, affecting the relationship negatively. Professionals often make decisions because (according to them) homeless people often make irresponsible or inappropriate decisions such as refusing medication (Table 2, Q10).

### **Homeless people and professionals have different perceptions of the care provided**

According to professionals, their approach to palliative care consists mainly of being involved in the daily life of a homeless person, making patients feel at home, being available for small talk, offering flexibility, knowing the homeless personally, asking about spiritual needs, discussing the last wishes and giving love and attention (Table 2, Q11).

According to homeless participants, however, the focus on palliative care in their residence is mainly on somatic care, while psychosocial care matters more to them. This is related to homeless participants' perceptions that there is too little staff time available, among nurses in particular. This is in turn related to the limited availability and frequently changing staff. They mentioned that professionals need to pay attention to e.g. their life story and psychological needs (without immediately referring them to a psychologist), and need to be more open about palliative care (Table 2, Q12).

### **Trusting relationships are essential for providing palliative care to homeless people**

In order to discuss palliative care with homeless people and/or determine their wishes, a trusting relationship between professionals and homeless patients is essential. This is especially the case because fear of death and not wanting to die are common among homeless people, according to professionals. According to both professionals and homeless participants, homeless people are often distrustful and need time and attention to build a trusting relationship (Table 2, Q13).

Homeless participants provided specific suggestions for establishing trusting relationships: they are more positive about professionals who pay attention and have more time available, and who have sincere interest in them.

### **Fewer barriers and flexible care are needed in palliative care for homeless people**

Both professionals and homeless participants mentioned that severely ill homeless people often perceive barriers to palliative care, and will often not approach professionals spontaneously (Table 2, Q14 and Q15). Professionals can overcome this barrier by regularly visiting where a homeless person stays and by taking the initiative. In addition, homeless people mentioned a need for care beyond the usual opening hours and possibilities (Table 2, Q16 and Q17).

Views on designing a consultation function to improve palliative care for homeless people

### **Relevance of consultation**

In this part of the focus groups, the primary question was whether and how consultation specifically might be helpful. In all four groups, most professionals saw added value in consultations. A number of professionals mentioned that since palliative care for homeless people is so complex, existing palliative care consultation is often not specific enough. Professionals see the added value of consultation for sharing, bundling and developing knowledge and expertise. This supports professionals with knowledge and experience in disciplines where they have less knowledge (Table 3, Q1). Additionally, increasing awareness about palliative care can be part of consultation (Table 3, Q2).

**[TABLE 3]**

Reciprocity seemed important for the added value of a consultation function (Table 3, Q3). On the one hand, professionals employed in social services, mental healthcare or psychiatry should be able to consult a medical consultant so that the homeless person can stay in a familiar place as long as possible. On the other hand, professionals employed in medical services could consult a consultant in social services to find out more about someone's background. In addition, consultation can be seen in a wider perspective according to the professionals. Consultation does not only have to be limited to social care and hospice or nursing home care, but can also concern generalist professionals who work in hospitals, home care or nursing homes and would like to receive advice from an expert in social care or palliative care for the homeless.

A small proportion of the participants were employed in organizations where consultations about palliative care for homeless people have already been used by professionals. Participants felt these consultations were very useful. In the focus groups with homeless participants, homeless participants were more likely to talk about current care and the problems they experienced than about consultation. Homeless people often gave practical suggestions for consultations, such as a social worker or a peer worker to help them express their needs (Table 3, Q4). When asked about consultation, homeless people considered a consultation function as a good option, as it could provide training for professionals in showing understanding and paying attention to homeless people at the end of life.

**Considerations in designing consultation**

Professionals described several issues that should be considered when developing a consultation function. First, a consultation function should fit the regional situation. It is important to take account of varying expertise and the organizations already available. In any event, consultation for palliative care for homeless people must be integrated into existing consultation services (Table 3, Q5).

Secondly, it is important to consider which characteristics a consultant should have. Aspects mentioned were knowledge in multiple disciplines, experience with homeless people and their characteristics, being able to connect different disciplines, taking initiative, and representing several organizations. A consultant should be approachable for professionals, and be flexible because of the lifestyle of homeless people (Table 3, Q6). Professionals mentioned that double consultations should not occur, consultation should ideally be available in a wide range of fields such as illnesses or combinations thereof that are typical for homeless people in the palliative phase and diversity among homeless people (including cultural and religious differences), symptom management (including cases of drug tolerance), behavioural problems of homeless people, addiction and drug use, practical issues such as insurance, and rituals and commemorations.

Thirdly, in addition to consultation in individual cases, consultants should also have a role in providing information and education. Participants said that there may be a barrier to approaching a consultant. A proactive approach could improve awareness that appropriate palliative care can be provided (Table 3, Q7). Professionals said that knowledge and information would make them feel more capable and self-confident when providing palliative care.

Homeless participants also made suggestions that may be important in developing consultation. Suggestions were that professionals should individually tailor palliative

care, take homeless people seriously, take time and pay attention, respect their need for control, care in a familiar environment, and understand and implement the patient's vision of palliative care (Table 3, Q8).

## DISCUSSION

### Main findings

Views of professionals and homeless people about palliative care are often influenced by its complexity for this target group, the wide variation in palliative care between professionals, institutions and cities, self-determination of homeless people, differing perceptions of professionals and homeless people about the care provided, trusting relationships between homeless and professionals when providing palliative care, and easily accessible, flexible care. Almost all participants saw a consultative role for helping caregivers care for individual patients as a good way of addressing those themes and providing appropriate palliative care to the homeless. Professionals supported this idea because of the complexity of problems and the need for sharing, bundling and developing knowledge and expertise from different disciplines. Homeless people saw consultation as a way of training professionals to show understanding and pay attention as they feel that there is room for improvement in the care given. It is noteworthy that the two groups emphasize different important aspects: professionals emphasize the need of exchange of knowledge and skills to respond to complex care needs and homeless people emphasize that consultation services have to result in person-centeredness. The regional situation, the characteristics of a consultant and their role in providing information and/or education must also be considered when developing consultative processes. This study is the first qualitative study that explores whether a consultative function can be used in order to provide timely and tailored palliative care for homeless people. It combines the views and experiences of professionals and homeless participants about palliative care. The fact that the homeless people included in our study were severely ill, but not necessarily in the palliative phase can be seen as a limitation of this study. However, we think this is not necessarily a limitation, given the challenges of identifying who might be palliative in this population. However, their responses should be regarded as a combination of views on preferences for current care and palliative care. Another limitation is related to the opportunity sampling of homeless participants; they all were residents in nursing home wards for homeless people. They are not representative of for instance homeless people who avoid care.

The complexity of homeless people's problems at the end of life was also noted in other recent studies conducted in other countries, as was the need for easily accessible, flexible care and the need for trusting relationships between professionals and homeless people in the palliative phase (<sup>11, 13, 15, 18, 25, 26</sup>). Additionally, our study revealed that professionals and homeless people have different perceptions about the meaning and content of palliative care, the actual or perceived roles of the homeless patient and of professionals; homeless people expressed a need for time, attention and being taken seriously. Furthermore, this study highlights new insights about the need and use of a consultative function in order to provide timely, appropriate, high-quality palliative care to homeless people, especially by providing specific knowledge, reciprocal exchange of skills and knowledge and a broader vision of the homeless patient. Finally, it became clear that consultation was not the only option



for providing more appropriate and on-time palliative care to homeless people. Homeless people expressed a need for support when severely ill. An intervention in which experts with practical experience help the homeless understand and communicate their needs better could perhaps be developed.

In order to realize a consultative function, more attention needs to be paid to the policy for financing palliative care for homeless people. The funding (and knowledge about the options for funding) was seen to vary greatly, so it seems that a regional structure needs to be provided so that every homeless person will have the same opportunities and quality of care at the end of life. Additionally, consultations about palliative care for homeless people should be embedded in existing care and consultation structures.

### **CONCLUSIONS**

In conclusion, given the fragmented and complex nature of palliative care for homeless people, multidisciplinary cooperation between professionals is necessary to improve palliative care for this group. Consultation can play an important role in improving palliative care by linking disciplines, supporting professionals and providing appropriate palliative care to homeless people and exchanging knowledge between disciplines. In addition to consultation, other ways to improve palliative care for the homeless are training and knowledge sharing, as well deploying of experts by experience to support the homeless.

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## FIGURES AND TABLES

Fig. 1. Interview guide for focus groups with professionals and homeless participants. EOL ¼ end of life.

Interview guide for focus groups with professionals	Interview guide focus groups with homeless participants
<ul style="list-style-type: none"> <li>• Introducing the subject, programme and discussing rules and topics</li> <li>• ‘Consultation intervention’ was introduced as follows. <i>‘A consultation function for healthcare providers employed in the medical or social care for homeless people, which can be consulted by a broad population of healthcare professionals who need knowledge or advice about palliative care for homeless people. The purpose of this consultation is to provide appropriate palliative care in good time when needed. Specialists in particular fields (e.g. shelter workers or palliative care nurses) are thus assisted by exchanging knowledge and experience with other disciplines.’</i></li> <li>• Short participant introduction</li> <li>• Introductory, general question</li> <li>• Care provided                             <ul style="list-style-type: none"> <li>○ pain and physical symptoms</li> <li>○ psychosocial</li> <li>○ spiritual</li> <li>○ contact with medical specialists</li> <li>○ cooperation with different organizations</li> </ul> </li> <li>• Care needs                             <ul style="list-style-type: none"> <li>○ severely ill homeless people</li> <li>○ involvement in decisions and care</li> <li>○ communication about health situation</li> <li>○ individual wishes of homeless people at EOL</li> </ul> </li> <li>• Consultation intervention                             <ul style="list-style-type: none"> <li>○ existing interventions</li> <li>○ need for consultation</li> <li>○ requirements for good consultation</li> <li>○ resolving problems in current care</li> </ul> </li> <li>• Summary and member check</li> </ul>	<ul style="list-style-type: none"> <li>• Introducing the subject, programme and discussing rules and topics</li> <li>• ‘Consultation intervention’ was introduced as follows. <i>‘A consultation function for healthcare providers employed in the medical or social care for homeless people, which can be consulted by a broad population of healthcare professionals who need knowledge or advice about palliative care for homeless people. The purpose of this consultation is to provide appropriate palliative care in good time when needed. Specialists in particular fields (e.g. shelter workers or palliative care nurses) are thus assisted by exchanging knowledge and experience with other disciplines.’</i></li> <li>• Short participant introduction</li> <li>• Introductory, general question</li> <li>• Care received                             <ul style="list-style-type: none"> <li>○ at the EOL</li> <li>○ problems experienced</li> </ul> </li> <li>• Care needs                             <ul style="list-style-type: none"> <li>○ when severely ill</li> <li>○ involvement in decisions and care</li> <li>○ communication about health situation with professionals</li> </ul> </li> <li>• Consultation intervention                             <ul style="list-style-type: none"> <li>○ need for consultation</li> <li>○ requirements for good consultation</li> <li>○ resolving problems in current care</li> </ul> </li> <li>• Summary and member check</li> </ul>

Table 1

**Inclusion and Exclusion Criteria for Health Care Professionals and Homeless Participants**

Healthcare Professionals	Homeless Participants
<p><b>Inclusion</b></p> <ul style="list-style-type: none"> <li>Participant is currently working in a shelter for homeless people (day or night care), respite care, nursing home ward, other facility aimed at homeless people, or palliative care facility.</li> <li>Participant works in one of the four major Dutch cities, which are Amsterdam, Rotterdam, The Hague, and Utrecht.</li> <li>Participant is a physician, nurse, social worker, and policy maker or has a related profession.</li> <li>Participant is available on selected moments for the focus groups.</li> </ul> <p><b>Exclusion</b></p> <ul style="list-style-type: none"> <li>Participant is not currently working in a facility for (care for) the homeless.</li> </ul>	<p><b>Inclusion</b></p> <ul style="list-style-type: none"> <li>Participant is currently homeless.</li> <li>Patient is currently seriously ill.</li> <li>Participant is being cared for in the nursing unit, nursing home, or outreach home care provided by the nursing home.</li> <li>Participant is willing to talk about palliative care or care when being seriously ill.</li> <li>Participant is older than 18 years.</li> </ul> <p><b>Exclusion</b></p> <ul style="list-style-type: none"> <li>Participant is not able to talk or is not understandable.</li> <li>Participant does not understand Dutch or English and/or is not able to communicate in one of those languages.</li> <li>Participant is younger than 18 years.</li> </ul>

Table 2  
Characteristics of Participants

Group	Number and Gender of Participants	Age Range (Mean)	Occupation <sup>a</sup>	Range of Years' Experience in Occupation (Mean) <sup>a</sup>	Health Status (Self-Reported) <sup>b</sup>
Homeless participants (1)	8 (7 M, 1 F)	40–64 (55.5)			Moderate: N = 5 Good: N = 2
Homeless participants (2)	7 (4 M, 3 F)	42–82 (63.1)			Poor: N = 1 Moderate: N = 3 Good: N = 3
Health care professionals (1)	7 (3 M, 4 F)	44–58 (53.3)	Two outreach nurses, nurse, elderly care physician, physician specialized in addiction, spiritual caretaker, and street pastor	13–32 (19.3)	
Health care professionals (2)	3 (3 M, 0 F)	36–68 (56.3)	Pharmacist specialized in medication for homeless people, physician specialized in addiction, GP working in a nursing home for homeless people	3–25 (12.7)	
Health care professionals (3)	6 (1 M, 5 F)	48–60 (52.3)	Social worker, hospice coordinator, spiritual caretaker, nurse, street pastor, and nursing specialist	10–24 (17.3)	
Policy makers and peer workers	3 (2 M, 1 F)	55–69 (60.7)	Policy advisor, client board advisor of an organization involved in care to homeless people, peer worker with experience of homelessness and addiction	4–42 (17.3)	

M = male; F = female; N = number.

<sup>a</sup>Only applicable to health care professionals.

<sup>b</sup>Only applicable to homeless participants.

*Table 3*  
**Summary of Themes Regarding Experiences and Perceptions of Care and Support**

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Themes and Subthemes

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- Complexity of palliative care for the homeless
    - Behavior of homeless people
    - Lack of expertise among professionals
    - Sharing of knowledge
  - Variety of palliative care
  - Self-determination
  - Different perceptions on care
  - Trusting relationship
  - Less barriers
  - Flexible care
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Table 4  
Quotes on Experiences and Perceptions of Care and Support for Severely Ill Homeless People

Theme	No.	Quote
Complexity of palliative care	Q1	"I regularly have contact with homeless people who are extremely ill and highly vulnerable, and increasing numbers are dying when with us. Then you come up against all kinds of things that are never in the picture for a GP, because you aren't familiar with the severe psychiatric issues and you don't see the addiction either." (Professional, FG 2)
Behavior of homeless people	Q2	"It's often awkward enough already for ordinary people in society to deal with the palliative phase properly, but with a target group like this it's even more so, because if they are admitted to whatever setting, they start behaving in highly inappropriate ways." (Professional, FG 1)
Lack of expertise	Q3	"If people are sedated at the last, and if they're heavy users you have to watch out very carefully that you have to begin with roughly a double dose, because apparently – well, you see it a lot with alcohol and morphine abuse – it doesn't work so well then. And yes, that means you need to know more about it." (Professional, FG 3)
	Q4	"I needed a sedative, but they were afraid that I'd change my day-night rhythm around. I had to get rid of the stimuli. The people who work here don't have enough of an all-round thought pattern to be able to understand someone with that kind of weird problems." (Homeless participant, FG 2)
Sharing of knowledge	Q5	"If it was left to our management, we'd be allowed to do minor operations as well, so then you have to be able to do everything. But there's a real lack of knowledge about palliative care. I know a fair bit about pain and addiction." (Professional, FG 1)
Variety of palliative care	Q6	"It's pioneering, it's finding everything out for yourself. It's actually also the lack of a doctor at our place who's well familiar with it and able to assist us a little as well. I sometimes speak to a GP who has some experience with palliative care and euthanasia. But she often has to look things up as well." (Professional, FG 1)
	Q7	"I work in a hospice and we occasionally get homeless people, off the streets. We have a sort of cooperative link with the homeless shelter so that they can stay there as long as possible and so that a nurse from the hospice will go and take a look there, do an intake, get to know the person a bit. And once it's no longer possible to stay there, the idea is that they then come to us." (Professional, FG 3)
Self-determination	Q8	"I'd like to have more influence over my own situation. It's not like the other person can decide what you should be doing. There are even rules about how late we should be going to sleep. Come on now, I'm 56 ..." (Homeless participant, FG 1)
	Q9	"I have one patient now who can put it beautifully: more rest and less condescension, fewer rules. Something simple – controlling their own medication, being able to drink a beer, rest, that there aren't other residents in particular knocking on the door all the time for a light or tobacco." (Professional, FG 1)
	Q10	"So it's about their pills and the benzos and the methadone and you sometimes end up in, well, an awkward area, because they sometimes want things that are medically irresponsible." (Professional, FG 2)
Different perceptions	Q11	"Have a look at what's coming to the fore with a person. Take a look at the dreams that they still have, for instance what they still want." (Professional, FG 1)
	Q12	"And if they do come in, or if she comes in saying she's in a hurry because there are two more patients after me, then as far as I'm concerned there's no point talking. So then I keep quiet. I say, do your work, dole out your medicines, give me the injection and bugger off." (Homeless participant, FG 3)
Trusting relationship	Q13	"Trust is often needed, but tricky because there's already a past history in which a lot of stuff has happened, and then at the end you have to build up that trust again. Sometimes you do have time, fortunately, because that relationship of trust has to be there. A lot of these people off the street have in fact lost that trust hugely – in the people around them, in humanity as a whole and in family relationships, because of all the circumstances." (Professional, FG 3)
Less barriers	Q14	"I couldn't sit in my room, because they never came there. So I had to go and sit in the living room, go and eat with them, and then at one point somebody just fell forward with their face in a plate, and I thought, right I'll go and have a chat with him and find out what's up. And so they gradually get to know your face and then trust does start to appear, and then you start hearing the stories." (Professional, FG 3)
	Q15	"There's nothing agreed, no discussions, nothing about reducing anything if I say that I've stopped taking my meds. It's tricky to talk to the doctor. Look – they should be starting the process. They're the doctors, not me." (Homeless participant, FG 1)
Flexible care	Q16	"Well, that comes from us but it's something the target group would say too, that's my experience. It's very important that they can just pop in and out. You actually need to be a bit more flexible." (Professional, FG 3)
	Q17	"Without you making an appointment on Monday that they'll let you sit there for quarter of an hour on the Thursday three weeks later. People just have to be accessible, able to make time quickly. And I'd like a bit of privacy too." (Homeless participant, FG 1)

M = male; F = female; GP = general practitioner; FG = focus group.

Table 5  
Quotes on Views on Developing a Consultation Function

Theme	No.	Quote
Relevance of consultation	Q1	<i>"I think that consultations can give security – that you know where you have to go with your questions, that you can ask targeted questions and you'll get specific answers. So that you don't have to start investigating things yourself and you know what the situation is. That keeps things calmer." (Professional, FG 1)</i>
	Q2	<i>"A consultant can give information, provide extra knowledge to people, bring other parties on board who are needed at that moment, as well as working on a process for improving awareness." (Professional, FG 3)</i>
Reciprocity	Q3	<i>"I think that consultations by bringing the social shelters and the hospice together, transferring knowledge from one to the other, can help make sure that someone can stay for as long as possible in their own familiar place. Which is often a care placement." (Professional, FG 3)</i>
Views of the homeless	Q4	<i>"Someone who knows the situation from the inside and knows how they can help me further. Someone who will look out for me a bit, who will get things pointed out to the nursing staff and tell them that they really have to listen to me." (Homeless participant, FG 1)</i>
Considerations: regional situation	Q5	<i>"Consultation ... the municipality: if you look at the consultations for social assistance, our policy for addresses for letters is very different than what Amsterdam does. So don't ask me how someone in Amsterdam gets a letter drop address; if you want to ask me how things are arranged in Rotterdam, then I'm a great consultant for that." (Professional, FG 4)</i>
Characteristics of a consultant	Q6	<i>"A consultant has to know where palliative care can be offered ... in fact they need to know everything that someone in that safety net role should know. That's one. And he has to know about how to arrange practical things – a letter drop, care insurance, income, financial management. And practical experience too." (Professional, FG 4)</i>
Information and education	Q7	<i>"Consultation is important, but so are awareness and training and things like that, I'd say. And you can keep on about that, I reckon, because I think you can give training from the palliative care sector to people in the homeless care circuit, the care providers. But the care providers in the homeless care sector can also give the people from palliative care training about the target group, the homeless and the people on the streets." (Professional, FG 3)</i>
View of the homeless	Q8	<i>"There simply needs to be more knowledge. They need to know more about these people as a whole, before they immediately start trying to respond. More understanding needs to be created about how you should deal with these people." (Homeless participant, FG 1)</i>

FG = focus group.