



# cancerless

Cancer prevention and early detection among the **homeless** population  
in Europe: Co-adapting and implementing the Health Navigator model

## Health Navigator Model for Europe

Christina Carmichael, Lee Smith

Anglia Ruskin University

WP2: Participatory co-adaptation of the Health Navigator Model  
in the European context meeting the needs of organisations,  
professionals, and the homeless population.

Date: 31/01/2022



The CANCERLESS Project has  
been funded by the European  
Commission's Programme Horizon  
2020 under the Grant Agreement  
965351



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



*CANCERLESS has been funded by the European Union's Horizon 2020 Programme under the Grant Agreement GA 965351. The contents of this publication are the sole responsibility of the partner organisations and do not necessarily reflect the opinion of the European Union.*

- WP No.: 2
- Deliverable No.: 2.5
- Co-authors:
  - Igor Grabovac, Radhika Seiler-Ramadas, Tobias Schiffler (MUV)
  - Maria Moudatsou, Ioanna Tabaki (PRAKSIS)
  - Pania Karnaki, Nadia Dalma, Matina Kouvari (PROLEPSIS)
  - Tomás Aguilar and Ascensión Doñate-Martínez (UVEG)
  - Christina Carmichael, Lee Smith (ARU)
- Level of Dissemination: Public

Versions:

<b>Version No.</b>	<b>Person in charge</b>	<b>Partner (acronym)</b>	<b>Date</b>	<b>Specifications</b>
<b>1</b>	Christina Carmichael	ARU	18.01.2022	Draft version shared with consortium for comments
<b>2</b>	Christina Carmichael	ARU	24.01.2022	Version following consortium comments, submitted for internal peer review
<b>3</b>	Christina Carmichael	ARU	31.01.2022	Final version for submission following internal peer review



# TABLE OF CONTENTS

List of acronyms.....	6
Executive summary.....	7
Introduction.....	10
Methodology.....	13
Study sample.....	13
Data collection.....	14
Data analysis.....	14
Ethical considerations.....	15
Results: Co-adaptation focus group discussions.....	16
Austria.....	16
Overview of co-adaptation activities.....	16
Programme goals.....	16
Community characteristics.....	17
Point of intervention.....	17
Setting(s) of intervention.....	18
Range of services offered by navigator(s).....	18
Navigator background and qualifications.....	19
Channels of communication between users and navigator(s).....	20
Navigator training.....	20
Navigator supervision.....	21
Evaluation measures.....	21
Greece.....	23
Overview of co-adaptation activities.....	23
Programme goals.....	23
Community characteristics.....	24
Point of intervention.....	24
Setting(s) of intervention.....	25



Range of services offered by navigator(s).....	25
Navigator background and qualifications.....	26
Channels of communication between users and navigator(s).....	27
Navigator training.....	27
Navigator supervision.....	28
Evaluation measures.....	28
Spain.....	29
Overview of co-adaptation activities.....	29
Programme goals.....	29
Community characteristics.....	29
Point of intervention.....	30
Setting(s) of intervention.....	30
Range of services offered by the navigator(s).....	31
Navigator background and qualifications.....	32
Channels of communication between users and navigators.....	32
Navigator training.....	33
Navigator supervision.....	33
Evaluation measures.....	34
United Kingdom.....	35
Overview of co-adaptation activities.....	35
Programme goals.....	35
Community characteristics.....	35
Point of intervention.....	36
Setting(s) of intervention.....	36
Range of services offered by navigator(s).....	37
Navigator background and qualifications.....	38
Channels of communication between users and navigator(s).....	38
Navigator training.....	39
Navigator supervision.....	39
Evaluation measures.....	40



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



**cancerless**

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

Discussion: Defining the Health Navigator Model ..... 41

References..... 46



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



**cancerless**

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

## LIST OF ACRONYMS

- ARU – Anglia Ruskin University
- D – Deliverable
- EU – European Union
- GDPR – General Data Protection Regulation
- H2020 – Horizon 2020
- HNM – Health Navigator Model
- MUW – Medical University of Vienna
- NGO – Non-Governmental Organisation
- PEH – Person/People Experiencing Homelessness
- UVEG – University of Valencia
- UK – United Kingdom
- WHO – World Health Organisation
- WP – Work Package



## EXECUTIVE SUMMARY

### Background and overview of purpose

'CANCERLESS: Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the health navigator model' is an EU Horizon 2020 project that aims to combine the principles of Patient Empowerment (WHO, 1998) and the core features of the Patient Navigation Model (Freeman, 2012) to create a new framework known as the Health Navigator Model (HNM). This person-centered model will be implemented with people experiencing homelessness across a series of European locations to help overcome health inequalities and facilitate this population's access to quality cancer prevention and screening services. This report, which forms the final deliverable of Work Package Two (WP2), presents both the findings of the cross-national co-adaptation focus group discussions and the proposed HNM that is to be piloted and evaluated in the next phase of the project.

### Methodology

Following the completion of a systematic scoping review and an exploratory qualitative study, the final stage of data collection for WP2 was a series of focus group discussions conducted with key stakeholders and individuals with lived experience of homelessness. The aim of these focus group discussions was to work collaboratively with stakeholders to co-adapt the HNM to ensure that it is suitable for and meets the needs of the homeless population and health and social care providers.

More specifically, it was intended that the focus group discussions would inform decision making with regards to the 10 core components of the HNM, as defined by DeGroff et al. (2014). These components cover all the various stages of the intervention, including the overall design, the remit of services provided, the profile of the navigator and the evaluation measures.

Focus group discussions were held in field settings and/or online via videoconferencing platforms in four countries (Austria, Greece, Spain, and the U.K.) during December 2021 and January 2022, and were facilitated by a multidisciplinary team of researchers from partner organisations of the CANCERLESS project.



## Results and discussion

Results from the co-adaptation focus group discussions indicate a high level of consistency and cross-national agreement with regard what the core components of the HNM should be, and how the intervention should be designed and implemented.

The country specific findings were then cross-compared and integrated to form an overarching framework which defines the core components of the HNM, as follows:

### Programme goals

- Deliver a person-centered intervention, responsive to user needs.
- Improve and build trusting relationships between users and health and social care providers, and between health and social care providers.
- Promote awareness and understanding of cancer (primary prevention).
- Increase rates and timeliness of cancer screening among homeless users (secondary prevention).
- Improve levels of self-care and overall wellbeing among homeless users.

### Community characteristics

- Make intervention accessible to people experiencing and/or at risk of all forms of homelessness as defined by the ETHOS typology (FEANTSA, 2006).
- Prioritise those at most high risk of cancer, those not currently engaged with healthcare services and those with complex support needs.

### Point of intervention

- Build trusting relationships and become embedded within the user population as the starting point for intervention.
- Implement intervention preventively, with continued care and follow-up for users where required.

### Setting

- Deliver main navigation activities in settings familiar and accessible to homeless users, and through mobile outreach.
- Facilitate access to formal clinical settings for full cancer screening and follow-up.

### Navigator services

- Identify health needs and barriers.
- Coordinate access to care.





- Offer practical assistance.
- Promote cancer awareness and self-management.

## Navigator background

- Select social or support worker, ideally experienced with user population and with local/community knowledge, to act as navigator.
- Establish and utilise local stakeholders (service managers, clinical professionals, and peers) to support implementation and delivery.

## Communication channels

- Deliver navigation activities through in person meetings, with optional phone 'check ins'.
- Maintain a presence within spaces familiar and accessible to homeless users.
- Ensure navigator-user meetings take place at regular intervals, with exact frequency and timing to be decided by users.

## Training

- Develop and deliver a comprehensive package of training with input from local stakeholders, covering:
  - Population-specific knowledge;
  - Communication and interpersonal skills;
  - Cancer education
  - Local context and resources.

## Supervision

- Provide the navigator(s) with administrative and clinical supervision from appropriate professionals, either external or internal.
- Utilise a combination of formal observations, peer coaching and informal 'check-ins'.

## Evaluation measures

- Evaluate intervention using a combination of qualitative and quantitative measures, and include direct feedback from users, navigators, and service providers.
- Collect pre- and post- data on cancer screening rates; level of user engagement with the intervention; user health and quality of life; and the quality of relationships between users and health and social care providers, and between different health and social care providers.



## INTRODUCTION

Previous research has consistently demonstrated that people experiencing homelessness are at increased risk of experiencing poor health-related outcomes. Infectious diseases, mental health conditions and substance-related disorders are all over-represented within the homeless population (Fazel, Geddes & Kushal, 2014), while rates of premature mortality are significantly higher than in the general population with an average age of death of just 47 years old (Thomas, 2012). Critically in the context of this project, cancer-related mortality has been found to be twice as high when compared to the general adult population in high-income countries (Asgary, 2018).

These poor health-related outcomes may be explained both by behaviours known to increase risk of ill health, and also by the existence of barriers in accessing what are often highly complex and fragmented health and social care systems. In particular, it has been found that people experiencing homelessness often present with symptoms that are missed by primary and secondary prevention strategies and are therefore over-reliant on acute healthcare settings such as emergency hospital departments (Field, Hudson, Hewett & Khan, 2019). Issues with access to appropriate healthcare for this population are often compounded by lack of insurance, legal problems, risk of stigmatisation and experienced discrimination (Hwang et al., 2013; Lebrun-Harris et al., 2013). While it is essential that steps are taken to prevent homelessness, there is also a pressing need for interventions to guarantee timely access to healthcare for those who are currently homeless.

‘CANCERLESS: Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator Model’ is an EU Horizon 2020 project that aims to design and implement a person-centered and community-based intervention called the **Health Navigator Model (HNM)** with people experiencing homelessness to facilitate their access to cancer prevention and screening. The HNM will combine the principles of two existing frameworks, both of which have been shown to improve the health outcomes of marginalised and underserved populations: the **Patient Navigation Model** and **Patient Empowerment**.

The Patient Navigation Model (Freeman, 2012) is an intervention whereby a worker or team of workers (navigator(s)) promote and facilitate timely access to healthcare and take steps to reduce any identified barriers to care. While existing patient navigation programmes have targeted wide



range of population groups and health outcomes, they have most commonly been used to address the prevention, diagnosis, and treatment of cancer (Kokorelias et al., 2021).

Patient Empowerment is a process through which people gain greater control over decision-making and actions relating to their healthcare (WHO, 1996). In this regard, programmes which adopt Patient Empowerment principles are generally focused upon encouraging people to actively participate in their health, and often make use of education and awareness building as a key tool for empowerment.

While existing evidence strongly indicates that both the Patient Navigation Model and Patient Empowerment are promising approaches for overcoming health inequalities, there are currently limited examples of this sort of framework being used specifically with people experiencing homelessness outside of North America. Consequently, the early stages of the CANCERLESS project have focused on engaging and working collaboratively with stakeholders to ensure that the HNM is designed and implemented in a way that is suitable for and meets the needs of health and social care providers and the homeless population in the European context.

**This report presents the final deliverable of Work Package (WP) 2 of the CANCERLESS project, the overarching aim of which has been to collect evidence in order to inform and specify the design of the HNM.** Following the completion of a systematic scoping review (D2.1.) and an exploratory qualitative study (D2.3.), the final stage of data collection for WP2 was a series of **co-adaptation focus group discussions** conducted with health and social care professionals and individuals with lived experience of homelessness.

The specific aim of the co-adaptation focus group discussions was to directly inform decision-making with regards to the 10 core components of the HNM, as informed by the framework set out by DeGroff et al (2014). These components cover all the various stages of the intervention, including the overall design, the remit of services provided, the profile of the 'navigator' and the evaluation measures, as follows:

- Programme goals
- Community characteristics
- Point of intervention
- Setting(s) of intervention
- Range of services offered by navigator(s)
- Navigator background and qualifications
- Channels of communication between users and navigator(s)
- Navigator training



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



**cancerless**

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

- Navigator supervision
- Evaluation measures

The following sections of this report provide an outline of the methodological approach adopted, and a summary of the key findings and outcomes from each of the partner countries' (Austria, Greece, Spain, and the U.K.) focus group discussions organised according to the 10 core components listed above. The final section of the report then brings together and integrates these findings and presents the proposed Health Navigator Model which is to be implemented and evaluated in the four European piloting sites in the next stages of the CANCERLESS project.



## METHODOLOGY

For the final stage of data collection in WP2, a qualitative cross-national research design was adopted, with data collected through a series of co-adaptation focus group discussions. These were held in field settings and/or online via videoconferencing platforms in four countries (Austria, Greece, Spain, and the U.K.) during December 2021 and January 2022, and were facilitated by a multidisciplinary team of researchers from partner organisations of the CANCERLESS project. The participant sample for the focus group discussions comprised a combination of relevant professional stakeholders and individuals with direct experience of homelessness.

Adopting a qualitative methodology for this stage of data collection allowed us to access participants' perspectives and priorities and ensure that these remain central as we move towards defining the HNM that is to be implemented. The use of focus group discussions in particular allowed for a range of ideas and views to be considered and encouraged debate and discussion between participants in a comfortable environment (Hennick, 2014). Previous research has also indicated that the use of participatory research methods such as this can result in healthcare services being designed in ways that are a closer fit to the needs of patients and clinicians, and lead to more innovative and creative solutions to healthcare concerns and disparities (see for example, Bowen et al., 2013; Boaz et al., 2018).

### Study sample

A total of seven focus group discussions were conducted, with an **overall sample size of 56 participants** comprising 41 professional stakeholders, including managers and representatives of health and social care providers, non-governmental organisations, local government departments and patient organisations, and peer support/social workers with prior experience of homelessness, and 15 persons currently experiencing homelessness.

Across all partner countries, participants were recruited through the use of existing professional networks and with the support of relevant health and social care organisations with whom relationships were established during earlier stages of Work Package 2.



## Data collection

Focus group discussions were held either in a field setting (e.g., homelessness support services) or online via videoconferencing platform, and generally lasted between two and three hours.

In advance of the sessions, a *Discussion Brief* was shared with confirmed participants. This short document covered the background, rationale and aims of the CANCERLESS project/Health Navigator Model and was designed to provide participants with some grounding in the topic area. This was either sent directly to participants by email, or where appropriate, shared through a gatekeeper (e.g., support worker). Each focus group discussion then began with the researcher(s) recapping this information.

A structured topic schedule was used to guide the discussion, and to ensure consistency in the cross-national data collection. This was based on the 10 core components of navigation interventions outlined by DeGroff et al. (2014) as listed above, which were introduced to participants and discussed in turn. Alongside the topic guide, the focus group discussions made use of participatory exercises designed to facilitate interaction, and help participants to share, organise and record their ideas with regard to each of the 10 core components of navigation interventions. The two main exercises used were *mind-mapping* and *diamond nine ranking* (see Clark, 2012). These activities were either delivered in person (e.g., on paper, or on a whiteboard) or adapted for the online environment. Researchers captured these activities through video and/or photographs which were then used to help inform the analytical process.

## Data analysis

Focus group discussions were audio-recorded and transcribed verbatim in their respective languages, either manually or using appropriate software, before being internally checked for quality.

Transcripts were analysed using a combination of inductive and deductive strategies. In the first stage of analysis, researchers adopted an inductive thematic approach (Saldaña, 2021) to coding the transcripts, attaching labels of a few words in a systematic fashion in order to capture relevant information in the data. Researchers then reviewed, synthesised, and merged the most significant of these codes, and organised these into a pre-determined thematic framework, consisting of the 10 core components of navigation interventions defined by DeGroff et al. (2014).



Informed by this analytical process, each of the four partner countries then produced a summary of their focus group discussion(s) with the key decisions, outcomes and themes organised according to this framework, each of which is provided in the next section of this report. Through a process of cross-comparison and collaborative discussion, these summaries were then integrated to form an overall framework for the **Health Navigator Model** which is presented in the final section of this report.

## Ethical considerations

The Ethics Committee of the Medical University of Vienna approved the overall study, and each partner obtained additional approval from their designated ethical review board or institution before beginning data collection. Written agreement was also requested from all organisations at which research activity took place, which confirmed their willingness for researchers to be present at their site(s).

Prior to the start of all focus group discussions, participants were supplied with a *Participant Information Sheet* and a *Discussion Brief* and given the opportunity to consider their involvement and ask questions. In all cases, participants were reminded that their involvement in the focus group discussion was voluntary and that they were not required to contribute to aspects of the discussion should they not want to. Full and informed consent was sought from and provided by all participants through a signed *Consent Form* and also through verbal confirmation.

At the start of each focus group discussion, the researchers introduced a set of 'ground rules' in order to ensure that conversations remained respectful and confidential. Participants were asked not to share details of who said what outside of the focus group setting. While the topics of discussion were not of an overly sensitive nature, researchers remained conscious for signs of emotional distress throughout, and avoided overly direct lines of questioning.

Data have been stored securely in line with GDPR (2016) regulations, and all files are encrypted and stored on computers that require password access, with unnecessary duplicates avoided. All focus group discussions were transcribed omitting identifiable details, and both transcripts and audio files have been labelled using reference codes rather than names. Consent forms are stored securely and separately, linked to their respective transcripts via the anonymous reference code.



# RESULTS: CO-ADAPTATION FOCUS GROUP DISCUSSIONS

## Austria

### Overview of co-adaptation activities

In Austria, one co-adaptation focus group discussion was conducted online using videoconference software by MUW with a total of **10** participants. The group comprised three social/support workers directly working in the field of homelessness, two peer support workers with prior experience of homelessness, two general practitioners working as volunteers in non-profit organisations, one homelessness social service manager, one healthcare manager of a charitable organisation offering services for uninsured persons, and one public health researcher from the field of medical anthropology working for the same organisation offering services for uninsured persons as a project consultant.

### Programme goals

During the focus group discussion, participants identified a set of goals that should form the basis of the Health Navigator Model, as follows:

- **Overcoming barriers** in current health and welfare systems in order to be able to adequately integrate homeless individuals and ensure that they receive appropriate care.
- **Raising sensitivity and establishing awareness** around cancer prevention and early detection in homeless people among health and social care professionals.
- Connecting different health and social care providers leading to the **centralisation of services**.
- Implementing **low-threshold access to services**.
- Improving healthcare service delivery with a specific focus on **accessibility of language and intercultural and gender awareness**.
- Offering **customised prevention measures** in order to provide the best possible outcomes with regard to early detection and prevention of cancer.
- **Improving the overall health of homeless individuals** through regular utilisation of medical check-ups.





- **Promoting a better understanding** of the needs and problems of homeless persons among healthcare professionals.

## Community characteristics

While overall participants agreed that the intervention should be provided to **all individuals experiencing homelessness**, it was felt that a number of sub-groups would also benefit were identified.

**Homeless people presenting with challenging behaviour and/or complex needs including those with severe mental illnesses** were felt to represent an important population for this intervention, as they often face exclusion from accommodation services, and therefore experience additional barriers in accessing health and social care services. For this group, it was felt that low-threshold services, with very few or no conditions around access, were required. Participants also indicated that homeless people who are known to have **additional risk factors for cancer**, for example people who smoke, should be prioritised. One participant also felt that the intervention should take special consideration of the needs of men as this represents a large proportion of the homeless population.

## Point of intervention

In general, there was consensus among participants that health navigation should **primarily be implemented preventively**. This was justified by the fact that timely intervention could prevent severe consequences. In this respect, continuous monitoring of the health status of those involved in the intervention was suggested.

With regards to prevention, respondents essentially highlighted two approaches. On the one hand, prevention needs to be addressed at a **biological-medical level**, and on the other hand on a **psychosocial level**. Indeed, the importance of integrating psychosocial aspects in prevention measures was heavily emphasised:

*“If I can integrate a person into a social network before he or she becomes ill, (...) it is more likely that this person will make use of or seek out certain services later on.”* (Peer support worker)

Participants were of the opinion that in case prevention was not sufficiently effective, **adequate acute measures** had to be taken. Several respondents agreed that homeless people should be



integrated into the healthcare system immediately after diagnosis. It was also pointed out that the **insurance status of those affected** should always be taken into consideration.

## Setting(s) of intervention

In terms of the setting in which the intervention should take place, the primary focus of the discussion was on the establishment of **outreach services**. Participants suggested that homeless people should be made aware of certain services offered openly and directly by professionals from the health and social sectors. In the discussion, a social worker suggested the use of a mobile bus that could move strategically around the city. Several participants expressed similar views and advocated **mobile services by interdisciplinary teams**. Teams consisting of a nurse and a homelessness support/social outreach worker were proposed as an example.

During the discussion, participants also suggested that **health and social care facilities** were settings in which navigators could be embedded. Specifically mentioned were hospitals, homeless hostels, emergency night shelters and day centres.

## Range of services offered by navigator(s)

Regarding the services that should be offered by health navigators, there was consensus that navigators should have a **clearly defined and limited scope of activities**:

*“I just wonder how much this person is supposed to do. (...) It would be more important to work in an interdisciplinary way and to know who can do which work. Because there are many professionals in the field who can do this, and for me it is somehow about a clear definition of what the services of this navigator are and what they do not have to do.”* (Public health researcher)

Participants indicated that health navigators should have the following tasks when working with homeless users:

- **Identifying health needs and barriers**
- Facilitating a **connection to health and social care services**
- Providing **emotional support** in challenging situations
- Assuming the role of a **mediator**
- **Linking health care providers and medical services** in a meaningful way
- **Filling out necessary forms** together with users



- **Accompanying users** to medical appointments
- **Case-specific work**, taking individuals' needs into account
- Establishing a **trusting relationship** with users
- **Organising** and ensuring user's attendance at medical appointments
- **Safeguarding the autonomy** of users
- Offering **practical assistance**, such as transportation, telephone, or medication storage

In contrast, participants also specified the tasks that should not be taken on by health navigators, as follows:

- Providing **cancer education**
- Delivering **medical diagnosis or prognosis**
- The promotion of **self-care and self-management should be limited in order not to overstretch the navigators' capacity**
- Supporting other needs that do not relate to cancer screening and prevention, as this could seem feel an 'overstep' to users

## Navigator background and qualifications

Participants named a number of personal qualities that health navigators should have in order to be qualified for this professional activity. These included the **ability to leave one's own assumptions aside**, the **ability to set personal boundaries** in terms of resilience, the **ability to feel comfortable and confident working with the user population**, as well as the **ability to empathise**. One general practitioner pointed out the need to **screen for professional aptitude**. It was emphasised in the discussion that the work as a health navigator could by no means be carried out by 'just anyone', but that the role required a very specific type of person. Participants also stated that a **high level of social competence** will be important for the navigator, as this promotes relationship building, which was key to the appropriate implementation of the model.

In addition to these personal eligibility criteria, participants also mentioned the need for prerequisites in terms of previous professions, training, and experience. In this context, participants explained that health navigators should have a **basic education in the psychosocial or medical field**. In addition, the possibility that people who have been through cancer themselves could work as health navigators was also raised in the discussion. Participants completely ruled out the necessity of being a cancer specialist.



## Channels of communication between users and navigator(s)

Participants agreed that the health navigation intervention should be available to homeless people through multiple channels. The establishment of a **central co-ordination office and contact point** responsible for health navigators was suggested several times. The homelessness social service manager who took part in the discussion felt very positive about the intervention as it could potentially compensate for current deficits in the care of homeless people, and stressed the importance of easy access:

*“And I would also like it if there were a variety of possibilities for the [health navigation] service. That is, if it were possible to get to the service not only through one channel ... If we could outsource this issue [subsequent care and support for homeless individuals] to someone else, it would of course be great, because we probably cannot solve it in social work and that is a problem.”* (Homelessness service manager)

An important aspect that came up within this context was the **inter-organisational exchange**. Participants agreed that the currently existing services could already cover many problems faced by homeless people, but that the knowledge about these services among homeless individuals was mostly insufficient. The focus group discussed using health navigators as an **interface between organisations** in order to be able to tackle individual needs of homeless persons. In this sense, the importance of **interdisciplinarity between social workers and healthcare professionals** was also underlined.

## Navigator training

Participants agreed that the job of health navigation must be linked to **comprehensive pre-practice training**. A set of compulsory training, with various sub-sections, (basic courses, medical courses, communication training) was proposed:

- **Basic courses**
  - Local health and social care systems
  - Basic knowledge about homelessness
  - Psychosocial training
  - Relationship building
  - De-escalation
- **Medical courses**



- Basic medical knowledge
- Cancer education
- Mental health
- Trauma and violence
- Addiction
- **Communication training**
  - Simple language
  - Motivational interviewing
  - Psychosocial interviewing
  - Trauma-sensitive conversation techniques

A potential limitation mentioned by participants was the **lack of financial resources** available for the comprehensive training of health navigators. Due to the presumably high workload and necessary skills for this profession, there was consensus that health navigators should not work on a voluntary basis.

## Navigator supervision

Concerning the supervision of health navigators, respondents highlighted different approaches. On the one hand, some participants pointed out the relevance of **case-specific supervision sessions** for navigators, while on the other hand, another part of the focus group emphasised the higher importance of **interview (peer coaching) and exchange between individual navigators and their experiences**.

What participants did agree on, however, was the need for **designated bodies to be responsible for interview and supervision**. One participant suggested the merger of institutions in terms of an allocation of responsibilities adapted to their core competencies.

## Evaluation measures

Participants agreed that evaluation measures could be carried out through **pre/post comparisons** or through **international comparisons**.

Participants effectively divided evaluation measures into quantitative and qualitative data collection, where **quality of life surveys** were assigned to both the quantitative and qualitative axis. Within the quantitative axis, respondents referred to the **elicitation of life expectancy data**. In addition, **case numbers** of homeless people served by navigators and **frequencies of their**



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



**cancerless**

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

**contacts** both came up during discussion. Moreover, according to one social worker, the timeliness of contact plays an important role, which is why the **time between the first contact with health navigators and the onset of cancer** should also be included in the evaluation.

Finally, in terms of the collection of qualitative data, the public health researcher participating in the focus group specifically referred to **qualitative interview evaluations**. She emphasised sustaining a continuous process of evaluation in order to ensure the highest possible quality of the intervention.



## Greece

### Overview of co-adaptation activities

Two co-adaptation focus group discussions were held in Greece by PRAKSIS and PROLEPSIS, with a total of **16** participants. Both were held online, aided by the use of videoconferencing software. The first focus group involved a sample of 14 stakeholders, comprising professionals working in non-governmental, health and social care, and patient organisations, experts in public health, and representatives of local government and public bodies. The second focus group discussion took place with two participants with direct experience of homelessness. While an in-person focus group with four people experiencing homelessness was initially scheduled, this could not take place due to the high instance of COVID-19 in the local area during in December 2021 and January 2022.

### Programme goals

Both groups of participants proposed a number of goals that they felt the HNM should focus upon, as follows:

- **Enhancing cooperation and improving the quality of relationships** between homeless users and healthcare services, between different health and social care services, and between health and social care services and the relevant government departments.
- **Providing capacity building** to professionals involved in delivering the intervention to allow them to offer meaningful support to people experiencing homelessness.
- **Increasing the rates and timeliness of cancer screening** among people experiencing homelessness, to ensure earlier diagnosis. Specifically, the intervention should aim to strengthen understanding of the importance of screening among both professionals and homeless users.
- **Organising and implementing a system/pathway of cancer screening**, ensuring ease of access for homeless users including those who are without social security numbers.
- **Taking steps to address the fundamental needs of homeless users**, such as access to accommodation and access to work/welfare benefits. These were viewed by participants as protective mechanisms which would better facilitate cancer prevention activities.



## Community characteristics

Both groups of participants agreed that the intervention should be designed for **people experiencing all forms of homelessness**, as set out by the ETHOS typology (FEANTSA, 2005), and also include those at **high risk of homelessness, the uninsured and those with severe physical and mental ill health**. It was also suggested that special consideration was needed with regards to engaging those **individuals who have already been diagnosed with cancer**, and particularly those with advanced stage cancer.

## Point of intervention

There was consensus among participants that a key factor for the success of the intervention will be the level of trust between the navigator(s) and homeless users. As such, it was felt that time would be needed at the start of the intervention to allow for **relationship-building**.

*“These people have broken lives, they have lost their faith in life, and they have lost their faith in themselves. People who will approach them must build a relationship of trust, try to make them believe in themselves in order to take the next step for their health ... trying to help them step by step, hand in hand, to support themselves.”* (Professional representative)

The role of **peers** was also recognised to be important at the start of the intervention, as input from people with prior experience of homelessness and/or cancer would help to encourage potential users of the importance of engaging with cancer prevention.

*“When you have a former [homeless person] and a current [homeless person] it carries a lot of importance, it gives him hope, it gives him confidence that I will get through this.”* (Professional representative)

While the **primary focus of the intervention is to be preventative measures**, it was also mentioned that the navigators may also facilitate access to palliative care and treatment where required.

*“We see people with cancer who are either on the street or in precarious housing conditions not even knowing about pain clinics and how they could access them in public hospitals.”* (Professional representative)





## Setting(s) of intervention

In the initial stages of the intervention, participants generally felt that the navigator should be focused on **outreach activities and therefore be based in settings where the homeless population generally reside** including on the streets, and in specific homelessness services.

For initial meetings and screening, it was felt that a **mobile healthcare unit** or “one stop shop” would be useful, particularly for those who face difficulties in accessing mainstream services. However, it was also recognised that for **full screening and follow-up, it would be important to be able to refer users into formal clinical settings.**

## Range of services offered by navigator(s)

Overall, it was agreed that the navigator(s) should adopt a **personalised and holistic approach to the services they offer** and adapt the intervention to meet the specific needs of each homeless user. This was felt to be particularly important given **the diverse profile of the homeless population in the country.**

However, specific key tasks were also agreed by the participants, as follows:

- Creating a trusting relationship with homeless users through **direct and regular communication** with them.
- **Understanding the users' immediate needs**, and facilitating solutions to these where possible (e.g., access to shelter, access to personal hygiene facilities, seeking treatment for emergency health needs).
- **Mapping and facilitating access to statutory, voluntary and health sector services in the local area, including those which can perform cancer screenings.**
- **Providing information around cancer symptoms and prevention in a simple and accessible manner.**
- Serving as a ‘link’ between homeless users and health and social care providers.
- Providing **practical assistance to users** (e.g., clothing, access to washing facilities) and **organising and accompanying them to appointments.**

In the case that a user is diagnosed with cancer, additional services provided by the navigator were suggested as follows:

- **Providing information on and facilitating access to healthcare services which provide cancer treatment and palliative care** (oncological hospitals, specialist pain management clinics).



- Offering **mediation between healthcare staff and homeless users**, to support their understanding of and compliance with treatment requirements.
- **Providing practical assistance** to ensure that treatment conditions are met (e.g., transportation to appointments, safe storage of medicines etc.).

A key theme within the discussions with both professional and homeless participants was that, while housing is not the primary focus of the intervention, it may be that the navigator needs to become involved in **resolving immediate housing needs**. It was felt that it would be unlikely that users experiencing literal rooflessness (sleeping on the streets) would engage with cancer screening or other preventative activity until their housing needs were managed.

## Navigator background and qualifications

Overall, participants felt that the navigator intervention would need to involve a **multidisciplinary team of health and social care professionals** (including primary care physicians, nurses, social/support workers, and psychologists). It was also agreed that it would be necessary **to involve people with lived experience of homelessness** to act as mediators between users and navigators.

*"I think an important factor that helps to reach out to the homeless population, are peer support workers ... people who have had experience with homelessness. These people should be the mediators and support, help with the communication of homeless with medical staff. A mobile unit is not easy for the homeless in terms of visiting a doctor. There should be a mediator who could more easily reach these people."* (Professional representative)

Participants also discussed **the involvement of cancer patients in the intervention**, who could assist by explaining their experience of cancer to users and emphasise the value of preventative activities.

A key point raised by participants was that the success of the intervention would rely on **direct communication and cooperation between relevant stakeholders** including local authorities/local government, and health and social care providers. This was felt to be particularly important to ensure a comprehensive support system and avoid overlap between services.



*“[It is necessary] to cooperate and combine the forces of the municipalities that provide services and the wider civil society. There should be no overlapping and the services offered should become more efficient.” (Professional representative)*

## Channels of communication between users and navigator(s)

Participants emphasised the difficulties associated with developing communication channels with people experiencing homelessness and felt that the navigator would need to spend time **developing trust with the users**, and as such **communication may be ‘slow’ in the initial stages of the intervention**.

Overall, it was decided that there would be a need for **direct face-to-face contact between navigator(s) and users** and felt that this would ideally take place consistently on a **systematic** basis, ideally once a week. However, it was also recognised that the type and frequency of communication would vary depending on the needs of specific users.

## Navigator training

The training of the navigators was felt to be one of the **most important aspects of the intervention**. A number of specific areas of training were suggested as follows:

- **Homelessness**
  - Causes and impacts of homelessness; different forms of homelessness; strategies for engaging this population; health issues and barriers faced.
- **Communication skills and empathy**
- **Cancer education**
  - Types and prevalence of cancer; risk factors; symptoms; preventative strategies.
- **Local context, resources, and accessible cancer screening services**

Professional participants also mentioned the need for the **education of staff working in homelessness services and medical staff in public hospitals** on the specific needs of the homeless population and the difficulties they face regarding their health management. This is because the involvement and understanding of these professional groups was felt to be imperative to the success of the intervention.



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



**cancerless**

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

## Navigator supervision

While the supervision of navigators was not a major topic of discussion among participants, it was agreed that navigators would require support when delivering the intervention. It was agreed **that coaching and ongoing supervision should be provided by professionals with relevant expertise** who have specific experience of working with the homeless population.

## Evaluation measures

From the focus group discussion with professionals, it was felt that in order to properly evaluate the intervention, there needs to be **continuous monitoring** of the progression of the users' needs and the assistance provided. It was also agreed that evaluation must consider not only the number of referrals made to healthcare services, but also the **rate of follow-up** as this is a known issue among this population.

It was also suggested that evaluation should include and be conducted by all parties involved in the intervention, including the navigators, local health and social care providers and also the homeless users themselves, who should be asked to feedback on the services received.



## Spain

### Overview of co-adaptation activities

Two co-adaptation focus group discussions were held in Madrid, Spain with a total of **18** participants by UVEG. The first focus group took place in person at a local homelessness service with a total of nine people experiencing homelessness, several of whom had currently or previously experienced cancer. The second focus group took place via videocall, with a sample comprising nine professional participants including both doctors and nurses with varying specialisms, oncologists, and social workers.

### Programme goals

Both groups of participants were in agreement regarding what the main objectives that the HNM should be, as follows:

- **To reduce healthcare barriers** by ensuring access to healthcare for people who are homeless and who have specific health condition including cancer and other chronic diseases.
- **To increase the rate of cancer detection** among people who are homeless through delivering interventions focused on health education and improving the current systems for early detection (e.g., screening).
- **To improve the quality of the relationships** between health and social care providers and patients.
- **To improve the quality of life of programme users**, both with regard to their health (early detection of cancer and other conditions, access to healthcare) and their social care (access to resources and benefits).
- **To involve the patient in their own care process**, enhancing patient empowerment through self-care, self-management, and decision-making.

### Community characteristics

Both the professional and homeless participants indicated the importance of making the intervention **accessible to all people who are experiencing homelessness**, regardless of age, sex, or gender. There was a specific suggestion that the intervention should involve **active outreach** to identify people living on the streets, in precarious and temporary housing and other 'hidden'



situations to ensure they are engaged. There was also consensus that it will be important to prioritise and provide more urgent assistance to **individuals who present with complex needs** (for example drug and alcohol dependency) and those who may have **other vulnerabilities** (for example, older people).

In addition, it was emphasised that given their poor living conditions, difficulties may arise in engaging the homeless population in this intervention. As a result, it was felt to be important to appropriately **motivate their interest and participation in the programme**.

## Point of intervention

Across both focus group discussions, participants agreed that it was important that the navigator be involved in outreach activities and become **familiar with the locations where people experiencing homelessness spend time**, such as soup kitchens, night shelters, parks, and areas of makeshift accommodation (e.g., 'tent villages').

Professional participants also indicated that given the **difficulties associated with providing a continuum of care** to people experiencing homelessness, who are often transient, the intervention would need to take **active steps to maintain engagement** and involvement in the intervention.

## Setting(s) of intervention

Regarding the settings within which the interventions should be carried out, there was consensus that spaces that are **familiar to and frequented by the homeless population** would be most appropriate as these spaces are considered safe and are most easily accessible for this group. It was also explained that using these familiar spaces would allow the navigator to deliver **both individual and group-based support**, and that by being present in these spaces, the navigator would be **best placed to develop trusting relationships** with those participating in the intervention. Specific settings suggested included **churches, soup kitchens, hostels, or community centres**. More conventional healthcare services were felt to be less appropriate as they would not offer users the same level of flexibility.

Several of the homeless participants also emphasised that the option of **telephone communication** would be useful, as this would allow them to contact the navigator easily and quickly and therefore remain more actively involved in the intervention. However, it was also



indicated that mobile phones would need to be provided, as many people experiencing homelessness are not in possession of one.

## Range of services offered by the navigator(s)

While the professionals expressed differing opinions with regards to the services that should be offered by the navigator, several common themes were identified. There was, for example, general agreement that a central aspect of the role should be **sharing information about and facilitating access to health and social care services**. The navigator was described as being able to provide a **'link' both between homeless users and health and social care services, and also between different services**:

*"The figure of the navigator should be a source of support and information. It is important that these professionals provide guidance to the patient and know the existing resources are able to solve the needs of patients."* (Community nurse)

There was also consensus that the navigator may need to be involved in **addressing the basic needs** of homeless users (for example, access to accommodation, food, and emergency healthcare). It was felt that without first attending to these fundamentals, any attempt to engage individuals in activities such as screening or self-care would not be successful.

*"The priority is that the navigator helps the patient to cover the basic needs, in this case housing. From that point, navigators should focus on the social determinants of health ... housing, food, access to health, barriers to medical care ... since screening or cancer diagnosis is not so much a priority."* (Mental health nurse)

From the perspective of homeless participants, it was felt that the primary role of the navigator should be to **identify the health and support needs of users and help them overcome any barriers faced**. More specifically, it was felt that users would benefit from support with organising and attending appointments, arranging transport, and support in managing medication and treatment:

*"What these people need most is to be able to have transportation, to help us with appointments, practical, real help, something that can be used and useful to us."* (PEH)

Finally, it was also agreed that the navigator could be involved in supporting **broader needs**, such as facilitating access to housing, employment and/or welfare benefits.



## Navigator background and qualifications

In the professional focus group discussion, there was general consensus that a **support or social worker** would be the most appropriate choice to take on the role of the navigator, as they would understand **local resources, and have a background in delivering care and support.**

*"If it is a single person who will coordinate and who has the right training for that and can be trained ... I think the figure is a social worker, since this is the person who normally knows all the resources." (Oncologist)*

However, it was also recognised that ideally, the navigator would also have **experience in healthcare, and an understanding of both cancer and homelessness.** As such, several participants indicated the value of a **multi-disciplinary team of navigators** encompassing individuals from both health and social care:

*"I see as necessary that there is a health figure with a focus on community and public health and also a social worker as part of this team who knows about the benefits and resources." (Mental health nurse)*

Homeless participants also agreed that either a **social or support worker, or a community-based health worker** would be the most suitable person to take on the role of the navigator. However, they also felt that the position could be fulfilled by another professional – for example, a cancer health worker – if given appropriate training:

*"The navigator could be a community health worker, because it has to be a person who knows about health but knows well the community and the people they are going to treat." (PEH)*

## Channels of communication between users and navigators

Across both sets of participants, it was agreed that the preferred means of communication between the navigator and users would be **face-to-face meetings, held periodically** (either weekly or monthly) as this would allow the navigator to gain a more in-depth understanding of the user's needs. It was also recognised that many people who are homeless **do not have e-mail or phone access,** making these forms of communication less appropriate. However, as noted above, homeless participants did also feel that being given access to a mobile phone would allow them





to better communicate with the navigator between face-to-face meetings. Regarding the frequency of appointments, the professionals felt that this would depend on multiple factors and that each user should have the option to decide when and how often to meet with the navigator.

## Navigator training

From the professionals' point of view, the training received by the navigator would need to be **extremely comprehensive and cover multiple topics**, as it was felt to be unlikely that a single professional profile would already have all the areas of experience needed to fulfil the role. The most vital areas of training were felt to be **cancer education, local context and resources, and mental health**.

From the perspective of homeless participants, the training of the navigators was deemed one of the most important considerations to ensure the success of the programme. Given that many homeless people are reluctant to engage with professionals, it was felt that the training should specifically focus on **how best to communicate and engage with this population**.

While other areas of knowledge/skills were felt to be important by both participant groups, it was felt that these should be prerequisites at the point of recruitment, rather than areas for training. This included **general medical knowledge/health training, social and communication skills, and problem-solving skills**:

*"The navigator should be a person with experience in the field of social exclusion and someone from the health world... they have to be people who can understand the health process and the level or stage the person is at. They should be professionals with psychosocial training and public health training." (Mental health nurse)*

## Navigator supervision

There was general consensus among participants that the supervision of the navigator must encompass a combination of **administrative, social and health oversight**, and that the navigator should receive **supervision and support from both health and social care services**.

In terms of the format of supervision, it was felt that the navigator needed to have access to **constant streams of communication** with a variety of professional figures (e.g., social workers, nurses, oncologists) to ensure the most positive outcomes for users.



It was also agreed that navigator supervision should include the observation of **formal meetings between the navigator and users** on a weekly basis, as well as the option of more intensive supervision during the critical points of the navigation and informal telephone contact throughout.

## Evaluation measures

From the perspective of homeless participants, **the relationship between users and health services and care providers** was viewed as one of the key outcome measures for this intervention and felt to be particularly important given that that people who are homeless often face extensive barriers to accessing these services. Linked to this, it was felt that **overall level of health and quality of life** should be tracked over time (pre and post intervention) to understand whether the intervention was positively impacting users at a more general level.

It was also agreed by homeless participants that it would be important to observe the **rate and timeliness of cancer screening**, as this would represent an important measure of cancer prevention and early detection:

*"Timeliness of cancer screening is paramount. It is important that they [i.e. appointments] are requested or that they make an appointment with you [i.e. the Health Navigator] as soon as possible in order to carry them out and that people learn about their own health status." (PEH)*

From the perspective of the professional participants, it was agreed that it would be beneficial to understand the number of people experiencing homelessness in each pilot area, including those with or at risk of cancer, to properly understand **the scale of the issue prior to intervention**. Once this information was established, it was considered important to measure both the **navigator caseload** (the number of users involved in the program), and specifically the **level of user participation and the relationship between navigators and users**.

Notably, the professional participants also felt it important to **specifically record what types of services the navigator provided to individual users** (e.g., practical assistance, education, emotional support) as this would facilitate understanding of which aspects of the intervention are most crucial. On this point, it was agreed the **detailed feedback should be obtained from the homeless people who have participated in the intervention**, in order to understand how they characterise the impacts of the navigation programme.



## United Kingdom

### Overview of co-adaptation activities

Two co-adaptation focus groups were held in the United Kingdom by ARU, with a combined total of **12** participants. The first focus group discussion was held online via videocall with seven participants comprising two homelessness service managers, two healthcare managers specialised in working with vulnerable populations, and three representatives of a charitable organisation offering cancer support services. The second focus group discussion was held in person at a homelessness service with five participants comprising four male service users with experience of homelessness, and one frontline support worker who also had prior experience of homelessness.

### Programme goals

Both groups of participants proposed a number of goals on which the programme should be based around, as follows:

- **Improving understanding and awareness** of cancer prevention, early detection, and screening entitlement among homeless users and professionals that directly support them.
- **Developing and improving the quality of relationships** between users and health and social care services, and between different health and social care services.
- **Increasing overall rates of cancer screening** among homeless users, both through direct intervention, as well as through advertising and education.
- **Improving access to cancer care pathways** for homeless users.
- **Improving overall wellbeing** among homeless users and effecting positive **behaviour and lifestyle changes**.
- Delivering a **person-centered approach**, driven by individual requirements and needs.

### Community characteristics

Overall, it was agreed that the intervention should be offered to **people experiencing all forms of homelessness**, including the 'hidden homeless' and those living in poor quality or precarious housing, and also to those at risk of homelessness. It was also agreed all age groups would benefit from the intervention.



From the perspective of participants with experience of homelessness, it was felt that particular focus should be placed on **encouraging men to engage with the intervention**, as it was agreed that – in general, there was less awareness of male-specific cancers and men in particular often neglect their health needs. It was also decided that **transient homeless populations** (i.e., people who move from place to place, including for work) warranted special attention given that they are less likely to be engaged with mainstream healthcare services.

## Point of intervention

There was overall agreement among participants that in order to meet the needs of people experiencing homelessness, the navigation intervention needed to **start from a point of the navigator(s) becoming embedded within the population** and their familiar spaces (e.g., homelessness day centres, soup kitchens, night shelters). It was explained that any attempt to roll out cancer prevention/ screening activities would not be as positively received by users if they did already not know or trust the person acting as navigator.

Given the programme goals, the focal point of the intervention was agreed to be **cancer prevention** – delivered through education, emotional support and improving access to general healthcare – and **cancer screening**. However, it was also felt that, where further follow-up or treatment was required, the navigator's involvement should **span the full continuum of cancer care**.

## Setting(s) of intervention

In terms of the most appropriate setting for the intervention to take place, both groups of participants agreed that **existing homelessness services** (e.g., day centres) should act as the central hub for the navigation activities, as these are likely to be **familiar and comfortable** for the majority of users. It was also recognised that in addition to this, the intervention may benefit from offering a more flexible **mobile or outreach service**, particularly for members of the 'entrenched' homeless population who are most likely to be disengaged from mainstream services.

While homelessness services were seen as an appropriate starting point for the intervention, the professional stakeholders indicated that – where needed – cancer screening, diagnosis and



treatment should all be taking place in more **formal clinical settings** to ensure that the seriousness of these activities is made apparent to users:

*“Shifting to a proper medical facility as soon as possible just so it underlines the gravity of the situation, it makes it that much more real.”* (Homelessness service manager)

In the context of the COVID-19 pandemic, participants also suggested that an **additional online or telephone service** by which users can engage with the navigation intervention would be of value.

## Range of services offered by navigator(s)

Differing views on the range of services that should be offered in the intervention were apparent within the discussion with professional stakeholders. Specifically, it was indicated that the **central tasks of the navigator would vary depending on what other support services are readily available to homeless users in a particular locality** (e.g., whether they are already professionals in place to provide housing and financial advice, emotional support, and practical assistance). It was also suggested that the range of services offered by the navigator might vary depending on the age of users; for example, focusing on self-care and education with younger users, and focusing on facilitating screening with older users. Overall, there was consensus that the navigator would need to **work flexibly and responsively to meet the needs of individual users**, and that their role may **need to adapt over time**.

From the perspective of the participants who had experience of homelessness, it was agreed that the most important tasks for the navigator would be to **offer practical assistance** in the form of transportation and phones, and to **organise and attend medical appointments** with users:

*“Making sure we have a phone so they can contact them [users], make sure they’ve got the right date for the appointment ... they might not have transport, they might not have a bus pass, then actually attending the appointment, that’s where the navigator should come in, then when they have to go back for another check-up if they need one, that sort of thing.”* (PEH)



## Navigator background and qualifications

There was a general consensus that a **person with either direct lived experience of homelessness or a professional already working with the homeless population** (e.g., a support worker or a community-based health professional) would be the most appropriate fit for the role of navigator:

*“Having a person who has lived with the experience of homelessness ... they have that empathy with the individual which is probably more important than having knowledge or experience of cancer.”* (Cancer charity representative)

*“If they [current homelessness support workers] were a health navigators, they would have tremendous strength because they’re already embedded”* (PEH)

While cancer-specific expertise was viewed as less important than an understanding of homelessness, it was generally agreed that health professionals would need to be involved in the delivery of the intervention in some way. However, it was recognised that this could be achieved through **clinical oversight/supervision** if the navigator was to come from a non-health background.

Given that, as above, practical assistance in the form of transportation ranked highly in terms of services offered by the navigator, it was agreed that a **driving licence** (or ability to travel across a region) would be an essential requirement.

## Channels of communication between users and navigator(s)

**Face-to-face meetings** were felt to be the most appropriate means of communication for delivering the majority of the navigation activities, although participants who had experience of homelessness also indicated that ‘**check in**’ **phone calls** would be beneficial for encouraging continued engagement and particularly for ensuring attendance at appointments. Online only services/use of email was not seen as appropriate given the low levels of digital literacy and access among the homeless population.

It was agreed by all participants that both informal ‘drop-in’ sessions and formal appointments should be offered by the navigator, as preferences would vary across the user population. It was



also suggested that the **navigator should maintain a regular presence within homelessness services** in order to be easily accessible to all users:

*“Like a weekly drop in but a more casual one, so if the navigators were at the day centre one day a week, if that person sat there and they could be working away on a laptop or having a cup of tea helping out just doing alternative voluntary stuff, then the people come to them.” (Homelessness service manager)*

Both participant groups reached the overall decision that **the style and frequency of communication between users and navigator(s) should be user-led.**

## Navigator training

It was agreed that while training would be an important component of the intervention, the contents **of training would depend on the background and qualifications of the navigator.**

General suggestions on the most important areas for training include:

- Mental health
- Substance use
- Safeguarding
- Trauma-informed care and harm reduction
- Local context and resources
- Cancer education (early detection and screening eligibility).

While **high quality communication, interviewing and knowledge of homelessness** were agreed to be to be vital skills for the navigator, it was suggested that these should be a prerequisite assessed at the point of recruitment rather than a central focus of a training programme. There was also consensus that **training should be an ongoing process**, and in particular, it was suggested that navigators should have access to a set of **paper or computer-based resources** to which they could refer on a day-to-day basis.

## Navigator supervision

Participants agreed that supervision of navigators should include both **in-house administrative support and external clinical oversight and supervision**, the latter ideally being provided by nurse or other health professional with specialism in cancer.



A model of supervision was proposed by the professional stakeholders which comprised a **combination of formal/structured meetings, informal weekly ‘catch-ups’ and the option for immediate debriefs** in response to or following specific issues/incidents.

## Evaluation measures

From the perspective of the homeless participants, the **rate and timeliness of cancer screening** were viewed as the most important outcomes to be measured. However, it was noted by professional stakeholders that any screening-related measure would need to take into account the number of users actually eligible for screening at the point of intervention and that the success of the programme should therefore not be evaluated based on screening rates alone. The professional stakeholders instead felt the **overall quality of life** of the users to be a more appropriate measure of evaluation.

There was a general consensus that is of importance to measure both the **caseload of the navigator** (i.e., the number of users involved) but also the **level of user engagement and the relationship between navigators and users** (i.e., the length, consistency, and quality of their involvement). It was also agreed that it would be valuable to capture the **reasons for disengagement** where this happens to understand the programme’s suitability for different subsections of the homeless population.

All participants expressed the importance of measuring how the intervention impacts the **level of engagement and the quality of relationships that users have with primary care providers**. Specifically, it was suggested that the programme evaluation should involve **seeking feedback from local stakeholders** (e.g., healthcare providers) to understand the impact of the intervention on the local context, the populations they are seeing, and the behaviours of homeless users presenting to them.





The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



**cancerless**

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

## DISCUSSION: DEFINING THE HEALTH NAVIGATOR MODEL

Through the implementation and evaluation of the Health Navigator Model, the CANCERLESS project aims to reduce the health inequalities and disparities experienced by the homeless population across Europe and facilitate their access to timely cancer prevention and screening.

The theoretical foundations of the Health Navigator Model draw upon the Patient Navigation Model and the principles of Patient Empowerment, both of which are established approaches to improving health outcomes, including cancer prevention and early diagnosis, among underserved populations. However, there are currently limited examples of this form of intervention being implemented specifically with people experiencing homelessness in a European context. The outcomes of this innovative intervention will therefore address this gap in evidence and provide further understanding of whether navigation models are feasible and suitable for addressing the needs of this population. This is of vital importance given that people experiencing homelessness are known to experience poor health-related outcomes, and specifically face a disproportionate risk of cancer-related mortality (Asgary, 2018).

The central aim of WP2 has been to specify the design of the Health Navigator Model that will be implemented in the next phase of the CANCERLESS project. To do this, we have worked in collaboration and partnership with relevant stakeholders including individuals with direct experience of homelessness. The participatory and qualitative approach that has been adopted during the process of co-adapting the Health Navigator Model is a clear strength of this project, as it ensures that the intervention has been designed in way that closely reflects the priorities and needs of people experiencing homelessness and health and social care providers. As noted above, the use of participatory methods has also been associated with the development of more innovative and creative responses to healthcare disparities (see for example, Bowen et al., 2013; Boaz et al., 2018).

The preceding sections of this report synthesised the findings from a series of co-adaptation focus group discussions conducted within the four partner countries (Austria, Greece, Spain and the U.K.) which involved direct input from a wide range of professional stakeholders and people with direct experience of homelessness. The main outcomes and decisions made within the co-adaptation focus group discussions have been cross-compared and integrated to form an



overarching framework that will guide the implementation of the Health Navigator Model in the next phase of the CANCERLESS project.

Overall, the findings from the co-adaptation focus group discussions indicate a high degree of consistency and cross-national agreement with regard to the design and implementation of the Health Navigator Model. However, it is also anticipated that this framework will be adapted to reflect the country-specific findings detailed in the preceding sections, so as to ensure that the HNM is appropriate to the local contexts in which it is piloted.

In summary, it is proposed that the Health Navigator Model will be a longitudinal, person-centered and community-based intervention focused on addressing both primary and secondary cancer prevention, as well as reducing wider barriers to healthcare. The Health Navigators will be professionals who have a background in providing social care and an understanding of the local user population and will be embedded in settings familiar and accessible to people experiencing homelessness. The primary aspects of the Health Navigator role will be to identify the health needs and barriers of users, promote cancer awareness and education, facilitate timely access to healthcare services and cancer screening, and provide practical assistance, delivered through regular in-person meetings. The Health Navigators will also utilise wider stakeholders, including healthcare professionals, to deliver the intervention, and will receive both clinical and administrative supervision. A comprehensive training package will be delivered to the Health Navigators, covering population specific knowledge, interpersonal skills, cancer education and local resources.

**Table 1** sets out the main principles of the proposed Health Navigator Model in further detail, organised according to the 10 core components of navigation-based interventions defined by DeGroff et al. (2014). Given that it has been highlighted in preceding sections that there is a particular need to clearly define the remit of the navigator role, an additional overview of the specific services to be provided by the navigator(s) is then provided in **Figure 1**.



## Core components of the Health Navigator Model

<p><b>Programme goals</b></p>	<ul style="list-style-type: none"> <li>• Deliver a person-centered intervention, responsive to user needs.</li> <li>• Improve and build trusting relationships between users and health and social care providers, and between health and social care providers.</li> <li>• Promote awareness and understanding of cancer (primary prevention).</li> <li>• Increase rates and timeliness of cancer screening among homeless users (secondary prevention).</li> <li>• Improve levels of self-care and overall wellbeing among homeless users.</li> </ul>
<p><b>Community characteristics</b></p>	<ul style="list-style-type: none"> <li>• Make intervention accessible to people experiencing and/or at risk of all forms of homelessness as defined by the ETHOS typology (FEANTSA, 2006).</li> <li>• Prioritise those at most high risk of cancer, those not currently engaged with healthcare services and those with complex support needs.</li> </ul>
<p><b>Point of intervention</b></p>	<ul style="list-style-type: none"> <li>• Build trusting relationships and become embedded within the user population as the starting point for intervention.</li> <li>• Implement intervention preventively, with continued care and follow-up for users where required.</li> </ul>
<p><b>Setting</b></p>	<ul style="list-style-type: none"> <li>• Deliver main navigation activities in settings familiar and accessible to homeless users, and through mobile outreach.</li> <li>• Facilitate access to formal clinical settings for full cancer screening and follow-up.</li> </ul>
<p><b>Navigator services (see Figure 1)</b></p>	<ul style="list-style-type: none"> <li>• Identify health needs and barriers.</li> <li>• Co-ordinate access to care.</li> <li>• Offer practical assistance.</li> <li>• Promote cancer awareness and self-management.</li> </ul>
<p><b>Navigator background</b></p>	<ul style="list-style-type: none"> <li>• Select social or support worker, ideally experienced with user population and with local/community knowledge, to act as navigator.</li> <li>• Establish and utilise local stakeholders (service managers, clinical professionals, and peers) to support implementation and delivery.</li> </ul>



<p><b>Communication channels</b></p>	<ul style="list-style-type: none"> <li>• Deliver navigation activities through in person meetings, with optional phone 'check ins'.</li> <li>• Maintain a presence within spaces familiar and accessible to homeless users.</li> <li>• Ensure navigator-user meetings take place at regular intervals, with exact frequency and timing to be decided by users.</li> </ul>
<p><b>Training</b></p>	<ul style="list-style-type: none"> <li>• Develop and deliver a comprehensive package of training with input from local stakeholders, covering:             <ul style="list-style-type: none"> <li>• Population-specific knowledge;</li> <li>• Communication and interpersonal skills;</li> <li>• Cancer education;</li> <li>• Local context and resources.</li> </ul> </li> </ul>
<p><b>Supervision</b></p>	<ul style="list-style-type: none"> <li>• Provide the navigator(s) with administrative and clinical supervision from appropriate professionals, either external or internal.</li> <li>• Utilise a combination of formal observations, peer coaching and informal 'check-ins'.</li> </ul>
<p><b>Evaluation measures</b></p>	<ul style="list-style-type: none"> <li>• Evaluate intervention using a combination of qualitative and quantitative measures, and include direct feedback from users, navigators, and service providers.</li> <li>• Collect pre- and post- data on cancer screening rates; level of user engagement with the intervention; user health and quality of life; and the quality of relationships between users and health and social care providers, and between different health and social care providers.</li> </ul>

*Table 1. Core components of the Health Navigator Model*

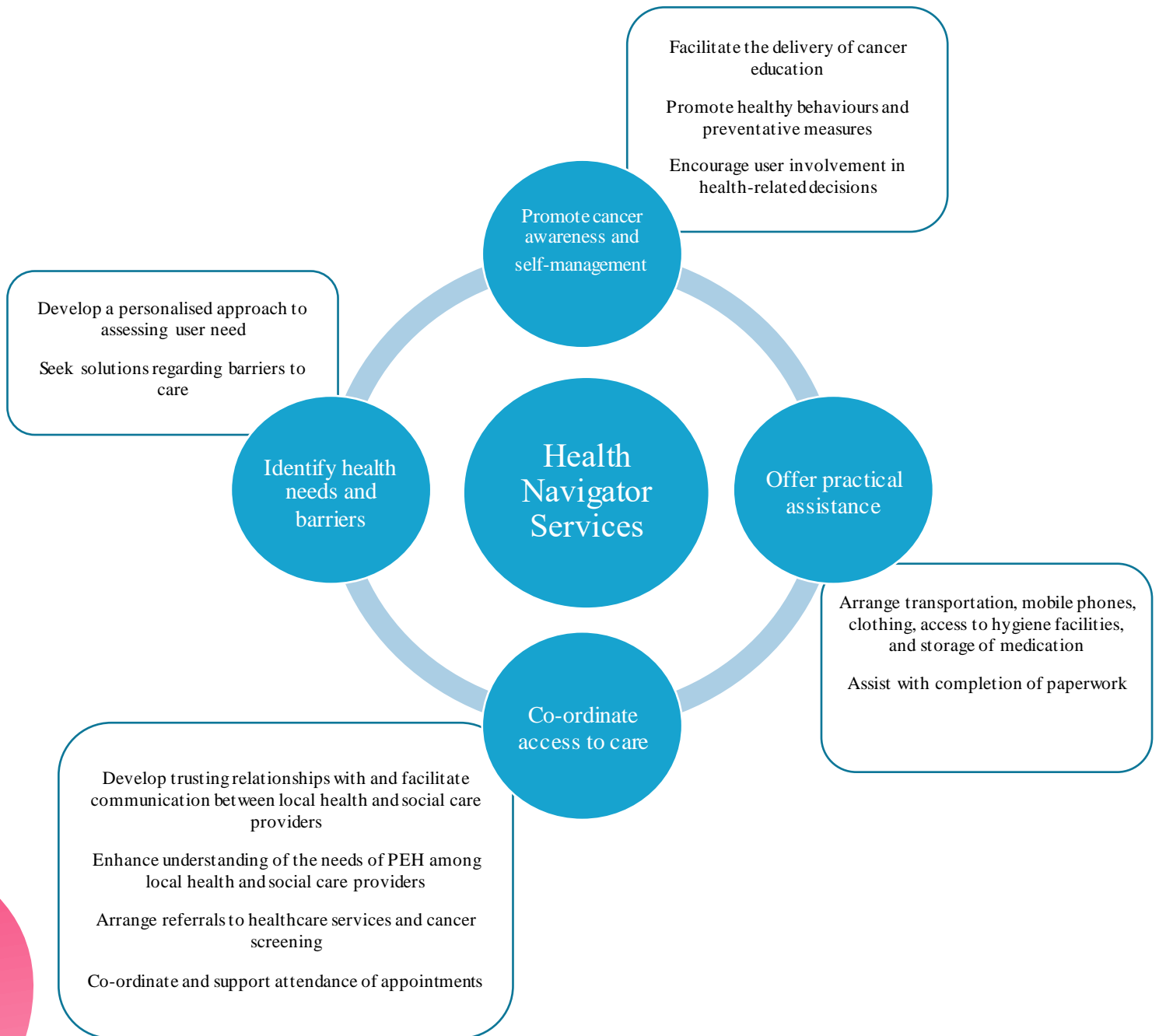


The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



**cancerless**

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model



*Figure 1. Overview of Range of Services Offered by Health Navigator(s)*



## REFERENCES

- Asgary, R. (2018). Cancer screening in the homeless population. *Lancet Oncology*, 19(7), pp. 344-350. [https://doi.org/10.1016/s1470-2045\(18\)30200-6](https://doi.org/10.1016/s1470-2045(18)30200-6)
- Boaz, A., Hanney, S., Borst, R., O'Shea, A. & Kok, M. (2018). How to engage stakeholders in research: design principles to support improvement. *Health Research Policy Systems*, 16(60). <https://doi.org/10.1186/s12961-018-0337-6>
- Bowen, S., McSeveny, K., Lockley, E., Wolstenholme, D., Cobb, M., & Dearden, A. (2013). How was it for you? Experiences of participatory design in the UK health service. *CoDesign*, 9(4), pp. 230-246. <https://doi.org/10.1080/15710882.2013.846384>
- Clark, J. (2012). Using diamond ranking as visual cues to engage young people in the research process, *Qualitative Research Journal*, 12(2), pp. 222 – 237. <http://dx.doi.org/10.1108/14439881211248365>
- DeGross, A., Coa, K., Morrissey, K. G., Rohan, E., & Slotman, B. (2014). Key Considerations in Designing a Patient Navigation Program for Colorectal Cancer Screening. *Health Promotion Practice*, 15(4), pp. 483–495. <https://doi.org/10.1177/1524839913513587>
- Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet*, 384(9953), pp. 1529–1540. [https://dx.doi.org/10.1016%2FS0140-6736\(14\)61132-6](https://dx.doi.org/10.1016%2FS0140-6736(14)61132-6)
- FEANTSA (2005). *Ethos Typology of Homelessness and Housing Exclusion*. Brussels: FEANTSA.
- Field, H., Hudson, B., Hewett, N. & Khan, Z. (2019). Secondary care usage and characteristics of hospital inpatients referred to a UK homeless health team: a retrospective service evaluation. *BMC Health Services Research*, 19(857). <https://doi.org/10.1186/s12913-019-4620-1>
- Freeman, H. (2012). The origin, evolution, and principles of patient navigation. *Cancer Epidemiology and Prevention Biomarkers*, 21(10), pp. 1614-1617. <https://doi.org/10.1158/1055-9965.EPI-12-0982>
- Hennink, M. (2014). *Understanding Focus Group Discussions*. Oxford: Oxford University Press.
- Hwang, S. W., Chambers, C., Chiu, S., Katic, M., Kiss, A., Redelmeier, D. A., & Levinson, W. (2013). A comprehensive assessment of health care utilization among homeless adults under a system of universal health insurance. *American Journal of Public Health*, 103(2), pp. 294-301. <https://doi.org/10.2105/ajph.2013.301369>
- Kokorelias, K. M., Shiers-Hanley, J. E., Rios, J., Knoepfli, A., & Hitzig, S. L. (2021). Factors influencing the implementation of patient navigation programs for adults with complex needs: a scoping review of the literature. *Health Services Insights*, 14, pp. 1-17. <https://doi.org/10.1177%2F11786329211033267>



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351



Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

Saldaña, J. (2021). *The coding manual for qualitative researchers* (4th ed). London: Sage Publications.

Thomas, B. (2012). *Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England*. London: The University of Sheffield for Crisis.

World Health Organisation (1998). *Health Promotion Glossary*. Geneva: WHO.



# cancerless

Cancer prevention and early detection among the **homeless** population in Europe: Co-adapting and implementing the Health Navigator model



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Picture by Carola68 Die Welt ist bunt / [Pixabay](#)

