Meg Margetts & Dr. Johannes Lenhard
University of Cambridge Medical Student & CHIRN Founder

Research Report: Video consulting - a way of increasing (digital) access to healthcare for people experiencing homelessness?

Abstract:

While the number of people experiencing homelessness have overall been relatively flat - partly because of emergency measures by the central government - the Covid-19 pandemic brought additional pressure onto the system of support services, particularly in healthcare. In this report, we are assessing an experimental project in Cambridge (conducted in Spring 2021) using digital means (video consultation) to increase access to healthcare for people experiencing homelessness.

Our observations were very encouraging, overall. Video consultations promise to be a valuable asset to improve access and engagement with healthcare services (e.g. reduction in "Did not Attend" rates) for people experiencing homelessness; they also tend to be superior to telephone consultations for rapport building and communication. Moreover, video consultations might be particularly beneficial for patients with mobility issues and those with depression or anxiety (e.g. by allowing consultations in a familiar and safe environment). However, our initial assessment indicated that the success of this service is heavily reliant on three main factors being integrated in the overall design: an adequate technological environment, adequate infrastructure and the availability of support staff when required and desired by the person receiving the support.

Overall, we advise to add video consultations as an additional pathway to healthcare adding to the portfolio of current services rather than replacing existing practices.

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1 Background

1.1 Homelessness and Healthcare

There are over 200,000 people experiencing homelessness – from people sleeping rough or in temporary accommodation to the ones being insecurely housed and sofa surfing - in England alone. It is well established that homeless individuals are at a greater risk of negative health and social outcomes, with an average life expectancy of 45 years for men and 43 for women (30-40 years less than the UK national average). It is unsurprising that numerous studies have highlighted disproportionate levels of cardiac problems, long standing TB, hepatitis C and mental health problems compared to age-matched housed individuals. Overall, people experiencing homelessness are some of the most in need of access to adequate healthcare, yet they are some of the most disadvantaged and excluded.

A clinical audit commissioned by the Royal College of Emergency Medicine highlighted that people experiencing homelessness are five times more likely to attend emergency services than housed controls yet 40% of them were not registered with a GP. Overall, there are a number of barriers preventing people from accessing primary care within this cohort:

- Unclear information about what services they are entitled to and difficulty registering with a GP (e.g. misconception that a proof of ID / address is required on registration)
- Lack of accountability of healthcare systems, and feelings of dismissal from healthcare practitioners based on drug addiction / stigma
- Difficulty travelling to healthcare services
- Inflexibility for appointments
- Competing priorities
- Digital exclusion

1.2 Homelessness and care provision during Covid-19

In the UK, increasing concerns about the impact of COVID-19 led to the implementation of a number of (policy) measures including the 'Everyone in' and the COVID-PROTECT scheme financed by the Treasury as an extension of the 2018 'Homelessness Initiative'. These schemes have helped to provide housing and basic support to people experiencing homelessness, with over 15,000 people housed. A further scheme called COVID-CARE was created to help provide testing and medically supported accommodation for individuals to isolate for 14 days if they were developing symptoms of COVID-19. A study by Daniel Lewer and colleagues using computer modelling estimated that these schemes had potentially prevented more than 20,000 infections, 1,100 hospital admissions and over 300 intensive care unit admissions among the homeless population.

However, a study by Crisis UK in 2020 highlighted that while these measures were encouraging, there was greater pressure on local homeless services. Higher rates of unemployment led to a rise in the number of newly homeless individuals while social isolation and deteriorating mental health increased the demand for social support.

Overall, Covid hit at a time when healthcare provision for people experiencing homelessness are suffering from years of austerity and funding cuts to public services (like substance use support services) resulting in a fragmented health and social care system overall.

1.3 Digital Inclusion and Digital Healthcare

While the implementation of video consulting has been on the rise for a number of years, we have seen a more sudden shift to remote consulting during Covid-19; this was primarily driven by an increasing need to reduce footfall in primary and secondary care and rapidly changing regulations.

Currently, there is a significant lack of long-term evidence to support the (health) implementation of video consulting, however, early studies have shown promising results for all areas of primary care particularly for mental health consultations, management of chronic conditions (including hypertension) and counselling for smoking and alcohol use.

While there is a certain consensus that face-to-face consultations provide the greatest levels of patient confidence and satisfaction, the level of satisfaction achieved with video consultations has still be found to be relatively high for a range of services, with some patients even preferring the anonymity that video consultations provide.

Video consultations demonstrated a potential to reduce wait times for appointments and barriers associated with the need to travel to primary care services (particularly for vulnerable or elderly patients). When compared to telephone consults, video consultations can provide non-verbal cues which can reduce miscommunication, improve rapport and reduce the additional strains on clinical decision by allowing clinicians to make a visual assessment of the patient. For patients who had access to private and familiar environments during the consultations, remote consultations were also shown to reduce anxiety.

However, the rapid implementation of video consultations is not without its limitations. Overall, patients were more dissatisfied if they had unmet expectations of a home visit or the need to be examined. Furthermore, many individuals express difficulty in finding a private space to conduct the video consultation, and many stated that for a video consultation to be successful there needed to be an existing level of trust between the patient and the clinician.

Technology was repeatedly cited as one of the greatest barriers to the success of video consultations. Poor internet connection reduces rapport building and leads to consultations switching from a video to telephone format. For patients, data privacy and technology literacy were seen as the most important limitations. For clinicians, a study by Randhawa and colleagues suggested that follow up face to face appointments were often required due to insufficient camera quality for dermatological consults and reduced confidence when referring to secondary care.

However, there has been encouraging evidence to suggest that digital technology may be the way forward for improving healthcare access for people experiencing homelessness.

A pilot study by Schueller et al demonstrated that mobile based intervention (in the form of phone delivered coaching sessions and mental health apps) could potentially improve engagement and mental health among young homeless people. A further two studies investigating mobile based buprenorphine treatment for homeless veterans demonstrated not only that mobile based buprenorphine intervention was feasible but an effective means of engaging individuals with a history of poor compliance with face to face intervention.

Mobile phone use and texting is already common within the homeless community, with between 89-94% of individuals having access to a mobile device. While these devices are not always appropriate or affordable (yet), Moczygemba LR and colleagues highlighted that a high proportion of homeless individuals would be interested in using their phone to manage their healthcare.

Hence this report aims to evaluate if the implementation of video consultations can be used to improve access to healthcare for individuals experiencing homelessness and how this can be done most effectively based on a pilot project conducted by the Cambridge Access Surgery in 2020/2021.

2 Methodology and ethics

The service assessment of the 'mobile consulting project' underlying this report was approved by the ethics committee of the department of Social Anthropology at the University of Cambridge (in consultation with the School of Medicine) following the standard protocol.

The core methodology for the assessment were semi-structured interviews with a variety of key stakeholders between January and May 2021. Initial planning discussions with the Cambridge Access Surgery (providing the healthcare) and service providers at the *Hostel*[1] for homeless people were conducted in January 2020. Staff members involved in the set up of the video consultation service provided assistance with identifying a list of service users, key informants and healthcare workers; they also provided background information about different homeless services (specifically healthcare services) currently available in Cambridge. Initial introductory conversations (as part of the setup of the service) were followed by in depth interviews with all participants. Interviews with service users were conducted in person at the hostel (adhering to Covid-19 restrictions and rules) after they tested the video consultation; all other interviews were conducted over video. The team also conducted an in-person focus group session with a local co-production group (including 4 individuals who have lived experiences of homelessness) after the period of service provision ended. Find an overview of our interview participants below (See Table 1). We are including our 'service assessment questionnaire' which served as a guideline for our interviews throughout in Appendix A and our Consent form template in Appendix B.

In addition to the interviews, we also conducted a brief stint of informal participant observation at the *Hostel* and three site-visits to the GP practice during our service assessment, one of these included a shift with the homeless outreach van. Unfortunately the impact of Covid-restrictions prevented a stronger reliance on participant observation as a way of triangulating the interview findings, which surely is the strongest limitation of our service assessment. All participants went through an informed consent process and were aware of the goal of the service evaluation and that the information they shared during the interview would be included in this anonymised report. All interviews were voluntary and no incentives were provided. Interviews were not recorded but both researchers took notes throughout the interviews which were written up afterwards. This report is the result of a collective writing process between the two researchers as well as a review of an initial version by several key stakeholders.

Participant role	Number of Individuals interviewed	Overall interviews
Healthcare professionals	5	9
Workers at the *Hostel*	3	5
Service users	3	3

[1] In order to safeguard the anonymity of all participants, most organisations (with the exception of the Cambridge Access Surgery (which gave us explicit approval to be named) and all research participants' names are anonymised.

Individuals with lived experiences (in co-production group)	4	1
Other key stakeholders	1	1
Total	16	19

Table 1: Overview of interview participants

3 Service (Assessment) Design

The idea to provide video consultations for people experiencing homelessness first came about in December 2020 with the explicit goal to improve their access to healthcare in the *Hostel* during the ongoing lockdown measures in the UK. The project overall was driven by the Cambridge Access Surgery focused on providing care for people experiencing homelessness.

Hostel
The *Hostel* was a temporary accommodation provided to people experiencing homelessness as part of the 'Everyone In' scheme. While other accommodation was first established in March 2020 (housing originally ~120 people), the *Hostel* first opened at the site the research team visited in November 2020. At the time of the study approximately 30-40 people remained at the *Hostel*, still with a high turnover rate. Approximately 40% of the residents were women and 60% were men. The *Hostel* was run by 2 administrative workers as well as a team of temporary workers (including a resettlement officer and several members of 24h on-site security staff). The *Hostel* closed at the end of May 2021.

Initial setup
The lead GP of the Cambridge Access Surgery approached the hostel staff towards the end of 2020 to discuss the implementation of a digital healthcare consultation access point and they agreed on the experiment. In parallel, the GP identified an adequate video platform (AccuRx) and approached the local Council which agreed on funding the £200 for the necessary equipment (smartphone with video capability, pulse oximeter (measure oxygen saturations and heart rate) and thermometer).

In January, the GP visited the *Hostel* in order to train the two administrative workers facilitating the project (on the video platform and the medical equipment) and establish the pathway. The project was formally launched in mid-January 2021.

Pathway for arranging a video consultation
In order to book a video consultation at the *Hostel*, two pathways to connect with the GP practice were most common: first, talk to one of the staff/security members at the *Hostel* who would book an appointment (via phone) with the GP practice directly or second, meet the outreach nurse (visiting the *Hostel* once per week) who could arrange the video consultation if desired. At times, the nurse would be informed by staff members of a resident's medical need. While residents could arrange a (face to face) appointment directly by calling the GP service, this was not used to arrange video consultations during the experimentation phase. In early March flyers explaining how residents could access a GP appointment were distributed to provide further transparency and raise awareness among the residents.

Set up of the video consultation
15 minute video appointments were bookable with two GPs on two days of the week (Thu and Fri, 2-4pm). At the time of the appointment, the GP surgery would send a text link to the smartphone device (using AccuRx) at the *Hostel*. If a patient had an appointment, they would be reminded by one of the

service providers on site, who would help to set up the phone either in a private kitchen within the *Hostel* or in the person's own room. The person had the option of having the video consultation in private or in the presence of the administrator.

4 Key Observations

4.1 Increased access: more people engaged, fewer DNAs

Overall the majority of service users (and other stakeholders) were **very positive** about their experience with video consultations. Residents, support workers and health professionals all commented that video consultations had the potential to reduce the barriers to accessing healthcare for people experiencing homelessness mirroring the findings of earlier studies.

This was summed up by a key worker at the hostel who commented that with the introduction of video consultations they were seeing "**terrific engagement** from a lot of clients who would not normally engage with the service". Furthermore, the number of DNAs ('Did not attend') was reduced to 11% from 23% over the last month, pointing towards an important potential benefit: being able to access healthcare from your own 'home' removed strong barriers. On the one hand, the need to travel disappeared (for one user even putting video over face-to-face consultation in some cases); this is particularly important for people who face mobility issues (such as one of the service users in the sample) or are 'entrenched' otherwise. Two people with lived experience mentioned that not having to travel also made it easier for people who struggle with anxiety or depression (and might not want to leave their house) to connect to healthcare in an environment they felt comfortable in. One commented:

> *"While the video appointment was still daunting it was far less scary than a face to face appointment and definitely helped with my anxiety around seeing health professionals"*

One support worker explicitly mentioned this encouragement for people to engage with healthcare as the core advantage of video consulting:

> *"Patient X was a deeply entrenched individual, encouraging this person to go to the surgery was always a difficult task… suddenly we were able to provide a consultation which meant that all we had to do was go from one side of the building to the other.. It was a real success to get him involved."*

For the healthcare providers, video consultation can hence **solve several issues at once**: they make DNA less likely, ensuring the continuing provision of consultation also during lockdown-conditions while reducing (in-person) appointments (potentially dangerous for vulnerable people). For one healthcare provider this was a very strong point: "It was another string to my bow that I can offer people when I am out on outreach."

4.2 Improved communication: video beats telephone (but not face-to-face)

There was a consensus among participants that face to face consultations were the gold standard for rapport building and communication. However, video consultations were often deemed to be far **better than telephone consultations** (the most common alternative used to date in healthcare provision, including among our informants).

Phone consultations came with severe limitations (e.g. poor volume, rapport building more complicated) some of which could be overcome with video consultations. Several of the healthcare providers commented that the video aspect allowed them to feel more connected to their patient; this was particularly important for mental health consults where body language and microexpressions are vital for assessing a patient's wellbeing.

This feeling was mirrored by the service users, one of whom commented that:

> *"I normally struggled with telephone consults, I would call and hang up… it was difficult for doctors to understand what was going on over the telephone… video consults were a lot better"*

For one consultation, the additional information gained through non verbal communication allowed the patient to express themselves more clearly to the extent that when the patient was asked if they would prefer a follow up video or face to face consultation the patient requested video. These benefits were summed up by another healthcare provider who commented that:

> *"Patients like seeing faces and feeling like they are being heard, by doing it in a remote way rather than over the telephone they feel like they are being heard. It's like someone has made time for them. Patients feel that they are not 'forgotten'"*

The obvious consensus, however, was that **face to face consultations could not be replaced** by video. Video consultations work particularly well for some needs (e.g. mental health) but far less for others which require physical examination (e.g. touching by the healthcare professional). Video might not be able to provide the 'full picture', as one healthcare professional concluded:

> *"A lot of information in a face to face consultation that cannot be caught on camera particularly the way the patient walks into the room. For example drug seeking patients may be dancing out the front of the building but when they come in they may be asking for pregabalin for their pain"*

Secondly, while building rapport over video or telephone was possible with some patients, many health workers commented that it is far more successful to build rapport in a face to face context before possibly moving to a digital platform in a second step. Video consultations might hence be particularly helpful when already established relationships can be built on.

The consensus among participants was that "the mode of consultation should be patient led and we should not force video consulting onto them as the main method for seeing their doctor", instead participants felt that video consultations should be provided as an "additional option" in cohesion with the current services. It may be appropriate to offer video consultations for "maintenance appointments" where a pre-established relationship between the doctor and patient is present; or as a "stepping stone" to encourage patients to engage with a health professional with the hope of a follow on face to face appointment.

4.3 Main barriers stemming from technological and practical issues

Technological barriers
Throughout the project, **technological barriers** were perceived as the greatest potential challenge by participants, healthcare professionals and people in the co-production group alike. How could you ensure

availability of a good enough (phone) connection, good camera resolution, strong enough phone volume and most importantly the technological literacy required to use such a device? While (partly driven by the stability of the wifi connection at the *Hostel)* we encountered few technical issues in this trial, a different context (e.g. people experiencing homelessness calling in themselves) risks increasing the frequency of the problems drastically.

For healthcare professionals willing to implement this technology within their GP practice, practical concerns around the time required to set up video consultations could compromise the length of appointments and reduce the quality of care patients were receiving. For healthcare professionals who did not partake in the initial trial, there was an overarching question of "would it be worth the effort" to enable this additional route of access. Trying to balance the perceived barriers of unfamiliarity with the technology and lack of IT support with the unclear benefits of video consultation over the now familiar telephone and face to face appointments left some healthcare professionals with the opinion that they would simply default back to their standard consultation methods.

Motivation
There was a fear from healthcare professionals that offering video consultations could inadvertently reduce engagement from patients. In order to motivate their patients to leave the security of their accommodation, doctors would specifically ask patients to attend in person appointments on the premise that they needed to "see them" to assess "how they were doing". As video consultations provided a visual component which negated the excuse for patients to attend a face to face appointment, thereby increasing detachment from healthcare services and the community.

Privacy
While the consultations were held in a private kitchen space or the patients' rooms to ensure that none of the other residents could overhear the conversation. The concern for privacy extends beyond the consultation. During the 3 month period of the study, no women requested a video consultation and one female service user asked specifically to speak to a GP in person as she was concerned about privacy. Women are "one of the most vulnerable subpopulations among the homeless", with higher levels of mental health problems, childhood trauma, previous history of physical and sexual abuse hence they may be more reluctant to reveal their need to access healthcare services.

Hence, while the consultations were held in a private space or the person's room (depending on their choice), there was still the fear that other residents could overhear the conversation or even hear that a consultation happened. Furthermore, with no-referral pathway that was anonymous or allowed the person requesting the consultation to contact the GP directly to make an appointment, people were required to speak to a member of staff both to make the original referral and to get access to the equipment for the consultation. Finally, a lack of client training sessions meant that digital privacy was not addressed and individuals who were unfamiliar with the technology often required facilitation (by members of staff) during the consultations which again may have made it more difficult for some individuals to open up. Overall, the initial design of the service did not take into account the specific needs of women and people with a heightened fear of being taken advantage of.

5 Conclusion and recommendations

As one of the healthcare professionals highlighted "total triaging and virtual consulting will be the model going forward". Without the correct consideration, the move to total triage and digital consults could create an additional barrier for people who already struggle with access, such as people experiencing

homelessness. Our interviews with and observations of service users, key workers and health professionals have identified factors that could be beneficial but also problematic for people experiencing homelessness but more widely other vulnerable populations when it comes to digitally accessing healthcare.

We have seen how video consultations have the potential to widen access for individuals with mobility issues and improve (non verbal) communication compared to telephone consults. Participants have emphasised their possibly positive impact for mental health consultations and simple medication reviews. However their effectiveness relies heavily on a number of factors, including the adequate technological environment (e.g. smart phone at hand, wifi in place), stable setting (e.g. ensuring privacy for requesting the consultations as well as during it), and where desired the availability of support staff (e.g. for arranging or facilitating the consultation). While we see a big opportunity in using video consulting to *increase* access to healthcare for people experiencing homelessness, the devil is in the detail. We want to hence end this report with three conclusions and related recommendations.

1. *Video consulting works to improve access to healthcare, but the right design is key*

    Video consultation can improve access to healthcare for people experiencing homelessness and we believe it can lead to comparable health outcomes as face-to-face (and definitely telephone consultations) for a wide range of issues. We hence suggest making video consultations an **option for homeless service provider's repertoire of healthcare access** (another string to the healthcare providers' bow).

    Some core principles should be applied when establishing video consultation within an institutional setup (e.g. in a homeless day center or homeless hostel, for instance):

    - Provide the **right infrastructure**:
        - Provide access to a private and safe space
        - Good internet connection is vital for maintaining good communication throughout the video conference
        - Ideally, provide access to a tablet or computer (preferable for bigger screen) or telephone with video capability and a camera with high resolution
        - In terms of medical equipment, the following would be preferable: blood pressure monitor, pulse oximeter, thermometer (allowing for calculation of a NEWS score (National Early Warning Sign) allowing doctors to rapidly assess how well or unwell a patient is), requiring trained personnel
        - Provide an on site or online link to quick access IT support for healthcare staff and participants who can resolve any technological problems/questions or concerns

    - **Train** all stakeholders and **communicate** well
        - Train all staff members, both at the homeless service provider and the healthcare staff, on how to use the equipment provided including taking basic observations and how to set up and facilitate a video consultation
        - Hold an information session on the different pathways for accessing the GP services, and e-consultations (and provide informational leaflets specifically about the video consultation with an in person question and answer session

where service users have the opportunity to ask questions about the service/provide feedback)
- ○ Establish a lead person (within the institution) who will be in charge of the video consultations as the first 'point of contact' (with the people experiencing homelssness as well as the healthcare provider)
- ○ Establish training (and necessary support and materials) for the people experiencing homelessness on technology literacy

2. *Ensure the inclusivity and comprehensiveness of the service design*

We have seen that designing an inclusive pathway to the healthcare service needs to happen with all stakeholders in mind. Ideally, provide various different ways for people experiencing homelessness to set up video consultations - so that they can choose. Options could include: call or text the healthcare provider, talk to their key worker to make the appointment, talk to a support worker in any other support organisation (e.g. day center), talk to an outreach worker. Ideally, at least one pathway (e.g. text message) would be available and accessible 24/7.

People experiencing homelessness who wish to undertake a video consultation must be offered the option to use their personal device or the shared device. Importantly, pathways should cater to people without digital access themselves, consider gender differences and specific barriers.

Communicating with all staff at both the healthcare provider and the participating homeless service providers is a key starting point, as discussed above. Importantly, this additional service should further enable (rather than disrupt) **continuity of care** for people experiencing homelessness (e.g. ensure that patient files are shared adequately and updated with every kind of appointment, including video consultations). Ideally, people should always be referred to (automatically) to the same healthcare provider.

3. *Establish a feedback and review process to continuously improve (and possibly extend) the service*

In order to ensure the efficacy of the video consultations as well as quality and effectiveness of the offering, continuous feedback and review should be enabled. This feedback could be collected via text message or in anonymous surveys (e.g. provided at the healthcare providers or the homeless service providers) and include feedback on staff from service users, feedback about the services provided (e.g. technical problems or timings). A local co-production group (where applicable) should be part of a bi-annual review process.

From our assessment of the limited trial of video consultations with people experiencing homelessness during Covid-19, we believe that establishing them as an **additional choice in access to healthcare** can complement existing pathways. While we observed it particularly when used for general GP consultations, our findings indicate that extending the offering to include drug, alcohol and mental health support would also be beneficial. In any case, it is quintessential that the different stakeholders (healthcare providers, homeless service providers, possibly even councils) work together to provide a cohesive and inclusive service. The focus should at all times be to improve access to healthcare for people experiencing homelessness.

Further research - possibly in a review of the above service (if extended) in the same context - is needed to confirm the impact on health outcomes and to hear from a more varied group of people who have used the service (including women). We intend to interview all key stakeholders again in 6 months to review the findings of this report.

Appendix A - Service assessment questions

1. Expectations
   - What is your initial impression of video consults?
     - What are the main benefits/concerns?
   - Which kind of services/ patients do you believe video consultations will benefit/not benefit?
2. Set up
   - Can you briefly describe how the video consulting project is integrated into your typical service/work day?

   - In terms of the general set up of the video consults, what do you feel works well and what do you think could be improved?
     - Prompts (tech, accessibility to consults, ease of use, privacy, how well does this integrate into the service you provide)
       - How comfortable do you feel using this technology?
       - How does it compare to the current services available?
3. Experiences – good and bad
   - After trialling this over the last 2 weeks what has worked well and what hasn't?
     - With specific examples?
   - How does this compare to a telephone or face to face consultations?
   - In what ways do you feel that this project has affected access to primary healthcare/ for who? Do you feel people are using the service?
   - Are there any other services/ other applications of this service that might work?
   - Do you have any other thoughts you wanted to bring up/ways to improve and adapt it?

Appendix B - Consent form

Interview Consent Form

Research project title: Mobile Consulting

Research Investigator:
Dr Johannes Lenhard,
Miss Megan Margetts

Research Participants name:

The interview will take 30 minutes.
We don't anticipate that there are risks associated with your participation, but you have the right to stop the interview or withdraw from the research at any time.

Thank you for agreeing to be interviewed as part of the above research project.

Ethical procedures for academic research undertaken from UK institutions require that interviewees explicitly agree to being interviewed and how the information contained in their interview will be used.

This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation.

Would you therefore read the accompanying information sheet and then sign this form to certify that you approve the following:

• the interview will be recorded in the form of paper notes or digitally and transcribed
• the transcript of the interview will be analysed by (Dr Johannes Lenhard and Meg Margetts) as research investigators
• access to the interview transcript will be limited to Dr Johannes Lenhard and Meg Margetts
• any summary interview content, or direct quotations from the interview, that are made available through academic publication or other academic outlets will be anonymized so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed

Interview Consent Form

Any variation of the conditions above will only occur with your further explicit
Approval

Quotation Agreement

I also understand that my words may be quoted directly
With regards to being quoted, please tick next to any of the statements that you
agree with:

All or part of the content of your interview may be used:
- · In academic papers, policy papers or news articles
- · On our website and in other media that we may produce such as spoken
- · presentations
- · In an archive of the project as noted above

By signing this form I agree that;

1. I am voluntarily taking part in this project. I understand that I don't have to
take part, and I can stop the interview at any time;
2. The transcribed interview or extracts from it may be used as described
above;
3. I can request a copy of the transcript of my interview and may make edits I
feel necessary to ensure the effectiveness of any agreement made about
confidentiality;
4. I have been able to ask any questions I might have, and I understand that I
am free to contact the researcher with any questions I may have in the
future.

Interview Consent Form

_____

Printed Name

_____ _____

Participants Signature Date

_____ _____

Researchers Signature Date