National Institute for Health and Care Excellence

Final

Integrated health and social care for people experiencing homelessness

[C] Evidence review for views and experiences of health and social care for people experiencing homelessness

NICE guideline NG214

Evidence reviews underpinning recommendations 1.1.1-13, 1.2.1-3, 1.2.6, 1.2.8-9, 1.3.1-8, 1.4.1-4, 1.5.1-17, 1.6.1-7, 1.8.3, 1.9.2, 1.11.1-6, 1.12.1-3 and research recommendation 2 in the NICE guideline

March 2022

Final

These evidence reviews were developed by the National Guideline Alliance which is a part of the Royal College of Obstetricians and Gynaecologists

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Views and experiences of health and social care for people experiencing homelessness

Review question

What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

Introduction

Homelessness and rough sleeping is an issue that is inherently complex, with individual, environmental and structural factors all implicated. In order to obtain a fuller understanding of this complexity it is advantageous to explore the experiences of those who use services and those who work in this area. This can provide evidence of good practice as well as barriers to access and engagement.

The committee are also aware of the depth of knowledge gained through experiencing homelessness and of working on the front line of homeless services. The committee value the opinions, views and expertise gained by experience which can provide an ethical framework of inclusivity and care. In turn, this analysis can inform future improvements of health and social care for those experiencing homelessness. The aim of this review was therefore to identify evidence of people's views and experiences of health and social care in the context of homelessness to provide an understanding of what works well and what could be improved. The particular focus was on issues around access to, engagement with and delivery of health and social care for people experiencing homelessness.

Summary of the protocol

See Table 1 for a summary of the Population, phenomenon of Interest, and Context (PICo) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	• People aged 16 years or older who are experiencing homelessness* • Families, supporters and advocates of people experiencing homelessness • Health, social care and housing practitioners involved in care and support for people experiencing homelessness. *People experiencing homelessness' is being defined as follows for this guideline: • People who are rough sleeping (meaning people without homes who sleep outside or somewhere not designed for habitation) • People who are temporary residents of hostel accommodation (such as emergency night shelters, short-stay hostels, longer stay hostels, domestic violence safe houses, safe houses for victims of modern slavery and probation hostels)

	• People who are in unsupported temporary accommodation (such as B&Bs) • People who use day centres that provide support (such as food, showers, clothing and advice) for people experiencing homelessness • People staying temporarily with family and friends ('sofa surfing') • Squatters • People with a history of homelessness (as defined by the groups above), who are at high risk of becoming homeless again because of ongoing complex health and social care needs.
Phenomenon of interest	The committee wish to locate qualitative evidence about what works well and what could be improved about access to, engagement with and delivery of care and support for people experiencing homelessness. They anticipate that data from included studies will cover a number of key themes relating to the three main objectives of this question although they are aware that other relevant themes and may also be identified: Access • **Availability**. Data may relate to the range of local services, their location, opening hours, appointment systems and eligibility criteria. • **Affordability**. There may be data about the cost of services, including direct costs, indirect costs, public funding and charitable donations. • **Acceptability**. Experiences relating to provider expectations and user expectations are expected to suggest ways of improving access to care and support. • Additional themes relating to access may include knowledge and awareness of services, prioritisation, registration for services, and the role of technology, transport, inequality, environmental factors, language and communication issues and discrimination. • The emotional impact of poor or limited access to health and social care. **Engagement** • The skills, training and values of practitioners for supporting and engaging people, including working with people from all communities and sub groups of this population. • Issues around fear, apprehension and trust • Communication. • The role of user led models built on trust between people with common experiences. • Sustaining ongoing engagement and active participation. • Identifying groups for whom engagement is particularly challenging and understanding which populations are 'missing' from certain services. **Delivery** • Care quality • Holistic responses to complex needs • Cultural sensitivity and cultural appropriateness • Individualised care and support • Stigma and discrimination

	• Role and availability of outreach • Consistency and care continuity • Navigating complex care and support systems • Language and communication
Context	• Studies conducted in the UK will be included. • Studies conducted in high income (according to the World Bank) sovereign state members of the European Federation of National Organisations working with the Homeless (FEANTSA) will also be considered for inclusion. Studies conducted in Canada, Australia and the US will also be considered for inclusion.

B&B: bed and breakfast; UK: United Kingdom; US: United States.

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A and the methods document (supplementary document 1).

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Qualitative evidence

Included studies

Seventy-seven qualitative studies were included for this review (Adkins 2017, Ake 2018, Alunni-Menichini 2020, Asgary 2015, Astra Zeneca 2012, Barker 2018, Batterham 2007, Bhui 2006, Biederman 2013, Biederman 2014, Black 2018, Broadbridge 2018, Campbell 2015, Canavan 2012, Chaturvedi 2016, Clark 2020, Croft White 2004, Csikar 2019, Davis-Berman 2016, De Veer 2018, Dickins 2020, Elder 2014, Gallardo 2020, Glumbikova 2018, Greysen 2012, Groton 2020, Groundswell 2015, Groundswell 2016, Groundswell 2017, Groundswell 2020, Gunner 2019, Hauff 2014, Health Scotland 2004, Healthwatch 2015, Homeless Link 2012, Hudson 2010, Jagpal 2019, Kachingwe 2019, Kennedy 2014, Kerman 2019, Kesia 2018, Klop 2018, Krakowsky 2013, Leggio 2020, Lester 2001, MacKenzie 2019, Mago 2018, Masson 2020, McNeil 2012a, McNeil 2012b, McNeil 2013, Mills 2015, Moore 2011, Munoz 2015, Nicholas 2016, Paisi 2020, Patient and Client Council 2015, Pendyal 2020, Pleace 2000, Pleace 2020, Purkey 2019, Rae 2015, Ramsay 2019, Reid 1999, Salem 2015, Shulman 2018, St Mungos 2009, Stajduhar 2019, Strange 2018, Sturman 2020, Sznajder-Murray 2011, The Queen's Nursing Institute 2015, Ungpakorn 2020, Vasillou 2006, Wille 2017, Wise 2013, Woith 2017).

The included studies are summarised in Table 2.

The studies included the views of people experiencing homelessness, families, supporters and advocates of people experiencing homelessness, and health, social care and housing practitioners involved in care and support for people experiencing homelessness. Data collection methods included interviews, focus groups, free text questionnaire responses, and stakeholder meetings.

Thirty-two studies were conducted in the UK (Astra Zeneca 2012, Barker 2018, Batterham 2007, Bhui 2006, Broadbridge 2018, Chaturvedi 2016, Clark 2020, Croft White 2004, Csikar 2019, Groundswell 2015, Groundswell 2016, Groundswell 2017, Groundswell 2020, Gunner 2019, Health Scotland 2004, Healthwatch 2015, Homeless Link 2012, Jagpal 2019, Kesia 2018, Lester 2001, Mills 2015, Paisi 2020, Patient Client Council 2015, Pleace 2000, Pleace 2020, Rae 2015, Reid 1999, Shulman 2018, St Mungos 2009, The Queen's Nursing Institute 2015, Ungpakorn 2020, Vasillou 2006); 4 studies were conducted in Australia (Black 2018, Moore 2011, Strange 2018, Sturman 2020); 13 studies were conducted in Canada (Alunni-Menichini 2020, Campbell 2015, Kerman 2019, Krakowsky 2013, MacKenzie 2019, Mago 2018, McNeil 2012a, McNeil 2012b, McNeil 2013, Nicholas 2016, Purkey 2019, Ramsay 2019, Stajduhar 2019); 1 study was conducted in the Czech Republic (Glumbikova 2018); 1 study was conducted in 14 European capital cities (Canavan 2012); 2 studies were conducted in The Netherlands (De Veer 2018, Klop 2018); and 24 studies were conducted in the US (Adkins 2017, Ake 2018, Asgary 2015, Biederman 2013, Biederman 2014, Davis-Berman 2016, Dickins 2020, Elder 2014, Gallardo 2020, Greysen 2012, Groton 2020, Hauff 2014, Hudson 2010, Kachingwe 2019, Kennedy 2014, Leggio 2020, Masson 2020, Munoz 2015, Pendyal 2020, Salem 2015, Sznajder-Murray 2011, Wille 2017, Wise 2013, Woith 2017).

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

No studies were identified which were applicable to this review question.

Summary of included studies

Summaries of the studies that were included in this review are presented in Table 2.

Table 2: Summary of included studies.

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Adkins 2017 **Study design** Grounded theory **Country** US **Study aim:** To better understand homeless youths' use of technology, mental health experiences and needs, and willingness to engage with technology-supported mental	**Total participants:** N=24 homeless youth. **Gender** Male: 9/24 Female: 15/24 **Age** Average age: 18.8 years (SD=0.8)	**Data collection:** Focus groups **Data analysis:** The interviews were audio recorded, transcribed, and coded using ATLAS.ti. Analysis was guided by the grounded theory approach.	Access • Role of technology Engagement • Communication • The skills, training and values of practitioners for supporting and engaging people Delivery • Quality of the relationship between provider and person using services

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
health interventions to help guide the development of future youth-facing technology-supported interventions.			
Ake 2018 **Study design** General qualitative inquiry **Country** US **Study aim:** A needs assessment of homeless women currently living at a shelter in Milwaukee, Wisconsin, to identify unmet needs related to maternal and infant perinatal health as the first step in designing a mutually beneficial patient-centred service-learning program for medical students to address these needs.	**Total participants:** N=26 homeless women. **Gender:** Not reported **Age:** Not reported	**Data collection:** Focus groups **Data analysis:** Data was analysed using a hybrid approach of directed and summative content analysis.	Access • Access to help/information • Transport
Alunni-Menichini 2020 **Study design** General qualitative inquiry **Country** Canada **Study aim:** An assessment of the current emergency response to homeless people who use substances in Montreal, a major North American city.	**Total participants:** N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness-breakdown of service provider profession not reported by authors) **Gender (of people experiencing homeless):** Cisgender man: 9/11 Transgender man: 1/11 Woman: 1/11 **Age:** Not reported. **Professions of service providers:**	**Data collection:** Interviews and stakeholder meetings **Data analysis:** All discussions were recorded and transcribed. For the World Cafe discussions, audio-based summaries were created. Thematic content analysis was performed using NVivo12 on the entire data set.	Access • Consistency and care continuity • Knowledge and awareness • Opening hours • Service users' views and experiences • Stigmatising attitudes Engagement • The role of user led models built on trust between people with common experiences Delivery • Experiences of stigma and discrimination • Role and availability of outreach

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	Police officer (2 from a mixed team in mental health or homelessness): 10/34 Professionals from homeless/addiction services: 5/34 Psychiatric hospital: 1/34 Community based stakeholders (2 had experienced homelessness): 6/34 People with lived experience: 3/34 Political actors: 3/34 Research community members: 6/34		• Service organisation and delivery
Asgary 2015 **Study design** Grounded theory **Country** US **Study aim:** To explore perspectives and perceptions regarding cancer and cancer screening among homeless.	**Total participants:** N=50 people experiencing homelessness. **Gender** Male: 21/50 Female: 29/50 **Age** Mean age: 51.66 years (±11.34) Age range: 25-79 years	**Data collection:** Interviews **Data analysis:** Grounded theory was used to analyse the results and content analysis was used for generating themes.	Access • Access to help/information • Availability of services • Provision of support to enable access to new services • Service users' views and experiences Engagement • Sustaining ongoing engagement and active participation Delivery • Holistic responses to complex needs • Role and availability of outreach
Astra Zeneca 2012 **Study design** General qualitative inquiry **Country** UK **Study aim:** To explore the health issues of young people experience homelessness in the UK	**Total participants:** N=26 homeless youth. **Gender (reported for interview participants):** Male: 15/26 Female: 11/26 **Age:** Not reported	**Data collection:** Interviews and 5 focus groups (4-10 participants in each focus group). **Data analysis:** Not reported	Access • Appointment systems • Eligibility criteria • Prioritisation • Role of technology • Service users' views and experiences Engagement • Fear, apprehension and trust • The role of user led models built on trust between people with common experiences

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
			- The skills, training and values of practitioners for supporting and engaging people Delivery - Consistency and care continuity - Experiences of stigma and discrimination - Quality of the relationship between provider and person using services
Barker 2018 **Study design** General qualitative inquiry **Country** UK **Study aim:** To understand the critical elements of intentional peer support with a homeless population, voiced by those who provide and/or receive this support	**Total participants:** N=57 (n=29 people experiencing homelessness, n=28 peer supporters). **Gender** Male: 23/29 Female: 6/29 **Age** 25–34 years: 8/29 35–44 years: 3/29 45–54 years: 10/29 55–65 years: 8/29	**Data collection:** Interviews **Data analysis:** Interviews were transcribed and analysed by thematic analysis.	Engagement - Fear, apprehension and trust - The role of user led models built on trust between people with common experiences - The skills, training and values of practitioners for supporting and engaging people
Batterham 2007 **Study design** Phenomenological **Country** UK **Study aim:** To investigate how homeless young people in the UK feel about their experiences of trying to access mental health services	**Total participants:** N=6 young people experiencing homelessness **Gender:** Male: 2/6 Female: 4/6 **Age:** 16 years: 2/6 17 years: 1/6 18 years: 1/6 19 years: 2/6	**Data collection:** Interviews **Data analysis:** Data was analysed using Interpretative Phenomenological Analysis	Access - Access to help and information - Discrimination - Knowledge and awareness - Mental health support - Service users' views and experiences Engagement - Trust in service providers
Bhui 2006 **Study design**	**Total participants:** N=10 people experiencing homelessness.	**Data collection:** Interviews	Access - Appointment systems - Availability of services

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
General qualitative inquiry **Country** UK **Study aim:** To explore the views of 10 people experiencing homelessness on the services they receive	**Gender** Male: 6/10 Female: 4/10 **Age** Age range: 19-54 years	**Data analysis:** The 'Framework' approach was adopted for data analysis	• Cost of services • Discrimination • Eligibility criteria • Service users' views and experiences • Stigmatising attitudes Delivery • Consistency and care continuity • Quality of the relationship between provider and person using services
Biederman 2013 **Study design** Phenomenological **Country** US **Study design:** To examine homeless women's interactions with service providers and the degree to which these interactions are perceived as social support.	**Total participants:** N=15 homeless women (same population as Biederman 2014). **Age** Average age: 43 years (SD = 10.9)	**Data collection:** Interviews **Data analysis:** Phenomenological analysis was used to analyse data.	Engagement • Sustaining ongoing engagement and active participation Delivery • Individualised care and support • Quality of the relationship between provider and person using services
Biederman 2014 **Study design** Phenomenological **Country** US **Study aim:** To better understand the experiences of homeless women's service encoutners	**Total participants:** N=15 homeless women (same population as Biederman 2013). **Age** Average age: 43 years (SD = 10.9)	**Data collection:** Interviews **Data analysis:** Phenomenological analysis was used to analyse data.	Access • Discrimination • Service users' views and experiences • Stigmatising attitudes Engagement • Fear, apprehension and trust • The role of user led models built on trust between people with common experiences Delivery • Experiences of stigma and discrimination • Quality of the relationship between provider and person using services

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Black 2018 **Study design** Phenomenological **Country** Australia **Study aim:** To identify barriers and facilitators for inter-service referrals for homeless youth with mental health issues who have already engaged with a service	**Total participants:** N=30 (n=10 homeless youth, n=20 mental health clinicians and homelessness support workers). **Gender (youth experiencing homelessness):** Male: 2/10 Female: 8/10 **Age (youth experiencing homelessness):** 17 to 23 years (mean=20.9 years) **Gender (Service providers):** Male: n=8/20 Female: n=12/20 **Age (Service providers):** Not reported	**Data collection:** Interviews **Data analysis:** Thematic analysis was employed for data analysis.	Access • Eligibility criteria • Provision of support to enable access to new services Engagement • Communication Delivery • Experiences of stigma and discrimination • Navigating complicated care and support systems • Quality of the relationship between provider and person using services • Service organisation and delivery
Broadbridge 2018 **Study design** General qualitative inquiry **Country** UK **Study aim:** To look at how people experiencing homelessness experience local mental health services	**Total participants:** N=23 people experiencing homelessness. **Gender:** Roughly 50/50 split of male and female participants **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Interview and focus group data was thematically analysed to identify patterns of similarity and difference in the data to address the research questions.	Access • Appointment systems • Eligibility criteria • Mental health support • Registration for GP services • Service users' views and experiences Delivery • Experiences of stigma and discrimination • Service organisation and delivery
Campbell 2015 **Study design** General qualitative inquiry **Country** Canada	**Total participants:** N=22 (n=11 people experiencing homelessness, n=11 service providers-breakdown of service provider profession not reported by authors).	**Data collection:** Interviews **Data analysis:** Thematic analysis was used for data analysis.	Access • Access to help/information • Cost of services • Discrimination • Location of services • Local services • Mental health support • Prioritisation

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Study aim: To qualitatively explore perceived healthcare needs and barriers among individuals experiencing homelessness	**Gender (people experiencing homelessness):** Male: 10/11 Female: 1/11 **Age:** Not reported		- Opening hours - Registration for GP services - Service users' views and experiences Engagement - Fear, apprehension and trust Delivery - Experiences of stigma and discrimination - Navigating complicated care and support systems - Quality of the relationship between provider and person using services
Canavan 2012 **Study design** General qualitative inquiry **Country** 14 EU capital cities **Study aim:** To assess current service provision and identify barriers to care for people experiencing homelessness with mental health problems in 14 European capital cities.	**Total participants:** N=28 experts in mental healthcare for people experiencing homelessness. **Gender:** Not reported **Age:** Not reported **Professions of experts:** - n= 8 Social workers - n=7 Psychiatrists - n=5 Psychologists - n=2 Educators - n=1 Psychiatric nurse - n=1 Medical Doctor - n=1 Lawyer - n=1 Nurse - n=1 Homeless service manager - n=1 Therapist	**Data collection:** Interviews **Data analysis:** The semi-structured interview transcripts were analysed using thematic analysis.	Access - Cost of services - Prioritisation Delivery - Experiences of stigma and discrimination - Service organisation and delivery
Chaturvedi 2016 **Study design** General qualitative inquiry	**Total participants:** N=7 homeless youth. **Gender:** Male: 2/7 Female: 5/7	**Data collection:** Interviews **Data analysis:** Transcripts were analysed using thematic analysis,	Access - Prioritisation Engagement - Communication

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Country UK **Study aim:** To ask young, people experiencing homelessness who had accessed counselling what they thought were the main barriers to counselling and how they could be overcome.	**Age:** Not reported	using an inductive approach where themes were derived from the data.	- Fear, apprehension and trust - Sustaining ongoing engagement and active participation Delivery - Quality of the relationship between provider and person using services
Clark 2020 **Study design** General qualitative inquiry **Country** UK **Study aim:** To evaluate the health care provided to patients experiencing homelessness who were seen in a specialist primary care service.	**Total participants:** N=15 (n=11 people experiencing homelessness, n=4 staff from a primary healthcare facility including administration, nursing, and medical staff). **Gender (people experiencing homelessness):** Male: 9/11 Female: 2/11 **Age (people experiencing homelessness):** 21-62 years	**Data collection:** Interviews **Data analysis:** Not reported	Access - Appointment systems - Literacy - Local services - Service users' views and experiences Engagement - Fear, apprehension and trust - Care continuity improves engagement - Lack of care continuity - Sustaining ongoing engagement and active participation - The skills, training and values of practitioners for supporting and engaging people Delivery - Consistency and care continuity - Individualised care and support - Quality of the relationship between provider and person using services
Croft White 2004 **Study design** Case study **Country** UK	**Total participants:** N=100 service providers (authors report service providers from key agencies, no other details reported). **Gender:** Not reported	**Data collection:** Interviews **Data analysis:** The analysis was undertaken from the interviews on a thematic basis	Access - Appointment systems - Availability of services - Knowledge and awareness - Registration for GP services Engagement

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Study aim: This study: • Explores the experiences of single people experiencing homelessness who have multiple health needs in their quest for accessible and acceptable health services. • Describes the characteristics; of service users in four case study areas. • Examines the experiences of homeless single people accessing and using health services. • Looks at the views and opinions of; individuals and agencies working with people experiencing homelessness.	**Age:** Not reported		• Fear, apprehension and trust • Identifying groups for whom engagement is particularly challenging • The skills, training and values of practitioners for supporting and engaging people Delivery • Experiences of stigma and discrimination • Role and availability of outreach • Service organisation and delivery
Csikar 2019 **Study design** General qualitative inquiry **Country** UK **Study aim:** A qualitative exploration of the barriers and facilitators for people experiencing homelessness achieving good oral health.	**Total participants:** N=16 people experiencing homelessness. **Gender** Male: 14/16 Female: 2/16 **Age:** Not reported	**Data collection:** Focus groups **Data analysis:** A theoretical or deductive approach was used to undertake the analysis after themes were developed inductively	Access • Appointment systems • Cost of services • Knowledge and awareness • Literacy • Location of services • Prioritisation • Stigmatising attitudes Engagement • Fear, apprehension and trust Delivery • Experiences of stigma and discrimination • Individualised care and support • Quality of the relationship between

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
			provider and person using services - Role and availability of outreach
Davis-Berman 2016 **Study design** General qualitative inquiry **Country** US **Study aim:** To understand and examine the service network for the provision of healthcare for serious illness and end-of-life care for the homeless.	**Total participants:** N=14 (n=4 people experiencing homelessness, n=10 community experts) **Gender (people experiencing homelessness)**: Male: 2/4 Female: 2/4	**Data collection:** Interviews **Data analysis:** Data was analysed by thematic analysis	Access - Appointment systems - Availability of services - Knowledge and awareness - Stigmatising attitudes Delivery - Navigating complicated care and support systems - Service organisation and delivery
De Veer 2018 **Study design** General qualitative inquiry **Country** The Netherlands **Study aim:** To give insight into the extent people experiencing homelessness have access to good palliative care	**Total participants:** N=64 (n=19 people experiencing homelessness, of which n=12 people who were deceased but included in data analysis, n=13 social workers, n=12 physicians, n=16 registered nurses, n=3 nurse assistants, n=1 sheltered housing facility coordinator). **Gender (people experiencing homelessness):** Male: 16/19 Female: 3/19 **Age (people experiencing homelessness):** Mean: 59.8 years Range: 45 to 72 years	**Data collection:** Interviews **Data analysis:** Data was analysed inductively	Access - Availability of services Engagement - Fear, apprehension and trust Delivery - Consistency and care continuity - Responses to complex healthcare needs
Dickins 2020 **Study design** General qualitative inquiry	**Total participants:** N=26 (n=15 people experiencing homelessness, n=11 service providers- mostly nurse practitioners, female, and in their	**Data collection:** Interviews **Data analysis:** Data was analysed using thematic analysis	Access - Prioritisation - Service providers' views and experiences Engagement

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Country US **Study aims:** To describe the experiences of homeless persons in accessing and using primary care services, post-implementation of the Affordable Care Act.	clinical role for less than 10 years). **Gender:** Not reported **Age:** Not reported		• Identifying groups for whom engagement is particularly challenging • Sustaining ongoing engagement and active participation • The skills, training and values of practitioners for supporting and engaging people Delivery • Experiences of stigma and discrimination • Navigating complicated care and support systems • Responses to complex healthcare needs
Elder 2014 **Study design** General qualitative inquiry **Country** US **Study aim:** To understand barriers and enablers to health for people experiencing homelessness with diabetes as perceived by homeless persons and providers.	**Total participants:** N=18 (n=7 people experiencing homelessness, n=6 social service providers, n=5 medical providers). **Gender:** Male: 10/18 Female: 8/18 **Age:** Mean age: 46.67 years (calculated by NGA) Age range: 31-68 years	**Data collection:** Semi-structured interviews **Data analysis:** Data was analysed by the editing method	Delivery • Service organisation and delivery
Gallardo 2020 **Study design** General qualitative inquiry **Country** US **Study aim:** To examine providers' experiences and perceptions of the barriers and facilitators of access	**Total participants:** N=17 service providers (n=7 social service providers, n=10 healthcare providers). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Not reported	Access • Appointment systems • Cost of services • Knowledge and awareness • Opening hours • Registration for GP services Engagement • Fear, apprehension and trust Delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
to healthcare that impact youth experiencing homelessness.			• Consistency and care continuity • Experiences of stigma and discrimination • Navigating complicated care and support systems • Quality of the relationship between provider and person using services • Role and availability of outreach • Service organisation and delivery • Service policies
Glumbikova 2018 **Study design** Grounded theory **Country** Czech Republic **Study aim:** To discuss the possibilities of using anti-oppressive social work as a way to reduce the barriers to access to health care services in a given target group.	**Total participants:** N=30 people experiencing homelessness. **Gender:** Male: 17/30 Female: 13/30 **Age:** 20-66 years (mean 48 years)	**Data collection:** Interviews **Data analysis:** The data was analysed using the constructivist grounded theory.	Access • Cost of services • Prioritisation • Registration for GP services • Transport Delivery • Consistency and care continuity • Experiences of stigma and discrimination
Greysen 2012 **Study design** General qualitative inquiry **Country** US **Study aim:** To understand patients' experiences of transitions from hospital to a homeless shelter, and determine aspects of these experiences associated with	**Total participants:** N=98 people experiencing homelessness **Gender:** Male: 78/98 Female: 20/98 **Age:** Mean age: 44 years <30 years: 17/98 (17 %) 30-39 years: 12/98 (12 %) 40-49 years: 37/98 (38 %) 50-59 years: 26/98 (27 %) ≥60 years: 6/98 (6 %)	**Data collection:** Interviews **Data analysis:** Data was analysed by the constant comparative method	Access • Service users' views and experiences Delivery • Quality of the relationship between provider and person using services • Service organisation and delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
perceived quality of these transitions.			
Groton 2020 **Study design** General qualitative inquiry **Country** US **Study aim:** To explore the barriers and facilitators of self-management of hypertension while experiencing homelessness.	**Total participants:** N=18 people experiencing homelessness. **Gender** Male: 14/18 Female: 4/18 **Age:** Early 20s to late 80s	**Data collection:** Focus groups **Data analysis:** Data was analysed using the constant comparative method.	Access • Service providers' views and experiences Delivery • Quality of the relationship between provider and person using services
Groundswell 2015 **Study design** General qualitative inquiry **Country** UK **Study aim:** An investigation into the oral health of people experiencing homelessness.	**Total participants:** N=44 people experiencing homelessness. **Gender:** Not reported **Age:** Not reported	**Data collection:** Focus groups **Data analysis:** Not reported	Access • Prioritisation • Registration for GP services • Knowledge and awareness Delivery • Role and availability of outreach • Service organisation and delivery
Groundswell 2016 **Study design** General qualitative inquiry **Country** UK **Study aim:** A peer-led health audit exploring the respiratory health of people experiencing homelessness.	**Total participants:** N=91 (breakdown of people experiencing homelessness and service providers not reported) **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews and focus groups **Data analysis:** Not reported	Access • Appointment systems • Availability of services • Cost of services • Knowledge and awareness • Mental health support • Prioritisation • Registration for GP services Engagement • Fear, apprehension and trust • Identifying groups for whom engagement is particularly challenging • Sustaining ongoing engagement and active participation

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
			- The role of user led models built on trust between people with common experiences - The skills, training and values of practitioners for supporting and engaging people Delivery - Consistency and care continuity - Experiences of stigma and discrimination Service organisation and delivery - Holistic responses to complex needs - Individualised care and support - Mental health support - Role and availability of outreach
Groundswell 2017 **Study design** Mixed methods **Country** UK **Study aim:** To tell the stories and experiences of healthcare from the perspective of people who are currently homeless across London.	**Total participants:** N=47 people experiencing homelessness. **Gender:** Male: 66/91 Female: 25/91 **Age:** Not reported	**Data collection:** Focus groups **Data analysis:** Not reported	Access - Access to help/information - Cost of services - Discrimination - Registration for GP services - Stigmatising attitudes Engagement - Fear, apprehension and trust Delivery - Language and communication - Quality of the relationship between provider and person using services - Role and availability of outreach
Groundswell 2020 **Study design** Mixed methods **Country**	**Total participants:** N=104 homeless women. **Age:** Average age (years)- 43 years	**Data collection:** Interviews and focus groups **Data analysis:** Not reported	Access - Appointment systems - Mental health support - Service users' views and experiences - Transport

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
UK **Study aim:** This study aimed to understand more about the health conditions women are facing and how their housing issues affect their health. The second aim was to understand more about women's experiences of accessing health services when homeless.	Age range (years)- 19 to 75 years		Engagement • The skills, training and values of practitioners for supporting and engaging people Delivery • Individualised care and support • Role and availability of outreach • Service policies
Gunner 2019 **Study design** General qualitative inquiry **Country** UK **Study aim:** To explore the perspectives of individuals who are homeless on the provision and accessibility of primary healthcare services.	**Total participants:** N=22 people experiencing homelessness **Gender:** Not reported **Age:** 24-70 years	**Data collection:** Interviews **Data analysis:** Data was analysed through a thematic framework	Access • Appointment systems • Knowledge and awareness • Literacy • Registration for GP services • Role of technology • Service providers' views and experiences • Transport Engagement • Fear, apprehension and trust • The skills, training and values of practitioners for supporting and engaging people Delivery • Consistency and care continuity • Experiences of stigma and discrimination • Service organisation and delivery
Hauff 2014 **Study design** Mixed methods **Country** US **Study aim:**	**Total participants:** N=24 (n=10 homeless shelter staff, n=14 health service staff) **Gender:** Not reported **Age:**	**Data collection:** Interviews **Data analysis:** Descriptive content analysis methods were used to analyse data.	Access • Cost of services • Service providers' views and experiences • Stigmatising attitudes • Transport Engagement

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
To describe homeless health care needs and barriers to access.	Not reported		• Fear, apprehension and trust • The skills, training and values of practitioners for supporting and engaging people Delivery • Navigating complicated care and support systems • Service organisation and delivery
Health Scotland 2004 **Study design** General qualitative inquiry **Country** UK **Study aim:** This study aimed to review health care delivery to rural; people experiencing homelessness, and assess barriers to service access.	**Total participants:** N=Not reported. **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Not reported	Access • Appointment systems • Knowledge and awareness • Local services • Location of services • Prioritisation Engagement • Fear, apprehension and trust Delivery • Consistency and care continuity • Individualised care and support • Language and communication • Role and availability of outreach • Service organisation and delivery
Healthwatch 2015 **Study design** General qualitative inquiry **Country** UK **Study aim:** An inquiry into the emotional and physical impact of hospital discharge.	**Total participants:** N=Not reported. **Gender:** Not reported **Age:** Not reported	**Data collection:** Focus groups and survey data **Data analysis:** Not reported	Access • Appointment systems Delivery • Consistency and care continuity • Experiences of stigma and discrimination • Service organisation and delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Homeless Link 2012 **Study design** General qualitative inquiry **Country** UK **Study aim:** To draw together the direct experiences of clients and staff to provide an updated national picture of hospital admission and discharge practice for people who are homeless.	**Total participants:** N=95 (n=57 people experiencing homelessness, n=38 members of staff from homelessness organisations, Local Authorities, and hospital trusts). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews and stakeholder meeting **Data analysis:** Not reported	Engagement • The skills, training and values of practitioners for supporting and engaging people Delivery • Experiences of stigma and discrimination • Service organisation and delivery
Hudson 2010 **Study design** General qualitative inquiry **Country** US **Study aim:** To explore homeless young adults' perspectives on barriers and facilitators of health-care-seeking behaviour and their perspectives on improving existing programs for homeless persons.	**Total participants:** N=24 homeless youth. **Gender** Male: 18/24 Female: 6/24 **Age:** Not reported	**Data collection:** Focus groups **Data analysis:** Content analysis was performed to analyse the data.	Access • Appointment systems • Availability of services • Opening hours • Stigmatising attitudes Delivery • Experiences of stigma and discrimination • Mental health support • Service policies
Jagpal 2019 **Study design** General qualitative inquiry **Country** UK **Study aim:** To conduct public involvement sessions with persons	**Total participants:** N=9 people experiencing homelessness. **Gender** Male: 7/9 Female: 2/9 **Age:** Not reported	**Data collection:** Focus groups **Data analysis:** Data were analysed using thematic coding	Access • Local services • Service providers' views and experiences Engagement • Fear, apprehension and trust Delivery • Role and availability of outreach • Service organisation and delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
experiencing homelessness with a view to inform the design of patient-centred clinical pharmacy healthcare services.			
Kachingwe 2019 **Study design** Phenomenological **Country** US **Study aim:** To explore how homeless female youth participating in a holistic sexual health program called Wahine ("woman") Talk decide whether to use birth control and which birth control method to select.	**Total participants:** N=11 homeless young females. **Age:** Age range: 14 to 18 years Mean age: 15.6 years	**Data collection:** Interviews and focus groups **Data analysis:** Data were analysed using Interpretative Phenomenology Analysis (IPA).	Access • Service users' views and experiences Engagement • Fear, apprehension and trust
Kennedy 2014 **Study design** Grounded theory **Country** US **Study aim:** To explore pregnancy intention and the barriers to contraceptive use as perceived by homeless women with children.	**Total participants:** N=22 women experiencing homelessness. **Age** Mean age: 32 years	**Data collection:** Interviews **Data analysis:** Data analysis was informed by grounded theory.	Access • Prioritisation • Service providers' views and experiences • Service users' views and experiences Engagement • Fear, apprehension and trust Delivery • Experiences of stigma and discrimination
Kerman 2019 **Study design** General qualitative inquiry **Country** Canada **Study aim:** To examine the service experiences	**Total participants:** N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). **Gender** Male: 23/52 Female: 28/52 Transgender female: 1/52	**Data collection:** Interviews **Data analysis:** Data were analysed using thematic analysis.	Access • Appointment systems • Eligibility criteria • Knowledge and awareness • Registration for GP services • Service users' views and experiences • Waiting time Engagement

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
of 52 currently and formerly people experiencing homelessness with mental health problems.	**Age:** Average age of participants who were formerly homeless: 47.62 years (SD=10.73) Average age of participants who are currently homeless: 41.85 years (SD=8.80)		• Fear, apprehension and trust Delivery • Quality of the relationship between provider and person using services • Role and availability of outreach • Service organisation and delivery
Kesia 2018 **Study design** General qualitative inquiry **Country** UK **Study aim:** To better understand the mental health needs of Nottingham's homeless population.	**Total participants:** N=60 (n=37 people experiencing homelessness, n=23 stakeholders). **Gender** Male: 21/37 Female: 16/37 **Age range:** Under 25 years: 4/37 25 to 34 years: 8/37 35 to 49 years: 16/37 50+ years: 9/37	**Data collection:** Interviews **Data analysis:** Thematic analysis was used to analyse data.	Access • Appointment systems • Eligibility criteria • Mental health support Engagement • The skills, training and values of practitioners for supporting and engaging people Delivery • Experiences of stigma and discrimination • Mental health support • Quality of the relationship between provider and person using services • Service organisation and delivery
Klop 2018 **Study design** General qualitative inquiry **Country** The Netherlands **Study aim:** To provide insights into the palliative care experiences of professionals and people experiencing homelessness, including barriers and facilitators to care, and to investigate whether	**Total participants:** N=34 (n=15 people experiencing homelessness, n=19 service providers- breakdown of service provider profession not reported by authors but sample composed of physicians, nurses, social workers, or policy makers). **Gender (people experiencing homelessness):** Male: 11/15 Female: 4/15 **Gender (service providers):**	**Data collection:** Focus groups **Data analysis:** Thematic analysis was used to analyse data.	Access • Availability of services • Opening hours • Service providers' views and experiences Engagement • Sustaining ongoing engagement and active participation • The skills, training and values of practitioners for supporting and engaging people Delivery • Service organisation and delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
a consultative function can help improve palliative care for people experiencing homelessness.	Male: 9/19 Female: 10/19 **Age (people experiencing homelessness):** 40-82 years **Age (service providers):** 36-69 years		
Krakowsky 2013 **Study design** General qualitative inquiry **Country** Canada **Study aim:** How a major urban city's palliative care resources can be improved to increase access and better serve the homeless.	**Total participants:** N=7 service providers (n=3 registered nurses, n=4 outreach workers). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Thematic analysis was used to analyse data.	Engagement • The skills, training and values of practitioners for supporting and engaging people Delivery • Individualised care and support • Quality of the relationship between provider and person using services
Leggio 2020 **Study design** Phenomenological **Country** US **Study aim:** To research how patients living at a homeless shelter experienced emergency medical servics	**Total participants:** N=18 people experiencing homelessness **Gender** Male: 12/18 Female: 6/18 **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Thematic analysis was performed.	Delivery • Experiences of stigma and discrimination • Quality of the relationship between provider and person using services
Lester 2001 **Study design** Grounded theory **Country** UK **Study aim:**	**Total participants:** N=25 general practitioners with experience with people experiencing homelessness. **Gender** Male: 18/25 Female: 7/25	**Data collection:** Interviews **Data analysis:** Data were analysed using the Framework method of manual analysis	Access • Service providers' views and experiences Engagement • The skills, training and values of practitioners for supporting and engaging people Delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
To examine in depth the barriers to primary healthcare for people experiencing homelessness from the point of view of the general practitioner.	**Age** Average age: 44 years (range: 30-62 years)		• Experiences of stigma and discrimination
MacKenzie 2019 **Study design** Phenomenological **Country** Canada **Study aim:** To examine health and social service providers' experiences providing end-of-life care to people experiencing homelessness, seeking recommendations to improve both patient and provider experience.	**Total participants:** N=10 service providers (same population as reported in Purkey 2019, breakdown of service provider profession not reported by authors). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Analysis was informed by a phenomenological approach.	Access • Availability of services • Eligibility criteria • Prioritisation • Role of technology Delivery • Experiences of stigma and discrimination • Role and availability of outreach
Mago 2018 **Study design** Ethnographic, phenomenological **Country** Canada **Study aim:** To reveal and describe from open-ended interviews how people experiencing homelessness in Vancouver interpret, appraise and cope with dental care.	**Total participants:** N=25 people experiencing homelessness. **Gender** Male: 18/25 Female: 7/25 **Age** Mean age: 51 years Age range: 25-64 years	**Data collection:** Interviews **Data analysis:** Data were analysed inductively.	Access • Cost of services • Discrimination • Role of technology • Service users' views and experiences Engagement • Fear, apprehension and trust Delivery • Experiences of stigma and discrimination • Service organisation and delivery
Masson 2020 **Study design** General qualitative inquiry	**Total participants:** N=20 people experiencing homelessness. **Gender**	**Data collection:** Interviews **Data analysis:**	Access • Access to help/information • Knowledge and awareness

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Country US **Study aim:** To study the experiences of homeless individuals related to accessing HCV care to inform the design of a shelter-based HCV prevention and treatment program	Male: 10/20 Female: 10/20 **Age:** 26-69 years	Data were analysed using qualitative thematic analysis	Engagement • Fear, apprehension and trust • Sustaining ongoing engagement and active participation
McNeil 2012a **Study design** General qualitative inquiry **Country** Canada **Study aim:** To explore the challenges of end-of-life care services to homeless illicit drug users based on data collected during a national study on end-of-life care services delivery to homeless persons in Canada.	**Total participants:** N=50 health and social services professionals (same population as McNeil 2012b, breakdown of service provider profession not reported by authors). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Data was analysed thematically to generate themes.	Access • Discrimination • Eligibility criteria • Prioritisation Engagement • Fear, apprehension and trust • The skills, training and values of practitioners for supporting and engaging people Delivery • Individualised care and support • Service policies
McNeil 2012b **Study design** General qualitative inquiry **Country** Canada **Study aim:** To identify barriers to the end-of-life care system for homeless populations and generate recommendations to improve their access to end-of-life care.	**Total participants:** N=54 health and social services professionals (same population as McNeil 2012a, breakdown of service provider profession not reported by authors). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Data was analysed thematically to generate themes.	Access • Eligibility criteria • Service providers' views and experiences Engagement • The skills, training and values of practitioners for supporting and engaging people Delivery • Consistency and care continuity • Service organisation and delivery Service policies

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
McNeil 2013 **Study design** General qualitative inquiry **Country** Canada **Study aim:** This study explored: • Clinicians' preparedness to provide care responsive to the social determinants of health in homeless populations • The steps taken by clinicians to overcome shortcomings in their clinical training in regard to the social determinants of health.	**Total participants:** N=24 people experiencing homelessness. **Gender** Male: 6/24 Female: 18/24	**Data collection:** Interviews **Data analysis:** An inductive and iterative process was used to analyse data.	Engagement • The skills, training and values of practitioners for supporting and engaging people
Mills 2015 **Study design** General qualitative inquiry **Country** UK **Study aim:** To examine how health professionals working in services for homeless persons view their patients' engagement with health care and explore how these views influence their practice.	**Total participants:** N=13 healthcare professionals. **Gender** Male: 3/13 Female: 10/13 **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Data analysis followed a framework approach.	Access • Appointment systems • Discrimination • Eligibility criteria • Service providers' views and experiences • Service users' views and experiences Engagement • Communication • Fear, apprehension and trust • Sustaining ongoing engagement and active participation • The role of user led models built on trust between people with common experiences Delivery • Consistency and care continuity

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
			• Individualised care and support • Navigating complicated care and support systems • Service organisation and delivery
Moore 2011 **Study design** General qualitative inquiry **Country** Australia **Study aim:** To examine the perceptions and experiences of people experiencing homelessness in relation to their health service needs as well as those of service providers involved with their care.	**Total participants:** N=47 (n=20 people experiencing homelessness, n=27 service providers-breakdown of service provider profession not reported by authors). **Gender (people experiencing homelessness):** Male: 15/20 Female: 5/20 **Gender (service providers):** Not reported **Age (people experiencing homelessness):** 50.5 years (SD 9.4), range 35 to 68 years **Age (service providers):** 40.2 years (SD 7.9), range 28 to 58 years	**Data collection:** Interviews **Data analysis:** Thematic analysis was used to analyse the results.	Access • Eligibility criteria • Opening hours Engagement • Communication • The role of user led models built on trust between people with common experiences Delivery • Service organisation and delivery
Munoz 2015 **Study design** General qualitative inquiry **Country** US **Study aim:** To report on homeless adolescents perceptions regarding obtaining health care and to use the data to	**Total participants:** N=30 homeless adolescents. **Gender** Male: 19/30 Female: 11/30 **Age** Mean age: 20.3 years	**Data collection:** Interviews and focus groups **Data analysis:** Thematic analysis was done by content analysis.	Access • Cost of services • Discrimination Engagement • Sustaining ongoing engagement and active participation Delivery • Experiences of stigma and discrimination

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
expand care for the homeless adolescent community whom we sampled.			
Nicholas 2016 **Study design** Grounded theory **Country** Canada **Study aim:** To investigate the experiences and perceptions of the service providers who assist street-involved youth with health care related issues.	**Total participants:** N=41 (n=20 hospital staff, n=21 community-based workers). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Data were analysed by the grounded theory methodology	Access • Appointment systems • Cost of services • Eligibility criteria • Prioritisation Engagement • Fear, apprehension and trust • The role of user led models built on trust between people with common experiences Delivery • Experiences of stigma and discrimination • Language and communication • Mental health support • Navigating complicated care and support systems • Quality of the relationship between provider and person using services • Service organisation and delivery • Service policies
Paisi 2020 **Study design** General qualitative inquiry **Country** UK **Study aim:** To identify strategies to improve oral health behaviours as well as access to and provision of dental care for people experiencing homelessness.	**Total participants:** N=23 (n=11 people experiencing homelessness, n=12 stakeholders). **Gender (people experiencing homelessness):** Male- 11/11 **Age (people experiencing homelessness):** Average age (mean±SD): 34.10±10.59 years Age range: 21.20-55.30 years	**Data collection:** Interviews and focus groups **Data analysis:** Data was analysed by thematic analysis.	Access • Access to help/information • Cost of services • Knowledge and awareness Engagement • Sustaining ongoing engagement and active participation • The role of user led models built on trust between people with common experiences • The skills, training and values of practitioners for supporting and engaging people

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	Gender (stakeholders): Male- 5/12 Female- 7/12		Delivery • Holistic responses to complex needs • Language and communication • Role and availability of outreach • Service organisation and delivery
Patient and Client Council 2015 **Study design** General qualitative inquiry **Country** UK **Study aim:** To understand the key issues with regard to people who are homeless accessing health and social care services and to scope out what work has already taken place in Northern Ireland	**Total participants:** N=18 stakeholders **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews and one group discussion **Data analysed:** Not reported	Access • Appointment systems • Availability of services • Discrimination • Eligibility criteria • Literacy • Mental health support • Prioritisation • Registration for GP services • Role of technology • Service providers' views and experiences • Stigmatising attitudes • Transport Engagement • Fear, apprehension and trust Delivery • Consistency and care continuity • Service organisation and delivery • Service policies
Pendyal 2021 **Study design** Grounded theory **Country** US **Study aim:** To identify the ways in which homelessness may impede successful SM of HF and engagement with the healthcare system.	**Total participants:** N=19 people experiencing homelessness. **Gender:** Male: 14/19 Female: 5/19 **Age:** Mean: 56 years Range: 34 to 72 years	**Data collection:** Interviews **Data analysis:** Data were analysed by a multidisciplinary team using a grounded theory approach.	Access • Prioritisation • Service providers' views and experiences Delivery • Experiences of stigma and discrimination

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Pleace 2000 **Study design** General qualitative inquiry **Country** UK **Study aim:** An overview of rough sleeping within the wider social problem of homelessness and briefly examines the health care needs of people sleeping rough	**Total participants:** N=112 (n=12 GPs, n=7 health authority workers, n=6 health workers, n=19 homelessness workers, n=4 representatives from different organisations, n=64 people sleeping rough). **Gender:** Male: 52/64 Female: 12/64 **Age range:** 18-24 years: 18/64 25-34 years: 20/64 35-44 years: 16/64 45-54 years: 5/64 55+ years: 5/64	**Data collection:** Interviews **Data analysis:** Not reported	Access • Appointment systems • Discrimination • Registration for GP services • Service providers' views and experiences • Stigmatising attitudes Engagement • Fear, apprehension and trust • The role of user led models built on trust between people with common experiences • The skills, training and values of practitioners for supporting and engaging people Delivery • Consistency and care continuity • Experiences of stigma and discrimination • Quality of the relationship between provider and person using services • Role and availability of outreach
Pleace 2020 **Study design** General qualitative inquiry **Country** UK **Study aim:** To explore the views of people with experience of sleeping rough on accessing health and care services.	**Total participants:** N=23 people with lived experience of sleeping rough. **Gender:** Female: 4/23 Male: 19/23 **Age:** 19 to 63 years	**Data collection:** Focus groups **Data analysis:** Not reported	Access • Local services • Location of services • Registration for GP services • Service users' views and experiences • Transport Delivery • Consistency and care continuity • Experiences of stigma and discrimination • Mental health support • Quality of the relationship between provider and person using services • Service organisation and delivery

Study and aim of the study	**Participants**	**Methods**	**Themes applied after thematic synthesis**
Purkey 2019 **Study design** General qualitative inquiry **Country** Canada **Study aim:** To examine the experience of accessing hospital-based services of persons experiencing homelessness or vulnerable housing in southeastern Ontario and consider the potential of Equity-Oriented Health Care (EOHC) as an approach to improving care.	**Total participants:** N=41 (n=31 people experiencing homelessness, n=10 health service providers). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews and focus groups **Data analysis:** The analysis was informed by directed content analysis.	Engagement • The role of user led models built on trust between people with common experiences Delivery • Experiences of stigma and discrimination • Quality of the relationship between provider and person using services • Service organisation and delivery
Rae 2015 **Study design** Phenomenological **Country** UK **Study aim:** To understand the perspective of the homeless about their healthcare encounters and how their experiences of receiving healthcare influence their health-seeking behaviour.	**Total participants:** N=14 people experiencing homelessness. **Gender:** Male: 12/14 Female: 2/14 **Age range:** 29 to 53 years	**Data collection:** Interviews **Data analysis:** Colaizzi's method for data analysis was used.	Access • Prioritisation • Registration for GP services Engagement • Communication • Fear, apprehension and trust Delivery • Quality of the relationship between provider and person using services • Service organisation and delivery
Ramsay 2019 **Study design** General qualitative inquiry **Country** Canada	**Total participants:** N=16 people experiencing homelessness. **Gender:** Male: 13/16 Female: 3/16	**Data collection:** Interviews **Data analysis:** Inductive thematic analysis was used to analyse the data.	Access • Discrimination • Location of services • Public funding • Registration for GP services • Transport Delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Study aim: To identify barriers and facilitators to accessing health care as perceived by people experiencing homelessness in the regional municipality of Niagara, Canada.	**Age:** Mean age: 42.9 years Age range: 18 to 65 years		• Quality of the relationship between provider and person using services • Role and availability of outreach • Service organisation and delivery
Reid 1999 **Study design** General qualitative inquiry **Country** UK **Study aim:** T investigate access to services, and views of service provision amongst young people experiencing homelessness aged 14-25 years.	**Total participants:** N=200 homeless youth. **Gender:** Male: 143/200 Female: 57/200 **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Not reported	Access • Location of services
Salem 2015 **Study design** General qualitative inquiry **Country** US **Study aim:** To assess perspectives among prefrail and frail, middle-aged and older homeless women.	**Total participants:** N=20 homeless women. **Gender:** Not reported **Age** Mean age (SD): 53.45 years (5.2) Age range: 43 to 62 years	**Data collection:** Focus groups **Data analysis:** Data was analysed by content analysis.	Access • Access to help/information • Appointment systems • Cost of services • Registration for GP services Engagement • Fear, apprehension and trust Delivery • Experiences of stigma and discrimination • Service organisation and delivery
Shulman 2018 **Study design** General qualitative inquiry **Country** UK	**Total participants:** N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). **Gender:** Male: 68/127 Female: 59/127	**Data collection:** Focus groups **Data analysis:** Thematic analysis was used to analyse themes from the data.	Access • Prioritisation • Service providers' views and experiences Engagement • Fear, apprehension and trust

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Study aim: To explore the views and experiences of current and formerly people experiencing homelessness, frontline homelessness staff (from hostels, day centres and outreach teams) and health- and social-care providers, regarding challenges to supporting people experiencing homelessness with advanced ill health, and to make suggestions for improving care.	**Age:** Not reported		• The skills, training and values of practitioners for supporting and engaging people Delivery • Consistency and care continuity • Experiences of stigma and discrimination • Individualised care and support • Quality of the relationship between provider and person using services • Responses to complex healthcare needs • Service organisation and delivery
St Mungos 2009 **Study design** General qualitative inquiry **Country** UK **Study aim:** To examine issues that people experiencing homelessness themselves think are important in relation to mental health and wellbeing.	**Total participants:** N=103 people experiencing homelessness. **Gender** Male: 72/103 Female: 31/103 **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Not reported	Access • Appointment systems • Mental health support Engagement • The skills, training and values of practitioners for supporting and engaging people Delivery • Holistic responses to complex needs • Individualised care and support Language and communication • Quality of the relationship between provider and person using services • Service organisation and delivery
Stajduhar 2019 **Study design** Ethnographic **Country** Canada **Study aim:**	**Total participants:** Number of people who were observed: N=119 (n=25 people experiencing homelessness, n=25 support persons, n=69 formal service providers). Number of people who were interviewed: N=58	**Data collection:** Participant observation and interviews **Data analysis:** Data were analysed by thematic analysis	Access • Prioritisation Engagement • Fear, apprehension and trust • Identifying groups for whom engagement is particularly challenging and understanding

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
To identify barriers to accessing care among structurally vulnerable people at End of Life.	(n=19 people experiencing homelessness, n=16 support persons, n=23 service providers). **Participant characteristics for those who were observed** **Gender (people experiencing homelessness):** Male: 16/25 Female: 9/25 **Gender (support persons):** Male: 11/25 Female: 14/25 **Gender (service providers):** Male: 25/69 Female: 41/69 Other (gender queer, two-spirit, trans): 3/69 **Age (people experiencing homelessness):** Average age: 59 years Age range: 19-81 years **Age (support persons):** Average age: 50 years Age range: 35-71 years **Age (service providers):** Average age based on 44 participants): 44 years Age range based on 44 participants: 24-67 years		which populations are 'missing' from certain services Delivery • Quality of the relationship between provider and person using services • Service organisation and delivery • Service policies
Strange 2018 **Study design** General qualitative inquiry **Country** Australia	**Total participants:** N=32 (n=27 people experiencing homelessness, n=5 allied service staff). **Gender (people experiencing homelessness):** Male: 20/27	**Data collection:** Interviews **Data analysis:** A thematic analysis was undertaken using Braun and Clarke's six phases.	Engagement • Fear, apprehension and trust Delivery • Experiences of stigma and discrimination • Individualised care and support

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Study aim: To explore patient and staff perspectives of a street-based, primary health service, to help identify factors influencing patient access and management.	Female: 7/27 **Age (people experiencing homelessness):** 23-45 years: 12/27 46-84 years: 15/27		- Role and availability of outreach
Sturman 2020 **Study design** General qualitative inquiry **Country** Australia **Study aim:** To explore the experiences' of homeless men seeking and receiving health care, and views about improving these.	**Total participants:** N=20 homeless men **Gender:** Not reported **Age:** Not reported	**Data collection:** Focus groups **Data analysis:** Data were analysed inductively.	Access - Appointment systems - Role of technology - Service providers' views and experiences Engagement - Fear, apprehension and trust Delivery - Consistency and care continuity - Quality of the relationship between provider and person using services - Service organisation and delivery
Sznajder-Murray 2011 **Study design** Phenomenological **Country** US **Study aim:** To gain a better understanding of homeless mothers' perceptions of service providers.	**Total participants:** N=28 homeless women. **Gender:** Not reported **Age:** Mean age: 29.2 years (SD=6.4) Age range: 18 to 40 years	**Data collection:** Interviews **Data analysis:** Thematic analysis was conducted to generate themes from the data.	Access - Service users' views and experiences Engagement - Fear, apprehension and trust Delivery - Experiences of stigma and discrimination - Language and communication Quality of the relationship between provider and person using services -
The Queen's Nursing Institute 2015 **Study design**	**Total participants:** N>180 nurses **Gender:** Not reported	**Data collection:** Interviews **Data analysis:** Not reported	Delivery - Service organisation and delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
General qualitative inquiry **Country** UK **Study aim:** To capture the feedback of current hospital discharge arrangements from nurses who directly work with people who are homeless.	**Age:** Note reported		
Ungpakorn 2020 **Study design** General qualitative inquiry **Country** UK **Study aim:** To understand how health-related street outreach is perceived by people experiencing homelessness with experience of sleeping rough.	**Total participants:** N=10 people experiencing homelessness. **Gender:** Female: 1/10 Male: 9/10 **Age:** 26-56 years	**Data collection:** Interviews **Data analysis:** Thematic analysis was conducted using an inductive approach.	Access • Service users' views and experiences Delivery • Language and communication • Quality of the relationship between provider and person using services • Role and availability of outreach
Vasillou 2006 **Study design** General qualitative inquiry **Country** UK **Study aim:** To report key findings specific to homeless young people's emotional support needs and mental health.	**Total participants:** N=59 (n=59 homeless youth, staff from n=123 services working in the field of housing and youth homelessness). **Gender:** Not reported **Age:** Not reported	**Data collection:** Interviews **Data analysis:** Not reported	Access • Access to help/information • Mental health support • Service users' views and experiences Engagement • The skills, training and values of practitioners for supporting and engaging people Delivery • Experiences of stigma and discrimination • Mental health support • Quality of the relationship between provider and person using services
Wille 2017	**Total participants:** N=28 (n=16 people	**Data collection:**	Access

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Study design General qualitative inquiry **Country** US **Study aim:** To identify barriers to care for homeless participants	experiencing homelessness, n=12 healthcare/social service providers). **Gender (people experiencing homelessness):** Male: 8/16 Female: 8/16 **Gender (service providers):** Male: 4/12 Female: 8/12 **Age (people experiencing homelessness):** Mean age: 37 years (SD 13.1) Age range: 19-57 years **Age (service providers):** Mean age: 45 years (SD 9.9) Age range: 26-57 years	Interviews **Data analysis:** Data was analysed using a general inductive approach.	• Appointment systems • Role of technology • Transport Delivery • Experiences of stigma and discrimination • Service organisation and delivery
Wise 2013 **Study design** Phenomenological **Country** US **Study aim:** To understand the experience of homeless persons in the health care system.	**Total participants:** N=11 people experiencing homelessness. **Gender:** Male: 6/11 Female 5/11 **Age:** 21 to 54 years	**Data collection:** Interviews **Data analysis:** Data was analysed by phenomenological analysis.	Access • Prioritisation • Service users' views and experiences Delivery • Experiences of stigma and discrimination • Service policies
Woith 2017 **Study design** Phenomenological **Country** US **Study aim:** To explore people experiencing	**Total participants:** N=15 people experiencing homelessness. **Gender:** Male: 10/15 Female: 5/15 **Age:**	**Data collection:** Interviews **Data analysis:** Data were analysed through content analysis identification of themes	Access • Cost of services • Discrimination • Service users' views and experiences Delivery • Service organisation and delivery

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
homelessness's perceptions of their interactions with nurses.	Age range: 18 to 53 years Mean age: 34.3 years		

GP: general practitioner; EU: European Union; UK: United Kingdom; US: United States of America.

See the full evidence tables in appendix D. No meta-analysis was conducted as this was a qualitative review (and so there are no forest plots in appendix E).

The themes identified through analysis of all the included studies are summarised in Table 3 together with their CERQual quality rating and the number of studies contributing to each theme.

Table 3: Summary table of themes, the number of studies contributing to the theme, and their quality rating

Themes and subthemes	CERQual quality	No. of studies
Access- What could be improved?		
A1.1 - Access to help and information	Moderate	9
A1.2 – Appointment systems	Moderate	7
A1.2.1 – Communication	Moderate	1
A1.2.2 – Missed appointment policies	Low	3
A1.2.3 – The length of clinical appointments	Low	4
A1.2.4 – Waiting times	Moderate	15
A1.3 – Availability of services	Moderate	10
A1.4 – Consistency and care continuity	High	1
A1.5 – Cost of services	High	10
A1.5.1 – Out of pocket expenses	High	8
A1.6 - Discrimination	Moderate	13
A1.7 – Eligibility criteria	High	8
A1.7.1 - Conditional treatment rules	High	3
A1.7.2 - Transition between child and adult services	Moderate	4
A1.8 – Knowledge and awareness A1.8.1 – Awareness about rights to healthcare	Low	1
A1.8.2 – Knowledge and awareness about dental provision	Moderate	1
A1.8.3 – Knowledge and awareness of issues surrounding homelessness and health	Low	1
A1.8.4 – Service provider's knowledge and awareness of services	High	9
A1.8.5 – Service user's knowledge and awareness of services	Moderate	4
A1.9 – Literacy	High	4
A1.10 – Local services A1.10.1 – Single point of contact for a range of services	Moderate	2
A1.10.2 – Availability of allied health services	Moderate	3
A1.11 – Location of services	Moderate	6
A1.12 – Mental health support	Low	2
A1.12.1 – Support for dual diagnosis	Moderate	7
A1.13 – Opening hours	High	6
A1.14 – Prioritisation A1.14.1 – Attitudes toward help seeking	High	2

Themes and subthemes	CERQual quality	No. of studies
A1.14.2 – Competing priorities	High	18
A1.15 – Registration for GP services	Moderate	12
A1.15.1 – Requirements around identification and paperwork	High	4
A1.16 – Role of technology	High	3
A1.16.1 – Lack of internet and phone access	High	4
A1.17 – Service providers' views and experiences	High	7
A1.17.1 – Managing medication	High	11
A1.18 – Service users' views and experiences	Moderate	12
A1.18.1 – Crisis response	Moderate	1
A1.18.2 – Counselling around screening	Moderate	1
A1.18.3 – Relationship between service user and service provider	High	8
A1.19 – Stigmatising attitudes	High	10
A1.20 – Transport	High	7
Access- What works well?		
B1.1 – Appointment systems	Low	3
B1.2 – Service users' views and experiences B1.2.1 – Receiving prompt care	High	1
B1.2.2 – Relationship between service user and service provider	High	4
B1.3 – Role of technology	Low	1
B1.4 – Transport	Moderate	3
B1.5 – Waiting time	High	1
Engagement- What could be improved?		
A2.1 – Communication	High	4
A2.1.1 – Respect	High	2
A2.2 – Fear, apprehension, and trust A2.2.1 – Feelings of apprehension	High	9
A2.2.2 – Feelings of fear	High	14
A2.2.3 – Self-esteem	High	11
A2.2.4 – Trust in service providers	High	9
A2.3 – Identifying groups for whom engagement is particularly challenging	High	4
A2.4 – Lack of care continuity	Moderate	2
A2.5 – Sustaining ongoing engagement and active participation A2.5.1 – Flexibility	Moderate	1
A2.5.2 – Information giving	Moderate	2
A2.5.3 – Ongoing support	Moderate	4
A2.5.4 – Provision of incentives	High	4
A2.5.5 – Service feedback	Moderate	1
A2.5.6 – Shared decision making	High	2
A2.6 – The role of user led models built on trust between people with common experiences A2.6.1 – Challenges faced by peer supporters	Moderate	1
A2.7 – The skills, training and values of practitioners for supporting and engaging people	Moderate	23
Engagement- What works well?		
B2.1 – Care continuity improves engagement	High	1

Themes and subthemes	CERQual quality	No. of studies
B2.2 – The role of user led models built on trust between people with common experiences	High	9
B2.2.1 – Peer support	High	3
Delivery- What could be improved?		
A3.1 – Quality of the relationship between provider and person using services	Moderate	9
A3.1.1 – Care experiences	Moderate	22
A3.1.2 Trauma informed care	Moderate	1
A3.2 – Responses to complex healthcare needs	High	3
A3.3 – Consistency and care continuity	Moderate	15
A3.3.1 – Data recording and sharing	High	4
A3.4 – Holistic responses to complex needs	Moderate	4
A3.5 – Individualised care and support	Moderate	10
A3.5.1 – Specialist services	Moderate	3
A3.6 – Language and communication	Moderate	7
A3.7 – Mental health support	Moderate	6
A3.8 – Navigating complicated care and support systems	High	9
A3.9 – Service policies	High	9
A3.10 – Service delivery and organisation	High	7
A3.10.1 – Availability of resources	High	10
A3.10.2 – Emergency care	High	7
A3.10.3 – Fragmented services	High	11
A3.10.4 – Hospital discharge procedures	High	14
A3.10.5 – Referrals between services	High	7
A3.11 – Experiences of stigma and discrimination	Moderate	36
Delivery- What works well?		
B3.1 – Quality of the relationship between provider and person using services B3.1.1 – Positive experiences of care	Moderate	13
B3.2 – Role and availability of outreach	Moderate	19
B3.3 – Service delivery and organisation B3.3.1 – Service collaboration	High	11

See summary of evidence section and appendix F for further details about the themes, review findings and CERQual ratings.

Summary of the evidence

A summary of the qualitative data is presented here, by overarching theme together with a thematic map after each section to visually illustrate the connection between the overarching themes and sub-themes.

Access to health and social care services:

- The evidence generated 20 themes and 23 sub-themes for things that need to be improved when accessing health and social care services, and 5 themes and 2 subthemes for things that do work well.
- 66 studies provided evidence for the things that need to be improved and 12 studies provided evidence for things that do work well.
- The overall quality of the evidence was mixed, ranging from high to low, with most of the evidence being of a moderate quality.

- The main reasons for low quality evidence were minor or moderate concerns with methodological limitations and relevance of evidence from 5 studies.

The evidence on things that need to be improved reported that:

- There was a lack of help or information on topics available for people experiencing homelessness, who reported requiring help in making appointments and with accessing support and welfare services (theme A1.1 [moderate quality]).
- Appointment systems were rigid, waiting lists were long, waiting times to see a service provider were long, and the duration of appointments were too short. People experiencing homelessness wanted appointment systems to be more flexible and responsive to their needs (theme A1.2 [moderate quality], subthemes A1.2.1 [moderate quality], A1.2.2 [low quality], A1.2.3 [low quality], A1.2.4 [moderate quality]).
- There is a lack of specialist services and continuity between services for people experiencing homelessness, for example palliative care, which is neither well developed nor visible for homeless populations (theme A1.3 [moderate quality]).
- There was limited availability of low-cost social service providers and dental health care for people experiencing homelessness. Out of pocket expenses hindered access to dental treatments, optometry, and mental health (theme A1.5 [high quality], subtheme A1.5.1 [high quality]).
- People experiencing homelessness face discrimination, which creates a barrier to accessing healthcare. Some people reported that due to being homeless they felt the treatment that was on offer was ‘lesser’ than the general population. They felt that prejudice and lack of empathy toward their situation alienated them from seeking care. Overall, it was suggested that acceptability was modulated by the nature of the relationships between users and providers. A relationship of trust, civility, and a strength-based approach with the providers encourages the use of services. It was easier to form trusting relationships with professionals who pay attention and have more time available, and who have sincere interest in them (theme A1.6 [moderate quality]).
- There were strict eligibility criteria in place to access healthcare services, sometimes forcing people experiencing homelessness into crisis situations before help could be provided or excluded people from accessing services at all. Homeless youth were more vulnerable to ‘falling between the cracks’ when transitioning between child and adult services. One study reported a participant’s professional assessment of mental health changing when they moved from child to adult services. As a child, they met the threshold for psychiatric services but as an adult they did not. There were mixed opinions from service providers on providing care to people experiencing homelessness. Some reported the challenging behaviour of people experiencing homelessness as distressing and complicating the provision of care. Others, who worked regularly with people experiencing homelessness, thought that they could sometimes be difficult, but no more so than many other patients (theme A1.7 [high quality], subthemes A1.7.1 [high quality], A1.7.2 [moderate quality]).
- Many people simply did not know their rights around healthcare. There was a sense that while people experiencing homelessness felt that they could access emergency care, many were unsure of their rights around accessing primary care, around making choices about their own care, and about other rights such as accessing healthcare records. All the people in the focus group welcomed the opportunity to have a better understanding of their rights to healthcare. Some people felt that having a better knowledge of these entitlements would immediately lead to a better use of healthcare (theme, A1.8 [low quality], subtheme A1.8.1 [low quality]).

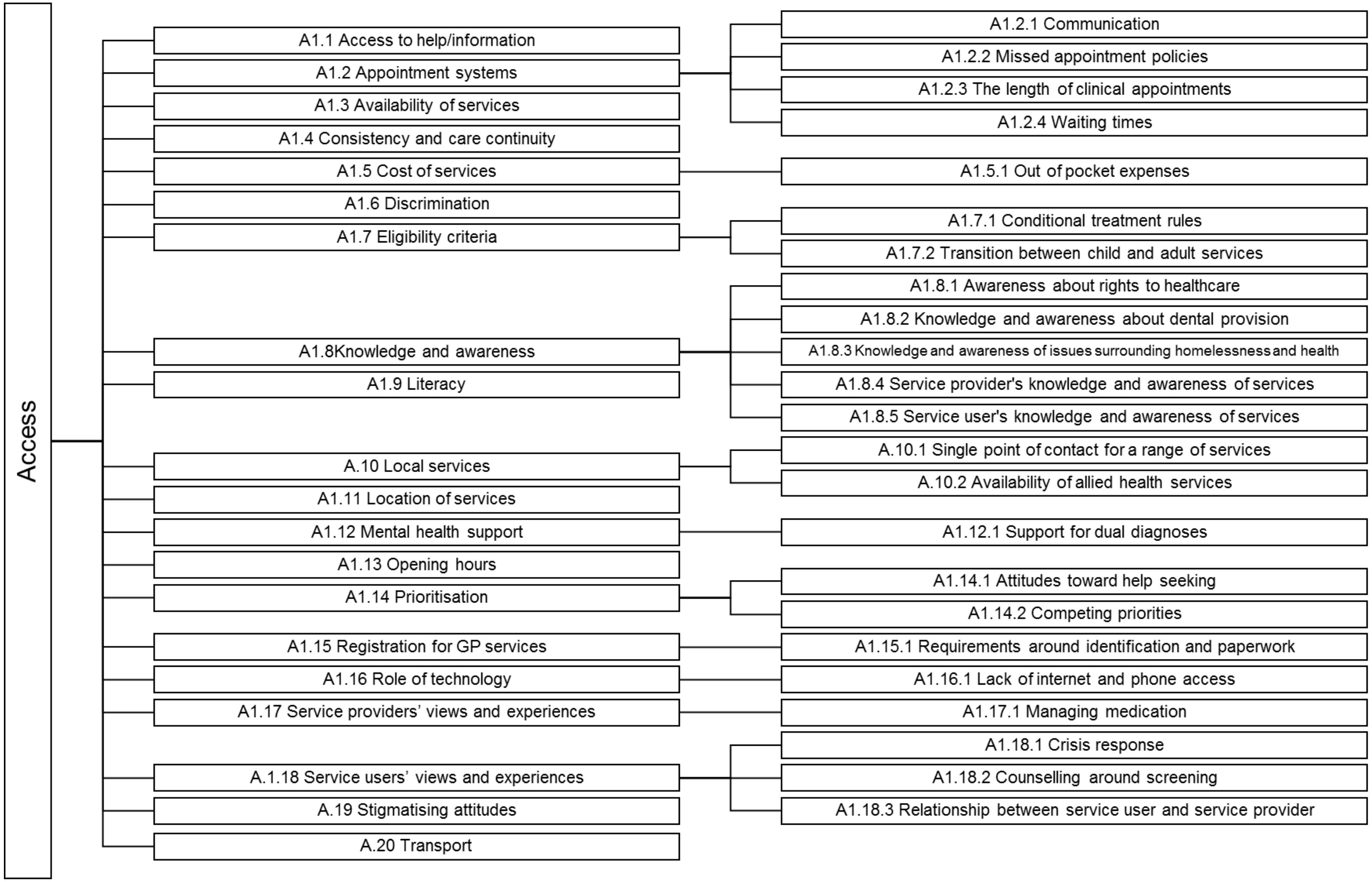
- One of the major barriers in accessing dental care services was the lack of an appropriate point of contact. This reduced participant's awareness of available high street or community dental services (subtheme A1.8.2 [moderate quality]).
- Overall, service users reported that service providers did not understand the practicalities of being homeless and their specific needs. Some people described difficulties managing their medication and their perceptions of prescribing practices (subtheme A1.8.3 [low quality]).
- Some service providers and service users had a knowledge gap of available services for people experiencing homelessness, which prevented them from accessing healthcare. Some service providers reported it was difficult to stay up to date on the full range of healthcare services available and as such found it difficult to signpost to relevant services (subthemes A1.8.4 [high quality], A1.8.5 [moderate quality]).
- Providing information and wider support to people experiencing homelessness may be challenging, since communicating through conventional means, such as emails, could be difficult. Further, low levels of literacy also contributed to difficulties in accessing care (theme A1.9 [high quality]).
- Other than care from medical doctors, people experiencing homelessness have an unmet need to access allied health services. These include nursing, dentistry, optometry, pharmacy, physiotherapy, and rehabilitation. Having a single access point was lacking and made it difficult to obtain support for the full range of needs (theme A1.10 [moderate quality], subthemes A1.10.1 [moderate quality], A1.10.2 [moderate quality]).
- The environmental barrier, location of services, limited accessibility to healthcare. Service users felt less willing to go to a clinic located in an area with which they were unfamiliar, saying they feel uncomfortable in clinics located far away. People preferred if services were located in one place or close together (theme A1.11 [moderate quality]).
- People experiencing homelessness had poor access to mental health support (theme A1.12 [low quality]).
- The complexity of dual diagnosis (an individual having a mental health illness and an addiction at the same time) causes difficulty as it is often hard to know which problem should be treated first. For example, it can be difficult to distinguish whether the mental health issue is caused by the addiction or if the addiction is caused by the mental health issue. This often leads to people falling through the gaps between services (subtheme A1.12.1 [moderate quality]).
- Limited opening hours made access to services very difficult. Some people reported that, other than emergency care, there was not an accessible healthcare facility open 24 hours to accommodate those who get sick on the weekends or after hours. Service providers reported wanting an after-hours referral system so that they could refer people experiencing homelessness to the appropriate services for the following morning (theme A1.13 [high quality]).
- Health needs, particularly physical health conditions, were not a high priority when compared to food and shelter. The studies reported that the lifestyle of people experiencing homelessness was too stressful and chaotic to prioritise health issues. Some people experiencing homelessness reported that when they sought care, it was for acute health issues rather than preventive or screening procedures (theme A1.14 [high quality], subthemes A1.14.1 [high quality], A1.14.2 [high quality]).
- There were many hurdles for people experiencing homelessness when registering for healthcare services. Service providers reported that many local GPs refused to register people experiencing homelessness without proof of address or proof of identity, although evidence from some studies reported that this should not be the case. Service users accessed other health and social care services through the GP,

therefore if the homeless population cannot get access to a GP they are more likely to struggle to get access to other services (theme A1.15 [moderate quality], subtheme, A1.15.1 [high quality]).

- Some people experiencing homelessness found themselves making use of emergency service departments for a variety of medical problems, and often to overcome the problem of not being able to register with a GP (theme A1.15 [moderate quality], subtheme, A1.15.1 [high quality]).
- The role of technology in enabling access to healthcare was mixed. Some service users considered mobile phone applications to be useful for things like general support and information. When it came to information available through search engines, although it was considered useful and handy to be able to get information quickly, there was some distrust in the credibility. A few service users had difficulty finding a local GP practice due to their lack of access to the internet. Those who did not have a phone experienced difficulties in making or cancelling an appointment and not receiving appointment reminders (theme A.16 [high quality], subtheme A1.16.1 [high quality]).
- There was inequality and prejudice in healthcare for people experiencing homelessness. Service providers reported that people experiencing homelessness did not receive the same quality of care as other patients. Access experiences by First Nations populations were reported as prejudiced. There were difficulties engaging with medication management and treatment compliance. This was due to theft, memory issues, or confusion about when to take medications. Day to day instability and a chaotic lifestyle led to difficulties in successful self-management behaviours (theme A1.17 [high quality], subtheme A1.17.1 [high quality]).
- People experiencing homelessness thought there was a lack of crisis response, a lack of mental health support, a lack of information and guidance about screening, and a lack of screening counselling; screening was considered a high priority for some people (theme A1.18 [moderate quality], subthemes, A1.18.1 [moderate quality], A1.18.2 [moderate quality], A1.18.3 [high quality]).
- People experiencing homelessness face stigma when accessing healthcare. The data reports that this stigma is heightened when the person also has mental health issues. Several service users in these studies reported feeling judged, stereotyped, and being disrespected in healthcare settings such as GP practices, emergency care, and dental surgeries. Service users reported feeling offended by providers or fearing their judgment, which led them to lose trust in providers to the point of unwillingness to return for care. Services users reported this behaviour as the main reason for not seeking regular care (theme A1.19 [high quality]).
- Transport is a barrier to accessing healthcare, including the lack of availability of transport to healthcare settings and the cost associated with the transport. Many service users reported that walking was their main mode of getting to an appointment, which could be difficult for those people with existing health issues and disabilities (theme A1.20 [high quality]).

The thematic map (Figure 1) illustrates these as overarching themes and subthemes.

Figure 1: Thematic map for Access- What could be improved?

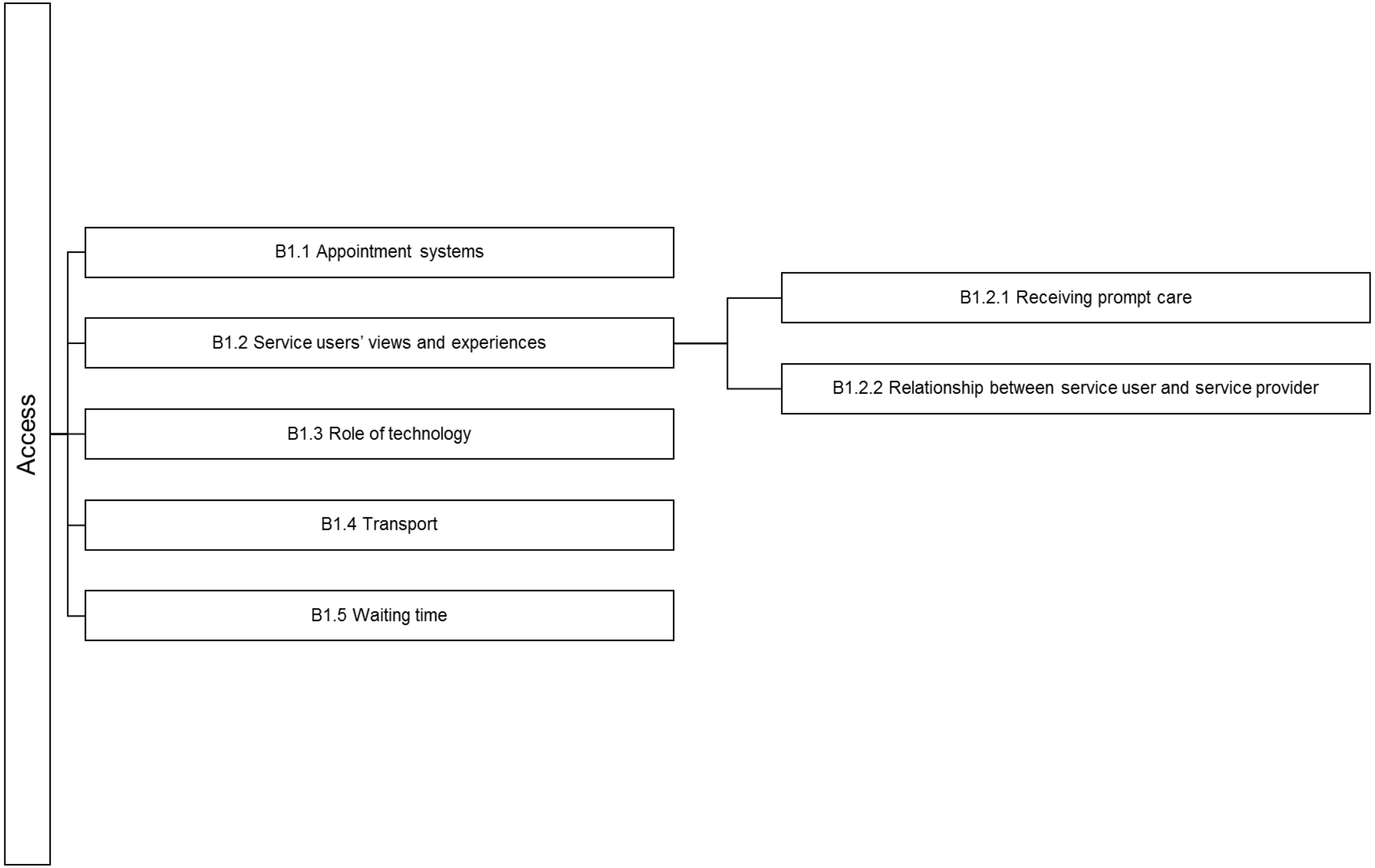


The evidence on things that work well reported that:

- Single appointments for consultation and treatment or an open access service would facilitate access to care (theme B1.1 [low quality]).
- Some people experiencing homelessness experience high quality care from staff, who went ‘above and beyond’. People spoke positively about those service providers with whom they had formed a strong and trusting bond. Often when they spoke about a positive experience with a service provider, this encouraged other people experiencing homelessness to access that service (theme B1.2 [high quality], subthemes B1.2.1 [high quality], B1.2.2 [high quality]).
- The introduction of texting services to remind individuals about their appointment at health services received positive feedback from service users (theme B1.3 [low quality]).
- Community resources such as, free bus passes or taxi vouchers help to lessen the impact of transport as a barrier to healthcare (theme B1.4 [moderate quality]).
- Waiting times affected people experiencing homelessnesss’ perceptions of treatment and care for better or worse and in turn made them more or less likely to access the care. Actions taken by service providers to expedite care were seen positively (theme B1.5 [high quality]).

The thematic map (Figure 2) illustrates these as overarching themes and subthemes.

Figure 2: Thematic map for Access- What works well?



Engagement with health and social care services:

- The evidence generated 7 themes and 12 sub-themes for things that need to be improved when engaging with health and social care services, and 2 themes and 1 subtheme for things that do work well.
- 53 studies provided evidence for the things that need to be improved and 14 studies provided evidence for things that do work well.
- The overall quality of the evidence was mixed, ranging from high to low, with most of the evidence being of a high quality.
- The main reasons for low quality evidence were minor or moderate concerns with methodological limitations and relevance of evidence from 2 studies.

The evidence on things that need to be improved reported that:

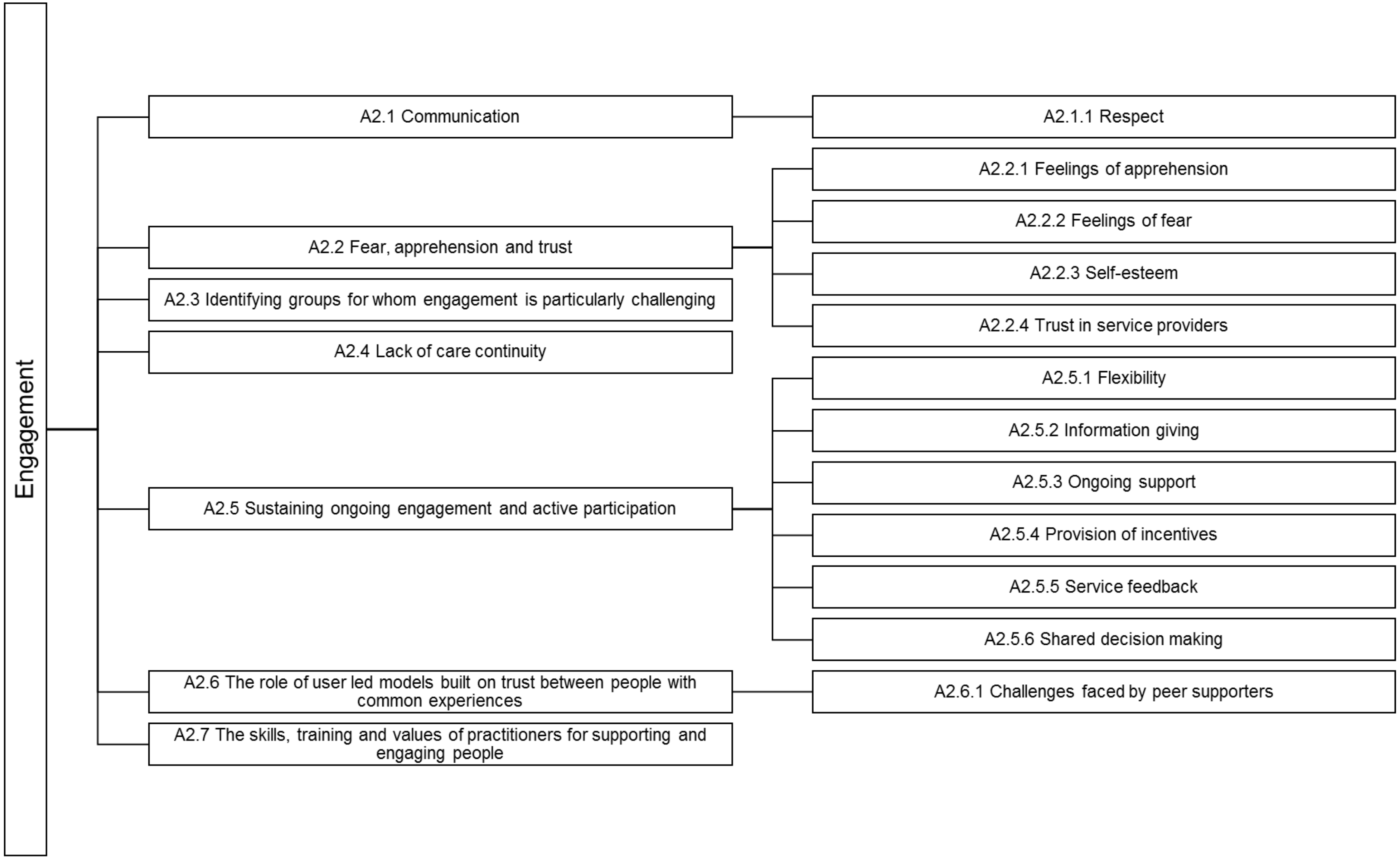
- Improved communication could help with health service engagement. Both services users and providers thought clear communication would significantly improve the care experience. Service users reported that using simple language and explanations, instead of jargon, would help engagement. For some, the service provider's communication style was important in creating a sense of comfort (theme A2.1 [high quality]).
- There is a need for respect within the carer-patient relationship and between different staff members either within an organisation or across institutions. Service providers referred to respect as an essential component contributing to the development of trust and improving the engagement with a homeless person. A trusting relationship enabled the patient to feel safe in the healthcare environment and was seen as key to promoting engagement (subtheme A2.1.1 [high quality]).
- People experiencing homelessness often experience feelings of apprehension, fear, and distrust during their care experience. Some people reported on feelings of fear of services providers and tests, fear of being perceived negatively, and fears held on to from previous negative experiences. Some people reported a lack of trust in service providers or in the healthcare system, mostly due to previous negative experiences (theme A2.2 [high quality], subthemes A2.2.1 [high quality], A2.2.2 [high quality], A2.2.4 [high quality]).
- Often people experiencing homelessness have low self-esteem or low feelings of self-worth, which affect the likelihood that they will seek help, sometimes feeling that they are not worth it, or that no one will listen to them (subtheme A2.2.3 [high quality]).
- There were some groups who were most likely to disengage from health and social care services. Examples include those with repeating patterns of substance use, migrants, refugees, asylum seekers, sex-workers, and those who require palliative care (theme A2.3 [high quality]).
- If continuity of care was interrupted, it could lead to disengagement (theme A2.4 [moderate quality]).
- It was important to adapt plans and provide flexibility in services to accommodate patient capacities as key to facilitating improved engagement (theme A2.5 [moderate quality], subtheme A2.5.1 [moderate quality]).
- Giving more information to people experiencing homelessness made them feel in control of their healthcare, allowing them to make choices about their care. Commonly, they felt they were not given their options or opportunities to shape their own care (subtheme A2.5.2 [moderate quality]).
- Those people who feel overwhelmed by support or resistant to accessing support might feel more motivated if the support was made available on an ongoing basis.

Attempts to engage them should be made repeatedly but without placing pressure on people (subtheme A2.5.3 [moderate quality]).

- Incentives are a strong motivator to engage with health and social care services. This included things like transport money cards, clothes and toiletries, and food (subtheme A2.5.4 [high quality]).
- A proactive approach is needed to involve people experiencing homelessness in shaping their own care. This is particularly so in terms of providing feedback on the care process. People experiencing homelessness felt that feedback processes were not always accessible. Further, people wanted to become more involved in decisions about their health or treatment, to improve shared decision making (subthemes A2.5.5 [moderate quality], A2.5.6 [high quality]).
- Although there is evidence on the positive effects of peer support, some peer supporters experienced numerous obstacles and challenges in fulfilling their role, including specific policies, their clients, maintaining their recovery, and certain professionals. Peer supporters reported that if there weren’t these obstacles to fulfilling their role they’d be more effective in encouraging engagement. Most people discussed how keeping boundaries is vital to be invested in the experience-based relationship, without being drawn back into drugs, alcohol, maladaptive behaviours, or losing compassion (theme A2.6 [moderate quality]).
- Increased training was needed to raise service provider awareness, improve their knowledge in this area, improve sensitivity and understanding for this population, and overcome preconceived ideas and judgemental behaviour towards people experiencing homelessness. Majority of the service providers reported that they were not equipped with sufficient knowledge of homelessness, knowledge on the effects of the social determinants of health, and the associated health needs for complicated health problems (theme A2.7 [moderate quality]).

The thematic map (Figure 3) illustrates these as overarching themes and subthemes.

Figure 3: Thematic map for Engagement- What could be improved?

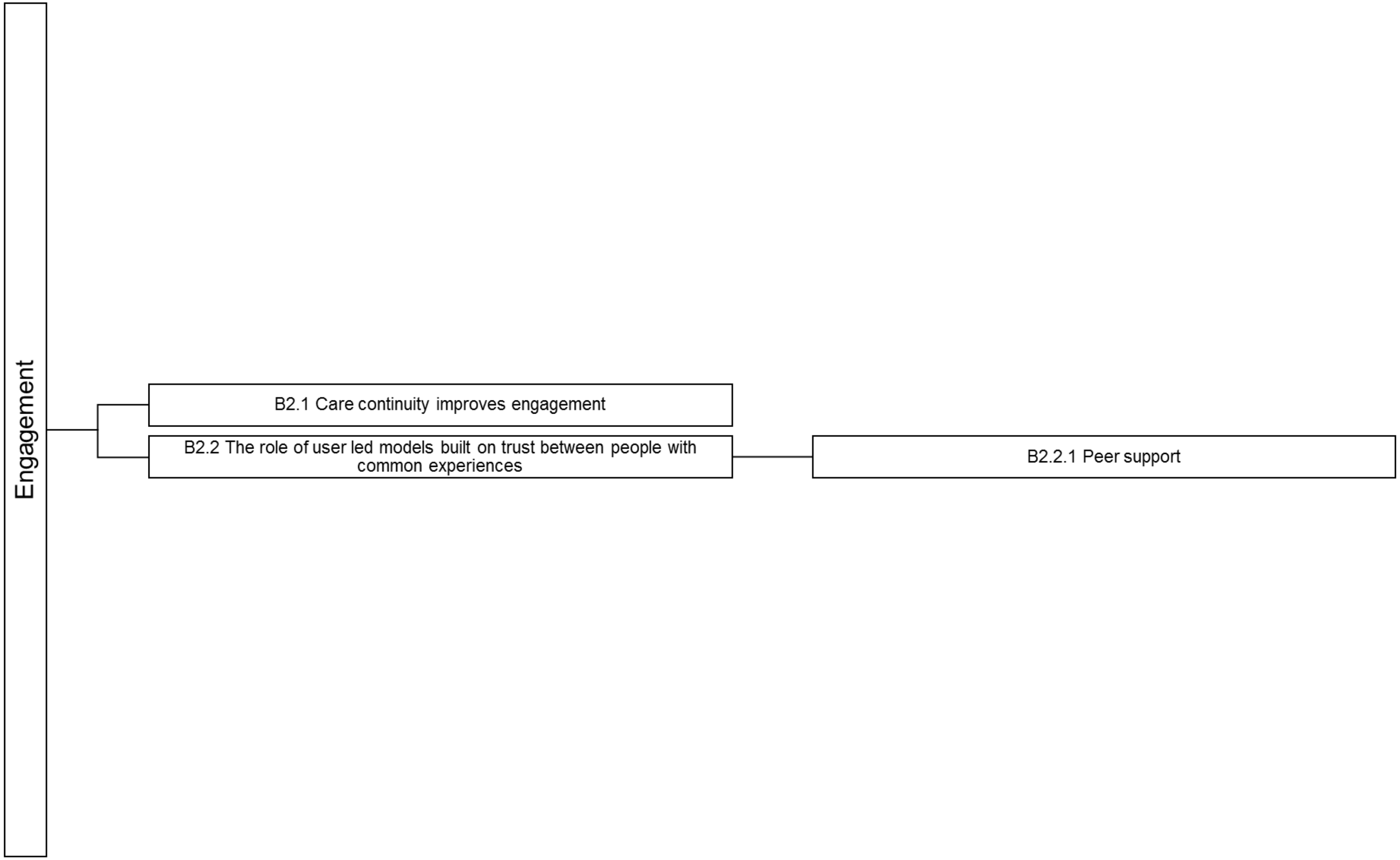


The evidence on things that work well reported that:

- Continuity of care had benefits and facilitated patient engagement (theme B2.1 [high quality]).
- People experiencing homelessness valued care and support from peer supporters. Peer supporters help by representing someone who has gone through a similar situation and grown from that experience. Peer supporters considered themselves to be role models, by breaking boundaries and providing individualised treatment and social support. Peer supporters can build a strong and unique relationship with clients, which becomes an important factor in helping people recover from homelessness (theme B2.2 [high quality], subtheme B2.2.1 [high quality]).

The thematic map (Figure 4) illustrates these as overarching themes and subthemes.

Figure 4: Thematic map for Engagement- What works well?



Delivery of health and social care services:

- The evidence generated 11 themes and 9 sub-themes for things that need to be improved when delivering health and social care services, and 3 themes and 2 subthemes for things that do work well.
- 70 studies provided evidence for the things that need to be improved and 34 studies provided evidence for things that do work well.
- The overall quality of the evidence was mixed, ranging from high to low, with most of the evidence being of a high quality.
- The main reasons for low quality evidence were minor or moderate concerns with methodological limitations and relevance of evidence from 2 studies.

The evidence on things that need to be improved reported that:

- Service users wanted to receive more compassionate care from healthcare providers and for providers to be more relatable. They also wanted providers to demonstrate an interest in their living situation and be more invested in them as people (theme A3.1 [moderate quality]).
- There were several descriptions of what was considered to be a negative experience, including seeing different doctors every time (for example, locum GPs), providing inconsistent information, poor communication or feeling unheard, and a lack of shared decision making. Service users reported negative experiences with dentists, GPs, hospice care, mental health services, and paramedics (subtheme A3.1.1 [moderate quality]).
- Some providers lack a deeper awareness of the impact that trauma has on a young person's life and how it may manifest in their behaviour. Providers who do not operate from a trauma-informed care approach may inadvertently serve as a barrier (subtheme A3.1.2 [moderate quality]).
- Health and social services have difficulty supporting the complicated requirements of some people experiencing homelessness. In the opinion of service providers, this can, in part, be due to their behaviour, which can be challenging and difficult to handle. Service providers described how mental health disorders can contribute to difficulties establishing and maintaining primary care relationships. Other challenges included supporting people with complex trauma and substance misuse in mainstream services, uncertainty around prognosis, and complexity associated with homelessness (theme A3.2 [high quality]).
- There was a lack of consistency and care continuity in service delivery. Many service users reported having multiple GPs, counsellors, and social workers. They said it was difficult to form a trusting relationship if they had to keep repeating their story and starting from the beginning with a new provider every time. Overall, service users wanted to have continuity of care to develop a trusting bond with the service provider. Service providers agreed and thought this improved compliance with treatment and medication (theme 3.3 [moderate quality]).
- Service providers suggested that people experiencing homelessness often have gaps in or no recorded medical history and this was attributed to their 'chaotic' lifestyles. Missing or incomplete documentation is often a major problem. Service users were mostly in favour of data sharing, as they thought this would mean they didn't have to explain themselves repeatedly (subtheme A3.3.1 [high quality]).
- Service providers needed to deliver a more holistic approach to health and social care for people experiencing homelessness. Service users wanted to be seen as a whole person and not just a set of discrete needs to be addressed separately (theme A3.4 [moderate quality]).

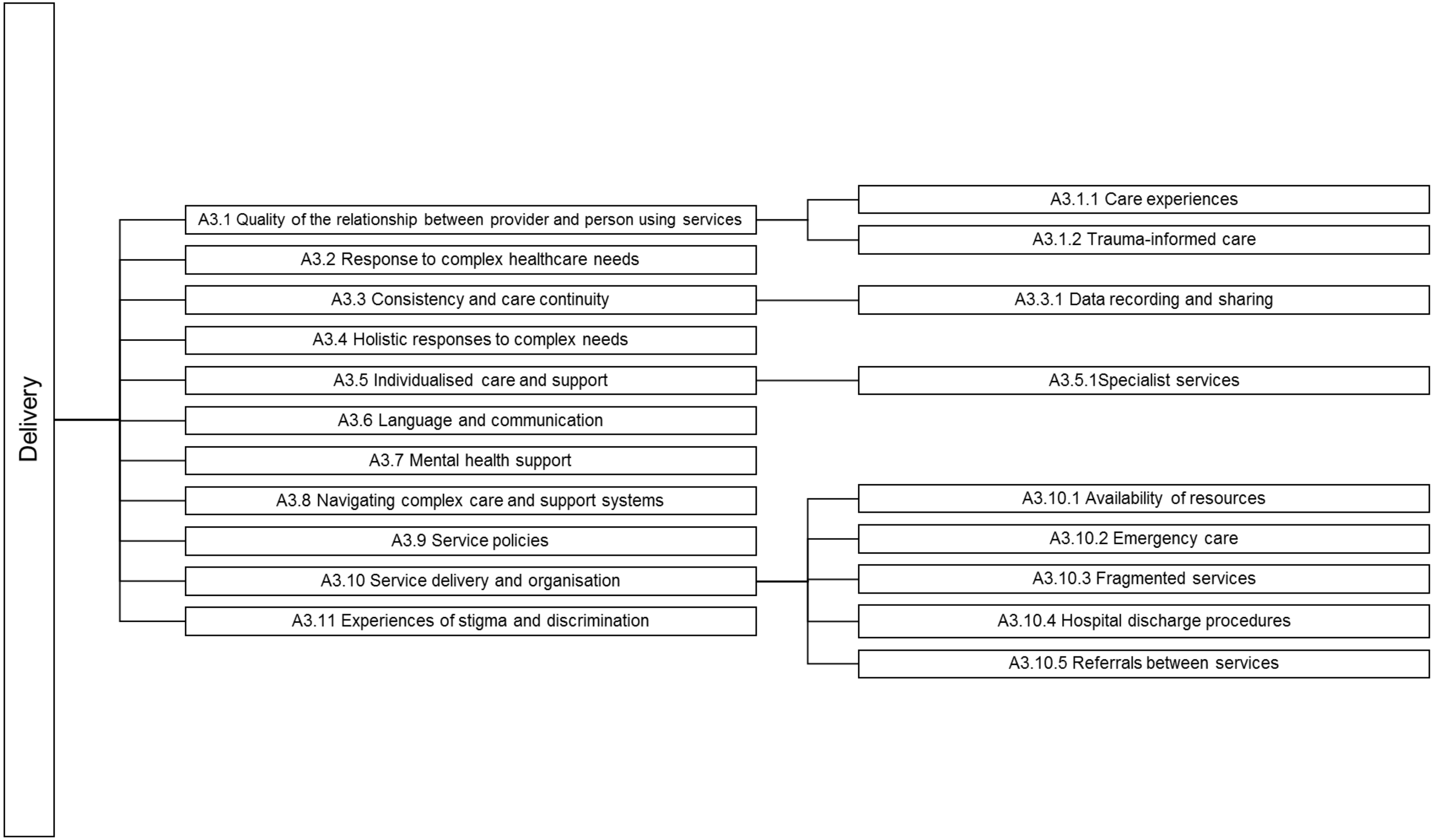
- People experiencing homelessness wanted more individualised care and support from service providers. Service users reported that service providers should listen actively, show interest in them, show humanity, and provide non-judgemental care (theme A3.5 [moderate quality]).
- People experiencing homelessness wanted more specialist services. They considered specialist services to have expert knowledge into the needs of people experiencing homelessness, which led to better care (subtheme A3.5.1 [moderate quality]).
- Effective communication between service providers and service users would improve the care experience. Service providers discussed that it was important to communicate clearly, avoid using technical jargon, and provide additional attention to people experiencing homelessness. Insensitive communication and closed body language were common experiences of service users (theme A3.6 [moderate quality]).
- There is a need for mental health support to be available to everyone experiencing homelessness, not just those with a diagnosed condition. Service users reported feeling that their mental health needs were unmet and that mental health services were insufficient, hard to access, and uncoordinated with other services (theme A3.7 [moderate quality]).
- Service providers recognised the current service system was complex, segregated, and difficult to navigate. This presented as substantial service delivery barrier for those who are unable or unaware of how to advocate for themselves to receive the care they require (theme A3.8 [high quality]).
- National and local policies could sometimes overlook the needs of people experiencing homelessness and by doing so, exclude them from certain services. Services users experienced rules and hidden agendas that prevented them from accessing care or using shelters (theme A3.9 [high quality]).
- Healthcare systems were not designed for people experiencing homelessness. Service providers reported that it was not tailored to meet the needs of people experiencing homelessness. The system was described as “designed by middle class people for middle class people”. People experiencing homelessness were expected to conform to the system rather than receive tailored care according to their differing needs, desires and challenges (theme A3.10 [high quality]).
- There were constraints on resource availability, such as higher than expected caseloads, lack of staff and time, lack of funding, and limited resources. Service users reported that there is too little staff time available and a high turn-over, especially amongst nurses (subtheme A3.10.1 [high quality]).
- People experiencing homelessness preferred emergency care to primary because it was a way to have multiple needs addressed immediately, in a single and streamlined visit. Emergency care was considered an open access service where care could be provided for physical health issues as well as other needs, including shelter and respite. Most people reported using emergency care due to problems accessing primary care, such as long GP waiting times and difficulties travelling to GP practices (subtheme A3.10.2 [high quality]).
- Health systems were complex and fragmented. Staff from all types of agencies recognised that most care is provided in “silos”, with minimal coordination between agencies and providers. A more coordinated approach was needed to support them (subtheme A3.10.3 [high quality]).
- There are several issues with discharge procedures for people experiencing homelessness. Most studies reported that discharge from hospital was abrupt with little explanation and no follow-up or signposting to other services. Many service

users reported that they were discharged without receiving adequate care (subtheme A3.10.4 [high quality]).

- There are long delays between referrals and the start of support or treatment, particularly in relation to secondary mental health services. Service providers were aware that providing a referral to a specialist service sometimes did not result in the homeless person attending that appointment due to the logistics involved with planning to attend an appointment in the future. There appeared to be little tracking of referrals to another service (subtheme A3.10.5 [high quality]).
- People experiencing homelessness experience stigma and discrimination in health and social care. People experiencing homelessness identified stigma and discrimination during visits to healthcare stemming from several factors including complex needs, ethnicity, gender, socioeconomic status (including homelessness), (perceived) substance use, and appearance. Most people experiencing homelessness reported experiencing discrimination on some level, with a majority recounting some form of prejudiced behaviour from service providers (theme A3.11 [moderate quality]).

The thematic map (Figure 5) illustrates these as overarching themes and subthemes.

Figure 5: Thematic map for Delivery- What could be improved?

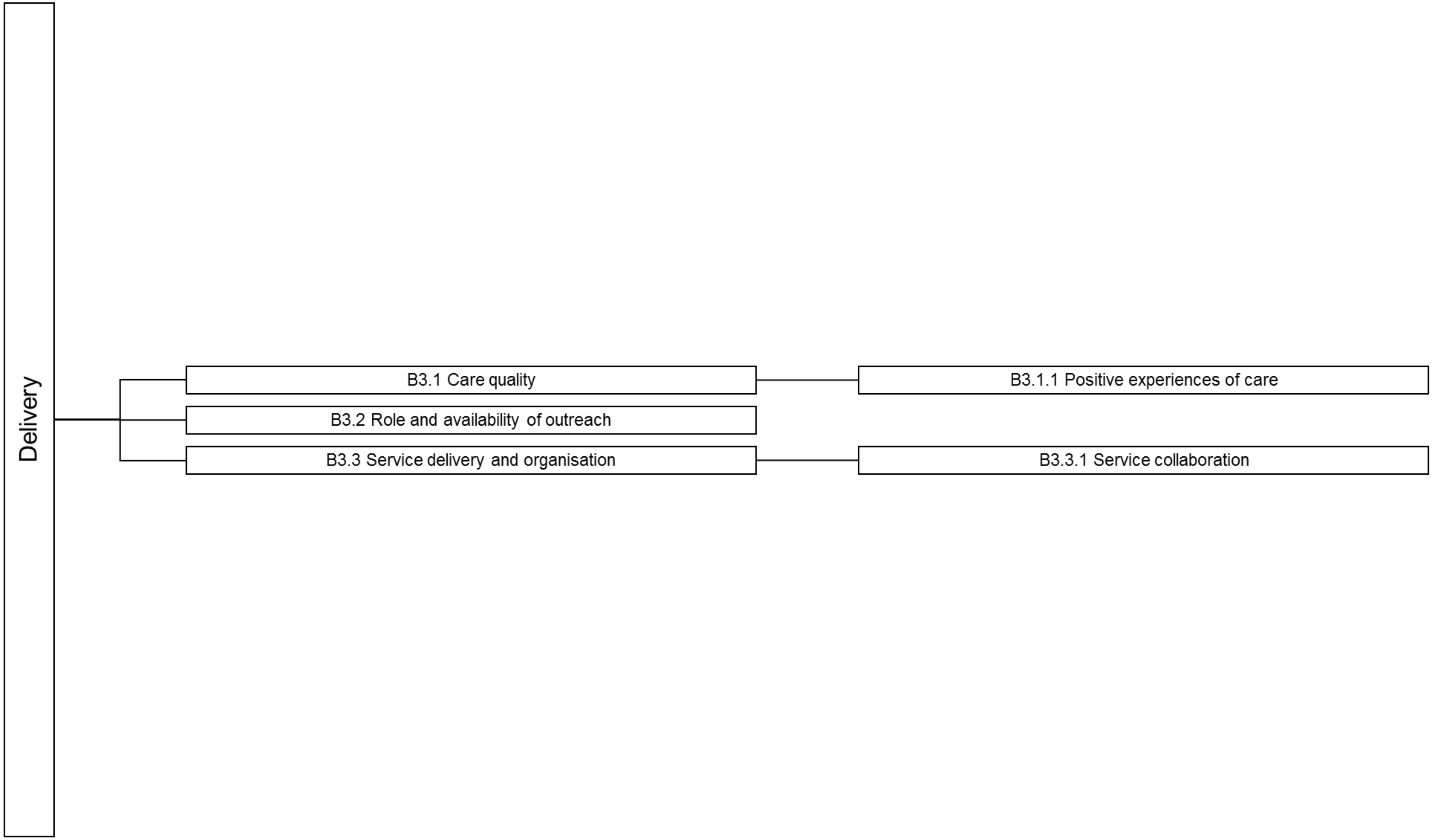


The evidence on things that work well reported that:

- People experiencing homelessness valued trusting relationships where they could express vulnerability. Positive interactions included being treated with dignity, remembering, acknowledging, listening, talking, giving advice, being available, creating a safe and/or welcoming environment, showing concern, joking, giving tangible aid, and reaching out (theme B3.1 [moderate quality], subtheme B3.1.1 [moderate quality]).
- There are many positive effects of outreach services, including increased access to care, increased knowledge around health issues, information on the available services (signposting), and healthcare entitlements. Outreach services bring a level of flexibility that is not possible in traditional healthcare services. The act of coming to the service users also helps to build trust and a strong connection with the service provider and reduces the sense of isolation. Several people reported having a more positive experience with outreach GPs than with GPs in a practice. Outreach services could help prevent people falling through the safety net of health and social care and were considered more beneficial for those who have a history of marginalisation (theme B3.2 [moderate quality]).
- There can be positive effects of service collaboration although there were clear variations in the success of joint working. Service collaboration: delineates roles so each provider knows what their input is, avoids doubling up on information or resources, increases efficiency, increases awareness of what other services provide, increases awareness of patient issues, and provides a consistent response to patients (theme B3.3 [high quality], subtjeme B3.3.1 [high quality]).

The thematic map (**Error! Reference source not found.**) illustrates these as overarching themes and subthemes.

Figure 6: Thematic map for Delivery- What works well?



See appendix F for full GRADE-CERQual tables.

Economic evidence

Included studies

A systematic review of the economic literature was conducted but no economic studies were identified which were applicable to this review question. A single economic search was undertaken for all topics included in the scope of this guideline. See Supplement 2 for details.

Excluded studies

Economic studies not included across all reviews are listed, and reasons for their exclusion are provided in Supplement 2.

Summary of included economic evidence

No studies were identified which were applicable to this review question.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

Evidence statements

Economic

No studies were identified which were applicable to this review question.

The committee's discussion and interpretation of the evidence

The outcomes that matter most

To answer the question of 'what works' and 'what could be improved' the review was designed to include qualitative data and as a result the committee could not specify in advance the data that would be found. Instead, they identified the following main themes to guide the review, although the list was not exhaustive and the committee were aware that additional themes could be identified:

Access

- Availability (range of local services, their location, opening hours, appointment systems and eligibility criteria)
- Affordability (cost of services)
- Acceptability (service provider experiences and service user experiences)
- Knowledge and awareness of services
- Prioritisation
- Registration for services
- Role of technology

- Transport
- Inequality
- Environmental factors
- Language and communication issues
- Discrimination

Engagement

- The skills, training and values of practitioners for supporting and engaging people, including working with people from all communities and sub groups of this population
- Issues around fear, apprehension and trust
- Communication
- The role of user led models built on trust between people with common experiences.
- Sustaining ongoing engagement and active participation.
- Identifying groups for whom engagement is particularly challenging

Delivery

- Care quality
- Holistic responses to complex needs
- Cultural sensitivity and cultural appropriateness
- Individualised care and support
- Stigma and discrimination
- Role and availability of outreach
- Consistency and care continuity
- Navigating complex care and support systems
- Language and communication

The quality of the evidence

The evidence was assessed using GRADE-CERQual methodology and the overall confidence in the findings for the qualitative review ranged from low to high, with most of the evidence being of moderate quality.

The review findings were downgraded because of methodological limitations of the included studies, including, for example not enough consideration of potential author bias. Some findings were also downgraded for adequacy because together, the relevant studies did not offer rich data. Finally, some findings were downgraded for relevance because in some cases the population included people other than those experiencing homelessness (for example, people experiencing mental illness) or included people who were not directly responsible for providing care to people experiencing homelessness (for example, law enforcement).

Data were not identified for the themes: direct costs, indirect costs, public funding and charitable donations; the emotional impact of poor or limited access to health and social care; and understanding which populations are ‘missing’ from certain services.

Some data were identified that created additional themes other than those initially anticipated by the committee: mental health support; service providers’ views and experiences; service users’ views and experiences; crisis response; counselling around screening; relationship between service user and service provider; responses to complex healthcare needs; service policies; and service delivery and organisation.

Benefits and harms

The committee discussed that the evidence identified from this review was rich and covered many topics and issues surrounding health and social care for people experiencing homelessness. The committee noted that a large body of evidence came from the UK, the results of which resonated with their own knowledge and experience of the topic area. The committee discussed that the findings demonstrated and highlighted aspects of health and social care that work well and those that need improvement from the service user's and service provider's perspective, which complemented evidence identified from the effectiveness reviews (Review A and Review B). The following sections capture the committee's discussions and conclusions based on the evidence and their expertise, which are presented according to the guideline structure.

How services should be delivered

General principles

Evidence from 4 themes (A1.3 [availability of services], A1.12 [mental health support], A1.18 [service users' views and experiences], A1.19 [stigmatising attitudes]) reported the need for high quality health and social care for people experiencing homelessness.

Moderate quality evidence from 1 theme (A1.18 [service users' views and experiences]) based on 12 studies showed that some people felt as though being homeless resulted in treatment that was 'lesser' than the general population and high quality qualitative data from 1 theme (A1.19 [stigmatising attitudes]) based on 10 studies showed that service providers concur with this. There was moderate quality evidence from 1 theme (A1.3 [availability of services]) based on 10 studies reporting on the lack of services available to people experiencing homelessness, especially for mental health (low quality evidence from 1 theme (A1.12 [mental health support]) based on 2 studies). The committee noted the absence of services for people experiencing homelessness is an issue in current practice, and agreed this was a tremendous access barrier. The committee discussed that this contributed to poorer health outcomes and furthered inequalities between people experiencing homelessness and the general population. The committee noted the NHS constitution's first key principle of providing comprehensive service available to all, more specifically "it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population". The committee therefore agreed that on the basis of the evidence and supported by their own experiential knowledge, the accessibility and availability of services for people experiencing homelessness required significant improvements. They agreed it was important to provide the same standard and quality of care to people experiencing homelessness as for the general population but more effort might be needed to achieve this for this population so made a recommendation in line with this.

Evidence from 1 theme (B2.2 [the role of user led models built on trust between people with common experiences]) and 1 subtheme (A2.5.5 [service feedback]) reported on the value of involving people with lived experiences of homelessness in co-designing and co-delivering health and social care. High quality evidence from 1 theme (B2.2 [the role of user led models built on trust between people with common experiences]) based on 9 studies reported that those with experience of homelessness were the best source of information, and provided the most effective support. Moderate quality evidence from 1 theme (A2.5.5 [service feedback]) based on 1 study reported people experiencing homelessness wanted to be involved in shaping their own care, by providing feedback about their previous care experiences. The committee discussed that service user feedback and input from experts by experience provides a critical and unique perspective required to reshape the delivery of health and social care. The committee discussed that experts by experience can involve their networks to support improvement for services, and in particular those that are specific to the local area and local context. As well as giving people a sense of control over their own care and support, it was valuable for them to feel listened to and to have their views respected and used to make positive changes to services. The committee agreed about the benefits of involving people in this way and therefore recommended it as a general principle. The committee also signposted to the section on involving people in service design and improvement in NICE's guideline on people's experience in adult social care services as well as NICE's guideline on community engagement which gives guidance to local authorities and health bodies on approaches to community engagement in order to improve health and wellbeing and to reduce health inequalities.

Evidence from 4 themes (A1.6 [discrimination], A1.19 [stigmatising attitudes], A2.1 [communication], A3.6 [language and communication]) and 3 subthemes (A2.2.2 [feelings of fear], A2.2.4 [trust in service providers], A3.1.2 [trauma-informed care]) showed that people experiencing homelessness face discrimination and often experience feelings of apprehension and fear when accessing healthcare services.

Moderate quality evidence from 1 theme (A1.6 [discrimination]) based on 13 studies, and high quality evidence from 1 theme (A1.19 [stigmatising attitudes]) and 2 subthemes (A2.2.2 [feelings of fear] and A2.2.4 [trust in service providers]) based on 33 studies reported that people experiencing homelessness feel reluctant to return to services after facing discrimination because they fear repeating previous negative experiences of services. The committee discussed that this is a considerable service engagement barrier and service providers should be aware of it and attempt to mitigate the effects. High quality qualitative data from 1 theme (A2.1 [communication]) based on 4 studies, and moderate quality data from 1 theme (A3.6 [language and communication]) based on 7 studies made clear that non-judgmental, empathetic communication could help with health service engagement. The committee discussed that communication should be responsive to people's individual experiences, for example gender, culture, ethnicity, and being part of the LGBT+ community, and also should consider the social determinants of health. The committee also recognised the importance of service providers addressing the underlying inequalities that people may face, which are underpinned by social determinants of health that shape people's experiences and health and social care needs. The committee discussed that a friendly and social approach to healthcare is particularly important for people experiencing homelessness, who are likely to have additional needs around their mental and emotional wellbeing.

Moderate quality data from 1 subtheme (A3.1.2 [trauma-informed care]) based on 1 study reported that providers should operate from a trauma-informed care approach. Trauma-informed care is an approach which improves awareness of trauma and its impact, to ensure that services offer effective support and do not re-traumatise those accessing or working in services. The committee discussed that mental health, addiction, and interpersonal issues are often associated with or are a result of previous trauma including psychological, emotional, physical, neglect or sexual abuse in child and/or adulthood. The experience of neglect, abuse or other traumatic life events can affect an individual's emotional wellbeing and their ability to form healthy, trusting relationships. The committee discussed how history of traumatic experiences are prevalent in people experiencing homelessness, this might be particularly prevalent in young people, especially young people who have been in care, women, refugees and asylum seekers. Furthermore, the experience of homelessness can in itself be traumatic due to feeling rejected or unsafe and feeling helpless or hopeless leading to an erosion of trust in support services and/or by exacerbating existing difficulties. This can lead to the individual developing coping strategies aimed at relieving psychological pain such as substance misuse, which can lead to addiction.

Based on the evidence and their expertise, the committee agreed it was important to be aware of the impact previous traumas and negative experiences with services and socio-economic circumstances can have on behaviour and engagement with services and promote engagement through approaches that are friendly, non-judgmental, culturally sensitive and use trauma-informed care or psychologically informed environments in service provision and practice which takes into account individuals' psychological and emotional needs, and their experiences of trauma.

Moderate quality evidence from 1 theme (A1.3 [availability of services]) and 1 subtheme (A3.5.1 [specialist services]) based on 13 studies reported there is a paucity of specialist services for people experiencing homelessness, who reported wanting more specialist care. They considered specialist services to have expert knowledge about their needs, leading to better care. The committee agreed about the benefits of specialist services, in particular the expertise of practitioners in these services playing a key role in developing and sustaining relationships with people experiencing homelessness.

There was also low quality evidence from 1 theme (A1.2.3 [the length of clinical appointments]) based on 4 studies suggested that short appointments were a barrier to service access, as people experiencing homelessness reported feeling rushed with insufficient time to discuss their needs. From their own knowledge and experience, the committee were aware that short appointment times are a key limitation in current practice. The committee discussed that a 10-minute appointment slot is inadequate to comprehensively address needs and to provide holistic care, and instead individual needs are often addressed in silos without consideration for how they are interlinked. The committee discussed that this is particularly the case for those with severe and multiple disadvantage. The committee discussed that longer contact times for people experiencing homelessness may help in the development of a trusting relationship and enables support to be provided across the multitude of needs.

Furthermore, moderate quality evidence from 2 themes (A3.1 [quality of the relationship between provider and person using services], A3.3 [consistency and care continuity]) and 1 subtheme (B3.1.1 [positive experiences of care]) based on 37 studies reported that people experiencing homelessness valued continuity of care and wanted more compassionate care from healthcare providers, as this contributed to developing trusting relationships where they could express vulnerability. High quality evidence from 2 subthemes (B1.2.2 [relationship between service user and service provider], A2.1.1 [respect]) based on 6 studies emphasised respect as an essential component in sustaining trusting relationships. People experiencing homelessness spoke positively about those service providers with whom they had formed a strong and trusting bond, which often encouraged other people experiencing homelessness to access that service. The committee were aware from their knowledge and experience that this population required more effort and time to build trusting relationships due to previous trauma and greater severe multiple disadvantage than the general population.

On the basis of the evidence as well as their own expertise they agreed about the importance of professional expertise and longer contact time as general principles underpinning considerations for service design and practice for this population.

High quality evidence from 3 subthemes (A1.14.1 [attitudes toward help seeking], A1.14.2 [competing priorities], A2.2.3 [self-esteem]) based on 31 studies reported that some people experiencing homeless did not prioritise their health needs due to feelings of very low self-esteem, which can reduce the likelihood of seeking help, and also due to other competing priorities, such as food and shelter. The committee discussed that the circumstances surrounding people experiencing homelessness are often unconducive to accessing health and social care, so they recommended supporting people to achieve control over their lives through improving self-reliance. The committee also discussed moderate quality evidence from 1 subtheme (A3.1.1 [care experiences]) based on 22 studies and high quality evidence from 1 subtheme (A2.5.6 [shared decision making]) based on 2 studies which showed that people experiencing homelessness wanted a more egalitarian partnership with providers, which incorporates shared decision-making. The committee agreed that a lack of shared decision-making and negative experiences can lead to mistrust. They therefore captured the issues of building self-reliance and promoting shared decision making because it would have the benefit of involving people in and taking control over their own health and social care, supporting their empowerment and improving engagement.

There was also some high quality evidence from 1 subtheme (A1.18.3 [relationship between service user and service provider]) based on 8 studies that showed a strength-based approach with service providers encourages the use of services. The committee discussed that focusing on one’s strengths can empower an individual and, in this case, improve service engagement. The committee used this evidence to support the effectiveness evidence from evidence reviews A and B to make a recommendation on recognising the importance of strength-based approaches as a principle of service provision and practice.

Moderate quality qualitative data from 1 theme (A2.5.3 [ongoing support]) based on 4 studies showed that people experiencing homelessness prefer service providers who are patient and consistent in offering treatment and support over a long period of time. The committee discussed that the need for care and support exists on a spectrum, where on one end accessing a service once every 6 months is sufficient to meet the needs of a person experiencing homelessness, and on the other end, much more intensive support is required. From their knowledge and experience, the committee agreed that in many cases intense long-term support is often needed for this population. This is especially the case for those with experience of rough sleeping, as this is often the extreme end of homelessness and people sleeping rough often have severe multiple disadvantage and various underlying issues, which led them to this situation. The committee therefore agreed to emphasise the importance of providing a long-term commitment to people’s recovery with the ultimate benefit of long-lasting positive outcomes as a basis for service design and practice.

High quality evidence from 3 subthemes (A1.14.1 [attitudes toward help seeking], A1.14.2 [competing priorities], A2.2.3 [self-esteem]) based on 31 studies reported that some people experiencing homelessness did not prioritise their health needs due to feelings of very low self-esteem, which can reduce the likelihood of seeking help, and also due to other competing priorities, such as food and shelter. Some people experiencing homelessness reported that health professionals would blame them for their poor health. From their knowledge and experience, the committee agreed that this was commonplace and reflects that understandably for most people, the priority is to fulfil the very basic needs of having shelter and something to eat. Deprioritising health needs often led to people experiencing homelessness not engaging with services or not attending their appointments. High quality data from 1 subtheme (A2.2.3 [self-esteem]) based on 11 studies showed that people experiencing homelessness often have very low self-esteem or feelings of low self-worth, which affect the likelihood that they will seek help, sometimes feeling that they are not worth it, or that no one will listen to them. The committee discussed that some people may refuse services or disengage because of various factors, including previous experiences and trauma. The committee agreed that practitioners should recognise that people may find it difficult to look after their health and personal care and to engage with services because of their circumstances and actively try to get people to re-engage, and if appropriate re-engage at the same point as they left the service. Having to start from the beginning of the pathway might be frustrating and ineffective, whereas being able to jump back in to the point of the pathway in which they left might make re-engagement more successful. However, the committee discussed that this might not always be appropriate or possible, for example, for drug and alcohol treatment services, where an individual may need to start from the beginning of the treatment plan.

Communication and information

High quality evidence from 1 theme (A1.19 [stigmatising attitudes]) based on 10 studies and moderate quality evidence from 1 theme (A3.11 [experiences of stigma and discrimination]) based on 36 studies reported that people experiencing homelessness experience stigma and discrimination in health and social care, where some people reported feeling oppressed and unwelcome when trying to access services. The committee discussed that whilst experiencing stigma and discrimination may be common among all people experiencing homelessness due to their homelessness, there might be additional stigma and discrimination for some people due to their racial or ethnic background, migrant status or them being LGBTQ+. High quality evidence from 1 theme (A2.1 [communication]) based on 4 studies and moderate quality evidence from 1 theme (A3.6 [language and communication]) based on 7 studies reported that insensitive communication and closed body language on the part of professionals were common experiences for people experiencing homelessness, sometimes a result of stigma and discrimination. The evidence indicated that clear communication would bring` a significant benefit to the care experience of people experiencing homelessness. For example, the evidence reported that service users preferred simple language and explanations, instead of jargon, as it created a sense of comfort.

Moderate quality evidence from 1 theme (A1.2.1 [communication]) based on 1 study reported variation in the preferences of communication methods amongst people experiencing homelessness. The evidence reported that receiving appointment information by letters was ineffective due to the transient living situation of this population. High quality evidence from 1 theme (A1.16.1 [lack of internet and phone access]) based on 4 studies showed that people without access to the internet and those without a phone were at a disadvantage, since they can't easily communicate via emails and text messages. High quality evidence from 1 theme (A1.9 [literacy]) based on 4 studies reported that low levels of literacy contributed to difficulties in accessing information and participating in effective communication.

The committee agreed that in order to provide the best possible experience of care, service providers would benefit from guidance in the recommendations on communication and information in NICE's guidelines on patient experience in adult NHS services: improving the experience of care for people using adult NHS services, people's experience using adult social care services and they therefore signposted to those guidelines, service user experience in adult mental health, and babies, children and young people's experience of healthcare. The last one covers young people up to 17 years of age, whilst this guideline covers people 16 years or older. These guidelines cover various aspects of communication and information provision that are relevant for all health and social care services. However, the committee agreed that there are issues that are particularly important to consider when working with people experiencing homelessness and made recommendations specifically about these.

The committee discussed the importance of non-judgemental, empathetic, and recovery-based language (language that conveys a sense of hope and potential), as words may effect a person's sense of self and lead to more disadvantage and social exclusion. The committee agreed that appropriate language is a vital component when communicating, as it can empower a person and increase their sense of self-determination. The committee discussed being mindful of the non-verbal aspects of communication, such as, appropriate eye contact and using body posture that is neither non-threatening nor disinterested. Therefore, the committee captured this in a recommendation.

The committee discussed that sending information through letters is still the main method of communication, highlighting this as a problem for some people experiencing homelessness. Moderate quality evidence from 1 subtheme (A1.2.1 [communication]) based on 1 study reported that some people never received their letter (as they had moved location), and the committee were aware from their knowledge and experience that some people were unable to understand the information in the letter. The committee discussed using electronic communication to send information (for example, emails and text messages) but from the evidence and from their knowledge and experience, the committee agreed that not everyone has access to a phone or the internet (digital exclusion). The committee discussed the benefits and harms of both methods of communication and ultimately recommended that communication should happen through a range of different formats, subject to the person's circumstances. The committee agreed that it was important to consider the person's access to phone, electronic devices or their access to internet, which can be varied. The committee recognised that although it might take more time and care to identify the person's preferred means of communication (for example, letters, text messages, or face to face), this would be outweighed by the benefit of ensuring information such as appointment times reaches the person and enables them to access that care.

The committee discussed that information resources are often written in a complex manner and mostly written in English, making them inaccessible to some people. The committee agreed that this further alienated populations whose first language is not English, and therefore recommended that translation services should be provided where required and that written information should be made available in different formats and languages (including Easy Read). The committee were aware from their own knowledge and experience that migrants who may have limited English language skills or understanding of the local health and care system, people with learning disabilities, people with acquired brain injury, and those with autism are over-represented in homeless populations than in the general population, so clear communication and information resources are particularly important. Therefore, the committee captured the need to tailor communication and information provision to the person's needs and preferences, with consideration for people with wide range of speech, language and communication difficulties, in a recommendation.

High quality evidence from 1 theme (A1.9 [literacy]) based on 4 studies showed that low levels of literacy contributed to difficulties in accessing care. People experiencing homelessness said that additional support (for example, an advocate or a peer advocate or a peer supporter) helped them to gain confidence (1 theme B2.2 [the role of user led models built on trust between people with common experiences] from 9 studies, high quality). The committee agreed that it is beneficial having people to support those with greater literacy requirements. Moderate quality qualitative data from 1 theme (A1.1 [access to help and information]) based on 9 studies showed that there was a lack of help or information available for people experiencing homelessness. This echoed the committees' own experience and they agreed it would therefore be beneficial to recommend that advocates should be considered as a means of supporting communication and helping to navigate services. The person acting as an advocate could be nominated by the person or appointed.

However, the committee were aware that in some circumstances, arranging independent advocates is mandated in the law. For example, Care Act 2014 mandates that local authorities must arrange an independent advocate to support and represent a person to assist in their involvement in specified social care processes if the person has substantial difficulty in being involved in the process, and if they do not have an appropriate person to support them. However, the committee agreed that even when this is not mandated, an advocate could be helpful. The committee were also aware that NICE is developing a guideline on advocacy services for adults with health and social care needs (publication expected September 2022).

Moderate quality qualitative data from 2 subthemes (A1.10.1 [single point of contact for a range of services], A1.10.2 [availability of allied health services]) based on 5 studies showed that people experiencing homelessness wanted more support for a full range of healthcare needs, as they have an unmet need when accessing allied health services. Moderate quality qualitative data from 1 theme (A1.1 [access to help and information]) based on 9 studies showed people experiencing homelessness wanted information on topics such as pregnancy education, cancer and screening, entitlement to care, oral health and prevalent illnesses such as the hepatitis C virus. The committee were aware, from their knowledge and experience that some people experiencing homelessness, and especially those from other countries, were not aware of what services are available to them and what their entitlements to health and social care are. The committee agreed that the information about their rights to access services (including for those with no or limited recourse to public funds); information and support on accessing and registering for primary care services (such as GP and dental health); specialist health services that people can directly access without a referral (for example alcohol and drug recovery, and mental health services, sexual health and maternity services); local outreach services; services provided by local authorities (including housing services and social care); and by voluntary and charity sector should be given. The committee discussed that information about these services should be provided to increase service user knowledge of the presence of services and how to access them. Therefore, if people have a need, they are aware how to seek help for it. The committee agreed that this could improve access to and engagement with services for people experiencing homelessness. The committee acknowledged some difficulties connected with this recommendation, for example practitioners needing knowledge of these services and having information materials to hand out, but felt that on balance the benefits of providing this information and therefore enabling access outweighed the challenges.

Planning and commissioning

The 2018 Rough sleeping strategy by the Ministry of Housing, Communities and Local Government sets out the strategy to end rough sleeping in the UK, which highlights the need for different agencies to work together to end rough sleeping and prevent homelessness. Based on their experience, the committee discussed that integrated working across agencies and disciplines is essential to bring all the knowledge and services together to ensure coordinated and holistic support for people experiencing homelessness. Cooperation and integrated working between relevant agencies and partners are also mandated in legal frameworks, such as section 6 in the Care Act 2014 “A local authority must co-operate with each of its relevant partners, and each relevant partner must co-operate with the authority, in the exercise of— (a) their respective functions relating to adults with needs for care and support …” and section 14Z1 in the National Health Service Act 2006 “Each clinical commissioning group must exercise its functions with a view to securing that the provision of health services is integrated with the provision of health-related services or social care services …”.

There was high quality evidence from 1 theme (B3.3.1 [service collaboration]) based on 11 studies that reported on the benefits of service collaboration, such as improving communication, reducing duplication of effort, and improving working relationships. There was high quality evidence from 1 theme (A3.8 [navigating complicated care and support systems]) and 1 subtheme (A3.10.3 [fragmented services]) based on 20 studies reporting that both service users and providers considered the health system to be complex and fragmented. Health systems were described as complex and fragmented, where provision of care is mostly in “silos” with minimal coordination between agencies and providers. The committee discussed that commissioners from other sectors where there is a known relationship with homelessness, such as criminal justice and domestic abuse, should be involved in the coordinated care of people experiencing homelessness as needed. The committee discussed that joint planning and commissioning and a more coordinated approach could increase efficiency of care provision and awareness of what other services provide, reduce duplication and delay in care, and close gaps in service delivery.

Moderate quality data from 1 theme (A3.5 [individualised care and support]) based on 10 studies reported that healthcare systems were not tailored to meet the needs of people experiencing homelessness. The committee discussed that people experiencing homelessness are disproportionately disadvantaged when compared to the general population. The committee discussed that there is an ethical argument that more resources should be allocated to this population because they have greater needs and are marginalised and disadvantaged. Therefore, they need greater efforts and resources as discussed in the concept of ‘proportionate universalism’ (resourcing and delivering universal services at a scale and intensity proportionate to the degree of need), first introduced in the 2010 Fair Society Healthy Lives (The Marmot Review), as an approach to address health inequalities. High quality evidence from 1 theme (A3.10 [service delivery and organisation]) based on 7 studies reported that service users wanted flexible and tailored services that incorporated user feedback. The committee discussed that the unmet health and social care needs of people experiencing homelessness were often more complex and the outcomes were often much more dire, including a significantly increased risk of premature mortality when compared to the general population. The committee were aware that many of the causes of death in this population are preventable. The committee therefore agreed that in order to address the stark inequalities in service engagement, needs and outcomes, a more targeted approach to service delivery is required for people experiencing homelessness.

The committee discussed that in order to improve health and social care services for people experiencing homelessness, it is important to have accurate records and documentation of people’s housing status and their use of services. There was high quality evidence from 1 subtheme (A3.3.1 [data recording and sharing]) based on 4 studies reporting that people experiencing homelessness often have gaps in or no recorded medical history, where missing or incomplete documentation is often a major problem. The committee agreed that data recording should be improved as this would benefit the person receiving care (for example, for improved continuity of care), and the service providing care (for example, by providing safer and more effective care). The committee were aware from their own knowledge and experience that attendance to emergency services is coded under a single code (related to housing), but it could be improved to better understand how people experiencing homelessness use this service. The committee discussed that reasons for service utilisation (for example, emergency services or mental health services) is not recorded accurately for people experiencing homelessness, when compared to how the general population use services. The committee recognised and discussed the risk of stigmatisation if people are ‘labelled’ as homeless, however on balance they thought it was an important issue as it can enable better data to drive resource allocation underpinned by consideration about how the data can be collected and used to identify and reduce health inequalities and service planning for the individual and as a whole.

Discussion around models of service design based on a local homelessness health and care needs assessment is discussed in evidence review A and B.

High quality evidence from 3 themes (A1.5.1 [out of pocket expenses], A1.13 [opening hours], A1.20 [transport]) based on 21 studies, moderate quality evidence from 1 theme (A1.5 [cost of services]) based on 12 studies, and moderate quality evidence from 1 theme (A1.2 [appointment systems]) based on 7 studies reported on barriers people experiencing homelessness experienced when accessing care. Examples of service access barriers included rigid appointment systems, out-of-pocket expenses for services, and transport. The committee discussed the importance of lowering barriers and agreed that it was important for commissioners to consider different ways to lower the barriers for access and engagement. The section on improving access to and engagement with health and social care services provides more detail of this discussion.

Moderate quality data from 1 theme (A1.15 [registration for GP services]) based on 12 studies and high quality data from 1 subtheme (A1.15.1 [requirements around identification and paperwork]) based on 4 studies reported that people experiencing homelessness faced challenges when registering for GP services. Service providers reported that many local GP practices refused to register people without proof of address or proof of identity, although NHS guidance reports that people have the right to register even without an address or an ID or despite their migration status. The committee were aware from their own knowledge and experience that this is a problem in current practice, and that people are being refused care. The committee discussed that when refused access to GP practices, people experiencing homelessness often turned to emergency care services. The committee discussed the responsibility of providers to register new clients with a GP practice, and agreed it was important for commissioners to ensure there are processes in place to support registration and document and address any registration refusals so that providers are able to follow the NHS guidance and allow access to GP services for people without an address, ID or despite their immigration status.

Models of multidisciplinary service provision

Moderate quality evidence from 2 themes (A3.4 [holistic responses to complex needs], A3.5 [individualised care and support]) based on 14 studies showed that people experiencing homelessness wanted more individualised care and support and that service providers needed to adopt a more holistic approach to health and social care. High quality evidence from 1 theme (A3.10.3 [fragmented services]) based on 11 studies described complex and fragmented health systems, where most care is provided in “silos”, with minimal coordination between agencies and providers. The committee discussed that people experiencing homelessness often have very complex care needs, which require the expertise and skills of different professionals specialised in homelessness to assess, plan and manage care jointly. Based on the evidence and their own knowledge and experience, the committee were aware that specialist multidisciplinary teams (MDTs), consisting of practitioners and professionals from health, care and allied disciplines and sectors, could work together to provide holistic, person-centred and coordinated care and support.

The committee discussed that healthcare providers specialising in homelessness issues are integral in providing care for people experiencing homelessness. The committee discussed that in areas where there are a larger number of people experiencing homelessness, specialist multidisciplinary teams should be in place to help and support people experiencing homelessness. A combination of expertise from a variety of disciplines and agencies could facilitate in providing holistic care, supporting individuals’ care goals, and delivering the right type of care to improve health outcomes. The committee discussed that a successful holistic care approach to homelessness integrates service providers from a range of health and social care settings, such as outreach, primary and secondary health, social care and housing. An important benefit of specialist MDTs covering a wide range of settings is to meet all elements of one's health, including physical, intellectual, emotional, social, cultural and spiritual. The committee discussed that these MDTs could also be valuable when working with other marginalised populations that are at risk of homelessness, for example injecting drug users, sex workers, or victims of slavery.

The committee discussed that there is variation in the composition of specialist homelessness MDTs across the country. There was some evidence that reported the benefits of involving people with experiences of homelessness (experts by experience) in shaping and providing care for people experiencing homelessness. The committee noted that experts by experience bring an important service-user point of view and valuable lived expertise to MDTs so that the support could better meet the needs of the people experiencing homelessness. The committee discussed that healthcare professionals with specialist expertise, social workers, and housing options or homelessness prevention officers could also be included in MDTs as integral players in providing needs assessment, care planning and support. The committee discussed that in current practice a lot of services, particularly temporary accommodation, are provided by voluntary and charity sector organisations and that professionals from this sector would be a valuable part of the MDT, as often they are the ones who see the person experiencing homelessness most.

High quality evidence from 1 theme (A1.15.1 [requirements around identification and paperwork]) based on 4 studies reported that services had numerous documentation requirements. Moderate quality evidence from 1 theme (A1.1 [access to help and information]) based on 9 studies showed that people experiencing homelessness valued help when accessing support and welfare services. The committee agreed that staff with expertise in various practical and administrative processes (such as securing identification documentation and benefit claims) could also be involved in MDTs. The committee discussed that a MDT is a combination of professionals with expertise and specialist skills in homelessness issues that can coordinate care and provide holistic and tailored care to the person’s needs. The committee agreed that this could benefit people experiencing homelessness since they would be able to access the correct service and service provider on their first visit rather than being referred several times to inappropriate services.

The committee discussed that when brought together a MDT reduces duplication of work and integrates care by providing expertise across many settings, for example, community, voluntary sector, mental health services, and hospitals. The committee discussed that since MDTs are composed of professionals from several different services, they are well positioned to identify people experiencing homelessness and undertake comprehensive needs assessment for different services, such as physical and mental health, and safeguarding. The committee agreed that the benefit of undertaking a comprehensive needs assessment is that providing faster and better-quality care to person experiencing homelessness.

There was some high quality qualitative data from 1 subtheme (A3.10.4 [hospital discharge procedures]) based on 14 studies that demonstrated several issues with hospital discharge procedures, such as abrupt discharge with no follow-up or signposting to other services. The committee discussed that the MDT should support a safe transition to community from hospital admission, taking into account social needs as well as health needs. The committee agreed that homelessness MDTs should support mainstream providers to ensure a safe and timely hospital discharge and onward care, for example by linking hospitals with homeless services to support discharge.

Moderate quality evidence from 2 themes (A3.3 [consistency and care continuity], A3.5 [individualised care and support]) based on 25 studies showed that people experiencing homelessness wanted more individualised care as they experienced a lack of consistency and care continuity in service delivery. Moderate quality evidence from 1 theme (A3.1 [quality of the relationship between provider and person using services]) and 1 subtheme (B3.1.1 [positive experiences of care]) based on 22 studies showed that people experiencing homelessness wanted more compassionate care from healthcare providers to develop trusting relationships.

The committee discussed that MDTs could ensure continuity of care, which would facilitate forming a trusting relationship with their care provider. The committee discussed that specialist MDTs are well positioned to provide person-centred care because they are able to dynamically assess the full requirements of a person’s health and well-being needs, due to the well-rounded expertise of the team. The committee discussed that person-centred case management values people as active participants in the planning and management of their care, which ensures that the care plan is meaningful and appropriate to the context of their whole life. The committee discussed that multidisciplinary teams can provide person-centred, tailored support with personalised case management by a designated person working within the multidisciplinary team which can improve continuity of care, and help build trusted relationships with service providers that could improve engagement with services and long-term outcomes.

The committee discussed that MDTs should provide various services that a person experiencing homelessness might require, reflecting the needs of the individual rather than availability of services (“wrap around” care), for example physical health needs and problem substance use needs. The committee agreed that “wrap around” care is beneficial as it can reassure the person experiencing homelessness that all their needs can be met. The committee discussed that this should also be an opportunity to support the person to engage with different services, depending on the individual’s needs, for example, physical and mental health care, drug/alcohol services, occupational health or physiotherapy services and social services.

The committee discussed that working with people experiencing homelessness can be challenging and can have a psychological impact on those providing care. The committee discussed that homelessness MDTs should be given time, in a protected space, to reflect on their actions and experiences to promote continuous learning. The committee agreed that MDTs should engage in group ‘reflective practice’ as a means to achieve this. The committee noted that reflective practice is an integral part of a psychologically-informed environment. Reflective practice gives opportunities for staff to:

- reflect on previous practice;
- talk about why they made the decisions they made, and why they acted or behaved in particular ways;
- talk about their emotional responses to their actions and the actions of others;
- engage in continuous learning.

Reflective practice may also provide insight into personal values and beliefs, and help practitioners understand how these influence their actions and decision-making. The committee noted that this would provide an opportunity for care professionals to share their experiences and learning with other teams, whilst allowing them to process difficult or complex situations.

The committee discussed that MDTs coordinate care for people experiencing homelessness, for example by signposting to available resources and referring on to other services. The committee discussed that MDTs have a comprehensive understanding of the needs of people experiencing homelessness and how they use services, so they could directly contribute to local needs assessment, service quality improvement, and reviews of complex or difficult situations including safeguarding reviews. The committee agreed that this would benefit services who could provide more focused and targeted care, and support greater information sharing between MDTs and professionals from other organisations. The committee made these recommendations on multidisciplinary teams based on some evidence, which complemented the effectiveness evidence on the benefits of joined up care and multidisciplinary teams found in Evidence Review B.

Moderate quality data from 1 theme (A1.3 [availability of services]) based on 10 studies reported a general lack of services available to people experiencing homelessness, especially specialist care such as palliative care. The committee discussed that a lack of specialist healthcare providers was a barrier to accessing health and social care. The committee discussed that palliative care co-ordinators (to oversee palliative care needs, including physical, social and emotional) can address this gap in services. The committee were aware of a service that already provided this care (for example, St. Ann’s service in Greater Manchester). The committee discussed that the number of people experiencing homelessness and those who are accessing services varies by region so being aware of what is happening in the local area is crucial (local homelessness health and care needs assessment). The committee agreed that in areas with greater number of people experiencing homelessness, the provision of specialist multidisciplinary teams should be in place to help and support people experiencing homelessness. Having specialist teams in place can enable a holistic and integrated approach to care and support, built around the needs and personal strengths of people experiencing homelessness.

Moderate quality evidence from 1 subtheme (A1.10.1 [single point of contact for a range of services]) based on 2 studies reported that the lack of a single access point made it hard for people experiencing homelessness to obtain support for their full range of needs. The committee discussed that in areas assessed as having low rates of homelessness, having specialist homelessness MDTs might not be feasible, and so in these areas, mainstream services should have a designated person to lead on homelessness issues. For example, there may be areas where a service only encounters a person experiencing homelessness once a month. Establishing a homelessness multidisciplinary team would therefore not be feasible, however, there is still a need to ensure that appropriate care and support is provided to people experiencing homelessness in these areas. Particular staff members could therefore act as leads on homelessness issues and work within their organisation and facilitate collaboration with other leads from other services, such as primary care and A&E, to improve care outcomes. The committee discussed that a designated lead can encourage better care coordination and quality by fostering collaboration between other designated leads. The committee discussed that this lead should have an understanding of local services and be able to support their organisation and colleagues to work with people experiencing homelessness. They should also consult homelessness MDTs in nearby areas where they exists, as needed, so that the expertise and learning from other areas can be shared. The committee discussed that if specialist services are provided, mainstream services should not avoid their responsibilities of providing care for people experiencing homelessness, as this could result in further marginalisation. Mainstream services should still be made available to people experiencing homelessness, when required, rather than viewing specialist homelessness services as the only services they can access.

The role of peers

The committee made recommendations on peer support based on quantitative evidence from Evidence Review A and Evidence Review B, their own knowledge and experience, and from evidence from this evidence review.

High quality data from 1 theme (B2.2.1 [peer support]) based on 3 studies reported on the benefits of peer supporters when people experiencing homelessness accessed health and social care services. High quality data from 1 theme (A2.2.4 [trust in service providers]) based on 9 studies reported that some people experiencing homelessness do not trust service providers or the healthcare system. Peer supporters can build a strong and unique bond with clients, as they come to the relationship as an equal to counter people's mistrust of healthcare professionals. The committee discussed that a peer supporter could help build trustworthy relationships with service providers and improve the overall communication.

High quality data from 1 theme (B2.2 [the role of user led models built on trust between people with common experiences]) based on 9 studies reported that people experiencing homelessness valued care and support from those with a shared, common experience. A number of people highlighted that those with experience of homelessness were the best source of information, as they could communicate it in a way that people could understand. High quality data from 1 theme (B2.2.1 [peer support]) based on 3 studies reported that peer supporters considered themselves as role models, by breaking boundaries and providing individualised treatment and social support. Most peer supporters saw themselves positively as role models, able to “inspire” and model a life without the everyday struggles of being homeless. Peer supporters felt that acting as role models might inspire people experiencing homelessness to do better, or to feel that their goals are achievable, and that there is hope. The committee discussed that role modelling can be encouraging and can lead to positive effects, such as increased confidence and self-esteem, and finding a source of hope and optimism.

High quality data from 1 theme (A3.8 [navigating complicated care and support systems]) based on 9 studies reported that the current service system was complex and difficult to navigate, which presented a substantial barrier for those who are unable or unaware of how to advocate for themselves to receive the care they require. The evidence reported that peer supporters could help navigate the system or the care management of people experiencing homelessness, such as by helping them attend appointments and act as their advocates. The committee discussed that this assistance and support could help improve the self-efficacy of people experiencing homelessness. The committee discussed that peer supporters are in a good position to deliver interventions, such as take part in outreach care, for example, in the committee’s experience peers have been valuable in taking part in delivering point-of-care testing. Peers are also well positioned to collect data on service use that could support audits, needs assessments, and quality improvement.

There was some high quality data from 1 theme (B2.2.1 [peer support]) based on 3 studies that reported peer supporters derived a number of psychological benefits when providing peer support, such as a general feeling of being “happy to help”, and feeling that they are making a difference in someone's life. There was some moderate quality evidence from 1 theme (A2.6.1 [challenges faced by peer supporters]) based on 1 study suggesting that some peer supporters experienced obstacles and challenges in fulfilling their role. The committee discussed that the role can be demanding since peer supporters are on their own journey of recovery. Therefore, peer supporters should be provided with training and support, such as individual clinical supervision and access to group reflective practice, and psychosocial support, according to their changing needs and circumstances. To further support peer supporters, the committee also recognised the importance of providing appropriate governance structures and training, for example on data protection and confidentiality but also on topics such as first aid, mental health first aid, safeguarding, trauma-informed care, advocacy, professional boundaries, facilitation, risk management and personal development. The committee discussed the value of providing peer supporters with supervision, both for their own wellbeing and for their professional development. The committee discussed the importance of organisations providing inclusive recruitment policies and procedures so that people with history of homelessness, possible criminal justice involvement, or lower educational qualifications are able to get employed. In their experience, many professionals working with people experiencing homelessness are themselves people with lived experience of homelessness and being able to support their peers has been a big part of their recovery. The committee emphasised the benefits working with peers may bring to the person experiencing homeless (for example, empowerment and finding their voice) as well as to the services (for example, challenging stigma and discrimination) but also the many beneficial effects that being a peer may bring to the peers themselves (for example, learning new skills and strategies).

Based on their knowledge and experience, the committee agreed that it is important to consider how to best use the experience, background and language skills of the peer when allocating them to the clients. For example, sometimes it might be beneficial to match people experiencing homelessness with peer supporters that have similar experiences, backgrounds, and language skills to them (for example similar cultural, religious or ethnic background). However, sometimes having a peer from the same background or from the community might be undesirable and people will refuse support due to fear of confidentiality breech or being judged. The committee discussed that matching a peer supporter to the needs and preferences of the person experiencing homelessness could result in mutual understanding, shared identity and shared experience, which could improve service engagement.

Improving access to and engagement with health and social care

Supporting access to and engagement with services

High quality evidence from 3 themes (A1.5.1 [requirements around identification and paperwork], A1.13 [opening hours], A1.20 [transport]) based on 21 studies, moderate quality evidence from 1 theme (A1.5 [cost of services]) based on 12 studies, and moderate quality evidence from 1 theme (A1.2 [appointment systems]) based on 7 studies reported on barriers people experiencing homelessness experienced when accessing care. Examples of service access barriers included rigid appointment systems, out-of-pocket expenses for services, and transport.

There was moderate quality evidence from 1 theme (B3.2 [role and availability of outreach]) based on 19 studies that showed outreach services could overcome access and engagement barriers. The committee discussed that outreach services can increase access to care and knowledge around health issues, and provide information on available services and healthcare entitlements.

High quality evidence from 1 theme (A1.7 [service providers' views and experiences]) and 1 subtheme (A1.7.1 [conditional treatment rules]) based on 11 studies showed low-threshold, flexible services could improve service access and engagement for people experiencing homelessness. The committee discussed that low-threshold services (services that make minimal demands on the client by offering support and care without attempting to influence their habits) could be beneficial as they could lower access barriers for people experiencing homelessness. From their own knowledge and experience, the committee were aware that some service eligibility criteria thresholds are too high, pushing people into crisis and out of treatment or support until their situation worsens.

Moderate quality evidence from 1 theme (A1.2 [appointment systems]) based on 7 studies reported that people experiencing homelessness described appointment systems as rigid in terms of access regulations, appointment slots and making appointments. They reported that appointment systems should be more flexible and responsive to their needs. Low quality evidence from 1 theme (B1.1 [appointment systems]) based on 3 studies reported different facilitators to help people experiencing homelessness attend health appointments, including a single appointment for consultation and treatment or an open access service, such as walk-in centres. From their knowledge and experience, the committee were aware that self-referrals and ‘one-stop shops’ could also facilitate access to care. The committee discussed that, for this population, appointment based services did not always work and that drop-in services may allow more flexibility in accessing care. However, the committee were aware that drop-in services did not always suit everyone, for example, there was some high quality evidence from 1 subtheme (A2.2.1 [feelings of apprehension]) based on 9 studies reporting that some people on a journey of recovery felt nervous about bumping into old acquaintances in waiting rooms. Therefore, the committee agreed that it was important to consider individual needs and preferences when considering different models of appointments.

High quality evidence from 1 theme (A1.13 [opening hours]) based on 6 studies showed that limited opening hours made access to services very difficult. Some people reported that, other than emergency care, there was not an accessible healthcare facility open 24 hours to accommodate those who get sick on the weekends or after hours. The committee agreed that flexible opening times would be more suitable for people experiencing homelessness, who do not necessarily need to access services between 9am and 5pm. The committee discussed that flexible opening hours would allow more people experiencing homelessness to access primary health care services, which could reduce the burden on emergency care services.

There was some high quality evidence from 1 subtheme (A2.5.4 [provision of incentives]) based on 4 studies that showed people experiencing homelessness considered incentives to be a strong motivator to engage with health and social care services. This included things like transport money cards, clothes and toiletries, and food. Service providers reported these incentives increased hepatitis C virus rapid testing and improved oral hygiene. The committee agreed with the evidence and also discussed how having access to technology and the internet, and having the skills to use it (digital inclusion) was a major enabler to accessing healthcare.

The committee discussed there is regional variation concerning free or subsidised travel, since the funding associated with it is not the designated responsibility of a single organisation. The committee were aware that in areas where there is no free transport the responsibility to provide it falls on hostels. The committee discussed that people experiencing homelessness can apply for the disability bus pass but the process is long and can be complicated since transport exemptions have to be signed by a medical professional (also subject to regional variation). The committee discussed that often service providers and people experiencing homelessness are unaware of the rights around getting a free bus pass. Many service users reported that walking was their main mode of getting to an appointment, which could be difficult for those people with existing health issues and disabilities.

There was some high quality evidence from 1 subtheme (A1.16.1 [lack of internet and phone access]) based on 4 studies reporting that some people experiencing homelessness do not have access to technology or the internet and therefore find it difficult to access and engage with services. The committee discussed how having access to technology and the internet, and having the skills to use it (digital inclusion) was a major enabler to accessing healthcare.

There was high quality evidence from 1 theme (B2.2 [the role of user led models built on trust between people with common experiences) and 1 subtheme (B2.2.1 [peer support]) based on 12 studies reporting that some people experiencing homelessness considered the presence of an advocate, a peer supporter, or a care navigator improved their care experience. The committee agreed that in their experience people experiencing homelessness benefit from having a dedicated person to support them in various ways when engaging with health and social care services and committee thought this as a valuable way to reduce access and engagement barriers.

High quality data from 1 theme (A1.14.2 [competing priorities]) based on 18 studies reported that health needs, particularly physical health conditions, were not always a high priority for people experiencing homelessness when compared to food and shelter. The committee discussed that the precarious and challenging situation many people experiencing homelessness are in where even the basic needs are not met, attending health and social care appointments might not be the highest priority. From their knowledge and experience, the committee agreed that this was commonplace and a barrier for engaging with services and attending appointments. Low quality data from 1 subtheme (A1.2.2 [missed appointment policies]) based on 3 studies reported on the difficulties people experiencing homelessness faced when they missed appointments with health and social services. Many facilities have missed appointment policies that can prevent individuals from seeking care. Some services charge financial penalties for missing appointments, particularly the case for dental services. The committee were aware of other published evidence that showed missed appointments are associated with premature mortality and not just a financial problem for the healthcare system (McQueenie 2019). Therefore, the committee agreed that it was important not to hastily remove people experiencing homelessness from the service.

Moderate quality evidence from 1 subtheme (A1.2.1 [communication]) based on 1 study reported that receiving appointment information by letters was ineffective due to the transient living situation of this population. The committee discussed that sending information through letters is still the main method of communication, highlighting this as a problem for many people experiencing homelessness. The committee were aware, from their own knowledge and experience, that people experiencing homelessness were often dropped from services even when they had not received their appointment letter. The committee discussed that services need to be more aware of the complexities people experiencing homelessness face. The committee agreed that people in these situations should not be dropped from services as it is through no fault of their own.

The committee discussed that people experiencing homelessness should not be refused care unless help is provided when needed or a ‘safe transfer of care’ has occurred. The committee were aware, from their own knowledge and experience, that there can be significant risks when people experiencing homelessness transition between or out of services. The committee agreed it was important to recommend a ‘safe transfer of care’ for the safety of the person experiencing homelessness. High quality data from 1 theme (B2.2.1 [peer support]) based on 3 studies reported on the benefits of peer supporters when people experiencing homelessness accessed health and social care services. The committee discussed that specialist help, such as peer supporters could help people experiencing homelessness build trustworthy relationships with service providers and improve the overall communication. The committee discussed that perhaps the use of a peer supporter or an advocate could provide support, and facilitate access and re-engagement in this situation.

High quality evidence from 1 theme (A1.7 [eligibility criteria]) based on 8 studies reported on strict eligibility criteria when accessing some healthcare services, forcing people experiencing homelessness into crisis situations before help could be provided. Some people reported that to access appropriate mental health services, people must first be recognised as having mental health issues. From their own knowledge and experience, the committee were aware that service thresholds are too high, pushing people into crisis and out of treatment until their health worsens. The committee discussed this was often the case in secondary mental health services, which led to misdiagnosis or no diagnosis at all. The committee discussed this was particularly prevalent for people with severe multiple disadvantage, such as when an individual has coexisting mental health problems and addiction, who often fall through the gap. The committee discussed that people are currently passed from drug and alcohol services to mental health services, or vice versa, not being eligible for either because of the ‘other’ condition, ending up getting no adequate support. The committee discussed that in reality the two issues are usually very much interlinked and there is reasonable consensus and evidence that people use substances to escape and cope with difficult thoughts and feelings. The committee agreed that these services should work together in tandem to support the individual, to prevent them falling through gaps in services. Sometimes, coexisting mental health problems and learning disability can also exclude people from accessing the respective services. The committee agreed that a ‘mental health support for all’ approach should be implemented rather than a ‘crisis intervention’ approach.

Strict eligibility criteria can also be an issue for people experiencing homelessness who are frail or have ‘premature aging’ and not been eligible for social care services usually provided for older people because of their younger biological age. The committee discussed that premature aging and frailty can be common in people experiencing homelessness, particularly those who have history of rough sleeping and substance use problems and unmet health needs. Therefore, the committee recommended that people experiencing homelessness who are frail and need social care support, receive the relevant care packages despite their potentially younger age. This would include access to appropriate residential care or supported housing, depending on needs.

High quality evidence from 1 theme (A1.5 [cost of services]) and 1 subtheme (A1.5.1 [out of pocket expenses]) based on 18 studies reported that there are few low-cost dental health care services. People experiencing homelessness wanted more clarity on the costs of dental treatment, which could be confusing at times. The committee discussed that costs for prescriptions, dental treatment, optometry, and travel can be covered under the NHS Low Income Scheme. This required paperwork to be completed (HC1 form) or to have a certificate of exemption (HC2 certificate), which can be complicated to access as they are often only available online. The committee discussed that these forms require detailed information and renewal every 6 months and that they were not available in different languages or with other accessibility requirements. The committee discussed that this disadvantages and creates barriers for many people, particularly for those who are not English speaking, those who do not have access to the internet or a computer, and those with learning difficulties or low literacy. The committee agreed that there was a need to provide help and support to people experiencing homeless when they are filling out forms that enable them to access services. For example, lack of access to dental services can mean important oral health problems are missed, such as infections and dysphagia, which may further worsen the person’s health situation.

There was some high quality evidence from 1 subtheme (A1.16.1 [lack of internet and phone access]) based on 4 studies, which showed that people without access to the internet and those without a phone experienced difficulties in accessing healthcare. The committee discussed that assuming everyone has access to a phone or the internet excluded many people experiencing homelessness (digital exclusion). The committee discussed many information resources and subsidy/exemption forms are available online, and so access to the online services is very important.

High quality data from 1 theme (A1.15 [registration for GP services]) and 1 subtheme (A1.17.1 [managing medication]) based on 13 studies, and moderate quality data from 1 theme (A1.3 [availability of services]) based on 3 studies reported that hurdles or entry restrictions when registering for services were widespread. Service providers reported that many local GP practices refused to register people without proof of address or proof of identity, although NHS guidance reported that this should not be the case. The evidence also reported that many times a stable address was required to access alcohol and drug rehabilitation services or learning disability services. The committee discussed that these practices excluded people without a stable address from accessing services, which often led to them using emergency care services. The committee discussed that primary care providers should ensure the health rights of people experiencing homelessness and that it is not compulsory to produce ID and address to access or register to a service.

Moderate quality evidence from 1 theme (A2.7 [the skills, training and values of practitioners for supporting and engaging people]) based on 23 studies reported that healthcare professionals felt unequipped and had insufficient knowledge of homelessness and the associated health needs for complicated health problems. High quality evidence from 1 subtheme (A3.10.5 [referrals between services]) based on 7 studies reported on the challenges of making referrals, such as long delays between referrals and the start of support or treatment (particularly secondary mental health services) and little tracking of referrals to another service. The committee discussed that care providers should be able to identify those who need a referral and that the referral should be done in a timely manner. From the evidence, one service provider reported that GPs receive little information from secondary health services about the outcome of referrals. The committee discussed that this puts the responsibility on the person receiving care to re-present to their GP, or actively seek alternative services, which can be particularly difficult for people experiencing homelessness. The committee agreed that care providers should ensure they are able to identify when a referral for specialist care is required. The committee discussed that staff involved in any aspect of care for people experiencing homelessness should be aware of their duties that fall under the Homelessness Reduction Act 2017. The committee agreed this could refocus local authorities on prevention work and join up services to provide better support for people experiencing homelessness and perhaps those leaving prison/hospital and other groups, such as people fleeing domestic abuse and care leavers. The committee discussed the duty to refer, which mandates public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams. The Ministry of Housing, Communities and Local Government have produced guidance on this. Furthermore, the Ministry has also published a homelessness code of guidance on how local authorities should exercise their homelessness functions in accordance with the Homelessness Reduction Act 2017.

Moderate quality data from 1 subtheme (A1.2.4 [waiting times]) based on 15 studies showed that long waiting lists hinder access to health and social care services. In one study, a nurse reported that waiting lists were unavoidable due to the volume of patients. However, people experiencing homelessness considered long waiting lists as direct contributors to the decline of their physical and mental health. The committee discussed that delayed presentation to services and often presentation at crisis point is common for people experiencing homelessness. The committee agreed that long waiting lists and inability to access care in a timely manner was a contributing factor for premature mortality in this vulnerable population. The committee discussed that implementing rapid access to some services, such as alcohol and drug services, could be more useful for people experiencing homelessness who have multiple disadvantage putting them at an increased risk of deterioration and premature mortality and morbidity. The committee discussed that services should consider moving people experiencing homelessness up the waiting list, taking into account that they may have severe multiple disadvantage and a significantly higher risk or premature mortality.

Outreach services

Moderate quality evidence from 1 theme (B3.2 [role and availability of outreach]) based on 19 studies reported on the positive effects of outreach services, which bring flexibility that is not possible in traditional healthcare services. The evidence reported that the act of coming to the service users also helps to build trust and a strong connection with the service provider and reduces the sense of isolation. People experiencing homelessness appreciated multidisciplinary outreach care such as from charity workers, GPs, nurse practitioner, pharmacists, and drug and alcohol service nurses. Several people experiencing homelessness reported having a more positive experience with outreach services than mainstream services. The evidence reported that outreach services provided an opportunity to introduce harm reduction strategies, and an opportunity for screening and immunisation.

The committee discussed that many health and social care services could be provided in non-traditional settings such as the street, hostels, or day centres. Outreach services could help prevent people falling through the safety net of health and social care and are considered more accessible for those who have a history of marginalisation, such as people who have concerns about eligibility to access services (for example, migrants). The committee discussed that outreach services are often key in identifying people experiencing homelessness, can be used to provide preventative and health promotion services such as national screening programmes, testing for chronic conditions and infectious diseases, as well as providing vaccinations, smoking cessation programmes and public health advice. Outreach can also provide support for multiple needs, such as primary healthcare needs, physical and mental health needs, and substance use needs. The committee discussed that this would particularly benefit those who have had previous negative experiences with services and service providers. The committee discussed that it is taken for granted that MDTs are best practice due to the range of skills and knowledge the teams can possess. However, having outreach teams, which are collaborative, provides a range of knowledge and competency in providing services, which are expert in safeguarding and social work interventions, psychological understandings of engagement, and an understanding of the individual’s physical, psychiatric needs including, for example, when a Mental Health Act assessment is warranted. Further, the committee agreed that it would be useful if outreach teams were equipped to respond to needs of people with different, intersecting experiences relating to for example gender, ethnicity and sexual orientation. Therefore, the committee agreed that outreach services can increase access to care and knowledge around health issues, and provide information on available services and healthcare entitlements.

Moderate quality data from 1 theme (A2.5.3 [ongoing support]) based on 4 studies showed that people who feel overwhelmed by an offer of support or resistant to accessing support might feel more motivated if the support was made available on an ongoing basis, over time. The evidence reported that frequent attempts to engage should be made, but without placing pressure on people. The committee discussed the concept of ‘assertive outreach’, which is a way often associated with mental health services to provide a proactive, persistent approach to engaging with individuals with mental health problems and severe multiple disadvantage. The committee agreed that assertive outreach would be beneficial to people experiencing homelessness to help with engagement with care and support, particularly those with coexisting mental health and problem substance use, but any person experiencing homelessness who are disengaged from services but would benefit from support could benefit from this approach.

Assessing people's needs

There was no evidence on the different approaches to improving access to services through needs assessments, so the committee used their own knowledge and experience to make recommendations. Based on their experience and knowledge, the committee agreed that a comprehensive, holistic needs assessment improves access to health and social care and support that matches the needs of the person. They agreed that a multidisciplinary approach is needed to ensure the full range of health and social care needs are identified, including consideration of risk and safeguarding issues.

From their knowledge and experience, the committee were aware that all health and social care workers have statutory and professional duties to identify immediate harm to self or others. These derive from the Care Act 2014 and the Mental Health Act (1983; amended 1995 and 2007), as well as various professionals codes of practice such as the Nursing and Midwifery Council Code, General Medical Council's Good medical practice and Social Work England's professional standards. The committee were keen to highlight this duty in the recommendations because this is particularly relevant in the context of homelessness due to a significant link between homelessness and risk of abuse, neglect and violence, serious mental health problems, self-harm and self-neglect. Based on their knowledge and experience, they were aware of cases where death or serious harm could have been avoided if this would been identified and acted on. The committee discussed that it is important for practitioners to be aware of this whenever dealing with vulnerable people experiencing homelessness.

The committee discussed that the needs assessment is an essential tool and a method of identifying the unmet health and social care needs of people experiencing homelessness, taking into consideration their housing and benefits situation. It allows for appropriate targeting of services, and can be an excellent opportunity to involve multiple agencies in service planning to increase ownership and sustainability. The assessment should include assessment of physical and mental health needs, including acute and chronic conditions, addiction and social care needs. The committee discussed that this assessment should also involve gaining an understanding of the person's backstory and historical context, which has influenced their current situation. Traumatic experiences and adverse childhood events, for example, can contribute to the person's situation and current needs. The committee discussed the benefits of incorporating a multidisciplinary approach to ensure a holistic assessment of needs, such as better treatment planning and compliance, and greater continuity of care across different care settings. This should include the person experiencing homelessness if they have the capacity (or their nominated or appointed advocate), because including people as active participants in the planning and management of their own health ensures that their care plan is meaningful and within the context of their whole life. The committee discussed that peers and advocates (who may be people with their own lived experience of homelessness) can have an important role in facilitating access and engagement with the assessment processes. The committee agreed that this multidisciplinary assessment should underpin and inform the local authority care and support needs assessment, under the Care Act 2014. NICE guideline on people's experience in adult social care services provides guidance on the care and support needs assessment so the committee signposted to this guideline.

The committee discussed that because hospital admissions are relatively common among people experiencing homelessness, these should be taken as opportunities to undertake a comprehensive assessment of needs for people experiencing homelessness to enable appropriate care planning. The committee discussed that an assessment at admission could integrate health and social care to achieve a personalised care and support plan. It provides an opportunity to capture and build on the benefits of a hospital stay and to address underlying problems. The committee agreed that this could lead to benefits in the care experience and in outcomes, such as improved treatment planning and compliance, a reduction in service utilisation (for example, A&E attendance), and an improved service user experience.

There was some high quality evidence from 1 theme (B2.2 [the role of user led models built on trust between people with common experiences]) and 1 subtheme (B2.2.1 [peer support]) based on 12 studies supporting the use of peer supporters or advocates in health and social care. People experiencing homelessness valued care and support from those with a shared, common experience, and considered them to be the best source of information, as they could communicate it in a way that people could understand. People experiencing homelessness said that the presence of an advocate or a peer supporter helped them to gain confidence and a sense of control over their health needs. For example, some people often found it easier to register with a general practice when they had an advocate. The committee discussed that advocates, who may be people with their own lived experience of homelessness (peers), can:

- support to navigate the system which can be hard for people experiencing homelessness;
- act as a point of knowledge, as people are not always aware of what their rights are;
- act as a point of contact to avoid the individual feeling overwhelmed by the system;
- support trust building and communication with services, helping the expression of the individuals views and wishes, having their interests represented, supporting access to information and having the time to support the individuals exploration into their choices and options;
- facilitate access and engagement with the assessment processes.

The committee were also aware that under the Care Act 2014, local authorities must appoint an independent advocate to support and represent a person to assist in their involvement in for example the local authority led care and support needs assessment or safeguarding enquiry when the people has substantial difficulty in being involved in the process, and if there is an absence of an appropriate individual to support them. The upcoming NICE guideline on advocacy services for adults with health and social care needs (publication expected July 2022) will give further guidance on advocacy services.

It is important to re-assess the person’s situation and needs as time goes by. However, the committee were aware that people experiencing homelessness sometimes experience needs assessment processes to be a process of excluding them from services or judging them, and they can be challenging, sensitive and have a profound psychological impact, potentially having to ‘re-live’ trauma and previous adverse experiences. The committee therefore agreed that standard review periods could only be harmful but instead the person’s needs, strengths and aspirations should be reviewed when their circumstances change or when they request it.

Transitions between different settings

For the most part, the committee made recommendations on transitions between different settings based on evidence from Evidence Review A, Evidence Review B, and from their own knowledge and experience.

Moderate quality evidence from 1 theme (A3.11 [experiences of stigma and discrimination]) based on 36 studies described negative healthcare experiences resulting from stigma and discrimination, including inadequate or rushed care with early discharge and no follow-up. High quality qualitative data from 1 theme (A3.10.4 [hospital discharge procedures]) based on 14 studies demonstrated several issues with hospital discharge procedures, such as returning to the streets, without adequate support. Service users described being in a vicious cycle, repeatedly going in and out of hospital because they were continually not being given the care and support they needed to recover in the long term.

The committee discussed that it is relatively common that people discharge themselves against medical advice (irregular discharge), or that a person is discharged to the street. The committee discussed that this contributes to poorer health outcomes and an increased use of emergency departments and repeated hospital readmission, creating a ‘revolving door’ scenario of missed opportunities to provide care. The committee agreed that it is important that there are procedures to minimise self-discharges and prevent discharges to the street so that risks can be reduced, and discharges are as safe as possible. Reviewing incidents of self-discharge or discharge to the street and learning from them should prompt changes to procedures to that self-discharges can be minimised and discharge to street avoided. The Department of Health and Social Care's Hospital discharge and community support: policy and operating model refers to a support tool and briefing notes on transforming out-of-hospital care for people who are homeless, which outlines how safe and timely transfers of care can be delivered.

Housing with health and social care support

The qualitative review found that the delivery of health and social care would be improved by addressing people’s needs more holistically and the quality of this finding was moderate (theme A3.4 [holistic responses to complex needs]). However this did not specifically relate to the configuration of services around people’s housing circumstances, which review B did provide data on, for example positive outcomes from health and social care support ‘wrapped around’ housing services such as through Housing First. These findings provided the basis for recommendations about the importance of wrap around support, which are described in review A and B but the committee were aware that with a lack of qualitative evidence they were unable to recommend how this approach to care linked with accommodation could be improved. In particular they agreed that it would benefit future guidance to have evidence about the system and structural factors in health and social care that could help or hinder commissioning and delivery of wraparound support integrated with housing. They therefore made a research recommendation to address this, which is described in appendix K.

Long-term support

The committee discussed that people experiencing homelessness often have severe multiple disadvantage and may have experienced various traumatic experiences. The committee agreed that this population required long-term commitment for support and a sustained effort from services and care providers to support them in their recovery journey. The committee discussed that the journey of recovery is likely to be non-linear, and service providers should expect ups and downs. People experiencing homelessness have experienced exclusion and marginalisation and it is crucial that health and social care services champion them despite their tumultuous journey to stability.

Moderate quality data from 1 theme (A2.5.3 [ongoing support]) based on 4 studies showed that people who feel overwhelmed by an offer of support or resistant to accessing support might feel more motivated if the support was made available on an ongoing basis, over time. The evidence reported that frequent attempts to engage should be made, but without placing pressure on people. The committee discussed that there is a spectrum of support and care needed, where on one end, some people wish not to engage. The committee discussed that often people may use a service but then ‘disappear’ until they re-appear. This illustrates the non-linear journey that many people experiencing homelessness can experience. The committee discussed that forcing care and support on a person is ineffective and that flexible approaches for re-engagement are important for this population.

High quality data from 4 subthemes (A1.18.3 [relationship between service user and service provider], B1.2.2 [relationship between service user and service provider], A2.1.1 [feelings of apprehension], A2.2.4 [trust in services providers]) and 19 studies reported on the importance of a trusting and respectful carer-patient relationship. The evidence showed that many people experiencing homelessness do not trust service providers and the healthcare system for several reasons, such as previous negative experiences. Those who had positive experiences spoke encouragingly about service providers with whom they had formed a strong and trusting bond. It was easier to form trusting relationships with professionals who pay attention and have more time available, and who have sincere interest in them. The committee agreed with the evidence and discussed that spending more time with a person, especially at the beginning of a relationship, allowed the formation of a strong and trusting bond.

There was some moderate quality evidence from 1 theme (A2.5.3 [ongoing support]) based on 4 studies where one person experiencing homelessness reported that it would help for service providers to be informal and not too distant. From their own knowledge and experience, the committee were aware that a relaxed and casual setting could facilitate putting someone at ease. The committee discussed that this approach could also help to form a relationship of trust, which is important to people experiencing homelessness. However, the committee also recognised the importance of assuring that appropriate lone worker policies are in place to ensure staff safety. The committee discussed that such a policy should take into consideration the potential risks faced by staff who meet clients alone and the responsibilities of both the employer and staff members in ensuring that this can be done safely.

There was some moderate quality evidence from 1 theme (A2.5.3 [ongoing support]) based on 4 studies that showed service providers should be patient and consistent in offering treatment since this would increase engagement with health services. The committee discussed that regular contact would strengthen the relationship between the care provider and the person experiencing homelessness.

High quality data from 2 themes (A1.4 [consistency and care continuity], A3.3 [consistency and care continuity]) based on 16 studies demonstrated there is a lack of consistency and care continuity in service delivery. Many people reported having multiple GPs, counsellors, and social workers, which meant it was difficult to form a trusting relationship if they had to keep repeating their story and starting from the beginning with a new provider every time. Service users valued continuity of care as it enabled them to form a relationship with their care provider. High quality data from 1 theme (B2.1 [care continuity improves engagement]) and 1 study showed that if care continuity was interrupted, this could lead to disengagement with services. The committee discussed that maintaining the same service provider or the same team of service providers was the main way to build a trusting relationship.

There was high quality evidence from 2 subthemes (B1.2.1 [receiving prompt care], A3.10.2 [emergency care]) based on 8 studies that showed people experiencing homelessness preferred receiving immediate care. The committee discussed that having your needs addressed immediately is a positive interaction that promotes engagement with the service, in the long term.

From their own knowledge and experience, the committee were aware that people experiencing homelessness did not always follow a linear recovery journey. The committee agreed to make a recommendation in line with this so that service providers are aware of potential hidden risks in the recovery journey of this population. The committee were aware that after initial progress, people experiencing homelessness may have a ‘relapse’ or crisis and it would be important for services to be there to support them in this situation. The committee discussed that it is likely that people in this situation would seek help from whoever has previously supported them or from people who they trust. The committee agreed that potential repeat homelessness and other adverse outcomes in this situation could be avoided if there were ‘open door’ services to which people can self-refer in order to re-gain access to relevant support instead of having to start the process from the start and potentially face delays and barriers for accessing timely and relevant support which has previously been helpful in their recovery journey.

The committee discussed that premature aging and frailty at an younger age is common in people experiencing severe and multiple disadvantage and homelessness and long-term support for people assessed as frail should reflect this. Being frail, however, does not necessarily mean the person is approaching the end of their lives and therefore, planning and providing appropriate long-term support and care is important.

At the same time, the committee recognised that premature death and advanced ill health are also common in people experiencing homelessness. Some people will not recover and death may not unexpected within the near 6 to 12 months, for example. The important thing then is to provide appropriate end of life care based on the preferences and needs of the person. The committee discussed that the level of palliative care support accessible to people experiencing homelessness tends to be low or not meeting the needs of the individual. There can also be difficulties in recognising the palliative care needs of a person experiencing homelessness when they already face multiple barriers when accessing and engaging with health and social care. The committee agreed to recommend that when the person is likely approaching the end of their life, palliative care needs should be discussed with the person through a multidisciplinary approach and coordinated palliative care meeting the person's needs should be provided.

Staff support and development

The committee discussed the importance of supporting and looking after the wellbeing of staff who work with people experiencing homelessness. The committee were aware from their knowledge and experience that working with this population can be demanding and challenging, for those who work with them on a regular basis, and also for those who work in the mainstream services but encounter people experiencing homelessness. The committee noted that few care providers had extensive training on the specific needs of people experiencing homeless and that the majority of service providers required more knowledge on how to manage the health and social care needs of this population.

Moderate quality evidence from 1 theme (A2.7 [the skills, training and values of practitioners for supporting and engaging people]) based on 23 studies reported that whilst training would raise awareness and improve provider knowledge in the needs of people experiencing homelessness, it would also improve sensitivity and understanding for this population, so that care providers overcome preconceived ideas and judgemental behaviour towards people experiencing homelessness. The committee agreed with the evidence and discussed that training should be provided to include understanding the health and social care needs of people experiencing homelessness and their rights to access services. This was based on some low quality evidence from 2 subthemes (A1.8.1 [awareness about rights to healthcare], A1.8.3 [knowledge and awareness of issues surrounding homelessness and health]) from 2 studies reporting that healthcare providers and people experiencing homelessness did not know the rights or entitlements around accessing healthcare. High quality evidence from 1 theme (A1.19 [stigmatising attitudes]) based on 10 studies and moderate quality evidence from 1 theme (A3.11 [experiences of stigma and discrimination]) based on 36 studies reported that most people experiencing homelessness reported experiencing discrimination on some level, with a majority recounting some form of prejudiced behaviour from service providers. The committee agreed with the evidence and discussed that training should be provided on the impact of discrimination and stigma.

The evidence and committee's discussion around consideration for trauma informed care is covered in the section on general principles. However, the committee recognised that health and social care staff working with people experiencing homelessness might not be familiar with it and training would be needed. The committee discussed that the principles of trauma informed approaches are useful when engaging with any patient or client groups although particularly relevant when working with people experiencing homelessness because of the prevalence of past experiences of psychological trauma in this population.

The committee were aware, from their own knowledge and experience that some practitioners were unaware of the full scope of their legal duties and powers and therefore, the committee recommended that training and support should be provided on legal literacy issues. This was also highlighted by the expert witness evidence which has been discussed in Evidence review A and B. Similarly, there may be a need for training on the legal entitlements to health and social care for migrant populations experiencing homelessness.

The committee discussed the section on competence in the NICE guideline on coexisting severe mental illness (psychosis) and substance misuse for secondary care mental health professionals and agreed to cross refer to it as it may be relevant to professionals involved in the care of people experiencing homelessness.

The committee discussed, based on their experience, that working with people experiencing homelessness can be challenging and tiring. In order to maintain staff motivation, help retain staff, and improve services, staff would benefit from ongoing support and professional supervision. As discussed previously, the committee agreed about the importance of reflective practice and supervision for staff working with people experiencing homelessness which could provide an opportunity for professionals to share their experiences, process potentially difficult situations and learn from their experiences. This also allows for the services to develop their practices.

Cost effectiveness and resource use

No existing economic evidence was identified for this review.

Some of the themes and recommendations in this review overlap with Evidence review A (Access to and engagement with health and social care for individuals experiencing homelessness) and Evidence review B (Joined up health and social care for people experiencing homelessness) with further committee discussions included in those reviews.

Trauma informed care and psychologically informed environments are approaches used in current practice to some degree but quality varies. The committee explained that properly adopting trauma informed approaches may require additional resources for services where this is not happening. For example, services may need to provide training and ongoing support to staff. However, the committee discussed that in the long term using trauma or psychologically informed approaches may result in cost savings. For example, such an approach may result in improved engagement with services, more supported discharges and fewer people coming back to services with unmet needs, practitioners who are able to build a trusting relationship with the client may prevent a crisis, and be able to initiate timely and appropriate care. These approaches may also improve staff motivation, wellbeing and increase staff retention. The committee noted that to adopt this approach, services may want to consider having a staff member with a trauma background on their team, or could have some additional training that coincides within existing training.

The recommendations on communication and information provision reinforce existing NICE guidelines for the general population. The committee explained that there may be a need for some additional training for staff around communication and the available health and social care services and support for people experiencing homelessness, including legal entitlements for care. The recommendations may require more practitioner time to communicate appropriately, provide the right information, and make information more accessible. The committee discussed that appropriate and timely information provision and communication will benefit relationship and trust building, and can lead to better access and engagement with services. For example, people experiencing homelessness may be more likely to access primary care services or specialist services directly instead of relying on emergency services. This may lead to problems being picked up earlier and appropriate management initiated, resulting in reduced morbidity and mortality, and associated costs. Timely communication that reaches the person will also reduce missed appointments which can be a considerable issue. The committee discussed that services varyingly already use different communication methods, for example, call, text message, email, letter, to facilitate access and engagement with services but the recommendations may mean that services will have to adjust the way information is provided or have more communication methods available and tailor the communication method to the preferences and needs of the person. This is not expected to lead to significant resource impact.

The committee explained that using advocates to reinforce or aid communication is not expected to result in additional resources to services. It was noted that the advocate role could be undertaken by various people, for example, a care coordinator, peer support worker, or a voluntary or charity sector worker. The advocacy role could also be undertaken by a friend or a family member. The committee explained that there are various advocacy models in existence aimed at developing a relationship and then supporting people, for example, to attend appointments. The committee noted that using advocates could be cost-saving as, for example, there is a link between non-attendance of appointments and increased morbidity and mortality.

In order to meet the needs of people experiencing homelessness and to tackle inequalities in outcomes, more targeted effort and approaches and more funding is likely to be needed than in a general universal service. There is a responsibility for integrated care systems and service planners to understand the inequalities in access and outcomes experienced by this population, and a need to respond in a way that addresses these inequalities even if it requires more funding.

Most services already have ways of recording data on people experiencing homelessness for audit purposes, although there is variation in practice how well this is done and some services might not be doing it or have processes flexible enough to record it in a meaningful way. This would not be expected to result in any significant resource impact and services could do this by adjusting existing data recording methods. The benefits associated with targeted and efficient health and social care service planning that meets the needs of people experiencing homelessness, such as reduced morbidity and mortality and reduced homelessness and associated cost savings, will likely outweigh any additional costs.

Accessing health and social care services is not always straightforward for people experiencing homelessness so it is important that there are various approaches to make services accessible and flexible for differing needs. For example, it may entail bringing services to places where people experiencing homelessness spend time, such as the street, day centres, hostels or soup kitchens. The more complex needs people have, the more flexible the system needs to be, including outreach-based services. Otherwise, people experiencing homelessness may have difficulty accessing care in a timely manner and may end up using expensive emergency services or if they are not accessing services at all, may result in premature mortality and complex morbidity. In order to facilitate access to appropriate care in a timely manner, services will have to consider a menu of approaches tailored to the specific needs of people experiencing homelessness. Access to support can also help them sustain tenancy, prevent a crisis point, and potentially avert repeated homelessness. The committee discussed that, for example, various outreach models exist and are used to deliver a range of services. The committee explained that commissioners generally understand the value of flexible services in enabling access and engagement, and some areas commission and deliver flexible services, but not cohesively, and as a result of these recommendations there may be some resource implications where this is not happening.

Transport costs are a considerable barrier to access, engagement, and continuity of care for many people experiencing homelessness. Practice is variable, with some services offering specialist services in the same location so that people do not need to travel to multiple locations to access different services, however, this approach is quite uncommon in current practice. Generally, primary healthcare services do not cover travel costs, with homelessness services often left to meet that cost or in many cases, people not having access to services or missing appointments because they have no means to get to the place. Some services offer taxis or pay for public transport and in some areas some people experiencing homelessness with for example multiple morbidities or disability can get free bus passes as long as the appropriate paperwork has been processed. However, there may practical issues that makes this difficult, for example that the relevant paperwork can only be signed off by a medical doctor. Overall, providing free travel or a bus pass would potentially have some resource impact, however, the cost of providing free travel would be relatively low compared with the cost of missed appointments, unaddressed needs, complex morbidity and repeat homelessness. For example, an annual bus pass costs approximately £900 (Transport for London 2021), if an individual with a leg ulcer misses multiple appointments due to inaccessible travel costs this may lead to an infection and in some cases to an amputation costing NHS at least £8,000 (NHS England 2021), not to mention the impact on the person themselves. Services will need to work collaboratively to agree within their local system who will pay for free travel.

The committee agreed that flexibility is important when planning and delivering services for this population. Every contact should be seen as an opportunity to engage people experiencing homelessness with health and social care. The committee also recognised that people often have increased interactions with health and care services before becoming homelessness and particularly around their first homelessness appointment and that this should be seen as an opportunity to intervene. The existing appointment system is often rigid and increases the risk of missing appointments and sometimes being dropped out of services altogether. The committee were aware of evidence that people who miss GP appointments have an increased risk of premature mortality. Penalising for missed appointments can disengage people experiencing homelessness even further, resulting in unnecessary morbidity and mortality and substantial costs to services due to unaddressed needs. For example, in general population missed GP appointments are costing NHS England around £216 million a year on top of the disruption for staff and other patients (NHS England 2019).

The committee discussed that people with coexisting mental health and substance use problems are often not eligible for care in one service due to the other coexisting condition, due to a strict eligibility criteria. The recommendation in this area may mean that services need to improve their collaboration and should lead to people with coexisting mental health and substance use problems experiencing homelessness accessing the care they need, and potentially a reduction in morbidity and mortality, and associated costs (averted crisis, A&E visits).

The committee discussed that another potential barrier for accessing care is filling in the right paper work. For example, filling in certain forms is a pre-requisite for accessing low cost or free-of-charge essential care, for example, dental care and optometry. Forms may require a lot of detail which may be challenging to fill in, they are only available in English and may be complex so people with a language barrier or low literacy levels may struggle. Furthermore, these forms might only be available online which people experiencing homelessness might not access. The committee discussed that in order to support people to fill in these forms, services may need to plan for more practitioner time. However, accessing essential care through these forms will likely offset potential additional costs. For example, if people cannot access care, their condition may deteriorate, resulting in increased morbidity and eventual expensive emergency care.

Digital exclusion can be a challenge for people experiencing homelessness, however, the committee discussed that in recent years the homelessness sector has started to use more and more digital ways of working and engaging, similar to other sectors. Services may have to improve their support for people experiencing homelessness to have access to online health and social care information and services. For example, it may require services to have equipment or WiFi to access the internet available at places that people experiencing homelessness spend time in, such as day centres and hostels. These recommendations may have some resource implications but overall, this would likely be small and supporting people to have access to online health and social care information and services, will likely help improve their engagement with services and result in reduced need for costly emergency care, unplanned hospital admissions, morbidity and mortality.

The committee discussed that a significant barrier to accessing health and care services is that general practices refuse registration without an address, despite there being NHS guidance that registration can be done without an address, ID or regardless of immigration status. The recommendation in this area reinforces NHS guidance and may result in more people registering with a general practitioner and accessing health and care services they are eligible and entitled to. The committee also discussed that long waiting times for appointments can be a significant barrier for engagement for people experiencing homelessness. The committee discussed that services understand the negative impact long waiting times can have in enabling access and engagement, and some services do prioritise people experiencing homelessness, but not consistently. In practice, this is not expected to require substantial changes to services, just being more aware of people experiencing homelessness and expediting their access to care, which may create pressure on practitioner time and require some flexibility. The committee discussed that the cost savings would outweigh any additional costs associated with more people accessing services (as a result of more people registering with a GP or expedited access to care). For example, an individual with diabetes picked up early due to registering with a GP may require only inexpensive treatment. However, if it is left undiagnosed and untreated, it can result in many costly complications, such as heart disease, nerve damage, blindness, kidney failure and amputations, there will be increased use of emergency and unplanned care, and also there will be a substantial negative impact on their quality of life and wellbeing.

The committee discussed that identification of immediate risk of harm to self or others reinforces a statutory and professional duty, and would not represent a change in practice. The committee explained that a comprehensive assessment of health needs, social care, and support needs takes a long time and a multiagency individualised approach is essential to do this properly. This should be happening across all services. However, practice is variable and these recommendations may represent a change in practice and result in a resource impact for services that are underperforming. A well done needs assessment would mean that relevant professionals across disciplines and agencies take part. The committee discussed that currently, it is sometimes difficult to engage social care services in this process and the process is often clinically-led. As a result of recommendations in this area more people may be referred to adult social care for care and support needs assessment, under the Care Act 2014. The committee explained that any additional costs should be offset by needs being identified earlier and appropriate support initiated before problems escalate requiring potentially costly interventions such as long hospitalisation.

Hospital can be a good place to provide a comprehensive and holistic assessment of safeguarding, physical and mental health, problem substance use and social care needs. Currently, hospital admissions in many cases are not utilised to do this and represent missed opportunities to start holistic assessment and initiate integrated care. The recommendation in this area may mean that services will need to plan for more tests, procedures and practitioner time and integrated working with different professionals across disciplines and agencies. Conducting a thorough assessment and planning of care during an inpatient stay may also prolong a hospital stay. So there may be some resource impact, however, it can be an efficient way to conduct a holistic assessment and would mean such a process would not be repeated in the community. However, a thorough assessment and planning of integrated care could save effort in the long term, such as preventing people from getting into crisis due to unidentified needs, reducing morbidity and mortality, and associated homelessness costs.

The committee discussed that perhaps the most common reason for irregular discharge (self discharge against medical advice) is when people do not have access to the appropriate dose of methadone in the hospital, and so they self-discharge to address their withdrawal symptoms. There is variation in practice but the recommendations will likely lead to many hospitals needing to review their procedures to avoid self-discharge. For example, hospitals may have to strengthen their links to community services where people experiencing homelessness get their methadone so that the hospital prescription matches the prescription in the community. Hospitals may also need to enhance connections with social services and local authorities so that people experiencing homelessness are linked with the right support after discharge from hospital. This emphasises the importance of an MDT approach and in the case of designated homelessness leads, the importance of being connected with local services. All this may have resource implications, however, there would likely be savings down the line offsetting the costs, through for example reduction in morbidity and mortality, less emergency service use, reduced repeat homelessness and associated costs.

The recovery journey for some people experiencing homelessness can be long, and services need to be persistent, invest in building trust, recognising that people who are experiencing homelessness often do not follow a linear pathway. Currently, such an approach is quite rare, and it could cost more money because it may require lower caseloads, for example. The committee explained that funding is generally available for a fixed caseload only. For example, once a practitioner closes one case, they have to take the next person on, meaning there is no capacity for longer-term support. The committee explained that the benefits associated with a more flexible and persistent approach, for example, reduction in morbidity and mortality, reduction in crisis care or use of emergency services, as well as a potential reduction in wider public sector cost such as homelessness costs and criminal justice system costs, will likely outweigh any additional costs. The committee discussed that when people are not supported, the same people tend to return to homelessness services over and over again and investing in longer-term support may prevent people from experiencing homelessness again. The committee acknowledged that services may need a bit more capacity initially, but there will potentially be fewer people returning to services, as timely help may stabilise people and prevent a complete crisis.

The committee discussed that taking more time (or smaller caseloads), long term engagement, and consistency is essential to building trusting relationships. Services may require additional resources, for example, more practitioner time may be needed to understand individuals history, situation, and needs. However, the benefits of increased engagement with health and social care will likely outweigh additional costs. The committee also discussed how meeting the person’s immediate needs such as providing food or a sleeping bag may improve their engagement. The costs of meeting such immediate needs would generally be negligible when compared with the downstream costs of people being homeless and not engaging with services. Services that can persist, sustain their input, invest in relationship and trust-building, can provide holistic and integrated care, and may potentially lead to a reduction in public sector costs associated with homelessness.

The committee discussed that people experiencing homelessness have generally had limited access to palliative care services. With the introduction of homelessness multidisciplinary teams, coordination and access to specialist services, including palliative care, should be improved. Palliative care services exist, and the recommendation in this area is only about making existing services more accessible.

Front line health and social care staff who are equipped with the right expertise and information to identify and support people experiencing homelessness at the right time and place is not only beneficial for the service user, but can also be beneficial for the services by providing timely and appropriate care. This can lead to reduced use of expensive services such as the need for crisis care, A&E visits, and hospital admissions and reduce other public sector costs associated with homelessness. Training to staff about the often complex and intersecting needs of people experiencing homelessness, the impact of trauma and the stigma and discrimination they often experience can also lead to improved care experiences and increased engagement, improvements in service provision and delivery and improved joined-up ways of working. The right training and support for staff can facilitate a holistic approach to care and enable services to meet individuals needs before their problems escalate. Services could deliver such training alongside existing staff training programmes and the committee were aware of various materials and free resources already available, such as such as e-learning for Healthcare resources: Tackling homelessness, free online training modules by the Faculty for Homeless and Inclusion Health and Public Health England’s guidance on Homelessness: applying All Our Health. Therefore, resource implications for providing staff with training on homelessness and related issues would not be expected to be significant. Furthermore, the recommendations in this area may encourage services to include these elements in their existing training more consistently. These recommendations may also influence the development of professional competencies for trainees and future practitioners

Other factors the committee took into account

From their knowledge and experience, the committee were aware of other NICE guidelines and legislation that is relevant to the topic area of this guideline. The committee agreed to refer to this information where appropriate.

The committee were aware of guidance on service user feedback and input from experts by experience to inform service development and referred to the section on involving people in service design and improvement in NICE's guideline on people's experience in adult social care services.

The committee were aware of guidance for service providers on communication and information and therefore referred to NICE's guidelines on Patient experience in adult NHS services: improving the experience of care for people using adult NHS services and People's experience using adult social care services.

The committee discussed that staff involved in any aspect of care for people experiencing homelessness should be aware of their duties that fall under the Homelessness Reduction Act 2017.

From their knowledge and experience, the committee were aware that all health and social care workers have certain statutory and professional duties under the Care Act 2014 and the Mental Health Act (1983; amended 1995 and 2007).

The committee were aware from their knowledge and experience that multidisciplinary assessments should underpin the local authority care and support needs assessment, according to the Care Act 2014, and follow guidance from care and support needs assessment and care planning in the NICE guideline on people's experience in adult social care services.

The committee discussed the section on competence in the NICE guideline on coexisting severe mental illness (psychosis) and substance misuse for secondary care mental health professionals, which could also apply to professionals involved in the care of some people experiencing homelessness.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.1.1-13, 1.2.1-3, 1.2.6, 1.2.8-9, 1.3.1-8, 1.4.1-4, 1.5.1-17, 1.6.1-7, 1.8.3, 1.11.1-6, 1.12.1-3 and the research recommendation on health and social care to support housing. Other evidence supporting these recommendations can be found in the evidence reviews on access to and engagement with health and social care for individuals experiencing homelessness (A) and joined up health and social care for people experiencing homelessness (B).

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Appendices

Appendix A Review protocols

Review protocol for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

Table 4: Review protocol

ID	Field	Content
0.	PROSPERO registration number	CRD42021230629
1.	Review title	Views and experiences of health and social care for people experiencing homelessness
2.	Review question	What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?
3.	Objective	To establish people's views and experiences relating to what works well and what could be improved about access to health and social care for people experiencing homelessness To establish people's views and experiences relating to what works well and what could be improved about engagement with health and social care for people experiencing homelessness To establish people's views and experiences relating to what works well and what could be improved about the delivery of care and support for people experiencing homelessness.
4.	Searches	The following databases will be searched: • Applied Social Science Index and Abstracts (ASSIA) • Cumulative Index to Nursing and Allied Health Literature (CINAHL) • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Database of Abstracts of Reviews of Effects (DARE) • Embase • Emcare

ID	Field	Content
		• Health Management Information Consortium (HMIC) • MEDLINE (including Medline EPub Ahead of Print; and Medline In-Process & Other Non-Indexed Citations) • PsycINFO • Social Care Online • Social Policy and Practice • Social Sciences Citation Index • Social Services Abstracts • Sociological Abstracts Searches will be restricted by: Date: 1999 onwards Language: English Other searches: • Inclusion lists of systematic reviews • Shelter • Groundswell • Crisis • St Mungos • Salvation Army • Centrepoint • Revolving Door • Homelessness Link • Centre for Housing Policy • Centre for Homelessness Impact • FEANTSA • Kings Fund reports

ID	Field	Content
		• Campbell Collaboration • Gov.uk • OpenGrey For each search (including economic searches), the principal database search strategy is quality assured by a second information specialist using an adaption of the PRESS 2015 Guideline Evidence-Based Checklist. The full search strategies for all databases will be published in the final review.
5.	Condition or domain being studied	Views, perceptions, and/or lived experiences of access to, engagement with and delivery of health and social care for people experiencing homelessness.
6.	Population	• People aged 16 years or older who are experiencing homelessness* • Families, supporters and advocates of people experiencing homelessness • Health, social care and housing practitioners involved in care and support for people experiencing homelessness. *'People experiencing homelessness' is being defined as follows for this guideline • People who are rough sleeping (meaning people without homes who sleep outside or somewhere not designed for habitation) • People who are temporary residents of hostel accommodation (such as emergency night shelters, short-stay hostels, longer stay hostels, domestic violence safe houses, safe houses for victims of modern slavery and probation hostels) • People who are in unsupported temporary accommodation (such as B&Bs) • People who use day centres that provide support (such as food, showers, clothing and advice) for people experiencing homelessness • People staying temporarily with family and friends ('sofa surfing') • Squatters • People with a history of homelessness (as defined by the groups above), who are at high risk of becoming homeless again because of ongoing complex health and social care needs.

ID	Field	Content
7.	Phenomenon of interest	The committee wish to locate qualitative evidence about what works well and what could be improved about access to, engagement with and delivery of care and support for people experiencing homelessness. They anticipate that data from included studies will cover a number of key themes relating to the three main objectives of this question although they are aware that other relevant themes and may also be identified: Access • **Availability**. Data may relate to the range of local services, their location, opening hours, appointment systems and eligibility criteria. • **Affordability**. There may be data about the cost of services, including direct costs, indirect costs, public funding and charitable donations. • **Acceptability**. Experiences relating to provider expectations and user expectations are expected to suggest ways of improving access to care and support. • Additional themes relating to access may include knowledge and awareness of services, prioritisation, registration for services, and the role of technology, transport, inequality, environmental factors, language and communication issues and discrimination. • The emotional impact of poor or limited access to health and social care. **Engagement** • The skills, training and values of practitioners for supporting and engaging people, including working with people from all communities and sub groups of this population. • Issues around fear, apprehension and trust • Communication. • The role of user led models built on trust between people with common experiences. • Sustaining ongoing engagement and active participation.

ID	Field	Content
		• Identifying groups for whom engagement is particularly challenging and understanding which populations are 'missing' from certain services. **<u>Delivery</u>** • Care quality • Holistic responses to complex needs • Cultural sensitivity and cultural appropriateness • Individualised care and support • Stigma and discrimination • Role and availability of outreach • Consistency and care continuity • Navigating complex care and support systems • Language and communication
8.	Comparator/Reference standard/Confounding factors	Not applicable as this is a qualitative review.
9.	Types of study to be included	• Systematic reviews of qualitative studies • Studies using qualitative methods: data collection via focus groups, semi-structured and structured interviews, observations • Surveys conducted using open ended questions and a qualitative analysis of responses • Note: Mixed methods studies will be included but only qualitative data will be extracted and risk of bias assessed.
10.	Other exclusion criteria	Inclusion: • Full text papers • Studies conducted in the UK will be included. • Studies conducted in high income (according to the World Bank) sovereign state members of the European Federation of National Organisations working with the Homeless (FEANTSA) will also be considered for inclusion.

ID	Field	Content
		• Studies conducted in Canada, Australia and the US will also be considered for inclusion. Exclusion: Concerned about ensuring included data have sufficient relevance to inform decision making about recommendations in the practice context of the scope, the committee agreed the following criteria: • Studies conducted outside the UK should be excluded if findings do not relate to innovative approaches* to health and social care for people experiencing homelessness • Additionally, studies conducted in the US should be excluded if findings relate to care and support for veterans • Studies conducted anywhere outside the UK should be excluded if they are published before 2010. *Within this context 'innovative' is taken to mean 'care and support delivered via outreach services or by a team of multidisciplinary professionals or a mix of professionals and peers'. Further exclusion criteria: • Articles reporting UK research published before 1999 • Papers that do not include any methodological details as they do not provide sufficient information to evaluate risk of bias/ study quality. • Studies using quantitative methods only (including surveys that report only quantitative data) • Surveys using mainly closed questions or which quantify open ended answers for analysis. • Non-English language articles

ID	Field	Content
		Thematic saturation: 1. Data or theme(s) from included studies will not be extracted for particular theme(s) if thematic saturation is reached. 2. Papers included on full text will subsequently be excluded when the whole anticipated framework of phenomena (see anticipated themes listed in row 7) has reached thematic saturation. That is, when evidence synthesis and the application of GRADE-CERQual show that data about all aspects of the phenomenon of interest are 'adequate' and 'coherent'. See row 7 above for details of the anticipated framework of phenomenon and associated rationale.
11.	Context	No previous guidelines will be updated by this review question.
12.	Primary outcomes (critical outcomes)	Outcomes, not applicable as this is a qualitative review. For anticipated themes, see row 7 above. 'Phenomenon of interest'.
13.	Secondary outcomes (important outcomes)	Outcomes, not applicable as this is a qualitative review. For anticipated themes, see row 7 above. 'Phenomenon of interest'.
14.	Data extraction (selection and coding)	• All references identified by the searches and from other sources will be uploaded into EPPI-reviewer v5 and de-duplicated. Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. • Duplicate screening will be undertaken for 10% of items. • Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed along with the reason for its exclusion. • The excluded studies list will be circulated to the Topic Group for their comments. Resolution of disputes will be by discussion between the senior reviewer, Topic Advisors and Chair.

ID	Field	Content	
		- A standardised form will be used to extract data from included studies, providing study reference, research question, data collection and analysis methods used, participant characteristics, second-order themes, and relevant first-order themes (i.e. supporting quotes). One reviewer will extract relevant data into a standardised form. This will be quality assessed by the senior reviewer.	
15.	Risk of bias (quality) assessment	Risk of bias of individual studies will be assessed using the preferred checklist as described in Developing NICE guidelines: the manual. The critical appraisal will be performed by one reviewer and this will be quality assured by the senior reviewer.	
16.	Strategy for data synthesis	- Extracted second-order study themes and related first-order quotes will be synthesised by the reviewer into third-order themes and related sub-themes as 'review findings'. - The GRADE-CERQual approach will be used to summarise the confidence in the review findings synthesized from the qualitative evidence ('Using qualitative evidence in decision making for health and social interventions'; Lewin 2015). The overall confidence in evidence about each review finding will be rated on four dimensions: methodological limitations, coherence, adequacy, and relevance.	
17.	Analysis of sub-groups	As this is a qualitative review sub group analysis is not possible. However, if data allow, the review will include information regarding differences in views held between certain groups or about different approaches to health and social care for people experiencing homelessness.	
18.	Type and method of review	☐	Intervention
		☐	Diagnostic
		☐	Prognostic
		☒	Qualitative
		☐	Epidemiologic
		☐	Service Delivery
		☐	Other (please specify)

ID	Field	Content		
19.	Language	English		
20.	Country	England		
21.	Anticipated or actual start date	December 2020		
22.	Anticipated completion date	December 2021		
23.	Stage of review at time of this submission	Review stage	Started	Completed
		Preliminary searches	☑	☑
		Piloting of the study selection process	☑	☑
		Formal screening of search results against eligibility criteria	☑	☑
		Data extraction	☑	☑
		Risk of bias (quality) assessment	☑	☑
		Data analysis	☑	☑
24.	Named contact	**5a. Named contact** National Guideline Alliance **5b. Named contact e-mail** HomelessnessIHC@nice.org.uk **5c Organisational affiliation of the review** National Institute for Health and Care Excellence (NICE) and National Guideline Alliance		
25.	Review team members	NGA Technical Team		
26.	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance, which receives funding from NICE.		
27.	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any		

ID	Field	Content	
		potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.	
28.	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10145/documents	
29.	Other registration details	Not applicable	
30.	URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021230629	
31.	Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: • notifying registered stakeholders of publication • publicising the guideline through NICE's newsletter and alerts • issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.	
32.	Keywords		
33.	Details of existing review of same topic by same authors	Not applicable	
34.	Current review status	☒	Ongoing
		☐	Completed but not published
		☐	Completed and published
		☐	Completed, published and being updated
		☐	Discontinued
35.	Additional information	Not applicable	

ID	Field	Content
36.	Details of final publication	www.nice.org.uk

CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; DARE: Database of Abstracts of Reviews of Effects; GRADE: Grading of Recommendations Assessment, Development and Evaluation; HTA: Health Technology Assessment; MID: minimally important difference; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; RCT: randomised controlled trial; RoB: risk of bias; SD: standard deviation

Appendix B Literature search strategies

Literature search strategies for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

Databases: Medline; Medline EPub Ahead of Print; and Medline In-Process & Other Non-Indexed Citations

Date of last search: 22/12/2020

#	Searches
1	HOMELESS PERSONS/
2	HOMELESS YOUTH/
3	(homeless$ or home less$).ti,ab.
4	(roofless$ or roof less$).ti,ab.
5	(houseless$ or house less$).ti,ab.
6	(without homes or without roofs or without house? or without housing or without accommodation or without dwellings or without habitation? or without residence? or without shelter?).ti,ab.
7	("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter").ti,ab.
8	((excluded or exclusion or evict$) adj3 (home? or house? or housing or accommodat$ or dwell$ or habitation? or residence? or shelter?)).ti,ab.
9	(un-housed or unhoused).ti,ab.
10	((unstab$ or un-stab$ or instab$ or insecur$ or precarious$ or marginal$ or improvis$) adj3 (house? or housing or accommodat$ or dwell$ or habitation?)).ti,ab.
11	((unstab$ or un-stab$ or instab$ or insecur$) adj3 residence?).ti,ab.
12	(vulnerabl$ adj3 (housed or accommodated)).ti,ab.
13	((unsupport$ or un-support$) adj3 (house? or housing or accommodat$)).ti,ab.
14	((temporar$ or emergenc$) adj3 (house? or housing or accommodat$ or dwell$ or habitation? or residence?)).ti,ab.
15	((hostel? or shelter? or safehous$ or safe hous$ or crisishous$ or crisis hous$) adj3 (temporar$ or emergenc$ or short$ term or stay$ or living)).ti,ab.
16	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or dormitor$ or halfway hous$) adj3 (temporar$ or short$ term)).ti,ab.
17	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or halfway hous$) adj3 living).ti,ab.
18	(sofa? adj3 surf$).ti,ab.
19	(squat$ adj3 (live? or living or stay$ or temporar$)).ti,ab.
20	squatter?.ti,ab.
21	((rough$ or out or outside) adj3 sleep$).ti,ab.
22	(street? adj3 (people? or person? or sleep$ or live? or living or dwell$)).ti,ab.
23	destitut$.ti,ab.
24	"no fixed abode?".ti,ab.
25	"no fixed address$".ti,ab.
26	or/1-25
27	interview:.mp.
28	experience:.mp.
29	qualitative.tw.
30	or/27-29
31	26 and 30
32	limit 31 to english language
33	limit 32 to yr="1999 -Current"

Databases: Embase; and Embase Classic

Date of last search: 22/12/2020

#	Searches
1	HOMELESSNESS/
2	exp HOMELESS PERSON/
3	(homeless$ or home less$).ti,ab.
4	(roofless$ or roof less$).ti,ab.
5	(houseless$ or house less$).ti,ab.
6	(without homes or without roofs or without house? or without housing or without accommodation or without dwellings or without habitation? or without residence? or without shelter?).ti,ab.
7	("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter").ti,ab.

#	Searches
8	((excluded or exclusion or evict$) adj3 (home? or house? or housing or accommodat$ or dwell$ or habitation? or residence? or shelter?)).ti,ab.
9	(un-housed or unhoused).ti,ab.
10	((unstab$ or un-stab$ or instab$ or insecur$ or precarious$ or marginal$ or improvis$) adj3 (house? or housing or accommodat$ or dwell$ or habitation?)).ti,ab.
11	((unstab$ or un-stab$ or instab$ or insecur$) adj3 residence?).ti,ab.
12	(vulnerabl$ adj3 (housed or accommodated)).ti,ab.
13	((unsupport$ or un-support$) adj3 (house? or housing or accommodat$)).ti,ab.
14	((temporar$ or emergenc$) adj3 (house? or housing or accommodat$ or dwell$ or habitation? or residence?)).ti,ab.
15	((hostel? or shelter? or safehous$ or safe hous$ or crisishous$ or crisis hous$) adj3 (temporar$ or emergenc$ or short$ term or stay$ or living)).ti,ab.
16	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or dormitor$ or halfway hous$) adj3 (temporar$ or short$ term)).ti,ab.
17	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or halfway hous$) adj3 living).ti,ab.
18	(sofa? adj3 surf$).ti,ab.
19	(squat$ adj3 (live? or living or stay$ or temporar$)).ti,ab.
20	squatter?.ti,ab.
21	((rough$ or out or outside) adj3 sleep$).ti,ab.
22	(street? adj3 (people? or person? or sleep$ or live? or living or dwell$)).ti,ab.
23	destitut$.ti,ab.
24	"no fixed abode?".ti,ab.
25	"no fixed address$".ti,ab.
26	or/1-25
27	interview:.tw.
28	exp HEALTH CARE ORGANIZATION/
29	experiences.tw.
30	or/27-29
31	26 and 30
32	limit 31 to english language
33	limit 32 to yr="1999 -Current"

Database: Health Management Information Consortium (HMIC)

Date of last search: 22/12/2020

#	Searches
1	HOMELESSNESS/
2	EVICTION/
3	SQUATTERS/
4	VAGRANCY/
5	(homeless$ or home less$).ti,ab.
6	(roofless$ or roof less$).ti,ab.
7	(houseless$ or house less$).ti,ab.
8	(without homes or without roofs or without house? or without housing or without accommodation or without dwellings or without habitation? or without residence? or without shelter?).ti,ab.
9	("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter").ti,ab.
10	((excluded or exclusion or evict$) adj3 (home? or house? or housing or accommodat$ or dwell$ or habitation? or residence? or shelter?)).ti,ab.
11	(un-housed or unhoused).ti,ab.
12	((unstab$ or un-stab$ or instab$ or insecur$ or precarious$ or marginal$ or improvis$) adj3 (house? or housing or accommodat$ or dwell$ or habitation?)).ti,ab.
13	((unstab$ or un-stab$ or instab$ or insecur$) adj3 residence?).ti,ab.
14	(vulnerabl$ adj3 (housed or accommodated)).ti,ab.
15	((unsupport$ or un-support$) adj3 (house? or housing or accommodat$)).ti,ab.
16	((temporar$ or emergenc$) adj3 (house? or housing or accommodat$ or dwell$ or habitation? or residence?)).ti,ab.
17	((hostel? or shelter? or safehous$ or safe hous$ or crisishous$ or crisis hous$) adj3 (temporar$ or emergenc$ or short$ term or stay$ or living)).ti,ab.
18	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or dormitor$ or halfway hous$) adj3 (temporar$ or short$ term)).ti,ab.
19	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or halfway hous$) adj3 living).ti,ab.
20	(sofa? adj3 surf$).ti,ab.
21	(squat$ adj3 (live? or living or stay$ or temporar$)).ti,ab.
22	squatter?.ti,ab.
23	((rough$ or out or outside) adj3 sleep$).ti,ab.
24	(street? adj3 (people? or person? or sleep$ or live? or living or dwell$)).ti,ab.
25	destitut$.ti,ab.

#	Searches
26	"no fixed abode?".ti,ab.
27	"no fixed address$".ti,ab.
28	or/1-27
29	QUALITATIVE ANALYSIS/
30	QUALITATIVE TECHNIQUES/
31	QUALITATIVE RESEARCH/
32	interview$.mp.
33	experience$.mp.
34	qualitative$.mp.
35	view?.mp.
36	survey$.mp.
37	focus group?.mp.
38	or/29-37
39	28 and 38
40	limit 39 to yr="1999 -Current"

Database: Social Policy and Practice

Date of last search: 22/12/2020

#	Searches
1	(homeless$ or home less$).ti,ab.
2	(roofless$ or roof less$).ti,ab.
3	(houseless$ or house less$).ti,ab.
4	(without homes or without roofs or without house? or without housing or without accommodation or without dwellings or without habitation? or without residence? or without shelter?).ti,ab.
5	("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter").ti,ab.
6	((excluded or exclusion or evict$) adj3 (home? or house? or housing or accommodat$ or dwell$ or habitation? or residence? or shelter?)).ti,ab.
7	(un-housed or unhoused).ti,ab.
8	((unstab$ or un-stab$ or instab$ or insecur$ or precarious$ or marginal$ or improvis$) adj3 (house? or housing or accommodat$ or dwell$ or habitation?)).ti,ab.
9	((unstab$ or un-stab$ or instab$ or insecur$) adj3 residence?).ti,ab.
10	(vulnerabl$ adj3 (housed or accommodated)).ti,ab.
11	((unsupport$ or un-support$) adj3 (house? or housing or accommodat$)).ti,ab.
12	((temporar$ or emergenc$) adj3 (house? or housing or accommodat$ or dwell$ or habitation? or residence?)).ti,ab.
13	((hostel? or shelter? or safehous$ or safe hous$ or crisishous$ or crisis hous$) adj3 (temporar$ or emergenc$ or short$ term or stay$ or living)).ti,ab.
14	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or dormitor$ or halfway hous$) adj3 (temporar$ or short$ term)).ti,ab.
15	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or halfway hous$) adj3 living).ti,ab.
16	(sofa? adj3 surf$).ti,ab.
17	(squat$ adj3 (live? or living or stay$ or temporar$)).ti,ab.
18	squatter?.ti,ab.
19	((rough$ or out or outside) adj3 sleep$).ti,ab.
20	(street? adj3 (people? or person? or sleep$ or live? or living or dwell$)).ti,ab.
21	destitut$.ti,ab.
22	"no fixed abode?".ti,ab.
23	"no fixed address$".ti,ab.
24	or/1-23
25	interview$.mp.
26	experience$.mp.
27	qualitative$.mp.
28	view?.mp.
29	survey$.mp.
30	focus group?.mp.
31	or/25-30
32	24 and 31
33	limit 32 to yr="1999 -Current"

Database: PsycInfo

Date of last search: 22/12/2020

#	Searches
1	HOMELESS/
2	HOMELESS MENTALLY ILL/
3	(homeless$ or home less$).ti,ab.
4	(roofless$ or roof less$).ti,ab.
5	(houseless$ or house less$).ti,ab.
6	(without homes or without roofs or without house? or without housing or without accommodation or without dwellings or without habitation? or without residence? or without shelter?).ti,ab.
7	("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter").ti,ab.
8	((excluded or exclusion or evict$) adj3 (home? or house? or housing or accommodat$ or dwell$ or habitation? or residence? or shelter?)).ti,ab.
9	(un-housed or unhoused).ti,ab.
10	((unstab$ or un-stab$ or instab$ or insecur$ or precarious$ or marginal$ or improvis$) adj3 (house? or housing or accommodat$ or dwell$ or habitation?)).ti,ab.
11	((unstab$ or un-stab$ or instab$ or insecur$) adj3 residence?).ti,ab.
12	(vulnerabl$ adj3 (housed or accommodated)).ti,ab.
13	((unsupport$ or un-support$) adj3 (house? or housing or accommodat$)).ti,ab.
14	((temporar$ or emergenc$) adj3 (house? or housing or accommodat$ or dwell$ or habitation? or residence?)).ti,ab.
15	((hostel? or shelter? or safehous$ or safe hous$ or crisishous$ or crisis hous$) adj3 (temporar$ or emergenc$ or short$ term or stay$ or living)).ti,ab.
16	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or dormitor$ or halfway hous$) adj3 (temporar$ or short$ term)).ti,ab.
17	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or halfway hous$) adj3 living).ti,ab.
18	(sofa? adj3 surf$).ti,ab.
19	(squat$ adj3 (live? or living or stay$ or temporar$)).ti,ab.
20	squatter?.ti,ab.
21	((rough$ or out or outside) adj3 sleep$).ti,ab.
22	(street? adj3 (people? or person? or sleep$ or live? or living or dwell$)).ti,ab.
23	destitut$.ti,ab.
24	"no fixed abode?".ti,ab.
25	"no fixed address$".ti,ab.
26	or/1-25
27	experiences.tw.
28	interview:.tw.
29	qualitative.tw.
30	or/27-29
31	26 and 30
32	limit 31 to english language
33	limit 32 to yr="1999 -Current"
34	limit 33 to ("0100 journal" or "0110 peer-reviewed journal")

Database: Emcare

Date of last search: 22/12/2020

#	Searches
1	HOMELESSNESS/
2	exp HOMELESS PERSON/
3	(homeless$ or home less$).ti,ab.
4	(roofless$ or roof less$).ti,ab.
5	(houseless$ or house less$).ti,ab.
6	(without homes or without roofs or without house? or without housing or without accommodation or without dwellings or without habitation? or without residence? or without shelter?).ti,ab.
7	("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter").ti,ab.
8	((excluded or exclusion or evict$) adj3 (home? or house? or housing or accommodat$ or dwell$ or habitation? or residence? or shelter?)).ti,ab.
9	(un-housed or unhoused).ti,ab.
10	((unstab$ or un-stab$ or instab$ or insecur$ or precarious$ or marginal$ or improvis$) adj3 (house? or housing or accommodat$ or dwell$ or habitation?)).ti,ab.
11	((unstab$ or un-stab$ or instab$ or insecur$) adj3 residence?).ti,ab.
12	(vulnerabl$ adj3 (housed or accommodated)).ti,ab.
13	((unsupport$ or un-support$) adj3 (house? or housing or accommodat$)).ti,ab.
14	((temporar$ or emergenc$) adj3 (house? or housing or accommodat$ or dwell$ or habitation? or residence?)).ti,ab.
15	((hostel? or shelter? or safehous$ or safe hous$ or crisishous$ or crisis hous$) adj3 (temporar$ or emergenc$ or short$ term or stay$ or living)).ti,ab.
16	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or dormitor$ or halfway hous$) adj3 (temporar$ or short$ term)).ti,ab.

#	Searches
17	((hotel? or "bed and breakfast?" or "B&B" or "B&Bs" or boarding house? or rooming house? or halfway hous$) adj3 living).ti,ab.
18	(sofa? adj3 surf$).ti,ab.
19	(squat$ adj3 (live? or living or stay$ or temporar$)).ti,ab.
20	squatter?.ti,ab.
21	((rough$ or out or outside) adj3 sleep$).ti,ab.
22	(street? adj3 (people? or person? or sleep$ or live? or living or dwell$)).ti,ab.
23	destitut$.ti,ab.
24	"no fixed abode?".ti,ab.
25	"no fixed address$".ti,ab.
26	or/1-25
27	interview:.tw.
28	exp HEALTH CARE ORGANIZATION/
29	experiences.tw.
30	or/27-29
31	26 and 30
32	limit 31 to english language
33	limit 32 to yr="1999 -Current"

Databases: Cochrane Central Register of Controlled Trials (CCTR); and Cochrane Database of Systematic Reviews (CDSR)

Date of last search: 22/12/2020

#	Searches
#1	MeSH descriptor: [Homeless Persons] this term only
#2	MeSH descriptor: [Homeless Youth] this term only
#3	(homeless* or "home less*"):ti,ab
#4	(roofless* or "roof less*"):ti,ab
#5	(houseless* or "house less*"):ti,ab
#6	("without homes" or "without roofs" or "without house*" or "without housing" or "without accommodation" or "without dwellings" or "without habitation*" or "without residence*" or "without shelter" or "without shelters"):ti,ab
#7	("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter"):ti,ab
#8	((excluded or exclusion or evict*) near/3 (home* or house* or housing or accommodat* or dwell* or habitation* or residence* or shelter or shelters)):ti,ab
#9	(un-housed or unhoused):ti,ab
#10	((unstab* or un-stab* or instab* or insecur* or precarious* or marginal* or improvis*) near/3 (house* or housing or accommodat* or dwell* or habitation*)):ti,ab
#11	((unstab* or un-stab* or instab* or insecur*) near/3 residence*):ti,ab
#12	(vulnerabl* near/3 (housed or accommodated)):ti,ab
#13	((unsupport* or un-support*) near/3 (house* or housing or accommodat*)):ti,ab
#14	((temporar* or emergenc*) near/3 (house* or housing or accommodat* or dwell* or habitation* or residence*)):ti,ab
#15	((hostel* or shelter or shelters or safehous* or "safe hous*" or crisishous* or "crisis hous*") near/3 (temporar* or emergenc* or "short* term" or stay* or living)):ti,ab
#16	((hotel* or "bed and breakfast*" or "B&B" or "B&Bs" or "boarding house*" or "rooming house*" or dormitor* or "halfway hous*") near/3 (temporar* or "short* term")):ti,ab
#17	((hotel* or "bed and breakfast*" or "B&B" or "B&Bs" or "boarding house*" or "rooming house*" or "halfway hous*") near/3 living):ti,ab
#18	(sofa* near/3 surf*):ti,ab
#19	(squat* near/3 (live* or living or stay* or temporar*)):ti,ab
#20	squatter*:ti,ab
#21	(rough* near/3 sleep*):ti,ab
#22	("sleep* out" or "sleep* outside"):ti,ab
#23	(street* near/3 (people* or person* or sleep* or live* or living or dwell*)):ti,ab
#24	destitut*:ti,ab
#25	"no fixed abode*":ti,ab
#26	"no fixed address*":ti,ab
#27	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26
#28	MeSH descriptor: [Qualitative Research] this term only
#29	interview*:ti,ab
#30	experiences:ti,ab
#31	qualitative*:ti,ab
#32	(view or views):ti,ab
#33	survey*:ti,ab
#34	("focus group" or "focus groups"):ti,ab
#35	#28 or #29 or #30 or #31 or #32 or #33 or #34

#	Searches
#36	#27 and #35
#37	#27 and #35 with Cochrane Library publication date Between Jan 1999 and Dec 2020, in Cochrane Reviews
#38	#27 and #35 with Publication Year from 1999 to 2020, in Trials

Database: Database of Abstracts of Reviews of Effects (DARE)

Date of last search: 22/12/2020

#	Searches
1	MeSH DESCRIPTOR homeless persons IN DARE
2	MeSH DESCRIPTOR homeless youth IN DARE
3	(((homeless* or "home less*"))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
4	(((roofless* or "roof less*"))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
5	(((houseless* or "house less*"))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
6	((("without homes" or "without roofs" or "without house*" or "without housing" or "without accommodation" or "without dwellings" or "without habitation*" or "without residence*" or "without shelter" or "without shelters"))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
7	((("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter"))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
8	((((excluded or exclusion or evict*) near3 (home* or house* or housing or accommodat* or dwell* or habitation* or residence* or shelter or shelters)))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
9	(((un-housed or unhoused))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
10	((((unstab* or un-stab* or instab* or insecur* or precarious* or marginal* or improvis*) near3 (house* or housing or accommodat* or dwell* or habitation*)))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
11	((((unstab* or un-stab* or instab* or insecur*) near3 residence*))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
12	(((vulnerabl* near3 (housed or accommodated)))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
13	((((unsupport* or un-support*) near3 (house* or housing or accommodat*)))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
14	((((temporar* or emergenc*) near3 (house* or housing or accommodat* or dwell* or habitation* or residence*)))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
15	((((hostel* or shelter or shelters or safehous* or "safe hous*" or crisishous* or "crisis hous*") near3 (temporar* or emergenc* or "short* term" or stay* or living)))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
16	(((sofa* near3 surf*))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
17	(((squat* near3 (live* or living or stay* or temporar*)))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
18	((squatter*)) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
19	(((rough* near3 sleep*))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
20	((("sleep* out" or "sleep* outside"))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
21	(((street* near3 (people* or person* or sleep* or live* or living or dwell*)))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
22	((destitut*)) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
23	(("no fixed abode*")) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
24	(("no fixed address*")) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
25	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24
26	MeSH DESCRIPTOR qualitative research IN DARE
27	((interview*)) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
28	((experience*)) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
29	((qualitative*)) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
30	(((view or views))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
31	((survey*)) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
32	((("focus group" or "focus groups"))) and ((Systematic review:ZDT and Bibliographic:ZPS) OR (Systematic review:ZDT and Abstract:ZPS))
33	#26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32
34	#25 AND #33

Databases: Applied Social Sciences Index & Abstracts (ASSIA); Social Services Abstracts; and Sociological Abstracts

Date of last search: 22/12/2020

#	Searches
	AB,TI (homeless* or "home less*" or roofless* or "roof less*" or houseless* or "house less*" or un-housed or unhoused or "unstable hous*" or "un-stable hous*" or "hous instability" or "unstable accommodation" or "un-stable accommodation" or "unsupport hous*" or "un-support hous*" or "unsupport accommodation" or "unsupport accommodation" or "temporary hous*" or "temporary accommodation" or safehous* or "safe hous*" or crisishous* or "crisis hous*" or hostel? or shelter? or "sofa surf*" or squatter? or "rough sleep*" or "sleep* rough" or "sleep* out" or "sleep* outside" or destitut* or "no fixed abode*" or "no fixed address*")
AND	AB,TI (interview* or experiences or qualitative* or view? or survey* or "focus group?")
AND	Additional limits - Date: From January 1999 to December 2020

Database: CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature)

Date of last search: 22/12/2020

#	Searches
S1	TX(homeless* or "home less*" or roofless* or "roof less*" or houseless* or "house less*" or un-housed or unhoused or "unstable hous*" or "un-stable hous*" or "hous instability" or "unstable accommodation" or "un-stable accommodation" or "unsupport hous*" or "un-support hous*" or "unsupport accommodation" or "unsupport accommodation" or "temporary hous*" or "temporary accommodation" or safehous* or "safe hous*" or crisishous* or "crisis hous*" or hostel? or shelter? or "sofa surf*" or squatter? or "rough sleep*" or "sleep* rough" or "sleep* out" or "sleep* outside" or destitut* or "no fixed abode*" or "no fixed address*") Limiters - Publication Year: 1999-2020; Clinical Queries: Qualitative - Best Balance

Database: Social Sciences Citation Index (SSCI)

Date of last search: 22/12/2020

#	Searches
# 1	TITLE: (homeless* or "home less*") Indexes=SSCI Timespan=1999-2020
# 2	TITLE: (roofless* or "roof less*") Indexes=SSCI Timespan=1999-2020
# 3	TITLE: (houseless* or "house less*") Indexes=SSCI Timespan=1999-2020
# 4	TITLE: ("without homes" or "without roofs" or "without house$" or "without housing" or "without accommodation" or "without dwellings" or "without habitation$" or "without residence$" or "without shelter$") Indexes=SSCI Timespan=1999-2020
# 5	TITLE: ("without a home" or "without a roof" or "without a house" or "without a dwelling" or "without a residence" or "without a shelter") Indexes=SSCI Timespan=1999-2020
# 6	TITLE: (((excluded or exclusion or evict*) near/3 (home$ or house$ or housing or accommodat* or dwell* or habitation$ or residence$ or shelter$))) Indexes=SSCI Timespan=1999-2020
# 7	TITLE: (un-housed or unhoused) Indexes=SSCI Timespan=1999-2020
# 8	TITLE: (((unstab* or un-stab* or instab* or insecur* or precarious* or marginal* or improvis*) near/3 (house$ or housing or accommodat* or dwell* or habitation$))) Indexes=SSCI Timespan=1999-2020
# 9	TITLE: (((unstab* or un-stab* or instab* or insecur*) near/3 residence$)) Indexes=SSCI Timespan=1999-2020
# 10	TITLE: ((vulnerabl* near/3 (housed or accommodated))) Indexes=SSCI Timespan=1999-2020
# 11	TITLE: (((unsupport* or un-support*) near/3 (house$ or housing or accommodat*))) Indexes=SSCI Timespan=1999-2020
# 12	TITLE: (((temporar* or emergenc*) near/3 (house$ or housing or accommodat* or dwell* or habitation$ or residence$))) Indexes=SSCI Timespan=1999-2020
# 13	TITLE: (((hostel$ or shelter$ or safehous* or "safe hous*" or crisishous* or "crisis hous*") near/3 (temporar* or emergenc* or "short* term" or stay* or living))) Indexes=SSCI Timespan=1999-2020
# 14	TITLE: (((hotel$ or "bed and breakfast$" or "B&B" or "B&Bs" or "boarding house$" or "rooming house$" or dormitor* or "halfway hous*") near/3 (temporar* or "short* term"))) Indexes=SSCI Timespan=1999-2020
# 15	TITLE: (((hotel$ or "bed and breakfast$" or "B&B" or "B&Bs" or "boarding house$" or "rooming house$" or "halfway hous*") near/3 living)) Indexes=SSCI Timespan=1999-2020
# 16	TITLE: ((sofa$ near/3 surf*)) Indexes=SSCI Timespan=1999-2020
# 17	TITLE: ((squat* near/3 (live$ or living or stay* or temporar*))) Indexes=SSCI Timespan=1999-2020
# 18	TITLE: (squatter$) Indexes=SSCI Timespan=1999-2020
# 19	TITLE: (((rough* or out or outside) near/3 sleep*)) Indexes=SSCI Timespan=1999-2020
# 20	TITLE: ((street$ near/3 (people$ or person$ or sleep* or live$ or living or dwell*))) Indexes=SSCI Timespan=1999-2020

#	Searches
# 21	TITLE: (destitut*) Indexes=SSCI Timespan=1999-2020
# 22	TITLE: ("no fixed abode$") Indexes=SSCI Timespan=1999-2020
# 23	TITLE: ("no fixed address*") Indexes=SSCI Timespan=1999-2020
# 24	#23 OR #22 OR #21 OR #20 OR #19 OR #18 OR #17 OR #16 OR #15 OR #14 OR #13 OR #12 OR #11 OR #10 OR #9 OR #8 OR #7 OR #6 OR #5 OR #4 OR #3 OR #2 OR #1 Indexes=SSCI Timespan=1999-2020
# 25	TITLE: (interview*) Indexes=SSCI Timespan=1999-2020
# 26	TITLE: (experience*) Indexes=SSCI Timespan=1999-2020
# 27	TITLE: (qualitative*) Indexes=SSCI Timespan=1999-2020
# 28	TITLE: (view$) Indexes=SSCI Timespan=1999-2020
# 29	TITLE: (survey*) Indexes=SSCI Timespan=1999-2020
# 30	TITLE: ("focus group$") Indexes=SSCI Timespan=1999-2020
# 31	#30 OR #29 OR #28 OR #27 OR #26 OR #25 Indexes=SSCI Timespan=1999-2020
# 32	#31 AND #24 Indexes=SSCI Timespan=1999-2020

Database: Social Care Online

Date of last search: 22/12/2020

#	Searches
	AllFields:'homeless or "home less" or roofless or "roof less" or houseless or "house less" or un-housed or unhoused or unstable hous or un-stable hous or hous instability or unstable accommodation or un-stable accommodation or unsupport hous or un-support hous or unsupport accommodation or unsupport accommodation or temporary hous or temporary accommodation or safehous or "safe hous" or crisishous or "crisis hous" or hostel or shelter or sofa or squatting or squatter or rough sleep or sleep rough or sleep out or destitut or "no fixed abode" or "no fixed address"'
	AND AllFields:'Interview or experience or qualitative or view or survey or "focus group"'
	AND PublicationYear:'1999 2020'

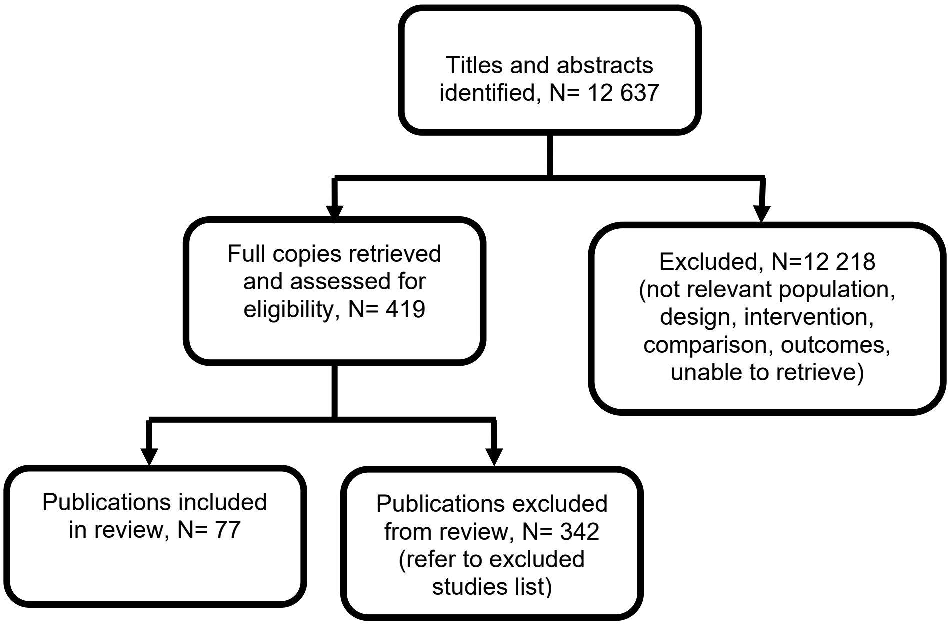
Please note that the webpages of the following organisations were also checked on 22/12/2020 for qualitative evidence relevant to this review:

- Shelter
- Groundswell
- Crisis
- St Mungos
- Salvation Army
- Centrepoint
- Centre for Homelessness Impact
- FEANTSA
- Revolving Door
- Centre for Housing Policy
- Homeless Link
- Kings Fund
- Gov.uk
- Campbell Collaboration
- OpenGrey

Appendix C Qualitative evidence study selection

Study selection for: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

Figure 7: Study selection flow chart



Appendix D Evidence tables – Qualitative evidence

Evidence tables for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

Table 5: Evidence tables

Adkins, 2017

Bibliographic Reference	Adkins, E. C.; Zalta, A. K.; Boley, R. A.; Glover, A.; Karnik, N. S.; Schueller, S. M.; Exploring the potential of technology-based mental health services for homeless youth: A qualitative study; Psychological services; 2017; vol. 14 (no. 2); 238-245

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	US
Setting	Focus groups took place at the shelter during a time that was convenient for all shelter residents.
Data collection and analysis	Five focus groups were conducted consisting of 4–6 participants per group along with 2–3 facilitators from the research team. Focus groups lasted 90-minutes. A semi-structured interview was used to guide a collaborative discussion. The interviews were audio recorded, transcribed, and coded using ATLAS.ti. Analysis was guided by the grounded theory approach.
Recruitment strategy	Homeless youth were recruited via referrals from case managers at a youth homeless shelter located in a large urban city.
Study dates	Not reported
Sources of funding	Funding received from Help for Children/Hedge Funds Care (HFC) and Sparrow: Mobile for All.

	Dr. Schueller (author) is supported by a grant from NIMH (K08 MH102336). Dr. Zalta (author) is supported by a grant from NIMH (K23 MH103394).
Inclusion criteria	• English-speaking • Homeless • Aged 18 – 22 years old • Currently sheltered • Willing and able to comply with requirements of the study protocol.
Exclusion criteria	Not reported
Sample size	N=24 homeless youth
Participant characteristics	**Gender** Male: 9/24 Female: 15/24 **Age** Average age: 18.8 years (SD=0.8)
Results	<u>Negative experience with a Mental Health System</u> The authors report that homeless youth had negative experiences with mental health services, including feeling like they are not heard, experience of poor relationships with service providers, and feeling like service providers wanted to get rid of them quickly. The latter was particularly true in the case of medications. *“I remember that about therapy that I never felt like I got listened to. I felt like it was supposed to be for me but the only one who was talking was my mom. The only one they were listening to was my mom.” “They forced me to take some type of medication and then I told them it doesn’t help my anger because my anger is not in like my head, it’s coming from the situations that I go through. And they told me that okay well we’re going to up your dosage. So I went from 20 mg to 40 mg then to 80 mg, which is close to lithium. Then I told them well it’s still not doing anything, so they put me on a mood stabilizer.”* [Quotes: p.6] <u>Positive experience with a Mental Health System</u> Some positive experiences included times in which therapists successfully built rapport, stayed neutral, empathised, and helped the youth with problems they felt were important. *“I had a therapist…I think she was like the most neutral lady*

	I've ever met. I mean she obviously showed emotion towards something things, but as far as like the way she went about helping with like my depression and stuff because I used to be depressed like every day all day, just based on what I was going through. But the lady, she kept it professional but she made it seem like she was part of my family in a way where she made me connect with my mom…I felt like therapy where like how she said they actually share with you information about (inaudible) just not a one-sided conversation like yeah, I need help with this and I'm here because of this. And she's like you know I actually dealt with this in my life where blah, blah, blah happens so I feel like for it to be successful like it to be successful like relationship or successful therapy like the other, the helper needs to vent also so whoever is receiving it feels like okay they actually know what they're talking about or that actually seems like a pretty good idea because look at how they are now." [Quote: p.6-7] <ins>Potential for Mobile Technology to Address Mental Health Needs</ins> Many participants reported that they would be interested in using a mental health, mobile phone application for general emotional support. This included seeking help with life decisions, planning, day-to-day stressors, problem solving, advice, and difficulties related to homelessness. *"Personally I think just like you know advice. I'd probably just like anything, just daily things, more so I'd probably just use this app to you know have somebody to talk to you know." "Yeah, if you're having bad day, send a quick text, tell them the day's been kinda rough, send you like a text like hey, you want to talk, you know?"* [Quotes: p.7]

mg: milligrams; SD: standard deviation; US: United States

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the Institutional Review Board at Rush University Medical Center)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Analysis was guided by grounded theory. The lead author (not involved in focus groups) led the coding of themes. The lead author and senior author reviewed themes and adjusted/consolidated where appropriate.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Relevant

Ake, 2018

Bibliographic Reference	Ake, Tegan; Diehr, Sabina; Ruffalo, Leslie; Farias, Emily; Fitzgerald, Ashton; Good, Samuel D.; Howard, Lindsay B.; Kostelyna, Stefan P.; Meurer, Linda N.; Needs Assessment for Creating a Patient-Centered, Community-Engaged Health Program for Homeless Pregnant Women; Journal of patient-centered research and reviews; 2018; vol. 5 (no. 1); 36-44

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	US
Setting	Focus groups were held in the common meeting room at the shelter
Data collection and analysis	Open ended questions were asked during the two focus groups. Notes were handwritten and transcribed at the end of sessions. Data was analysed using a hybrid approach of directed and summative content analysis.
Recruitment strategy	Participation was limited to current shelter residents. Flyers inviting shelter residents to attend one of two focus groups were posted in the common living areas. Shelter staff again announced the time and location of each focus group and invited residents to attend
Study dates	Ethical approval was granted in March 2017. The dates for data collection were not reported.
Sources of funding	Financial support was received from the Medical College of Wisconsin’s 2016 Community of Innovators Award. We also appreciate the financial support of the Wisconsin Medical Society Foundation’s 2017 Summer Fellowship funding.
Inclusion criteria	• Healthy, adult women residing at the Milwaukee Women's Centre
Exclusion criteria	Not reported
Sample size	N=26 homeless women

Participant characteristics	Not reported
Results	Unmet needs identified Focus group participants most frequently spoke about the lack of, or appreciation for, pregnancy education both during and after pregnancy, and requested short and focused modules concerning specific topics. The women believed that having better access to such educational modules would have helped during prior pregnancies and childbirths as well as being beneficial for current health and wellness. Access to physician appointments and transportation presented various levels of difficulty. Some women found that community resources, such as free bus passes, made it easy to get to appointments, whereas others found bus rides too difficult and had to apply for taxi vouchers instead. Lack of childcare was a barrier to health care, and the need of bringing younger children along to doctors' appointments was particularly difficult when taking the bus. The women in the focus groups also requested assistance in making doctor appointments for their babies, noting how difficult it can be to find a physician with whom they feel comfortable. Many women "felt like a number." Several women had trouble comprehending or reading information at their doctor appointments, either because of a language barrier or functional illiteracy. *"I wished someone would've been there to help answer questions and explain things."* [Quote: p.40]

US: United States

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not provide any details on why they decided to use focus groups to collect data for this study.)*

Critical appraisal		
Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The Medical College of Wisconsin institutional review board granted expedited approval (PRO00028835))*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The project team used summative content analysis techniques to determine codes from focus groups, and to identify which codes were used most frequently and therefore the most dominant themes. All coders met face-to-face to discuss any areas of confusion or potential bias in the coding. Most of the project team had also been facilitators/scribes during the focus groups.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Relevant

Alunni-Menichini, 2020

Bibliographic Reference	Alunni-Menichini, K.; Bertrand, K.; Roy, L.; Brousselle, A.; Current emergency response in montreal: How does it fit in the services offered to homeless people who use substances?; International Journal of Drug Policy; 2020; vol. 82; 102758

Study Characteristics

Study type	General qualitative inquiry An evaluative study using a needs analysis
Country/ies where study was carried out	Canada
Setting	Not reported
Data collection and analysis	1. World cafe- six tables with service providers, who discussed the emergency response currently offered to homeless people who use substances 2. Semi-structured interviews with participants from groups that were under-represented at the World care, lasting one hour

	3. Semi-structured interviews with individuals experiencing homelessness and substance use, lasting one hour All discussions were recorded and transcribed. For the World Cafe discussions, audio-based summaries were created. Thematic content analysis was performed using NVivo12 on the entire data set.
Recruitment strategy	Participants were recruited through expert and snowball sampling. Participants were contacted via email or through in person visits to organisations.
Study dates	Not reported
Sources of funding	Grants from: • the “Fonds de recherche du Quebec - Sante (FRQS)” (number 000032367) • the “Institut universitaire sur les dependances (IUD)” *(Redaction funding)* • the “Charles- LeMoyne - Saguenay-Lac-Saint-Jean sur les innovations en sante (CR-CSIS)” research center *(Grant)* • “Recherche et intervention sur les substances psychoactives - Quebec (RISQ)” addiction infrastructures *(Research and translation fundings)*.
Inclusion criteria	1. Competence to give free and informed consent 2. Clinical, research, or political/advocacy experience with homeless individuals who use substances or personal experience in this regard 3. Ability to speak French For service providers: 1. Minimum one year's experience in their organisation.
Exclusion criteria	Not reported

Sample size	N=47 n=34 service providers (World Cafe) n=5 health and social services professionals n=8 people experiencing homelessness
Participant characteristics	**Service providers** Professions: Police officer (2 from a mixed team in mental health or homelessness): 10/34 Professionals from homeless/addiction services: 5/34 Psychiatric hospital: 1/34 Community based stakeholders (2 had experienced homelessness): 6/34 People with lived experience: 3/34 Political actors: 3/34 Research community members: 6/34 **Homeless participants (including those involved in World cafe)** Gender: Cisgender man: 9/11 Transgender man: 1/11 Woman: 1/11
Results	<u>Service approachability and users' ability to perceive their needs and seek services</u>

The study reported mixed views regarding service providers' views on users' approachability to services. Most people were aware of the services available to them, however there were some homeless people and emergency service providers who were unaware of the resources available to them. Some people reported that once a first contact is established, access to other resources is easier. Some people reported that personal difficulties may impede access to services, whilst others may have trouble perceiving their own needs before they become urgent. This can be heightened if the people have complex physical or mental health issues. Thus, the service providers identified the need to improve outreach support. *"I didn't know [the resources], but I got to know [Organization A] quite quickly. Then, from [Organization A], I got to know all the others. […] but if I [hadn't] known [it], forget it: me, I was lost!" (Participant experiencing homelessness and substance use 3)* [Quote: p.4]

Service acceptability and users' ability to engage

Acceptability of the services varied according to the consistency between the services offered, the needs identified by the users, and their abilities when they received the services. For example, according to most participants, fast, flexible, person-centred, and long-term services have better acceptability than restrictive, short-term services. Acceptability also seems to be modulated by the nature of the relationships between users and providers. A relationship of trust, a helping vision and a strength-based approach with the providers encourages users' initiation and engagement in a process. *I am, after all, someone who is quite marginal […]. So, places that are too strict, that's not made for me either. And, that's the mistake I made: I went into a place that was really too strict for me […] I don't mind reporting on my procedures, but when it gets to the point that I have to respect things that I've never respected in my life. (Participant experiencing homelessness and substance use 3)* [Quote: p.5]

Service availability and users' ability to reach them

Most of the current services are not timely and flexible enough to meet the needs of people experiencing homelessness. This seems to be due, partly, to the complexity and fragmentation of the local health system. Services are over-specialised with stringent admission criteria (for example, age or gender) that vary from one place to another, and sectorisation (for example, available according to residential sector). For example, few services accept people under the influence of substances, and those that do, have stringent admission criteria. Another limitation of the current services is the lack of long-term resources, as noted by the participants. This keeps people experiencing homelessness in emergency mode and does not meet their needs. Individuals experiencing homelessness and substance use particularly mentioned this issue in our one-to-one interviews, especially regarding psychological, substance use, and housing support. Finally, the limited number of places and of opening hours also restrict the availability of the services when homeless people need them. "*They [Sobering-Up Center A] are never full, it's just that they won't take them; either they're too far under the influence so they don't want them anymore, or you have to answer 50 questions. They can't be in withdrawal, they can't have diabetes, they can't have this or that. At the end of the day, it's a place for homeless people who aren't using substances." (Table 6, World Café)* [Quote: p.6]

	Approachability and availability of emergency services, and users’ ability to reach them Participants were aware that emergency services could be accessed 24/7 and some thought of emergency services as a gateway to the health system. However, the availability of the emergency services is also limited by their fragmentation and sectorisation according to health professionals and participants experiencing homelessness. According to the participants, the emergency response is relevant when homeless people are a danger to themselves or to others, for example, in cases of overdoses or suicide attempts. However, hospital emergency departments also have the role of stabilising acute health problems of the population, whether homeless or not. These problems may be physical, psychological, or addiction-related, such as medical-risk withdrawals. Health professionals consider hospital emergency departments inappropriate for addressing basic needs, management of chronic conditions, as well as substance intoxication and withdrawal without medical risks (for example, opioids and cannabis). Acceptability and users' ability to engage in the services Acceptability of the emergency services is modulated by the professionals’ attitudes and their capacity to establish a relationship of trust with homeless people. Some attitudes hinder acceptability, whereas others encourage it. For instance, stigmatisation and discrimination, still very present among emergency service providers, hamper acceptability according to the participants. Providers mentioned substance use as being more stigmatised than other problems, such as mental health or homelessness, mainly because of the disturbing behaviours it causes. Some participants explained that negative attitudes and behaviours by emergency service providers may be caused by a lack of training, work overload, sense of powerlessness, and compassion fatigue. Conversely, other participants spoke of the importance of adopting relational attitudes, such as openness, empathy, tolerance, and respect, to improve acceptability of emergency services. Appropriateness: Capacity of emergency services to refer to adapted services According to emergency service providers, the lack of service availability and of time combined complicate the referral process, mainly because of the multiple, constantly changing admission criteria and lack of 24-hour continuum of services. Some people reported that having personalised contacts made referral easier, however that was not always the case as there are a lack of service channels between emergency services, specialised services, and community based organisations. Service continuity A major barrier to access that the participants identified was the lack of continuity between the services. There is a lack of information continuity between the services (for example, efficient information-sharing between the providers) due to fragmentation of the services. Therefore, multiple waiting lists, assessments, and interventions occur with the same

	people, sometimes without the organisations and professionals communicating amongst themselves. "*Through cooperation and good knowledge of the people in the organisations, we manage to give proper referrals and to have easier access: I know you, you know me, we've done business together, we have a mutual trust. Sometimes, this will allow all the flexibility needed for a client who may not fit perfectly […]." (Table 4, Synthesis, World Café) "If there's no suicide or just substance use, or even sometimes more of a bipolar crisis, they put you in jail instead of taking you to the hospital. They don't distinguish anything; they aren't trained to. The fact is they're police officers, not social workers. But that's what they should have: better mental health and addiction training, especially in cities like Montreal." (Participant experiencing homelessness and substance use 1) "[…] it's hard to know who is handling people's cases. And we find out, in a crisis, there are six of us on the case, so maybe we could have collaborated before, if there had been a mechanism to know one other. We want to do it, we're able to do it, but we don't know who's involved." (Table 4, Synthesis, World Café)* [Quotes: p.9]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Can't tell *(The researchers use a combination of methods to address the research goal. The researchers do not clarify why this has been done.)*
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes

Critical appraisal

Section	Question	Answer
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The CIUSSS de l'Estrie - CHUS ethics committee approved this multi-centre project (MP-31-2017-1231) and all participants provided free and informed written consent at the beginning of each data collection activity.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The project team (assumed to be all authors) performed a thematic content analysis based on a conceptual framework of access to health care and of collaboration.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Relevant

Asgary, 2015

Bibliographic Reference	Asgary, R.; Sckell, B.; Alcabes, A.; Naderi, R.; Ogedegbe, G.; Perspectives of cancer and cancer screening among homeless adults of New York City shelter-based clinics: a qualitative approach; Cancer Causes and Control; 2015; vol. 26 (no. 10); 1429-1438

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	US
Setting	Not reported
Data collection and analysis	Semi-structured interviews were conducted to collect data. Interviews lasted 45 minutes on average. All interviews were transcribed verbatim from notes collected at the time of interviews. Grounded theory was used to analyse the results and content analysis was used for generating themes.
Recruitment strategy	Participants were recruited using both random and criteria sampling techniques.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=50 homeless people
Participant characteristics	**Gender** Male: 21/50

	Female: 29/50 **Age** Mean age: 51.66 years (±11.34) Age range: 25-79 years
Results	<u>Prioritising cancer screening and openness toward screening during homelessness</u> Many participants were worried about getting cancer and very few reported any cancer screening experiences. Most participants (>75%) considered themselves to be at higher risk of cancer than the general population. Women in this study considered cancer screening a high priority, especially if they were younger than 50 years. Overall, both men and women were open to having their cancer screening during homelessness. <u>Individual- and health systems-levels barriers or challenges for cancer screening</u> All participants reported a lack of screening counselling and opportunities, a lack of information and guidance about cancer screening and its importance, limited resources, fear of screening of its results, and embarrassment as barriers to screening. Other barriers included lack of proper information in how to get to screening sites or appointments or transport issues, could not find the place, not getting help from case workers in arranging logistical issues, frustration in waiting for appointments, not being settled in, and competing or unexpected tasks at the time of screening. *"Awareness, a lot of people don't know" [M50] "Fear. I mean, there is the logical and there's the illogical. Logically, I know I should have all these tests, but emotionally…I don't want to deal with it now" [M61]* [Quotes: p.1433] <u>Suggestion and strategies to improving cancer screening</u> Overwhelmingly both men and women suggested providing education regarding cancers and screening process with discussion initiated by providers and offering screening openly. People also suggested reminders and helping with navigating the health system to improve screening. *"You can't just help people with a portion of their lives, you have to help them wholly. Most people don't have the knowledge of outside resources. Some people don't even know what their needs are. They always put medical needs last, especially if someone is mentally ill and doesn't know what their needs are, so make it part of a protocol"* [F43] [Quote: p.1435]

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers did not provide any details on how participants were recruited for this study.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study received IRB approval from the NYU Lutheran Family Health Centres, New York City)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Data was analysed by 2 authors using content analysis to identify core knowledge and perceptions of the subject matter. The 2 authors independently reviewed codes, then adjusted/corroborated codes after joint discussion.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Astra Zeneca, 2012

Bibliographic Reference	Astra Zeneca, Depaul Uk; Making it better: improving the health of young homeless people; 2012; 61p

Study Characteristics

Study type	General qualitative inquiry A mixed methods approach was used.

Country/ies where study was carried out	UK
Setting	**1:1 interviews** Interviews were conducted face-to-face and by telephone (depending upon preference of the participant).
Data collection and analysis	Data were collected by 1:1 interviews and focus groups. **1:1 interviews** A total of 26 semi-structured interviews were completed with young people accessing services from Depaul UK. Interviews were conducted by three researchers using a standardised semi-structured question template of eight core questions. Contemporaneous notes were taken during the interviews which lasted between 20 and 30 minutes. **Focus groups** Each focus group was attended by between 4 – 10 participants, lasted up to two hours and was structured around a number of interactive activities. One focus group took place at the Women @the Well project, with whom Depaul UK are working. However, the women who participated were of a different age (all over 25), and therefore the focus group findings were separately reported due to the different age of the participants.
Recruitment strategy	**1:1 interviews** Recruitment was via the questionnaire – young people could indicate if they would like to participate in an interview or a focus group, for which they received a £20 voucher. **Focus groups** A total of five focus groups with people accessing Depaul UK services were carried out.
Study dates	May to October 2011 **1:1 interviews** Interviews took place between 26th September and 7th October 2011.
Sources of funding	Astra Zeneca

Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=26 1:1 interviews with homeless youth N=5 focus groups with 4-10 participants in each focus group
Participant characteristics	**1:1 interviews** Male: 15/26 Female: 11/26
Results	<u>Support for mental health issues</u> Young homeless people had a mixed view on the availability of mental health support. Some wanted more help/support for mental health problems because they felt they were not getting any or were not getting enough, but others thought the support they received was enough. There were those who stated they did not need any support. Service providers reported that access to services was hindered due to long waiting times. Young people were unanimously supportive of peer mentoring, not just with regards to mental health, but across a broad range of issues. All young people would be supportive of accessing support advice & signposting from their peers, where they knew that the peer mentors/advisers had themselves received training and support in that role. The vast majority of young people also expressed a keenness to take on a peer mentor/support role themselves. *“Yes it would be good (peer mentoring) having advice from someone who has been through what I have been through and come out ok on the other side.” “I’d prefer someone a bit older really who has more experience and some training to talk to, who understands from the inside.”* [Quotes: p.27] <u>Physical health</u> From the interviews, it was clear that health needs, particularly physical health conditions, were not a high priority in these young people’s lives. Young homeless people are, understandably, pre-occupied with ensuring they have a warm place to sleep, food and drink etc, rather than seeking help with physical health problems such as joint-aches, difficulty seeing or health problems. *“To be honest, I ain’t got time to worry about my health, have I? No money, no roof over my head, no job, no girlfriend and no fags”. [Quotes: p.33]* <u>Prescription medication</u>

An issue highlighted by both staff, and the homeless young people is the difficulty adhering to courses of medication. Reasons suggested for non-adherence were chaotic lifestyles as well as motivational issues. A limited understanding of medical conditions was also suggested by the qualitative research. It was suggested by staff as well as the young people that sometimes the very short GP appointment times contributed to homeless young people not taking medication, or not being adequately diagnosed, as they did not have adequate time to feel comfortable enough to open up and discuss their problems. *"Since I've actually had to take medication I think I've taken one course of tablets which was four weeks. I took that course, I felt absolutely fine after that, but I stopped taking my tablets and I think that it's actually opened back up again which is why I need to go to the hospital again to get more tablets to close my heart up."* (Male, London, Ethnographic study). [Quote: p.43]

Accessing Healthcare Information

There was a very mixed response to using the internet to access information or support for health services. Some young people described this as the first thing they would do if they wanted to find out any information: 'just Google it!' However, others were less convinced about the level of access homeless young people would have and whether or not you could trust the information you got back. Staff felt that whilst factual and educational information on many healthcare issues is widely available, it does not produce inability to promote true engagement with or a lasting impact with health issues. *"…depends if you've got access at home or not. Won't reach every one. Have used it before but didn't give me that much information so I had to phone up as well and ask them. Loads of writing [on websites] & I just get bored of looking at writing so don't really …obviously you get information but get bored of reading a load of paragraphs."* [Quote: p.44]

Waiting times

A common experience of the homeless young people seeking help for their mental health was having to wait a significant time in order to see a counsellor or mental health specialist. Both staff and the young people themselves recognised in the qualitative research that by the time the young people admit they need help it is normally because they are at crisis point, and so need help immediately. *"Two years for a psychologist to get back to us...It took about four to five months to get referred to an alcohol service for my drinking."* (DPUK Female Client, peer Interview) [Quote: p.45]

Attending appointments

Relevant factors raised by young people in interviews and focus groups (in relation to the higher access levels of flexible provision) related to homeless young people's difficulty in keeping appointments. In some cases this was due to practical factors – such as lack of access/money for transport – but mainly was about a lack of motivation and organisational skills. Both staff and young people felt that the structure of the health system does not allow for appointment flexibility which is needed in the lives of young homeless people. A significant few of the young people did

	not feel listened to or taken seriously when they had reported health issues so they did not persist. Appointments systems seemed to them to be lengthy, off putting and if relying on the written word (form filling) extremely daunting. Several young people related negative experiences when seeking help with regards to mental health problems. *"I do try and make an appointment but I always end up missing them. I keep forgetting about them or I won't come in the night before."* (Male, London, Ethnographic study). *"I have to keep going up to the doctors every week to go and pick up a new prescription and it just seems very long to me, a lot of money wasted, jumping on the buses, it's a lot of money, £2.20 now."* (Male, London, Ethnographic study). [Quotes: p.45 & 46] Interactions with professionals There were mixed reports of interactions with healthcare professionals. In the experience of the young people interviewed by their peers, some GPs could be judgemental and did not always provide the support and compassion required in order for the young person to feel that they could be open. Some young people felt that some counsellors were condescending and others appeared to be clock watching. The experience of having to repeat one's story due to changing GP or counsellor was felt to be a negative one, and one that deterred young people from accessing services. Other young people were far more positive about their interaction with their GP. Some GPs in particular were talked about in glowing terms as being "brilliant" or that "my doc always gives me a hug". *"Quite patronising, the doctor, when I was trying to explain how I felt...I was trying to explain that I didn't get on with the counsellor, and she just really didn't understand."* (DPUK Female Client, peer Interview) [Quote: p.46] *"She listens to me and I can trust her, I can tell her (my G.P.) anything and I have known her years."* [Quote: p.47] GP survey The GPs surveyed identified mental health issues and substance misuse as the main health issues for the young homeless population. Poor nutrition and physical health problems featured also, but were felt to be more minor. Overall the GPs who responded reported that they did not find treating 'the young and homeless' satisfying because they can be difficult to engage, hard to treat, require more counselling rather than medical attention. It was a shared feeling that young homeless people can have a "do not fit with the system'" attitude (for example, they want healthcare on their own terms), which results in a lack of empathy from the healthcare professionals. However, some of the GPs did report having empathy for, and understanding of the chaotic nature of the homeless people's lives, for example, poor family backgrounds, transient nature and lack of stability. Moving from paediatric to adult services An issue identified by staff as creating difficulties for homeless young people in accessing healthcare was the breakdown when young people move from paediatric to adult services. This was problematic for several reasons. Continuity of care and of practitioners was seen as one of the success factors in homeless young people persisting with treatment or medication, or having the confidence to seek help when needed. Having to repeat stories to a new

	healthcare professional was described as being traumatic and a reason that young people would choose not to access services. Having to wait for services due to switching to adult services was seen as damaging for young people who had been consistently receiving treatment from paediatric services. *"When I was moving from one house to another, I just started getting settled down to one doctors and then having to switch to another straight away to get used to another one, it was a bit confusing cos I was only little, so I didn't really understand why."* (Female, NE, Ethnographic study) [Quote: p.48] Emotional and motivational Both staff and the expert advisory group felt strongly that homeless young people often lack motivation to access care. This was illustrated by the young people in the interviews, focus groups and peer research. In many cases, despite knowing that health care was available, and even knowing how to access it, young people appear to be unmotivated to do so. A number of different reasons were felt to be behind this, including a lack of confidence, very low self-esteem, previous negative experiences, and often a lack of guidance during their childhood.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on any potential biases arising during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers discuss ethical issues but do not report on how ethical issues have been considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not provide sufficient detail on how the data was analysed in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the results within the context of current practice/policy but they do not identify new areas of research, nor do they report the transferability of findings from this study to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Barker, 2018

Bibliographic Reference	Barker, Stephanie L.; Maguire, Nick; Bishop, Felicity L.; Stopa, Lusia; Peer support critical elements and experiences in supporting the homeless: A qualitative study; Journal of Community & Applied Social Psychology; 2018; vol. 28 (no. 4); 213-229

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	The study was conducted over four organisations that utilise peer supporters in their homeless services. Interviews were done in a private room except for two conducted in an open communal space.
Data collection and analysis	A qualitative design was adopted, utilising semi-structured interviews to obtain an in-depth understanding of participants' experiences of IPS use within homelessness. One researcher conducted single in-depth, semistructured, face-to-face, active interviews at the participants' respective organisations. Interviews averaged 32.70 min. The research proceeded iteratively; interviews were transcribed and analysed as they were conducted, allowing later interviews to be informed by earlier analysis and identify when themes were approaching data saturation. Although peer supporters and clients are included in this study, they were not considered as two groups and interview procedures were consistent across all participants.
Recruitment strategy	Participants were recruited through emails and face-to-face meetings, where a brief description of the study was provided. Snowball sampling was utilised to supplement recruitment.
Study dates	Not reported
Sources of funding	Not reported

Inclusion criteria	• Participants aged 18 years and above • Participants had experience with homelessness • Participants who have provided and/or received intentional peer support (IPS)
Exclusion criteria	Not reported
Sample size	N=29 homeless people
Participant characteristics	**Gender** Male: 23/29 Female: 6/29 **Age** 25–34 years: 8/29 35–44 years: 3/29 45–54 years: 10/29 55–65 years: 8/29
Results	<u>Never give up</u> Participants described how peer supporters were persistent and committed to building meaningful and trusting relationships in order to help homeless clients. They felt such persistence was essential for intentional peer support (IPS) to be successful. Almost all participants discussed how they had to be persistent in trying to support clients who had been labelled by professionals as “resistant.” From their own experience of being on the streets, participants spoke about how they “weren't ready for the help” and it is a matter of not giving up on the client. Participants spoke about the isolation that one endures when experiencing homelessness, rejected from all aspects of society, and feeling a lasting sense of being unwelcome. Participants described how these events chip away at the individual's self-worth leaving them feeling suspicious of people who try to help. They understood how vulnerable people, such as those living on the streets, often have to assess the intentions of other people to avoid being taken advantage of to keep themselves safe. In this position, participants described how those experiencing homelessness learn to trust their

	intuition. However, their status as peer supporters can help to reduce distrust or minimise the time to develop trust. Peer supporters may have lived in a hostel recently and built a positive reputation with clients, creating a "vibe" or a feeling that they belong in this group and are trustworthy. Once trust is established, maintaining it becomes vital. Otherwise, the clients can write the relationship off as another person or service who has let them down and pushed them further to the margins of society. Experience-Based relationships Peer supporters discussed the value of shared experiences, which can be conceptualised as experiential knowledge, that is, learning a truth from personal experience of a phenomenon (Borkman, 1976). Peer supporters have intimate knowledge of homelessness, which contributes to the peer supporters wisdom regarding treatment, barriers, and recovery. Experiential knowledge comprises two elements: information on which the knowledge is based and the individual's attitude towards that knowledge (Borkman, 1976). Information includes the whole experience of being homeless, but it is the individual's attitude towards their experience that determines whether this "knowledge" is useful. Participants discussed how attitudes towards their own experiences are important. *"You know there was a part of my life that for years, and years I was very embarrassed about. Quite ashamed, you know … that I had and I wasted so much of my life. And coming here, I realised well, actually it's not a waste, its qualifications … It's when you can stand up and say, well that's my experience … That is something you cannot be taught … I was out there and instead of looking at it like a waste of time and as a victim, actually what I was doing was gaining my qualifications."*—Carl (recipient to provider) [Quote: p.219-220) Overcoming obstacles participants discussed numerous obstacles and challenges they encountered in fulfilling their role as a peer supporter, including specific policies, their clients, maintaining their recovery, and certain professionals. Peer supporters must meet certain criteria to become a peer, specifically the length of time in recovery from drugs and/or alcohol. When dealing with challenging clients, peer supporters discussed the need to know themselves, controlling their emotions and identifying triggers to maintain their recovery. Often, peer supporters are faced with clients who are using drugs or drinking, and they need to be secure in their own recovery to be able to cope with any situation that occurs. Peer supporters can become a bridge between professionals and clients, helping clients get the treatment they need without experiencing any negative comments from professionals. *"So, what I have learned from being homeless and what I've learned from here, I apply to myself and then it helps me to, uh, make sure that when I apply this knowledge that I help other people as well."*—Muhammad (recipient to provider) *"Someone coming alongside, you know shoulder to shoulder, there's no kind of hierarchy, so to speak."*—Rick (recipient to provider) [Quotes: p.220] How peers help

	participants discussed four main ways in which they helped people: being role models, breaking boundaries, providing individualised treatment, and social support. Peer supporters help by representing someone who has gone through a similar situation and grown from that experience. Most peer supporters saw themselves positively as role models, able to "inspire" and model a life without the everyday struggles of being homeless. Participants felt that peer supporters acting as role models might inspire clients to do better, or to feel that their goals are achievable, and that there is hope. *"There are a couple of people that, you notice are paying attention and they might feel stuck where they are at and they might start saying well you know. He was, like, in my position and he's moved on and he's moved on pretty quickly so maybe that could happen for me."*—Rick (recipient to provider) *"At first, I didn't quite understand the importance of having boundaries and um you know you're exposing yourself and that is, is um, can cause problems. So I know that, nowadays, I do know the importance of boundaries and I keep them at all times, it's easier."*—Diane (recipient to provider) [Quotes: p.223] Benefits for peers Peer supporters reported deriving a number of psychological benefits, which ranged from a general feeling of being "happy to help" to feeling that they are making a difference in someone's life, as described by 28 participants. Peer supporters benefit from engaging with clients through emotional investment in the experience-based relationship, and this contributes to emotional satisfaction when they see that one of their clients is doing well. Most noteworthy are the internal benefits peer supporters gained from being in a helping role; peer supporters consistently reported increases in self-esteem, confidence, and self-efficacy. The work helps to further their own recovery; peer supporters feel that they are useful, have purpose, and lead meaningful lives, and this helps them stay sober.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval was gained by the University of Southampton.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis was used to interpret the data. Coding was done by one author and then discussed by the research team to make any changes or to corroborate themes.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers do not discuss whether or how the findings can be transferred to other populations)*
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Batterham, 2007

Bibliographic Reference	Batterham, Mark; Watching cars go past: a study of homeless young people's experiences of accessing mental health services in South Gloucestershire; 2007; 87p

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	Participants were interviewed using a non-validated, semi−structured interview schedule. The data gathered from the interviews was analysed using Interpretative Phenomenological Analysis.
Recruitment strategy	Participants were recruited from local housing agencies and the 'Connexions' service. Local mental health services were approached, but struggled to identify any potential study participants.
Study dates	Not reported
Sources of funding	South Gloucestershire Council's Children and Young People's Department and South Gloucestershire Primary Care (NHS) Trust
Inclusion criteria	• 16 to 19 years of age; • Homeless or homeless within the past year; • Mental health needs. The study is concerned with young homeless people who have mental health problems. This is defined either by a diagnosis or by the young person themselves;

	• Living or ordinarily resident in South Gloucestershire.
Exclusion criteria	• People deemed by the referrer not to have capacity to consent; • Young people who do not consider themselves to have mental health needs; • Young offenders who are detained in the prison system; • Non−English speakers and those with special communication needs.
Sample size	N=6 young people experiencing homelessness
Participant characteristics	**Gender** Male: 2/6 Female: 4/6 **Age** 16 years: 2/6 17 years: 1/6 18 years: 1/6 19 years: 2/6
Results	<u>Feeling let down by services</u> When participants sought help with their mental health, their experiences were frequently disappointing. In particular, many participants felt that their mental health needs were not taken seriously. Little or no discussion of participants' mental health

was initiated by housing services and primary healthcare responded clumsily, even when the young people brought themselves to the attention of services.

In relaying and reflecting upon their experiences of mental health services, participants described feeling ignored, frustrated and discriminated against on the grounds of age. In some instances, these young people even thought that mental health services did not believe what they were telling them. Assumptions were being made and clinical decisions were being taken based on very limited information. The assessment and monitoring of participants' mental health was generally poor and mental health services appeared not to recognise the significance of homelessness and associated poverty in relation to these young people's mental health.

The support participants received in terms of their mental health needs was patchy and often poor. Two out of the three participants who had contact with statutory adult mental health services whilst, or shortly after, they were homeless felt that services were too quick to withdraw and this left them feeling let down and abandoned. Even following crises, the response from services was often sluggish and inadequate. For one young person already known to services, it was over six months following an overdose leading to a hospital admission before she was seen, and then only as a result of the young person and her family actively chasing mental health services.

Some of the implications of the situation described above were evident in participants' accounts of their experiences. Where participants failed to see the purpose or benefit of their involvement with mental health services, they tended to disengage and seek out alternative support. Sometimes the decision to end contact was made for these young people by services unable to respond flexibly to homelessness. Whatever way the service arrangement came to end, participants identified a lack of trust in their relationship with mental health services as a problem. On the part of these young people, this mistrust appears to be influenced by negative experiences during childhood and adolescence and fed by a poor understanding of mental health services. Related to this is a fear of the consequences of disclosing information.

On the whole, participants demonstrated a poor understanding of mental health services, not only in terms of the types of services available and the purpose of interventions used but also in terms of access arrangements and the classification of their own mental health needs. The notion that mental health services might be accessed via their GP came as a surprise to one participant, others viewed this route as unhelpful and more of an obstacle than a gateway. Where participants had been given a mental health diagnosis, the meaning and implications of this appeared unclear to the young persons concerned. This reflects a wider sense of distance and confusion in the relationships participants appeared to have with mental health services.

These young people's experiences of mental health services were not exclusively negative. Where participants had established a relationship over a period of time with someone to whom they related well, this support was viewed as invaluable, particularly during times of crisis. The skills of mental health workers were recognised and valued by participants who enjoyed positive relationships with workers.

"So I just went to the doctor and said, you know, I'm depressed I think I need anti-depressants and they just basically handed it over – did not ask me anything, about past history or anything and then later on, I think about a couple of months later or maybe a year, I think, I think it was in the press wasn't it about, you know, they're handing them out to kids willy-nilly and not asking about past history or past feelings or why you're feeling depressed. They didn't ask me any of that which made me quite concerned, but I felt they were helping me so I carried on taking them." [Quote: p.69]

Someone there to talk to

All six participants felt that talking to someone had, or would have, helped during times of crisis: *"I really needed someone to speak to then*" (Participant 5) [Quote: p.72]. The four participants who had received counselling all described their experiences as positive: "*...in the long run I think that [counselling] does help, definitely*" (Participant 1) [Quote, p.72]; "*...it does really help, talking to a counsellor. It helps up here...*" (Participant 6) [Quote p.72]. Too frequently however, the young people had been left to seek out talking therapies themselves. The emotional and psychological dimension of youth homelessness appears to have been either forgotten or not even considered by the services with which the participants came into contact. For one participant, an almost blind preoccupation with practical issues on the part of housing services meant that her emotional needs were left unmet.

Three participants specifically talked about wanting someone to notice, to ask them how they were feeling and to offer support. These participants tended to feel embarrassed, incapacitated by their mental health needs or just too overwhelmed by their circumstances to actively seek out help themselves: *"....I didn't feel in the right state of mind to go round wondering, like..where do I go if I feel like this?"* (Participant 3) [Quote: p.72].

This is not to say that practical support was not seen as helpful by the participants. Participants commonly felt afraid whilst they were homeless and perceived that they had little control over their lives: "*I was like, all over the place*" (Participant 1) [Quote: p.73] and so practical assistance was valued, particularly when combined with emotional support: *"[name of support worker] actually listens and like, she helps me with things. It's not like, I don't feel on my own"* (Participant 5) [Quote: p.73].

It was to those they trusted that participants turned for help during times of crisis. Participants appeared only to seek help from health services when a relationship with a particular worker had already been established. One participant enjoyed a particularly good relationship with her GP, another with a voluntary sector counsellor. Those without pre-existing mental

	health support tended to seek help from peers: *"I just talk to my mates"* (Participant 6) [Quote: p.73], from youth services or from housing workers. Established routes into the mental health system such as via primary care were rarely considered. The response of one participant when asked if he would consider seeking help from a GP reveals much: "I wouldn't think of it because I don't think they'd care....someone like me, like ain't got no job. What's the point of spending time on me?" (Participant 6) [Quote: p.73] Two participants mentioned the stigma associated with having a mental health need and three expressed a preference for open, accessible, age-appropriate services. Participants described what it was about a services or, more commonly, an individual worker, that made them approachable. For these young people at least, a positive therapeutic relationship appears to be characterised by trust: *"I just feel I've actually got someone to rely on"* (Participant 5) [Quote: p.74]; familiarity: *"..you just get to know people so it's a lot easier to talk to people"* (Participant 1) [Quote: p.74]; friendliness and approachability: *"[name of housing support worker] is just like a normal person, he's not like some bloody snotty cow who thinks she knows everything*" (Participant 3) [Quote: p.74]; shared experience: "*I reckon the best people to do it is the people who've been there themselves*" (Participant 4) [Quote: p.74]; and a non-judgemental approach: "*They just wanna help you, no matter what you've done, they just wanna help you out*" (Participant 6) [Quote: p.73].

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes

Critical appraisal		
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(NHS Research Ethics Committee. NHS Research & Development approval was granted.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The data gathered from the interviews was analysed using Interpretative Phenomenological Analysis.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Bhui, 2006

Bibliographic Reference	Bhui, K.; Shanahan, L.; Harding, G.; Homelessness and mental illness: a literature review and a qualitative study of perceptions of the adequacy of care; International Journal of Social Psychiatry; 2006; vol. 52 (no. 2); 152-165

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Most interviews took place at Groundswell offices.
Data collection and analysis	Data were collected over a one-year period. Interviews were semi-structured and conducted using a topic guide. Interviews lasted 1–2 hours. All interviews were recorded on audiotape and transcribed for analysis. The ‘Framework’ approach was adopted for data analysis
Recruitment strategy	We recruited subjects who used homeless services in the voluntary and statutory sector in East London. Posters explained the purpose of the study, and invited homeless people with mental health problems to attend a research interview. Recruitment was supported by a national organisation for the homeless, called Groundswell.
Study dates	Not reported
Sources of funding	This study was funded in part by East London & City Health Authority.
Inclusion criteria	Not reported for participants in the qualitative part of this study.
Exclusion criteria	Not reported for participants in the qualitative part of this study.
Sample size	N=10 homeless people
Participant characteristics	**Gender** Male: 6/10 Female: 4/10 **Age** Age range: 19-54 years

	Nationality UK: 5/10 English: 1/10 Somali: 2/10 Sudanese: 1/10 US: 1/10
Results	<u>Stigma</u> Homeless people face significant stigma, as do people with mental health problems. Among homeless people, homeless people with mental health problems were considered to be of lesser status, perhaps because they were less able to fend for themselves when intimidated. There was prejudice against the mentally ill within the homeless circuit, perhaps also preventing open admission of mental health problems and help-seeking. One woman said that admitting to having a mental heath problem led to people treating her like dirt. <u>Experience of services</u> A recurrent theme was that there was insufficient help during times of crisis. By the time appointment times from professionals arrived subjects said that their problems had been resolved. Other services that were valued provided computer facilities and training. A project run by nuns was also mentioned as providing care, accommodation and food, as well as training. One woman said that women were not always seen as ‘homeless’ because they often slept on other people’s floors, or stayed in relationships that they really wanted to leave, just to be in accommodation. She regretted staying in sexual relationships to retain a roof over her head and emphasised how she did not fit a stereotype. There were a few people from minority ethnic groups, and fewer women than men, so the range of views may be incomplete. However, it is striking that a Somali man said that the homeless person’s unit was ‘always closed’, and that they ignored him. General practitioners were mentioned many times as sources of help, unlike mental health practitioners, who were rarely mentioned. Women doctors were considered more helpful, going out of their way to find accommodation. <u>Recommendations for services</u>

	Subjects felt that there were too few general practices that worked with homeless people in London. Although they wanted more hostels, they specifically wanted hostels with high support, and hostels that were free of people using drugs and alcohol.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval was provided by the local research ethics committee.)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The 'Framework' approach was used for data analysis, where one researcher extracted information from transcripts and charted it in a systematic way, and another researcher conducted more analysis by reference to the original transcripts and charts, improving the reliability of the extracted data. Any areas of disagreement were resolved by consensus. Data was also scrutinised by a medical sociologist, blind to the analyses already conducted.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Biederman, 2013

Bibliographic Reference	Biederman, Donna J.; Nichols, Tracy R.; Lindsey, Elizabeth W.; Homeless women's experiences of social support from service providers; Journal of Public Mental Health; 2013; vol. 12 (no. 3); 136-145

Study Characteristics

Study type	Phenomenological

Country/ies where study was carried out	US
Setting	A homeless drop-in day centre and winter emergency shelter. All interviews were conducted in private rooms at one of the two study sites.
Data collection and analysis	Semi-structured interviews were conducted to collect data for this study. Interviews lasted between 23 and 103 minutes (M=41; SD=19). The first author transcribed all interviews verbatim. Phenomenological analysis was used to elicit the collective essence of a service encounter experience.
Recruitment strategy	Participant recruitment occurred at study sites through introduction by a staff member, the snowball method whereas one participant suggested another potential participant or direct approach.
Study dates	December 2011 and March 2012
Sources of funding	Not reported
Inclusion criteria	Participants must be: • At least 18 years of age • Female • English speaking • Currently experiencing homelessness using the US Department of Housing and Urban Development (HUD) definition at the time • and have utilised services of a provider or agency that provides services to homeless people
Exclusion criteria	Not reported
Sample size	N=15 homeless women (same population as Biederman 2014)
Participant characteristics	**Age**

	Average age: 43 years (SD=10.9)
Results	Directive guidance Directive guidance included experiences of feeling cared for as a result of receiving feedback, instruction, or guidance. Some participants described instances, considered to be the typical experience, where they were given a resource list of the services they were seeking from a homeless service agency. However, several participants described encounters where the service provider who was making the referral guided them through the process of securing the needed serviced. One young woman, who had been homeless for five years and had a diagnosed mental illness, recalled an encounter with a hospital case worker who assisted her in calling local shelters and coached her on how to interact with intake staff. This was quite different from her typical experience of being “discharged to the street” following a stay in a psychiatric unit or shelter. Another woman, who became homeless after the death of her common law husband, described how a shelter worker helped to secure much needed grief counselling. The few women who reported this type of encounter described it in terms of feeling cared for stating “they helped me with a lot” and “she completely goes out of her way.” Non-directive support Non-directive support, the largest subcategory of the “cared for” theme, accounted for more than half of the service provider encounters experienced as care. Non-directive support included when service providers actively listened to participants, remembered details of the participant’s lives, verbalised unconditional availability, demonstrated trustworthiness, and/or demonstrated concern for participants physical, mental, and emotional comfort, safety, and/or overall wellbeing. Some participants described an unwillingness to express vulnerability in the company of their homeless peers to avoid being perceived as needy or weak. These women counted on the support of trusted service providers who listened to their issues and encouraged them to talk about intimate details of their lives. Positive social interaction While women desired intimate encounters and trusting relationships where they could express vulnerability, they also appreciated service providers who joked with them, talked about shared interests, or provided other diversionary activities to lighten the stress associated with homelessness. Tangible assistance Participants reported feeling cared for in service provider interactions where they received unexpected services, money, other physical objects of value, or some other sort of tangible assistance. Some participant encounters resulting in tangible assistance were within agency norms of providing clothes, food, and/or toiletries; still many women

	were surprised by the quality, quantity, or variety of items offered. Other tangible assistance women reported included receiving a needed service that, at the moment, was beyond their reach. One participant who was fleeing a violent relationship described how service agency staff provided child care while she secured a restraining order. Two other participants described instances where shelter staff did their laundry.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the university's Institutional Review Board.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Authors analysed data by phenomenological analysis.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Biederman, 2014

Bibliographic Reference	Biederman, D. J.; Nichols, T. R.; Homeless women's experiences of service provider encounters; Journal of community health nursing; 2014; vol. 31 (no. 1); 34-48

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	US
Setting	All interviews were conducted in private rooms at one of the two study sites

Data collection and analysis	Interviews lasted between 23 and 103 min (*M* = 41; *SD* = 19). All interviews were transcribed verbatim. Phenomenological analysis was used to elicit the collective essence of a service encounter experience.
Recruitment strategy	Participant recruitment occurred through introduction by a staff member at a study site, snowball method, or direct approach.
Study dates	December 2011 and March 2012
Sources of funding	Not reported
Inclusion criteria	Participants must: • Be at least 18 years of age • Be female • Be English speaking • Be currently experiencing homelessness using the current HUD definition (HUD, 2011) • Have utilised services of a provider or agency that provides services to homeless people
Exclusion criteria	Not reported
Sample size	N=15 homeless women (same population as Biederman 2013)
Participant characteristics	**Age** Average age: 43 years (*SD* = 10.9)
Results	<u>Neutral theme</u> These interactions were what one would expect from any given agency, service provider and/or situation and therefore represent participants' expectations of service providers. Participants expected service providers to: (a) act in a professional manner, (b) assist in securing the service sought, and (c) be competent in their field.

	Unmet expectations Some women described times when their expectations of service providers or agencies went unmet. These unmet expectations included perceiving a mismatch between what they were told would happen and what actually happened, double standards where rules were not uniformly enforced, interagency discordance, and intra-agency inconsistency. Some women described interactions where their needs and time seemed irrelevant. Judged This theme captures the homeless women's overriding experience of being judged and, specifically, as being stereotyped as homeless and treated accordingly. One participant commented that being judged is so common it is an expectation. Another participant compared being judged as homeless to being judged based on race. The judgment that accompanies homelessness is sometimes based on a stereotypical association with criminal activity or untrustworthiness. One participant described how she felt under constant surveillance at a shelter. Minimised Participants described minimised as feeling service providers held them solely responsible for their homelessness, while ignoring the larger social context in which homelessness arises. Feeling or being minimised was considered worse than being judged. Alienated participants described feeling alienated in interactions where they felt disregarded, unwelcome, or like they were a nuisance or bother to the service provider. The experience was described as "disheartening," "awful," "brutal," and "horrible." Powerless In this theme, women felt they had no voice, had no privacy, were infantilised, or felt exploited. In many instances, women felt the inability to advocate for themselves within a situation or lack of action when they attempted self-advocacy. One woman who had left a violent relationship recalled an encounter at a job skills class where she and two other women were trying to discuss job leads. The instructor silenced them and then went on to talk about a football game. Cared for Being cared for was the prevailing positive experience for homeless women, accounting for over three-quarters of positive significant statements. These interactions encompassed a multitude of actions on behalf of service providers

	(for example, remembering, acknowledging, listening, talking, giving advice, being available, creating a safe and/or welcoming environment, showing concern, joking, giving tangible aid, reaching out) and resulted in participants feeling worthy of care; recognised as a valid individual. Caring service providers were described as “wonderful,” “very, very nice,” “one out of a million,” and “an angel.” Through being cared for, women developed a sense of trust with service providers. Some described the relief of being able to talk freely, of letting their guard down and expressing vulnerability. Trusted Many women mentioned that they trusted service providers, but only two women described being trusted by service providers. In both instances, being trusted implied that these women had moved beyond the stereotypical untrustworthy homeless person and were seen as an individual capable of reason and responsible for their own choices and actions. One woman’s experience of being trusted was when a day centre staff member invited her over on Christmas. The trust this participant experienced was not explicit in her significant statements. During a member check, she explained this was an experience of being trusted because few homeless women are invited to service providers’ homes and the participant felt that trust is a prerequisite for such an invitation. Shared past/identity Participants reported experiencing a shared past/identity with some service providers, particularly if they knew the service provider had previously experienced homelessness or substance abuse. In some instances, participants stated that the commonality made them feel more comfortable or increased the credibility of the service provider. The hope associated with having a shared past/identity with a service provider is evident in one woman’s account. *"Just to hear somebody else’s story and they were there in your shoes, it’s like, wow! And lookin’ at ’em now and they succeeded and it’s good. It gives me a positive outlook that I’ll be there one day. Because there’s days that I’m like, no I’m gonna just give up, quit, say I’m done, but then I think, you know, I can’t, I’ve got two kids to live for. I need to get goin’."* [Quote: p.44] Empowered Several participants reported experiencing empowerment through their interactions with service providers. These experiences included interactions that resulted in increased independence for the participant through increased self-sufficiency, self-understanding, or self-esteem.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the university's Institutional Review Board (IRB).)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Both authors analysed data by phenomenological analysis.)*
Findings	Is there a clear statement of findings?	Yes

Critical appraisal

Section	Question	Answer
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Black, 2018

Bibliographic Reference	Black, E. B.; Fedyszyn, I. E.; Mildred, H.; Perkin, R.; Lough, R.; Brann, P.; Ritter, C.; Homeless youth: Barriers and facilitators for service referrals; Evaluation and program planning; 2018; vol. 68; 7-12

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Australia
Setting	Interviews with the homeless youth took place at a community location nominated by the participant, or at EACH Social and Community Health's office. Interviews with the service providers took place at their workplace.

Data collection and analysis	Two semi-structured interview schedules were developed: one for service providers and one for young people. All interviews were recorded using a digital voice recorder. Interview duration for homeless youth ranged from 44 to 72 minutes (mean=53.28). Purposeful sampling was used to ensure an information-rich sample of service providers. The duration of the interviews with mental health clinicians ranged from 32 to 72 min (mean=54.07), and the interviews with homelessness support workers were between 33 and 70 min (mean=48.93). Recorded interviews were transcribed and managed using NVivo 9 software for qualitative data. Thematic analysis was employed for data analysis.
Recruitment strategy	Homeless youth learnt about the study through posters placed in homelessness and mental health services, and through flyers distributed by the mental health clinicians and the homelessness support workers to youth who met the inclusion criteria. Staff from mental health and homelessness services were notified about the study via recruitment posters located in their workplace and via email or phone calls from the researchers.
Study dates	Not reported
Sources of funding	This work was supported by the Australian Government’s Department of Families, Housing, Community Services, and Indigenous Affairs (ID#1-9GN6JN).
Inclusion criteria	**Homeless youth** • Aged 16-25 years • Having experienced homelessness (past or present) • Being located in Melbourne's Eastern Metropolitan Region • Having experienced mental health issues
Exclusion criteria	Not reported
Sample size	N=30

	n=10 homeless youth n=20 service providers
Participant characteristics	**Homeless youth** Gender: Male: 2/10 Female: 8/10 Age range: 17 to 23 years (mean=20.9 years) Homeless at the time of the study: n=3/10 Experienced a past episode of homelessness: n=7/10 **Service providers** Gender: Male: n=8/20 Female: n=12/20 Sector: Homelessness sector: n=10/20 Mental health sector: n=10/20 Years of experience in their sector: Range 2.5 to 35 years (mean=13.2 years).
Results	Referral barriers identified by homeless youth Another barrier was not receiving the support homeless youth believed was needed, thus, perceived abandonment and a lack of stability of care were prominent themes. Specifically, homeless youth described the detrimental effects of abrupt service discharges (with little explanation or follow-up), and of being inappropriately referred on to a service. A lack of communication between services when inter-service referrals were made also resulted in young people telling

	their story repeatedly to each new provider. This lack of communication also occurred when a young person was already engaged with multiple providers; this in turn could have a large impact on the referrals made and eventual outcomes for the young person. Referral barriers identified by service providers Service providers described the current service system as complex, segregated, and difficult to navigate. Referrals to services across the sectors were seen as problematic due to a lack of clarity about appropriate referral pathways. This confusion was identified as contributing to young people not receiving the support they needed. Further, given a multitude of programs, their varying eligibility criteria, and sometimes relatively short funded life-spans, it could be challenging to keep abreast of what is available for young people, particularly when this knowledge falls outside the area of expertise of workers in a given sector. It was difficult to identify appropriate services in the other sector Inflexible eligibility criteria for services and programs were identified as an issue for young people. Criteria were often considered to be too strict, forcing young people into crisis situations before help could be provided. Despite the best of intentions, service providers reported caseloads higher than expected, impacting on the referral transition activities they were able to undertake. "*It's the resources. Everybody is busy, too busy to have the time to do what needs to be done. The funding pressures are also… some programs end after 12 sessions and then you closed, then you move on too, and it's not really built into programs to allow the transitions. And I think that's what needs to happen, people pick up the phone and ring the other agencies and talk about the young people, and help with those transitions, get in the car and take those young people to appointments, literally. More client focused services rather than statistical, funding-type stuff.*" (Participant #20, homelessness sector) [Quote: p.9] Referral facilitators identified by homeless youth The most commonly reported referral facilitator was when young people thought that service providers were offering a client-centred response, or going out of their way to help. Staff qualities such as being non-judgemental, friendly, and understanding, also assisted with engagement. Participants frequently mentioned that receiving the type of support they believed they needed at the time was a turning point in their lives. Young people indicated they were more likely to engage when providers seemed competent, had good knowledge of available services, acted as advocates, and provided consistent support. Another facilitator was service accessibility; such as outreach or after hours support being available. Communication or collaboration between agencies also facilitated referrals and service engagement. Referrals were also facilitated by existing providers supporting the young person to access a new service, as this could be a daunting time for the youth. "*I loved [mental health service], I really did. Umm, you know, they help me out through a lot of things, but you know it was that someone I had to talk to, and in that time no matter where I was, like they paid for a taxi to every appointment so I can get to and from every appointment without having to worry… I was always able to access them no matter what. So that was like a one stable place I had from fourteen all the way through to, I was about seventeen. So I was linked in with them and had the same psychiatrist the whole time that never changed on me either, which was good because she knew who I*

	was and then at the end she was starting to come to my DHS things, going [to DHS] 'You've got to do this better, you have to do that better'." (Participant #22, young person) [Quote: p.10] Referral facilitators identified by service providers Communication or collaboration between agencies also facilitated referrals and service engagement. Referrals were also facilitated by existing providers supporting the young person to access a new service, as this could be a daunting time for the youth. Service providers consistently indicated that increased communication and supported referrals facilitated the referral process. This often involved helping the young person transition to a new service provider by introducing them directly to the new provider, and/or liaising with the new service on the young person's behalf. Supported referral and service collaboration relies on the young person consenting to services sharing information. Interestingly, service collaboration was cited as producing positive outcomes even when consent was not provided by young service users. Service collaboration helped to facilitate referrals in several different ways. As indicated above, it facilitated the young person engaging with the new service. It also had positive outcomes at the service or provider level, by: delineating roles so each provider knew what their input was; avoiding doubling up on information or resources to increase efficiency; being aware of what other services provide; increased awareness of client issues; and, providing a consistent response to clients.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Critical appraisal

Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This research was approved by Eastern Health's Human Research Ethics Committee [HREC # E34/2011] and by EACH Social and Community Health's Board of Directors.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Firstly, 2 researchers independently coded the interviews, who then resolved any differences together afterwards. Consensus discussions between the researchers were used to group themes.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the findings from this study make to existing knowledge and identify new areas where research is necessary. They do not discuss whether or how the findings can be transferred to other populations.)*

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Broadbridge, 2018

Bibliographic Reference	Broadbridge, Ang; Blatchford, Shelia; Views and experiences of local mental health services for people with experience of homelessness or insecure housing; 2018; 15

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	Data was collected using 1:1 semi-structured interviews and focus groups. Audio recordings were made with participant's permission, transcribed verbatim and analysed by the peer researchers and the Lead Researcher. Interview and focus group data was thematically analysed to identify patterns of similarity and difference in the data to address the research questions.

Recruitment strategy	Study participants were recruited using purposive sampling from a range of settings in Gateshead and Newcastle.
Study dates	October to December 2018
Sources of funding	The Big Lottery Fund
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=23 homeless people
Participant characteristics	**Gender** Roughly 50/50 split of male and female participants **Support access** Newcastle: 13/23 Gateshead: 10/23
Results	<u>Access to mental health support</u> Perhaps inevitably given that most participants had multiple and complex needs, many of the stories we heard about access to mental health support were clustered around accessing support in a crisis, and around dual diagnosis. There was a sense from people that their situations needed to escalate in order for them to get access to mental health support. Three participants spoke about their escalating chaos as a ‘cry for help’ which saw them come into contact with the criminal justice system. One frontline worker told us that “for many people the route to help is your GP, you and I would go to the GP, our clients, it’s a very different, difficult pathway” – this was reflected by participants who spoke about feeling “too complex”. Generally services highlighted similar themes to those our participants identified, and also highlighted that the voluntary and community sector experience challenges in securing crisis support for clients, though reported positively on the support people received once they were able to access support. People spoke about feeling stigmatised by services because of their complex needs, four participants described speaking to

	their GP about their mental health needs and feeling stigmatised by their complexity. People spoke of their frustration at not being able to access support whilst using drugs and alcohol, two peers shared the view that mental health and drug and alcohol treatment should be offered together. Some people felt they had to lie to get access to support, others feel let down and have not returned to seek mental health support. *"It was difficult when I was homeless, I had to go to an extreme which was breaking the law before I got help. I was living homeless under a bridge for about three/four months and it come to one day where, thinking about suicide, I was gonna do it. I went into a shop and I went to rob it, it was a cry for help really and I accessed MH through the crisis team. It took the extreme of doing something silly, and putting other people in danger, to get help." "I was told if you have problems ask for help. When I have asked for help I have been refused it, I asked for help the wrong way and I knew if I acted violently they take you to hospital and you get the help, that was the only way I knew I could get help."* [Quotes: p.4] Experiences of mental health treatment In the main themes around treatment and effectiveness were clustered around two areas, talking therapies and medication and people told us that their experiences about both came up short. Interestingly four people told us that their experience of talking therapy did not meet their expectations which were high before they accessed this type of treatment because of how it was explained to them, it struck us as significant that two participants used the words 'magic wand' here too. Another participant reflected on how she didn't know what talking therapies was, and commented on the need for aftercare for people with complex trauma. Two participants spoke about group therapy settings as being inappropriate for them. Overwhelmingly people told us that they wanted someone to talk to, that sleeping rough and living in insecure accommodation and experiencing mental distress is lonely and they would like to have more people to talk to, and more time with people in support roles, and a free phone number for support. People's experiences around medication varied widely, from self-medicating with drugs and alcohol to not being able to access medication they had previously been prescribed, some people had been on a journey to getting the right medication for them and reflected positively on this. Those participants who had not been able to access medication said that they self-medicate while trying to have their prescriptions re-instated. People told us that they did not understand health professionals' reasons for changing their medication and would like support to understand these reasons, and to follow up. "*There was a lot of things, group therapy and that…I don't like talking in large groups I can't deal with like loads of people, and it didn't seem like enough support, like once a week*" [Quote: p.5] *"There should be a free number so you don't annoy the 999 people looking, we don't want to sit in waiting rooms, we want to speak to someone, the right professional - there should be an emergency line for mental health not just the NHS, people on 999 don't see mental health as an emergency." "I felt as though I needed someone to be there all the time, I'd spent so much time on my own homeless. I see the CPN once a month, there's a lot of things I'd want to talk about in between time" "My phone bills were huge, just calling all of these people for help…my friend in desperation was just phoning around, phoning around"* [Quotes: p.6] Stigma of past history

	We expected people to talk about stigma in relation to their mental health, however we found that people were most vocal about being stigmatised by services because of their drug, alcohol and offending histories. Crisis response Generally, people we spoke to had come into contact with Crisis services at multiple points and with mixed results, at one end of this continuum a participant had made a complaint about this experience as contact with the Crisis team on the telephone had made them feel significantly worse and led to relapse, others had positive experiences, some people reported accessing emergency services and accident and emergency to bypass Crisis services. *“I kept going to hospitals and going help me, help me, help me, begging…give me something to calm me down” “Living on the streets and going to the hospital, taking just enough tablets to overdose and be kept in because I felt broken, and I’d do that maybe twice, three times a year” “I can never knock the staff at that hospital, but that first port of call was the crisis team, I won’t ring them, I don’t think I probably ever will, I’d go straight to A&E” “I’ve got the crisis team, they’ve been good, Step Up team helped us and referred us to a CPN Nurse and talking therapies, but they said I could be waiting a while”* [Quotes: p.7] Timeliness, transience and accessing medical appointments Lots of comments in our scrapbook featured timeliness of support, “the waiting times are literally beyond the joke” and “waiting, not having no end in sight, is this going to go on forever”- participants recognised that services want to help them but are stretched “to the max” and one participant told us that it was very clear to him that services wanted to help but “red tape and funding mean they couldn’t.” We found a relatively high level of transience in the cohort we interviewed; as well as people with no fixed abode finding it difficult to register with a GP, other participants had moved between Gateshead and Newcastle and two participants felt happier staying with their GP practice and did not have the financial resources to travel to appointments. Despair and desperation Some people we spoke to are still in a very despairing situation, voluntary sector staff we spoke to spoke of how anxiety provoking this is for them in their support roles and about how the voluntary sector is filling the gaps in services. Three participants found it very difficult to talk about their experiences accessing mental health support and were focussed on living in the moment, one of these participants describe life as being “stuck in a loop, I don’t go anywhere…for weeks on end… and them what’s supposed to be helping us…well nowt changes.”

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell *(The researchers have discussed the research design but there are no details regarding how they decided which method to use.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers did not report on their own role, or any potential biases that may arise during the analysis.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers have not reported any details on consideration of ethical issues.)*
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(The authors provide a short description of the analysis process. Although thematic analysis was used, it is unclear how the themes were derived from the data. There was sufficient data presented to support findings.)*

Critical appraisal

Section	**Question**	**Answer**
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers do not report details on the contribution of this study to existing knowledge. There are no details reported on new areas where research is necessary and there is no discussion surrounding the generalisability of the results.)*
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Campbell, 2015

Bibliographic Reference	Campbell, D. J.; O'Neill, B. G.; Gibson, K.; Thurston, W. E.; Primary healthcare needs and barriers to care among Calgary's homeless populations; BMC family practice; 2015; vol. 16; 139

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	Canada
Setting	Not reported
Data collection and analysis	Data was collected using qualitative methods including face-to-face semi-structured individual interviews and focus groups. The interviews and focus groups were audio recorded, then transcribed verbatim. Data analysis began by establishing a coding template based on relevant literature. Thematic analysis was used for data analysis.
Recruitment strategy	Purposeful sampling was used to recruit participants who could speak to issues around access to primary care
Study dates	Not reported
Sources of funding	Dr. Campbell is supported by a Clinician Fellowship award from Alberta Innovates – Health Solutions. Dr. Thurston is supported by a team grant and an operating grant from the Canadian Institutes for Health Research. This study received limited funds from a local organisation which provides healthcare services to Calgary's homeless population – the Calgary Student-Run Clinic.
Inclusion criteria	• Participants who had been homeless for at least one week once in the last 6 months; • Participants who were 18 years of age or older • Participants who could speak and understand English • Participants who had no clear active mental illness (such as mania or psychosis) or other conditions that would preclude ability to give informed consent.
Exclusion criteria	Not reported
Sample size	N=22 n=11 service providers n=11 homeless people

Participant characteristics	**Homeless participants** Gender: Male: 10/11 Female: 1/11
Results	Medical services Addictions and mental health were the most commonly cited health concerns of Calgary’s homeless populations as well as some of the greatest needs mentioned. It was suggested that due to the stressful conditions of living on the street, there were high rates of depression and more rapid decompensation from other psychiatric disorders. The lack of mental health services was believed to act synergistically to reduce overall health outcomes Some clients expressed concerns that care providers do not adequately assist those with addictions and mental health. Several clients posited that some providers may believe addiction is a self-inflicted problem, and as a result they would be less inclined to provide assistance. Beyond care from medical doctors, respondents indicated that homeless individuals have a great need for allied health services. These include: nursing, dentistry, optometry, pharmacy, and rehabilitation. Insurance and paying for healthcare is a barrier. Public health insurance does not cover optometry or corrective lenses; prescription coverage is not available through the Alberta Health Care Insurance Plan. Most homeless people pay out of pocket for their treatment/medications. Patient-level: emotional barriers Due to the complex life stressors faced by individuals experiencing homelessness, this may prevent some from seeking care. This fear is further complicated by the fact that many homeless people do not have a support system upon which they can draw if they receive a poor prognosis or alarming diagnosis. Another negative emotional experience client may have is fear of their provider. The clinical relationship is one with an inherent power dynamic, and feeling subordinate in that relationship can arouse feelings of fear in patients. Clients acknowledged the apprehension that their peers experience disclosing to healthcare professionals that they are homeless. "*Most of our people have a fear of authority. Medical systems are structured to represent that. They're incredibly hierarchical and even physically they're set up to be daunting to get through… a lot of our clients will hide ailments and I think that just comes from a lifetime of fear of authority.*" (female provider 1) "*The psychological barrier of having to walk in and say that you're homeless. Part of it is our fault, part of it is us turning around and feeling uncomfortable and projecting that when it happens. The other half is a definite, darker side of the medical community that turns around and goes ‘oh, is that what you are?’*" (male client 1) [Quotes: p.5] Patient level: patient knowledge and priority setting

As many informants noted, preventive healthcare is often deprioritised in favour of managing other more acute issues. Informants noted that lack of education about prevalent illnesses among the homeless community also created a barrier in accessing care, in that individuals are often unable to identify that a problem even exists and are therefore not motivated to seek care. *“There seems to be a lack of education in a lot of the clients, or people who are homeless and somehow we’ve got to get across to them exactly how to reduce the spread of viruses such as colds and flus and other kinds of ailments that involve the transference of bacteria”* (Male client 3). [Quote: p.6]

Provider-level: environmental barriers and discrimination

Informants identified that there are a multitude of environmental barriers in existence that limit accessibility. Some of these barriers include the location of medical services, and the atmosphere within clinics or hospitals. Individuals may be less willing to go to a clinic if it is located in an area they are unfamiliar with or feel uncomfortable in because of the potential for greater public and/or police surveillance and control. Informants expressed that clients felt they had received poor care, including a lack of understanding on the part of healthcare providers of their social context and ongoing stressors in their lives. Healthcare providers may also make inaccurate assumptions about how the living conditions of their homeless patients affects their ability to maintain their health. Issues such as a lack of transportation or money can be overlooked by healthcare providers when patients are discharged home, leading to a negative emotional experience and reluctance to return to care in future. Negative past experiences with healthcare providers were often cited as contributing to a sense of mistrust and reluctance to disclose personal information to health professionals. Even if an individual has not had a poor healthcare experience, others’ experiences may be transmitted via word of mouth and lead to apprehension and fear of healthcare centres in general. In addition to the stigma associated with being homeless, members of other sub-communities are also subject to discrimination that can negatively impact their care. One provider singled out the Aboriginal homeless community as one that faces significant discrimination. “*We don’t have a great sense of understanding about this population or their needs and so they either get under served or inappropriately served*” (female provider 1) "*Attitude of staff is a barrier. The attitudinal issues that a staff has regarding the nature of who that patient is – that’s racism, bias, all that kind of stuff. Discrimination exists for the homeless population in general and the Aboriginal homeless population. I think that's a primary issue that generates how an individual accesses a system or turns away from a system after they've accessed it. The perception that they're not going to be treated well is part of a series of access barriers*." (male provider 1) [Quotes: p.7]

System level barriers: financial barriers

Some commonly cited financial barriers deterring homeless individuals from accessing healthcare include: money for transportation, health benefits, or coverage for prescriptions and allied health services.

System level barriers: other structural barriers

	These barriers largely relate to health system organisation and include: patients’ lack of identification, scarcity of resources leading to inconvenient clinic hours; and navigation. Many stakeholders, including both providers and clients, described that an important barrier to accessing healthcare services is a lack of government-issued identification, including their provincial healthcare card. Clinic hours repeatedly arose as a key structural barrier. Many members of Calgary’s homeless population are considered “working poor” and cannot afford to take time off of work to visit clinics which are only open during regular business hours. Navigation through the complex healthcare system presents a substantial barrier, particularly if patients are unable or unaware of how to advocate for themselves to receive the care they require. “*One of the things I just thought of that could be a potential barrier is missing or stolen ID*” (male client 1) "*Identification is something that you often need when you go to clinics and a lot of our [clients] do not have ID - whether or not they even have Alberta Health Care cards with them or have even applied for their Alberta Health Care cards. We have a lot of out-of-province [clients] that come through, a lot of immigrants that come through so then that whole issue is do they even get access to certain types of care just due to not having the proper documents.*"(female provider 8) [Quotes: p.7]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This research protocol was approved by the Conjoint Health Research Ethics Board at the University of Calgary's Faculty of Medicine.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Two researchers independently coded transcripts then met to discuss their initial coding, and to outline themes and patterns that appeared in the data.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Canavan, 2012

Bibliographic Reference	Canavan, R.; Barry, M. M.; Matanov, A.; Barros, H.; Gabor, E.; Greacen, T.; Holcnerova, P.; Kluge, U.; Nicaise, P.; Moskalewicz, J.; Diaz-Olalla, J. M.; Strassmayr, C.; Schene, A. H.; Soares, J. J.; Gaddini, A.; Priebe, S.; Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities; BMC health services research; 2012; vol. 12; 222

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	14 EU capital cities 1. Vienna 2. Brussels 3. Prague 4. Paris 5. Berlin 6. Budapest 7. Rome 8. Dublin 9. Amsterdam 10. Warsaw 11. Lisbon 12. Madrid 13. Stockholm 14. London
Setting	Not reported
Data collection and analysis	The semi-structured interview was developed using an iterative process involving all partners and translated into the languages of all participating countries. All interviews were transcribed, ensuring the removal of any identifying information to maintain anonymity, and were translated into English. The semi-structured interview transcripts were analysed using thematic analysis.
Recruitment strategy	The experts were identified during the assessment of services phase of the study where service managers were asked to identify suitable interviewees
Study dates	Not reported
Sources of funding	This study was supported by the Directorate General for Health and Consumer Affairs (DG SANCO - contract: 800197).
Inclusion criteria	• A good knowledge of local service provision • Professional experience of providing or facilitating access to mental health care for homeless people

Exclusion criteria	Not reported
Sample size	N=28 experts in mental health care for homeless people
Participant characteristics	The interviewees were employees in a wide range of services in the not-for-profit and state sector and had a variety of professional backgrounds: • n= 8 Social workers • n=7 Psychiatrists • n=5 Psychologists • n=2 Educators • n=1 Psychiatric nurse • n=1 Medical Doctor • n=1 Lawyer • n=1 Nurse • n=1 Homeless service manager • n=1 Therapist
Results	<u>Barriers to care</u> A common theme identified was the difficult and chaotic life circumstances of homeless people (23 experts), including alcohol and substance abuse issues and difficulties in maintaining medication compliance. The unwillingness amongst the homeless population to engage with the services was also seen as a barrier, often due to a lack of trust in health professionals. <u>Financial reasons</u> Barriers relating to health insurance were frequently reported, mainly relating to not having insurance or not being registered with a General Practitioner (GP). <u>Distinction of services and lack of collaboration</u> Admission and discharge procedures in the health services were also highlighted, with the main barrier here being a lack of clear responsibility within the services in relation to the treatment of homeless people and complex rules in relation to catchment areas. Lack of collaboration between mental health, social welfare and homeless services was also highlighted frequently by the experts, as was a lack of mental health outreach provision. <u>Prejudice</u>

	Prejudice/negative responses by health professionals towards homeless people were regularly highlighted.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval was not required in the participating countries for this study, as there was no health intervention and no personal information was collected.)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Data was analysed using thematic analysis. The data were coded independently by researchers from two capital cities and a coding frame was produced. A separate researcher used this coding frame to code the remaining data and produce the themes, which were revised and discussed within the wider international project group.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Relevant

Chaturvedi, 2016

Bibliographic Reference	Chaturvedi, S.; Accessing psychological therapies: Homeless young people's views on barriers and facilitators; Counselling and Psychotherapy Research; 2016; vol. 16 (no. 1); 54-63

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Within a homelessness charity in the UK, interviews were conducted in a private space within each participant's hostel with only the researcher and participant present.
Data collection and analysis	Data were gathered by the researcher via individual, face-to-face semi-structured interviews lasting 45-60 minutes. Interviews were audio-recorded and transcribed verbatim. The researcher transcribed the interviews herself to familiarise herself with the data. Transcripts were analysed using thematic analysis, using an inductive approach where themes were derived from the data.
Recruitment strategy	Purposive sampling was used. Young people were included in the study if they had accessed the organisation's counselling service between April 2013 and June 2014.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	• Participants who had attended at least two sessions of therapy and were not currently undergoing therapy. • Participants aged 16-25 years.
Exclusion criteria	• Participants who had been in therapy with the researcher
Sample size	N=7 homeless youth
Participant characteristics	**Gender** Male: n=2/7 Female: n=5/7

Results	<u>Resistance to opening up</u> Participants referred to a hesitation about opening up to someone and a resistance to accepting support, either due to feeling overwhelmed or the prospect of having close interpersonal contact with someone. This signifies, perhaps, a personal barrier for the young people in the sample and to some extent communicates a desire to keep one's internal life hidden away. The reference by Bobbi to feeling overwhelmed highlights why someone who feels very vulnerable may turn down offers of support. <u>Stigma</u> Participants' responses indicated that perceptions about what it means to see a counsellor, and fears of being perceived negatively by others if they were to go see a mental health professional, can influence a young person's decision on whether to access counselling. This suggests an internalisation of the stigma surrounding mental health in general. Robin's comment indicates feeling singled out in the hostel and defensive when advised to access psychological support. Robin also highlighted how use of a professional title can be off-putting. The stigma attached to seeing a counsellor was also evident in the fact that participants felt better when counselling was seen as something many people did and therefore, viewed less negatively. The quote suggests that for Sam, feeling that counselling was not a bad thing was the direct result of knowing that many people have counselling. Arguably, not having this knowledge may have led to Sam continuing to hold on to a stigma about receiving counselling. <u>Past experiences of help-seeking</u> The template of what to expect from counselling is shaped by prior experiences and can lead to rejecting an offer of support based on this expectation. A pattern emerges of young people having been let down in the past or not having had positive experiences of support, which makes them mistrustful and reluctant to seek support again. Another participant explicitly stated that homeless young people in particular are especially vulnerable to the effects that breaches of trust can have on willingness to seek help. Mika also stated how a positive experience of counselling made her more open to accessing it again. *Mika: 'I was only able to do the second counselling due to the fact that the first counselling was really good.'* [Quote: p.58] <u>Denial about needing help</u> Another barrier identified pertained to young people's perceptions about their own abilities to cope with problems, and their denial about the need for help. <u>Lack of familiarity with therapy</u>

The idea of talking to a health professional about personal issues emerged as a source of fear that was related to not knowing what it would involve. Some participants had no previous experience of therapy and their expectations of what happens in counselling were based on portrayals in the media or what they had heard within their families. A lack of exposure to the idea of talking to a professional about problems coupled with preconceived ideas can create a mystique surrounding counselling, which can instil fear and create a mental barrier.

Patience and consistency of offer

Participants’ responses indicate that those who feel overwhelmed or resistant to accessing support might benefit from the support being made available consistently, but without imposition. Bobbi and Robin also spoke about how their refusal of support gradually weakened as their difficulties became hard to ignore, suggesting that the passage of time can enable young people to realise that they are vulnerable and need support. Persisting with counselling helped overcome any initial resistance or feelings of ambivalence. Participants were able to comment on what enabled them to be open-minded. Clear communication of client choice, including the option to terminate counselling, was integral to clients being open to giving counselling a ‘try’. It seemed that participants needed to feel in control of the process and like they were not tied into anything long-term. This is understandable given the lack of familiarity with counselling or negative prior experiences of help-seeking. Participants entered counselling with a view to trying it out to see if it would help, and having the option to disengage from the service was essential in order for them to take that step. *"Bobbi: ‘I don’t know. . . like. . . Give them time you know? Like even me.. at the start I was not ready for the support because I just wasn’t. . . uh. . . I wasn’t in a good place and didn’t want to meet anyone or talk to anyone. . . but with time I became more open to it.’ Bobbi: ‘Just keep at it. . . that’s what I would say to staff and whoever is supporting a young person. Keep letting them know that the help is there.’"* [Quote: p.58] *Bobbi: ‘In the first session or like the first two sessions I didn’t really feel good. I wanted to run away and like not go. . . because that’s just how I was feeling then you know?’ Bobbi: ‘But then it became more easier. I didn’t feel like that. . . so much anymore and I was more open and sharing.’ Interviewer: ‘So what do you think made it easier for you?’ Bobbi: ‘I don’t know really. . . just keeping on going I guess.’"* [Quote: p.58-59]

Simple explanations

Participants’ suggestions for overcoming the stigma surrounding counselling were in the area of using simple language and explanations instead of professional jargon. Simple and clear explanations in promotional materials were also identified as factors that can help raise awareness of counselling and therefore, motivate young people to seek help. Given that there exists a perceived stigma surrounding counselling and a perception that young people may get defensive if asked to see a health professional, it is not surprising that the suggestion to overcome this possible barrier involves explaining what counselling is and how it can help. *Robin: ‘When I listen to that word, I think “nah, I don’t need a psychologist. I just need someone to talk.” And after they explain in simpler way like “it’s for talking, talking what you want. It’s not because you look crazy or something.”’* [Quote: p.59]

	Demystifying and normalising counselling Normalising and demystifying emerged as the ways of reducing the stigma surrounding counselling as well as helping alleviate any fears young people may have about seeing a counsellor. Group sessions and the opportunity to interact with the counsellor outside of the therapy setting were regarded as possible ways to make counselling more accessible. Giving more information to the young person about what counselling involves was also seen as important, especially to facilitate engagement of young people who may not be familiar with counselling. For some, the counsellor’s communication style was important in creating a sense of comfort. Sam talked about how it would help for the counsellor to be informal and not too distant. This suggests that it is important for the counsellor to seem approachable and communicate with young people on their level. In addition to the above, two participants mentioned how access to counselling could be influenced by one’s accommodation. Mika held the view that the hostel in which a young person lives can affect choice of support available and Jo commented on losing one’s hostel accommodation as one of the reasons why young homeless people might prematurely terminate therapy. Although not a theme recurring across all participants, these views are important as they highlight vulnerabilities that only affect homeless clients.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes

Critical appraisal

Section	**Question**	**Answer**
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Permission to conduct the study was sought from the organisation, and British Association for Counselling and Psychotherapy's (BACP) guidelines for ethical research were followed.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The codes were reviewed by the supervisor and an external reviewer until they reached an agreement. In the final phase, another researcher examined all codes to arrive at the major themes. The researcher arrived at nine themes and upon review by the supervisor and external reviewer, eight themes were agreed.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Clark, 2020

Bibliographic Reference	Clark, Emily; Player, Emily; Gillam, Tara; Hanson, Sarah; Steel, Nicholas; Evaluating a specialist primary care service for patients experiencing homelessness: a qualitative study; BJGP Open; 2020; vol. 4 (no. 3); 1-10

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	A bespoke, city centre primary healthcare service providing healthcare services for people who find it difficult to visit mainstream GP services
Data collection and analysis	Face-to-face, semi-structured interviews were used to explore patients' experiences of the care provided and the perspectives of staff. Separate topic guides were used for staff and patient interviews. Interviews were carried out by the lead researcher and another female GP with experience of working with patients experiencing homelessness. All interviews were completed at the surgery and took 20–60 minutes. They were audio-recorded and transcribed by the main author. The lead researcher transcribed patient and staff interviews and used NVIVO software (version 12) for data organisation.
Recruitment strategy	Clinical staff suggested patients to be interviewed so as to represent the range of patients who use the services, including rough sleepers and patients living in hostels. Patients who had been registered at the practice for at least 6 months were selected. Staff were included if they had worked for the service for ≥1 year and were selected using purposive sampling to include administration, nursing, and medical staff.

Study dates	Not reported
Sources of funding	National Institute for Health Research (NIHR) Applied Research Collaboration East of England (ARC EoE) Programme
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=15 n=11 homeless people n=4 service providers
Participant characteristics	**Gender** Male: n=9 Female: n=2 **Age** Age range: 21-62 years
Results	**Patient perspectives** Ease of access The interviews also gave insight into the reasons why individuals struggled to engage with mainstream primary care services. For example, many had previous negative experiences with services, which further inhibited trust of professionals. The practice improved access and attendance for patients by a proactive approach to missed appointments. Tolerance of behaviour in the waiting room was also felt to improve access for patients compared with mainstream primary care. The only disadvantage of a specialist service was that patients on a journey of recovery found having contact with old acquaintances in the waiting room difficult. "*A couple of times, you have had people that are cantankerous, that are difficult, that raise their voices … But the guys here seem to know exactly what to do and seem to be on top of that.*" "*It's a bit of a bummer bumping into the odd person. And they are still using [drugs] or whatever and it's like ''get away from me''. But that's the only difficulty.*" [Quotes: p.5]

Continuity of care

Continuity of care was important for patients, especially in terms of developing an honest and open relationship with their GP, which improved compliance with treatment and engagement. This continuity of care had benefits for the patient and doctor, and facilitated patients' engagement when relapsing, perhaps in terms of addiction. There was also a sense that if this continuity of care was interrupted, it could lead to disengagement. *"I have been coming here that long, my doctor gets me, knows where I am at, when I am going off at the deep end and when I am doing well. So she has insight into that. And that's built up over time." "I am comfortable here, I know everyone. I hate change. When change happens, the way I deal with is to walk away from it. Which isn't always good I know."* [Quotes: p.5]

Person-centred care

A person-centred approach, incorporating staff listening, showing humanity, and being 'non-judgmental', was valued by many patients. A further aspect to person-centred care was addressing patients' basic needs. This appears to be a key mechanism to enable patients to engage and would suggest that only once the basic physiological needs for shelter, nutrition, and warmth are addressed can deeper issues such as addiction or mental health problems be looked at.

High quality care

High quality care was demonstrated by staff going 'above and beyond'. *"Yeah, the text messages show they care about you. It's only a little text but things like that, the food vouchers. Things like that. They care about you."* [Quote: p.6]

Staff perspectives

Ease of access

The impact of literacy and challenging behaviour on patients' ability to access care was recognised by staff. *"A number of our patients are illiterate. A lot of our patients would just collapse with any forms, even if they can read and write."* [Quote: p.6]

MDT care

Gaps in the MDT were identified by staff. *"How wonderful would it to have a podiatrist, an optician, and someone who does dental health. It would be wonderful to have those things here under one roof."* [Quote: p.7]

High quality care

Staff felt that the lack of clinical capacity was impacting on the quality of care, as well as longer waiting times for appointments.

	Person-centred care When asked what progress looked like in this group of patients, increased and meaningful engagement, medication compliance, improved self-care, and motivation were identified. Safety of services In the domain of keeping services safe, there were mixed opinions from staff. Other staff felt that the lack of clinical coverage was impacting on safety. Reflection and learning In the domain of commitment to reflection and learning, staff recognised the impact of working within the service on staff. Given the nature of the work, which can be emotionally demanding, it perhaps attracts conscientious individuals who go above and beyond. It was felt that emotional wellbeing of staff could be improved. *"There is not enough emotional support for the workers dealing with those stories."* [Quote: p.7]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes

Critical appraisal

Section	**Question**	**Answer**
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This evaluation was approved by the UEA Faculty of Medicine and Health Sciences Research Ethics Committee.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The lead researcher transcribed and analysed interviews using the principles of framework analysis.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Croft White, 2004

Bibliographic Reference	Croft White, Clare; Parry Crooke, Georgie; Hidden homelessness: lost voices - the invisibility of homeless people with multiple needs; 2004

Study Characteristics

Study type	Case study
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	The data were analysed to provide both descriptive and explanatory, illustrative material. The analysis was undertaken from the interviews on a thematic basis from which a series of charts were prepared on which all comments and views were summarised. **In-depth discussions with key agencies** The framework for these interviews was the six evaluative ‘qualities of healthcare accessibility, equity, appropriateness, effectiveness, acceptability and efficiency. **Consultation with key agencies with a local or national strategic overview** The purpose of these interviews was to elicit and subsequently describe at a strategic level the current provision for homeless people with multiple health needs as well as perceived visions for the future. The content covered topics similar to those outlined above but with a view to the ‘broader picture’ as it was affected by local and national contexts.
Recruitment strategy	**In-depth discussions with key agencies** The researchers contacted as many agencies as possible directly to arrange interviews with them as well as seek their advice on where else to go. **Consultation with key agencies with a local or national strategic overview** A further series of 12 interviews were conducted with representatives of agencies with an interest in this field.

	Consultation with homeless people with multiple health needs The researchers aimed to identify people who were willing to contribute through the follow-up interviews with providers.
Study dates	Not reported
Sources of funding	Crisis
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	**In-depth discussions with key agencies** N=100 service providers
Participant characteristics	Not reported
Results	<u>Availability of services</u> Homelessness workers in the case study areas said that the typical inner-city problem of GP registration was exacerbated for homeless people, and especially those with additional health needs. In their experience, the majority of local GPs refused to register homeless people without a fixed address or refused saying they were ‘family doctors’. For homeless people with multiple health needs the barrier became even higher. Where problematic drug and/or alcohol use was one of the presenting problems, the barrier was almost insurmountable, with only a handful of GPs in each of the case study areas being prepared to register this group of clients. This was consistently highlighted as a major obstacle to the care of this client group. Some homeless people found themselves making use of A&E departments for a variety of medical problems, and often to overcome the problem of not being able to register with a GP. Many found the waiting times very difficult particularly where they were already anxious and leading a chaotic life. Whilst no definitive solutions were identified to overcome these problems, a number of participants pointed out that increased resources could result in greater availability of staff thus facilitating a reduction in high caseloads and long waiting lists. Others suggested that there should be a reconfiguration of roles and activity. *“If they are local, they may have had a GP. But usually there is a substance misuse problem and therefore they have been struck off. So we act as a GP –*

	and we are prepared to do this. We don’t turn people away. This is the policy agreed by our consultant.” (Senior staff nurse at an A&E department) [Quote: p.18] Flexibility within services Primary care services needed to recognise the irregular lifestyle and attendance patterns of homeless people. Workers recounted occasions where GPs refused to see homeless patients when they were late for their appointments and where their clients were removed from GP lists simply for non-usage for a couple of years. Both homelessness service providers and users welcomed the flexibility that was offered by health services brought directly to them. The key advantage to these approaches was that they maximised the opportunity to build up trust between the service user, key worker and professional, thus demonstrating that this person would not have to jump through hoops in order to use a service. Service providers said that users also appreciated being able to access the support and treatment they needed ‘under one roof’ and that they, the providers, were able to establish a relationship and work more closely with health services because they were on site on a regular basis. The provision of appropriate care Appointment systems were also problematic when homeless people attempted to access services that operated a waiting list. Both staff and service users had some positive experiences. Many of the issues about availability and flexibility identified above appeared to be partially resolved by specialist healthcare teams for homeless people. Whilst homelessness agencies welcomed visiting health professionals to treat the homeless person who – for physical health or psychological health reasons – could not access mainstream health services, a significant number in the case study areas reported that the service was being withdrawn – or was under threat – unless space was adapted to become a dedicated ‘health’ room with appropriate panic-alert systems. Other difficulties for homeless people who were drug users included locating GPs who were prepared to prescribe; locating pharmacies prepared to dispense and the need for walk-in, easy-accessible detox services. Non-prejudicial treatment Many homeless people with multiple health needs feared that their ‘label’ affected the response they received and made them fearful of accessing their services. One worker from a housing project for people with multiple needs said that residents were reluctant to go for help for less desirable conditions such as sexually transmitted diseases and HIV, self-harm and mutilation, or eating disorders. There were concerns about the way in which prejudicial treatment resulted in depriving homeless people with multiple health needs of necessary health services. This included treatment (or often more accurately, the lack of treatment) at A&E because a patient was known to be homeless and perceived as looking for a bed; and exclusion of homeless people from methadone programmes and detox because they had been struck off a GP’s list within a preceding three-month period. Both community mental health services and in-patient services were identified as demonstrating a lack of sensitivity towards homeless people with multiple health

	needs. This, one homeless service provider noted, often culminated in a refusal to work with 'complex' cases where there was drug and/or alcohol use, and an absence of hospital discharge planning. Workers in a range of different settings (statutory or voluntary, specialist or generic) felt that an important role for them was to advocate for homeless people with multiple health needs. For some, this meant assisting them to access mainstream health. To others, it was a 'hand-holding' operation that gave a little stability in a consistent way to people whose lives were often chaotic. An agency working with sex workers frequently attended an antenatal clinic appointment with a pregnant client. Staff accompanied clients to hospital A&E departments whenever possible, especially if the client was a drug user. *"Nurses shouldn't judge but the staff in one hospital made me feel like dirt on a shoe. They were clearly not interested in me and made me feel as if everything was self-inflicted. But in another hospital, everything was absolutely fine and I felt treated like an equal." "The attitude of hospital staff affects the service: many of them look down on sex workers and think of them as 'dirty women'. There is a lot of buck-passing, and there is no-one there to advocate for them". "We often have to stay with them to check they don't get shoved to the back of the queue; and even when they see the doctor we need to make sure they get the treatment they need, which might mean a hospital bed or a script."* (Outreach worker) [Quotes: p.23] Support and advocacy Staff from all types of agencies recognised that a more coordinated approach was needed to support them. However, one manager said that coordinated work was hampered by the 'parochial' and 'protectionist' attitudes of some agencies which were, it appeared, fearful of 'losing ground' through working too closely with others. In one case study area, regular case reviews were held with all the agency staff working with particularly chaotic clients. This facilitated joint decision-making and provided the opportunity to develop strategies to make contact and support the individuals. The need for training was also an issue where homeless people with multiple health needs constituted just a small part of the patient or client group. The lack of sensitivity of some health professionals highlighted in the previous chapter may well be due to the lack of training and support in this area. "*It is not the role of nurses to be judgmental. Let's face it; we all do risky things in our lives. But I cannot guarantee that some are not judgemental. We have not had any training in this area and none of us are involved in any forums.*" (Senior staff nurse, A&E) [Quote: p.28] Information for the service user Additionally, their frustration in relating to this patient group may have been exacerbated by a lack of knowledge of services appropriate to them. Training in itself was not considered by everyone to be the only answer to improving services for homeless people with multiple health needs. Indeed, a small number of services felt their time and resources were better spent in other ways. *"We need access to more information. We need to know what services exist and how to make referrals to them. Many nurses don't know and so people are falling through the net. Maybe a telephone Information Line would help."*(A&E nurse) [Quote: p.28]

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on any potential biases arising in the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval was granted by Scottish Multi-Site Research Ethics Committee)*
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(Thematic analysis was used to analyse the data but the authors do not provide any more details.)*
Findings	Is there a clear statement of findings?	Yes

Critical appraisal

Section	Question	Answer
Research value	How valuable is the research?	The research has some value *(The researchers discuss the findings of this study within the context of existing knowledge, however they do not report any details of new areas where research is necessary and whether the findings from this study are transferrable to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Csikar, 2019

Bibliographic Reference	Csikar, J.; Vinall-Collier, K.; Richemond, J. M.; Talbot, J.; Serban, S. T.; Douglas, G. V. A.; Identifying the barriers and facilitators for homeless people to achieve good oral health; Community dental health; 2019; vol. 36 (no. 2); 137-142

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK

Setting	Three focus groups were undertaken at two homeless support services in Leeds using a pre-piloted interview topic guide.
Data collection and analysis	Convenience sampling was the appropriate approach as the coordinators knew their clients and were able to identify those who could interact with this process without distress or inconvenience to themselves. All focus groups were audio recorded, transcribed verbatim and then analysed in conjunction with the written accounts of the facilitators from each group. A theoretical or deductive approach was used to undertake the analysis after themes were developed inductively from the focus group transcripts, driven by the research questions.
Recruitment strategy	Co-ordinators at the two homeless centres were asked to identify 4-6 homeless people who were current service users to take part in a focus group for up to 1 hour.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	• Participants with capacity to participate • Participants not under the influence of alcohol and other substances • Participants who posed no safety risk to the research team
Exclusion criteria	Not reported
Sample size	N=16 homeless people
Participant characteristics	**Gender** Male: n=14 Female: n=2
Results	<u>Patient-related factors: dental anxiety</u> Most participants recalled feeling some degree of anxiety when attending dental clinics. One participant indicated that his fear stemmed from the noise of the hand piece he heard as a child The participants reported that their levels of

	anxiety were exacerbated when they knew the dentist they were going to be treated by was newly qualified or if they were a dental student working under the direction of a qualified dentist. Participants reported feelings of panic and anxiety even over routine dental check-ups where no formal treatment takes place. "*…when I was … younger … my family would take me to the dentist. As soon as I'd hear the drill, I'd be off! They'd have to physically restrain me! To… get owt done!*" [Quote: p.2] Patient-related factors: low priority of dental care Having to deal with a myriad different problems and the competing needs experienced on a daily basis was reported to reduce oral health as a priority in everyday life. Participants also reflected that their prioritisation of oral health may be linked to literacy, which may also impact on their health literacy. This is further compounded by the impact of a chaotic and busy lifestyle. *"If you have got loads of other stuff going on in your life, dental hygiene is probably down there until obviously it becomes painful and then it goes up there..."* [Quote: p.2] Patient-related factors: cost of dental treatment One participant outlined that financial constraints have an impact of their ability to pay for dental treatment. Dental treatment debt was expressed as a contributing factor to their current financial burden. "*And then I got a letter through saying that I owed seventy-five pound for work that they had done. And I erm, you know, I explained to them and said look I am on benefits this that and the other, and they weren't having any of it and eventually people came knocking on my door to take stuff out of my flat, you know. And that put me off as well.*" [Quote: p.3] Oral healthcare professional-related factors Participants reported feeling stigmatised, disrespected and not treated like every other patient when attending dental consultations. Participants expressed this as one of the main reasons for not seeking regular dental care and did not feel confident in their interactions with oral health teams. Many participants complained that dental care professionals have a paternalistic attitude towards them, which in return had a negative impact on their self-esteem and dignity. The participants mentioned that oral health professionals tend to rush their interactions with them, and don't seem to have enough patience to listen and understand their concerns. Participants felt that oral health professionals should be less judgemental towards people who are experiencing homelessness in order to make them feel more comfortable when seeking dental care. A general feeling that the dentist focuses on "customer loads" rather than patient care was expressed. Many participants recalled being rushed out of the dental practice. *"When they are just saying this is what is wrong with you I will give you this now, you have got to go cos I have got to see the next patient, it's like well wait a minute I haven't even explained what's wrong with me. You are just fobbing me off and giving me this medicine and then letting me go. It's like how am I supposed to make myself feel better."* [Quote: p.3] Governmental, political and societal factors

	Participants explored the issues relating to access, information and fitness for purpose in accessing NHS dental care services. One of the major barriers outlined by participants in accessing dental care services was the lack of an appropriate point of contact. This reduced their awareness of available high street or community dental services, illustrated by a participant attempting to find a dentist who is accepting NHS patients. After securing an appointment, the challenges still remain as to locating the dental practice and getting there at the designated time. These barriers were reported to increase frustrations with the dental system and increasing their mistrust of the dental system, often abandoning further attempts at seeking oral healthcare. Participants proposed possible solutions (facilitators) to help them attend dental services. A single appointment for consultation and treatment could be helpful. Oral health promotion or oral health education sessions delivered at the facilities where participants usually go for their meals would also be beneficial. The participants outlined that dental teams have a crucial role and provided a service which they felt they wanted to access. "*You phone someone up for help, right, and by the time they have got round to the third or fourth person you might have got about half the information that you need to be able to go and see them kind of thing. But it's like they make it so complicated." "I would like to go there and get seen straight away and get what you need to get pulled out of your mouth straight away. Instead of having to make another appointment and going back and then making another appointment and going back, do you know I mean? I would just like to go to a dentist explain what happened and get it pulled out and there you're done. You don't have to mess about*." [Quotes: p.3]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval was obtained from the University of Leeds Dental Research Ethics Committee (DREC: 191214/KV/154).)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The preliminary coding was undertaken by one author and discussed with two further members of the research team. Codes were developed and refined by discussion between the research team and organised into a framework. All codes were reviewed, and redundant codes explored and discounted as appropriate final codes were agreed and an analytical framework produced.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Highly relevant

Davis-Berman, 2016

Bibliographic Reference	Davis-Berman J; Serious Illness and End-of-Life Care in the Homeless: Examining a Service System and a Call for Action for Social Work; 2016; vol. 14 (no. 1-11)

Study Characteristics

Study type	General qualitative inquiry Needs Analysis Method
Country/ies where study was carried out	US
Setting	The interviews took place at the shelter in a private room.
Data collection and analysis	The interviews lasted approximately 1-1 ½ hours each and were based on an interview guide. All interviews were transcribed and topic coded. Thematic analysis was used.
Recruitment strategy	Community experts were selected through a snowball sampling procedure, after being referred by the program director of the overnight homeless shelter.

	Recruitment of people residing at the shelter was done by the investigator approaching them at the shelter and asking them to participate.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=14 n=10 community experts n=4 homeless people
Participant characteristics	**Homeless participants** Gender: Male: 2/4 Female: 2/4
Results	<u>Lack of services for serious, chronic, and life threatening illnesses</u> All of the respondents talked about a lack of services for homeless patients with chronic and serious illnesses. Lack of funding and available resources were cited as the most compelling reasons for this lack of services. Thus, people potentially needing end-of-life care had nowhere to go. Services were mostly for acute conditions. Frustration with lack of services was expressed by the homeless men and women who were interviewed. In detailing the struggle to attain medical care, stories were told about chronic back and neck conditions, epilepsy and cancer that were being under-treated. The director of the overnight shelter shared her frustrations with the lack of available care for chronic and serious illness. In addition to lack of funding being a problem, she pointed to the hospital as having some responsibility in not adequately treating chronically sick people, and discharging them before it was appropriate to do so. <u>Barriers to access to service</u>

	One of the biggest barriers to accessing healthcare services is the difficulty inherent in navigating the medical service network and understanding health insurance. The nurse supervisor at the homeless medical clinic talked about the waiting times as being unavoidable due to the sheer volume of patients requesting and needing service. Since the demand for service is so high, homeless patients often must wait even longer periods of time to be seen by any kind of physician specialist. A homeless patient talked about trying to be seen at the clinic for chronic back problems. *"I had to wait three months for a back doctor. I waited three months and he told me they were still waiting. I waited another four months. It's been two and a half years and I'm still waiting."* [Quote: p.6] Stigma Negative attitudes toward the homeless and their right to adequate healthcare abound and were discussed extensively by the respondents. These attitudes restrict access to care and further complicate care for chronic, serious or life threatening medical conditions. Lack of knowledge about poverty and homelessness were cited as reasons for this stigma. Public perception tends to be that the homeless are mainly drug addicts or mentally ill. *"A lot of people have the idea that our patients are drug addicts and have mental health issues. That's the case for some, but we're seeing a different face of homeless now. We have patients in the clinic who have doctoral degrees that lost their jobs and they just can't find work. So, to be judgmental with the perceptions of homelessness compared to what it really is, I think people need to be more educated."* [Quote: p.6] End-of-life care A great deal of conversation during the interviews revolved around the topic of serious illness and death among the homeless. There was widespread agreement that death was a taboo subject, particularly when talking about the poor. Respondents agreed that end-of-life care is not very well developed or visible in this community. The hospice social worker talked extensively about end-of-life care issues and hospice care in particular. Interestingly, she seemed surprised when asked if hospice as an organisation was involved with end-of-life care of the homeless. One barrier to service that she discussed was the fear that some people have that the purpose of hospice is to actually euthanise patients. With this kind of misinformation, it is difficult to generate patient referrals. Other barriers really affect services to the poor, like the requirement of having two physicians certify that a patient is terminally ill. With a general lack of health care, many people in poverty do not have any relationships with physicians. A hospice social worker remarked that her organisation used to be more open to serving people in poverty. Now, nurses and social workers are more reluctant to enter certain neighbourhoods, and they would certainly be uncomfortable working in a homeless shelter.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	No *(The authors do not report details on how ethical issues were considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(All interviews were transcribed and topic coded by the authors. In order to address the issue of bias in data interpretation, an independent rater also read and coded the transcripts. Both of the raters then met and discussed the independent codes that were generated, highlighting the similarities and differences in the codes. Following this in-*

Critical appraisal

Section	Question	Answer
		depth discussion, themes for analysis were derived by combining identical or similar codes into overriding themes.)
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

De Veer, 2018

Bibliographic Reference	De Veer, A. J. E.; Stringer, B.; Van Meijel, B.; Verkaik, R.; Francke, A. L.; Access to palliative care for homeless people: Complex lives, complex care; BMC Palliative Care; 2018; vol. 17 (no. 1); 119

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	The Netherlands
Setting	The interviews were almost always held in the shelter in which the person was living or had lived.
Data collection and analysis	The interviews were conducted by the lead researcher. The interviews lasted between 20 and 90 min. After interviewing the person experiencing homelessness, the researchers asked their consent for also interviewing the professionals closest to them, specifically at least one professional who knew their personal circumstances (for example, a social worker) and one professional who knew their medical circumstances (for example, physician or nurse). Each interview was audiotaped and transcribed verbatim, and data was analysed inductively. The researchers included cases of those who had been interviewed but had deceased since publication.
Recruitment strategy	The researchers purposively recruited people experiencing homelessness, both men and women, in different living circumstances, who were at the end of their lives.
Study dates	Not reported
Sources of funding	The study was funded by FNO and RCOAK.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=64 n=7 people experiencing homelessness (n=12 people who were deceased who were included in data analysis) n=13 social workers

	n=12 physicians n=16 registered nurses n=3 nurse assistants n=1 sheltered housing facility coordinator
Participant characteristics	**Participant characteristics for people experiencing homelessness** **Gender** Male: 16/19 Female: 3/19 **Age** Mean: 59.8 years Range: 45 to 72 years
Results	Late access: difficulty in recognising palliative care needs Due to the chaotic lifestyle, people experiencing homelessness often have gaps in or no recorded medical history. The professionals involved were often social workers who were not trained in recognising medical problems and potential palliative care needs. Late access: Ambivalence towards accepting care People experiencing homelessness did not readily ask for help, even when they experienced healthcare needs. They had often suffered many losses in the past (for example, their job, home, family and friends, dreams and hopes, and now their health), suffered from social exclusion, and had learned to solve things themselves. They often had no confidence in professionals due to previous disappointing contacts, feelings of not being treated equally, perceived stigmatisation and being disparaged by professionals. Feelings of shame, for instance because of physical neglect or persistence in addiction, were also mentioned as a barrier to seeking help. The maintenance of autonomy and self-control was generally very important for them. From this perspective they did not easily ask for help, nor did they easily accept help, even if they had a strong need for help.

	<u>Late access: No palliative care facilities</u> In the Netherlands, there are a limited number of nursing-home facilities with specific expertise in palliative care for people experiencing homelessness. However, in most parts of the Netherlands there is insufficient capacity in specialised nursing homes for people experiencing homelessness and so these people depend on mainstream care, for instance in hospitals, nursing homes, hospice facilities or shelters. If a person failed to show up to an appointment in a hospital, for instance, the physician generally did not undertake further initiatives and in the worst-case scenario they just closed the file. <u>Capricious trajectory: Behaviour that is challenging for professionals</u> Many of the professionals interviewed, both in facilities for people experiencing homelessness and professionals elsewhere, mentioned that the behaviour of people experiencing homelessness is often challenging and difficult for them to handle. *“He behaved very pettishly, very badly. He let happen what had to happen, but he was absolutely condescending…He could not accept authority at all.”* (Nurse) [Quote: p.6]

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not provide details on how they decided which method to use.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The research protocol was approved by the Medical Ethics Review Committee of VU University Medical Center.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The data were analysed inductively. All transcripts were analysed by the first author, while each of the other authors analysed at least three transcripts. Differences between the researchers in the analysis and interpretations were discussed until consensus was reached. Thus the coding scheme was jointly refined over time.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not provide any details on how the findings from this study can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Minor concerns

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Highly relevant

Dickins, 2020

Bibliographic Reference	Dickins, K. A.; Buchholz, S. W.; Ingram, D.; Braun, L. T.; Hamilton, R. J.; Earle, M.; Karnik, N. S.; Supporting Primary Care Access and Use among Homeless Persons; Social work in public health; 2020; vol. 35 (no. 6); 335-357

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	US
Setting	This study took place at six sites in one Midwestern urban area, within a state that expanded Medicaid under the ACA.
Data collection and analysis	Interviews were conducted following an interview guide. The interviews were audio-recorded and data was analysed using thematic analysis.
Recruitment strategy	Homeless persons were recruited in shelter lobbies and providers/staff were e -mailed an invitation
Study dates	2018
Inclusion criteria	**Participant inclusion criteria**

	- shelter utiliser - ≥18 years of age - English speaking - Able to demonstrate decisional capacity to consent by passing the University of California, San Diego Brief Assessment of Capacity to Consent instrument **Provider inclusion criteria** - ≥18 years of age - English speaking - Employed at FQHC in a clinical role (for example, provider [nurse practitioner, physician], medical assistant, registered nurse)
Exclusion criteria	Not reported
Sample size	N=26 participants n=15 homeless people n=11 service providers
Participant characteristics	**Homeless shelter users** - Predominantly African American/Black, male, under the age of 50, and with healthcare insurance. **Providers/staff** - Mostly nurse practitioners, female, and in their clinical role for less than 10 years
Results	<u>Residential and occupational instability</u> The participants in this study described experiences of social instability, specifically precarious housing and employment, as a key factor that influenced access and primary care use patterns. Homeless persons and providers/staff described how issues of residential instability and unstable income took precedent over health-related

	matters, contributing to absences from care. Even in the setting of being medically insured, survival needs continued to take priority, and patterns of primary care use did not shift substantially; rather, the emergency department continued to serve as a venue that, in the perspectives of homeless persons, continued to provide a temporary shelter. Mental health disorders Mental health disorders were noted as a “common denominator” in explaining primary care access and use patterns, particularly absences from care. Homeless persons relayed observations of the prevalence and impact of mental health disorders in their communities. Providers/staff detailed how myriad mental health disorders contribute to difficulties establishing and maintaining primary care relationships. “*Psychiatric disorders is a big one . . . there’s such a range . . . they’re maybe avoidant in a lot of ways . . . they might not get care until they’re in a really major crisis . . . mental illness has a lot to do with the really hard to get people.” (Nurse Practitioner)* [Quote: p.340] Substance use Substance use (alcohol or other drugs [for example, opiates]) was described as contributing to patterns of engagement/disengagement from primary care services. Having a substance use disorder was noted to be a barrier to receiving primary care services, while seeking recovery facilitated greater linkage and engagement. Self-care and self-management limitations Homeless persons articulated challenges with engaging in self-care and self-management activities, including attending scheduled clinic appointments, and following-up on evaluation and treatment recommendations. This was expressed as a decreased sense of self-efficacy, which was in-part attributed to resource limitations. Providers/staff also described the importance of adapting plans to accommodate patient capacities as key to facilitating improved clinical outcomes when working with homeless patients. *“I was very much more rigid in my treatment plans until I came here . . . I figure out . . . how much they can engage . . . I also realise they have less energy, mental room to devote to keeping track of their meds, and did they run-out of their prescription, or can they take a TID [three times per day] regimen?” (*Nurse Practitioner) [Quote: p343] Perceived discrimination and distrust Several participants discussed their perceptions of discrimination, and resultant distrust, within healthcare settings. Homeless persons talked about feeling as though they were perceived not even as a “human being” and being treated as though they did not deserve the same quality of care as other persons. While multiple homeless persons described being previously uninsured, several homeless persons shared their experiences of being previously privately insured, detailing how they were treated differently when enrolled in “good insurance” (private health insurance). Care coordination

Homeless persons and providers/staff alike discussed the challenges that they experienced while attempting to navigate complex healthcare systems. Homeless persons discussed difficulties with knowing how to rectify certain systems issues, such as addressing lapses in insurance coverage, or requesting an early prescription refill. *"[T]he hoops that we need to jump through in order to navigate healthcare, even as providers is extremely difficult, so I can understand what participants must go through . . . because of all the moving parts of healthcare makes it really difficult for people to navigate and I think that scares people off."* (Nurse Practitioner) [Quote: p.344]

Shared decision making

The importance of shared decision-making, or care that integrates patient and provider perspectives and preferences, was emphasised by homeless persons and providers/staff alike. Homeless persons discussed the pivotal importance of providers/staff valuing their experiences and perspectives, and moreover, considering this perspective when making decisions. Also expressed by homeless persons was a desire to understand information better about their own health and healthcare processes. Providers/staff similarly recognised the value of hearing, recognising, and valuing patient's perspectives, highlighting the necessity of respecting boundaries of the patient's own authority and honouring patients as their own experts, while extending efforts toward patient education and information sharing.

Medication access and management

Some homeless persons discussed how when insured, they were able to obtain medications without concern for financial burden; others described an inability, lack of understanding, or difficulties with obtaining certain prescriptions, particularly when medications were lost or stolen, requiring reliance on settings such as the emergency department to address prescription refill needs. Providers/staff expressed similar sentiments regarding medication access, describing frustrations associated with prior authorisations and prohibitive co-payments. Also described were management concerns regarding patient ability to independently adhere to a prescribed treatment regimen.

Supportive housing and recuperative care

Providers/staff recognised how factors related to housing insecurity contribute to inconsistent primary care use, along with over-reliance on emergency/inpatient settings.

Outreach services

The importance of outreach services (for example, shelter-based care) was described by both homeless persons and providers/staff: homeless persons described remarkable long-term satisfaction, while providers/staff relayed a sense of

	connection and meaning derived from providing outreach services. Preventive screenings, medications, providing health education, and advising patients on primary care use were noted as important outreach activities.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Institutional Review Board (IRB) approval was obtained from the federally qualified health centre (FQHC) IRB and the University IRB with which the authors are affiliated)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Data analysis was conducted by the PI and an external service. The PI reviewed all transcripts for accuracy against original audio-recordings as part of the data familiarisation process. Three research team members reviewed the initial themes; all three research team members had training and experience in community-based research with vulnerable populations, as well as qualitative methods. Once the themes and sub-themes were finalised, the PI independently applied the finalised coding scheme to the entirety of data.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Elder, 2014

Bibliographic Reference	Elder, N. C.; Tubb, M. R.; Diabetes in homeless persons: barriers and enablers to health as perceived by patients, medical, and social service providers; Social work in public health; 2014; vol. 29 (no. 3); 220-231

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	US
Setting	Not reported
Data collection and analysis	Each individual participated in a 45-minute semi-structured interview that was audio-recorded. Data was analysed by the editing method
Recruitment strategy	Participants were a convenience sample of local providers and patients.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=18 n=7 homeless people n=6 social service providers n=5 medical providers
Participant characteristics	**Gender** Male: 10/18 Female: 8/18

	Age Mean age: 46.67 years (calculated by NGA) Age range: 31-68 years
Results	Role of Social Service Providers in the Care of Homeless Patients with Diabetes Primary care and social service providers note that, for homeless adults in this community, most care is provided in “silos,” with minimal coordination between agencies and providers. All saw lack of time and staff as additional barriers to communication. Social service providers desired more training and education about diabetes and medical providers desired regular meetings with agency providers to “learn what they do, and how we can work together better to promote evidence based care.”

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers have not discussed how they decided which method to use to collect data for this study.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study received approval from the University of Cincinnati Institutional Review Board.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Each interview was read multiple times by the researchers who met frequently to discuss the themes. Each researcher then independently coded each interview.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Relevant

Gallardo, 2020

Bibliographic Reference	Gallardo, K. R.; Santa Maria, D.; Narendorf, S.; Markham, C. M.; Swartz, M. D.; Batiste, C. M.; Access to healthcare among youth experiencing homelessness: Perspectives from healthcare and social service providers; Children and Youth Services Review; 2020; vol. 115; 105094

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	US
Setting	All interviews were conducted in a private location (for example, an office or private room) at the provider's affiliated agency, with only the researcher and participant present.
Data collection and analysis	17 semi-structured interviews were conducted with providers from 10 participating healthcare and social service agencies. The interviews lasted approximately 1 hour. Open-ended questions were used to guide each interview. All interviews were digitally recorded and professionally transcribed.
Recruitment strategy	A purposive sampling method was used to recruit providers from organisations that offer mental and physical healthcare services to youth experiencing homelessness and social services agencies that serve youth experiencing homelessness.
Study dates	November 2017 to February 2018
Sources of funding	This work was supported by the Simmons Foundation.
Inclusion criteria	Providers were eligible to participate if they were an agency administrator or a staff member designated by agency administrators as someone who could speak and respond knowledgeably about the agency services.
Exclusion criteria	Not reported
Sample size	N=17 care providers

	n=7 social service providers n=10 healthcare providers
Participant characteristics	Not reported
Results	Lack of awareness of healthcare services Social service providers reported they sometimes were unaware of various healthcare services available to YEH. For example, in reference to a specific healthcare clinic that serves the general homeless population. Healthcare providers also expressed that the knowledge gap of available services prevented youth experiencing homelessness from accessing healthcare. A shelter-based nurse practitioner explained that youth were often unaware his clinic existed. Providers expressed difficultly with continuously staying up-to-date on the full range of healthcare services available to YEH, especially while trying to fulfil other organisational and job responsibilities. To address the knowledge gap of available services, several providers expressed the need for a community-level healthcare navigator who could meet with YEH, identify their healthcare needs, and establish a plan to connect youth to the appropriate healthcare services. *"I've been here six years, and I still get people, they're saying, 'I didn't even know it was a clinic in here.'… So that's the main thing, just letting them know"* (P15, healthcare [HC]). [Quote: p.4] Incorporating health assessments into intake protocols To better facilitate the process of connecting YEH to needed health services, one social service agency incorporated an in-depth health exam into their intake protocols. Additionally, some agencies included additional health-related questions in their housing enrolment intake forms to help case managers determine to which healthcare services they should connect a young person. Furthermore, to ensure that all YEH referred into a housing program have an opportunity to discuss their health needs, leaders of the continuum of care reported that they were working to standardise the practice of how Rapid Re-housing providers assess and connect YEH to services. Lack of agency inclusivity of sexual and gender minority youth Healthcare providers expressed an unwillingness to collaborate with organisations that were perceived as non-affirming environments for sexual and gender minority youth. Organisation's religious stigma against these minority groups was seen to be a barrier when accessing services. Lack of trauma-informed care approach

Social service providers expressed that some providers lack a deeper awareness of the impact that trauma has on a young person’s life and how it may manifest in their behaviour. Providers who do not operate from a trauma-informed care approach may inadvertently serve as a barrier. Another social service provider discussed the challenges that his organisation faced with connecting YEH to a shelter-based clinic due to the clinic’s non-trauma informed policies. Specifically, the clinic’s strictly enforced rules and high behavioural expectations lacked consideration for the YEH population.

Building trust and promoting an accepting service environment

Several healthcare providers attributed their success in reaching YEH to creating a service-delivery environment in which YEH felt welcomed, accepted, and comfortable. Providers expressed that YEH often feel stigmatised as a result of their homelessness situation and subsequently, it is important for providers to be non-judgmental and provide care in a manner that makes YEH feel comfortable. Providers discussed the importance of building trust with YEH, as establishing trust with YEH served as a bridge to service engagement. For example, healthcare providers who conducted outreach at a YEH-serving agency were able to build trust with YEH by engaging them in a collaborative manner.

Complex, high-barrier healthcare service delivery system

Many social service providers described the existing healthcare service delivery system as a complex, high-barrier system-of-care that was challenging for YEH to navigate. Providers expressed that YEH often struggle to meet healthcare agencies’ paperwork and documentation requirements. For example, one provider reported that many YEH lack knowledge about their personal and family medical history and subsequently encounter difficulties completing medical intake forms. Providers also expressed that agencies’ numerous documentation requirements for service eligibility (for example, ID, letter of verification of homelessness, proof of health insurance) often required YEH to visit multiple agencies to obtain the necessary documentation for services, thus creating immense access barriers for a population that has low self-efficacy to complete multiple steps for services. Several providers discussed the need for agencies to provide immediately accessible, point-of-contact healthcare services to YEH because providing a referral or scheduling an appointment in advance usually did not result in service connection. Given YEH’s need for immediately accessible healthcare services, providers expressed that healthcare facilities’ limited hours of operation were a barrier. Aside from the emergency room, to which YEH often have to resort, providers reported that there was not an accessible healthcare facility that is open 24 hours to accommodate YEH who get sick on the weekends or after hours. Limited slots for walk-in appointments were also a barrier as one shelter-based healthcare provider reported that his clinic only had capacity to service two walk-in patients per day. *"…it’s not uncommon for us to try to make four or five referrals for a kid to [agency name] …So we try to work on them—work with them, make them an appointment—so [agency name] is right over there, you can see it across the street and sometimes they don’t get there so we’ll circle back with them again"* (P13, HC). [Quote: p.6]

	Offering healthcare navigation assistance and accompanying YEH to appointments Social service and healthcare providers discussed the importance of providing navigation assistance to YEH, as many YEH may not have previously received guidance from their parents or guardians on how to navigate the healthcare system. Social service providers reported that accompanying YEH to healthcare appointments, as opposed to simply providing a referral, helped better ensure that YEH made it to a healthcare appointment. Providers also expressed that accompanying YEH to healthcare appointments enabled case managers to advocate on YEH's behalf, as a young person seeking services alone may encounter long wait times or be ignored when they ask for help. Mobile services and co-location of services To better facilitate YEH's connection to services, several healthcare providers brought their services to youth-serving agencies. One provider reported co-location of services could meet a critical mental health services gap at his agency. *"We do have a dental unit that goes out. It is a mobile unit that goes out to several locations and is stationed there for a month, until it takes care of the entire community in that area*" (P9, HC). [Quote: p.6] Interagency partnerships and inter-professional collaborations Providers reported that interagency partnerships helped streamline the referral process between agencies, thereby reducing some of the barriers YEH encounter when navigating the healthcare delivery system. Several providers also commented that building inter-professional relationships provided them with direct organisational contacts that helped facilitate the service connection process. Cost of healthcare services Social service providers reported there was limited availability of free and low-cost healthcare services for YEH. While social service providers collaborated with several healthcare facilities in their communities, many of the services that these clinics offered were based on insurance or sliding scale fees. Healthcare and social service providers reported that the high cost associated with some healthcare services (for example, dental and vision services, psychiatric medication) made them inaccessible to YEH. Using multiple funding sources within and across Healthcare providers strategically used multiple state and federally funded grants to meet the healthcare needs of YEH. Public health insurance and financial assistance program

	YEH who were currently involved or aged-out of the foster care system qualified for Medicaid, which provided access to a range of preventative care and other medical services. A social services director reflected on the healthcare services available to YEH involved in the foster care system. Several healthcare providers expressed that a county-level healthcare financial assistance program, commonly known as the Gold Card, was a critical facilitator to healthcare access for YEH. Individuals experiencing homelessness can access free healthcare services at affiliated clinics. Lack of consistency and continuity of care Several participants reported challenges with providing consistent care due to the transient nature of YEH's living situation. Because providers typically only met with YEH one time, providers did not have the opportunity to establish a strong provider-patient relationship in which they could become familiar with a young person's healthcare needs and provide continuity of care. Healthcare providers also reported challenges with providing continuous care, as they often could not reach YEH to follow-up about an appointment reminder or share positive test results. Lack of care coordination across healthcare facilities Some providers reported challenges with coordinating care across healthcare facilities, which negatively impacted the care they were able to provide to YEH.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study was approved by the institutional review boards of the universities of the lead investigators.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The coding team included the first author, a doctoral student, the HYHI lead investigators, and a research assistant with lived experience of homelessness. The four members of the research team independently coded transcripts and met multiple times to discuss, refine, and develop themes.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Highly relevant

Glumbikova, 2018

Bibliographic Reference	Glumbikova, K.; Gojova, A.; Grundelova, B.; Stankova, Z.; Spilackova, M.; Krausova, A.; Anti-oppressive social work as a tool to reduce barriers to access health care services for homeless people; Kontakt; 2018

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	Czech Republic
Setting	Interviews took place in the shelter
Data collection and analysis	The data was collected using a semi-structured interview. The data was analysed using the constructivist grounded theory.
Recruitment strategy	The selection of participants was intentional (purposeful) through the institution of shelters.
Study dates	2017

Sources of funding	Student grant competition called Health and Use of Health Services by the Residents of Shelters.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=30 homeless people
Participant characteristics	**Gender** Male: 17/30 Female: 13/30 Age range: 20-66 years (mean 48 years) Range of current length of stay in a shelter: 1 month to 4 years (average= 7.5 months)
Results	Serious illness Participants reported only going to a doctor when they have an acute health problem and so there is no or little concept of prevention. "*I don't use preventive examinations unless I'm completely K.O., so no... Because I don't even care... I'm not active, I always start becoming interested only when something starts to hurt…"* (Male CP 7, 51 years old) [Quote: p.319] Financial reasons Total costs and payments for travelling to the doctor's office, paying for medication, etc were barriers to accessing doctors. Distance between services The distance was often related to the fact that shelter users' general practitioner was in the place of their original residence. Participants stated that transportation was difficult, or the distance was too great. Psychological problems Participants experiencing mental health issues such as depression or severe anxiety reported these as reasons for avoiding healthcare services or lacking the motivation to seek care.

Administrative barriers

Missing or incomplete medication documentation is often a major problem. *“They just wrote down that the card was missing… and that I didn’t have any doctor”* (Male CP 13, 41 years old). *“They couldn’t find that card. They called an archive, and they found nothing at all. So I have had no doctor ever since. Nobody at all”* (Male CP 12, 40 years old). [Quotes: p.320]

Registration issues

Participants reported finding a new doctor as complicated and difficult.

Attitude of doctors

Some participants reported the behaviour of doctors as 'oppressive' or 'negative'. They felt this was because they were being blamed for being homeless- in the context of the belief that the life situation of homeless people is self-inflicted and there is no influence of structural causes of homelessness. "*A parasite... So, the doctors just look at those people in a certain way... It is sometimes so unpleasant”* (Male CP 8, 41 years old). *“So they took me to O., where I had a surgery so I had to stay in the hospital for a few days… and the bandages fell off my leg and a nurse came to me to redress it and said to me: ‘You can fix it yourself, can’t you?’ ‘I tried, but I am not able to do it.’ And she said, ‘Well, you’re lazy and clumsy’... just because I live in a shelter… I know she knew about it and that is why she called me names”* (Male CP 9, 56 years old). *“I’ll tell you directly that when someone’s life is in pieces, some doctors behave terribly. You’re just trash to them, and that’s terrible. I’ve experienced it a few times…”* (Male CP 6, 60 years old). [Quotes: p.320]

Racial issues

Some participants reported feeling oppressed because of their race. “*I’ve experienced it so many times. Even though I’m not Roma, you can see it right away... even at the doctors, when a Roma woman comes in, the attitude is just different*” (Female CP 11, 53 years old). [Quote: p.320]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical Principles in Human Research, adopted by the APA in 2010.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The researchers do not provide an in-depth description of the analysis process.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Greysen, 2012

Bibliographic Reference	Greysen, S. R.; Allen, R.; Lucas, G. I.; Wang, E. A.; Rosenthal, M. S.; Understanding transitions in care from hospital to homeless shelter: A mixed-methods, community-based participatory approach; Journal of General Internal Medicine; 2012; vol. 27 (no. 11); 1484-1491

Study Characteristics

Study type	General qualitative inquiry Mixed methods
Country/ies where study was carried out	US
Setting	Not reported
Data collection and analysis	Semi-structured interviews were conducted. Data was analysed by the constant comparative method.
Recruitment strategy	Not reported
Study dates	April to May 2010
Sources of funding	The RWJF and the US Department of Veterans Affairs. The Yale Clinical Centre for Investigation also supported the specific efforts of this program to develop community-based participatory research projects. Additionally, Dr. Wang is supported by the National Heart, Lung, and Blood Institute (NHLBI, K23 HL103720).
Inclusion criteria	Not reported

Exclusion criteria	Not reported
Sample size	N=98 homeless people
Participant characteristics	**Gender** Male: 78/98 Female: 20/98 **Age** Mean age: 44 years <30 years: 17/98 (17 %) 30-39 years: 12/98 (12 %) 40-49 years: 37/98 (38 %) 50-59 years: 26/98 (27 %) ≥60 years: 6/98 (6 %)
Results	Expectation of Suboptimal Coordination Exacerbate Delays in Seeking Care Given their experiences with hospital care, many participants reported they were likely to delay in seeking care. Hospital Providers Should Consider Housing a Health Concern Participants expressed that hospital staff would be better able to address health concerns of participants if they asked about housing status and other social determinants of health. *"They [hospital providers] should be more worried about whether people have a safe place to stay beyond just physical or medical needs."* [Quote: p.1487] Hospital and Shelter Providers Should Communicate During Discharge Planning

	Participants reported that even if hospital staff addressed their need for safe transportation and a safe place to stay after discharge, they still might not be able to gain access to shelter for the night. Discharge Planning Should Include Safe Transportation Participants were particularly concerned about the safety of public transportation or walking if discharge occurred after dark. "*They should make sure people don't leave late at night and that they have a safe ride to a safe place to stay."* [Quote: p.1488]

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not report why they chose a mixed methods research design.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers do not report how the participants were selected.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report how ethical issues have been considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(A multi-disciplinary team of four study authors with expertise in homelessness, hospital discharge planning, community-based participatory research, and qualitative methods independently coded the open-ended responses and met as a group to resolve discrepancies through negotiation. The team reviewed the code structure throughout the analytic process, and revised the scope and content of codes as needed.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Relevant

Groton, 2020

Bibliographic Reference	Groton, D. B.; Leavitt, M. A.; Opalinski, A. S.; "You got to eat, but then what you are eating, it's going to kill you": Living with hypertension while experiencing homelessness; Public Health Nursing; 2020

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	US
Setting	Not reported
Data collection and analysis	Participants attended one of three focus groups held on three consecutive weeks. The lead author open-coded all three transcripts using the constant comparative method. Focus group sessions were audio-recorded and transcribed verbatim.
Recruitment strategy	Participants were recruited from a well-established hot meal program for people experiencing homelessness
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Eligibility criteria included answering yes to one of two eligibility questions: • Are you currently on medication you have been told is for treatment of high blood pressure • Have you been told by a health provider that you have high blood pressure?
Exclusion criteria	Not reported
Sample size	N=18 homeless people

Participant characteristics	**Gender** Male: 14/18 Female: 4/18 Age range: early 20s to late 80s
Results	Medication issues Ten participants faced barriers to access or manage their medications for hypertension. Most participants had access to medication refills, however, refills ranged from monthly to yearly, so some participants indicated they had to pick up refills more frequently than others, which could be difficult given the resources required to get to the pharmacy (for example, find transportation, spend the day at a clinic, and so on). Participants described how their prescriptions were often targeted for theft or were easily misplaced since they did not have a home to secure their belongings. Participants also described how difficult it was to remember to take their medications or the correct dosage. Participants described treatment noncompliance due to theft, memory issues, or confusion about when to take medications. The individual who intentionally stopped taking his medication did so because his insurance expired, and he did not feel the lengthy process to renew it would be worth the medication. *"So, I had just got my medication, and I put it in my bookbag. I sat my book bag next to me and fell asleep. Somebody tap on my shoulder and say, "Are you here?" I jumped up and took off without my book bag [nonverbal indicating it was gone]. All the medications, gone. How can I go back to my doctor and say, "Hey, you know my book bag was stolen with my medications…".* [Quote: p.3] Negative health care provider experience Nine participants described how health care providers or settings negatively impacted their ability to manage their care. Some participants reported that their primary care physician never explained to them what medication they were receiving. Care fragmentation is also a factor; one participant did not even realise her doctor had diagnosed her with hypertension until she switched providers and found out from her new doctor. Most often, participants described an arduous process to access their health care provider with lengthy waiting times to see a health care provider. Other times, participants described not feeling heard or respected by their primary care doctor. One participant described his experience talking to his doctor about having migraines. Managing medications Participants described a myriad of ways to access their medication. A few participants, currently residing in a more traditional housing setting, described having prescription refills delivered to their address. The majority of participants

	utilised local pharmacies. One participant, without health insurance, described using the emergency room whenever his prescription runs out.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes *(The researchers describe how they responded to difficulties in controlling and managing the focus group and the implications of this. The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the researcher's associated Institutional Review Board.)*

Critical appraisal		
Section	**Question**	**Answer**
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The lead author open-coded all three transcripts using the constant comparative method. The lead author completed memos to track the development of codes and any changes in the coding structure in this process. After the lead author reached saturation, two authors discussed the codes and memos and refined the codebook. Following, two of the authors independently re-coded a transcript. The codebook was further refined, and the authors independently coded the transcript. After, the lead author re-coded the remaining transcripts using the established code book. As part of the analytic process, the focus group facilitator's field notes were discussed to help frame the context of the findings.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Relevant

Groundswell, 2015

Bibliographic Reference	Groundswell; Room to Breathe; 2015

Study Characteristics

Study type	General qualitative inquiry A mixed method approach was used.
Country/ies where study was carried out	UK
Setting	Focus groups were conducted in homelessness hostels and day centres
Data collection and analysis	Questions in the focus groups were deliberately broad allowing participants to discuss their perceptions, opinions and attitudes towards homelessness and healthcare services as well as to highlight myths and misgivings that may be associated with respiratory health issues. Focus Groups recorded and then audio recordings were transcribed, coded and analysed.
Recruitment strategy	Not reported
Study dates	Not reported
Sources of funding	The Trust of London.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=44 homeless people (included in 6 focus groups)

Participant characteristics	Participant characteristics were not separately reported for the participants in the focus group.
Results	Primary Care Management People experiencing homelessness and asthma/COPD can struggle to manage their condition within primary care and seek care in A&E where everything is managed in one visit. Barriers: Drugs and Staff A further issue relates to the way that health may not be a 'priority' for people experiencing homelessness and the staff in homelessness services they are supported by. Often persistent coughs can be explained as a 'drug issue' or due to smoking – when there may be interrelated or underlying issues which therefore go unaddressed. This is further complicated by the fact that 80% of participants who use drugs find it difficult to know when they are ill and 84% have used crack or heroin to kill pain or get over an illness. Focus group participants commonly spoke about how staff might not prioritise health as an issue instead focusing on issues relating to accommodation, benefits and mental health. This can mean that coughs or other ailments often go unquestioned. GPs While registration is high the ability to access a GP is made increasingly difficult by sleeping rough: 63% of participants agreed or strongly agreed that "getting to a doctors when you sleep rough can be difficult". Even when people are in temporary accommodation, getting to a GP can be difficult. Access to smoking cessation The rates of smoking in the homeless population are higher compared to the general population, for various reasons. Accessing smoking cessation clinics may be an issue of awareness rather than availability of service. One Focus Group participant explained that he wasn't aware of the smoking support that was available to him and the options available to aid quitting. "*The fact that they haven't got access to information to tell them about what is available and where to go and things like that. Because you are in such a bubble when you are in that life, when you are on the streets. It really is and you withdraw from quite a lot of agencies that can help you. So it's about having the information in the first place as to where to go to get help with this and where to go to get help for that. And when you don't know you tend to withdraw even more and then just sit and suffer in silence*." – Focus Group Participant [Quote: p.25]

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(The researchers do not report how the participants were selected other than that they were recruited from homelessness hostels.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on any potential biases arising during the study duration.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers have not reported any details on whether ethical issues have been taken into consideration.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors did not report any details on how data was analysed in this study.)*
Findings	Is there a clear statement of findings?	Yes

Critical appraisal

Section	Question	Answer
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the findings from this study make to existing knowledge on this topic. The researchers do not report new areas where research is necessary, nor do they discuss the generalisability of the findings to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Groundswell, 2016

Bibliographic Reference	Groundswell; More than a statistic; 2016

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Not reported

Data collection and analysis	In total, 13 Focus Groups and 2 one-to-one Interviews were held – which engaged participants from 24 London boroughs. Audio recordings were transcribed, coded and analysed through NVivo1 data analysis software. Co-researchers fed into the analysis of the data and the report writing on an on-going basis.
Recruitment strategy	Participants were engaged through homelessness and community based services across London. Focus Groups were arranged through staff in these services, recruitment aided by advertising ahead of the groups.
Study dates	October 2016
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=91 participants
Participant characteristics	**Gender** Male: 66/91 Female: 25/91
Results	Access and flexibility Flexibility in service delivery was a key topic explored throughout the focus groups. Rigid systemic approaches in health services, related to access regulations, appointment slots and short windows for consultations, can act as a barrier for many people experiencing homelessness. The access issues extend beyond GP practices – barriers to making use of other areas of primary care were evident. A common example involved the systems employed to make bookings with GPs. Another common issue was GP referrals to specialists, for further tests or prescriptions. Some justified their preference for using hospital A&E departments by explaining that A&E offered access to more diverse treatment. “*I have to ring at 7 am in the morning. And if you miss that time – it’s only 7 till 8. Maybe no one is going to pick up the phone for the rest of the day, at my GP. So you are only going to be to make a regular appointment. Then you will have to wait a few weeks for an appointment.*” Focus Group Participant [Quote: p.10]

Specialist homelessness GPs

For those participants who had accessed specialist homelessness GP services there was a general feeling that the service offered by these practices was of high quality and met the needs of people experiencing homelessness. While these conversations were predominantly held in focus groups in central London boroughs, there were also examples of participants who were willing to travel long distances to use these practices. A key factor in this was that many participants who had been of no fixed abode had difficulty signing up with general GPs, and specialist homelessness GPs were more willing to take on patients in these circumstances. For some participants ease of access was most fundamental. Specialist homelessness services offer people a range of support beyond physical health needs. It was noted that focus group participants particularly valued the drop in appointments offered at specialist homelessness GP services. This more flexible approach enabled participants to get to an appointment when issues were identified, and when motivation to attend appointments was still strong. Specialist GP services were also seen to offer more time to individuals in consultation and follow-up. While there was a general acceptance that GPs were under pressure, and this led to all patients not being given sufficient one-to-one time, for individuals with existing feeling of being undervalued,

this could further embed this sense of self. Furthermore, participants highlighted the expert knowledge specialist homelessness GP services have, and how they enable access to a range of physical and psychological support tailored to the prominent needs of people experiencing homelessness. For other participants specialist GP practices offered an environment of acceptance, due it was felt to the well-informed staff and non-judgmental environment. *"That's why I go to [Specialist Homelessness GP Service] for 20 years because she knows what homeless people need and you know you are going to get sorted. Rather than go to a doctor who just refers you on. Every single person in that building that I am aware of is actually trained around homelessness. And they have experience. And it kind of gels and it works.[…] I mean I know a lot of people that go just to talk to some of the staff or whatever."* Focus Group Participant [Quote: p.12]

Health Outreach and Mobile Services

Often for people experiencing homelessness basic survival needs like food or managing a dependency take priority over addressing health needs. Mobile and outreach services are popular. In addition to addressing immediate needs, such as preventing conditions getting worse or contagious conditions spreading, they effectively signpost individuals to building based NHS services. Participants also spoke of the value of services that come to 'where they are' in particular day-centres, hostels and community centres. Participants reported that if a nurse is present at one of these services on a regular basis, then they are more likely to see them. For others there were psychological barriers to accessing support that were overcome by the medical personnel meeting people in the support services they use. Mobile services were universally seen as a key tool in screening and treating people. Many participants reported to have used a mobile tuberculosis (TB) screening unit, and some had used the mobile dental unit. While it was felt that mobile screening was not an answer to improving health, it was felt they were an important aid in supporting people to

	make the first steps towards positive change, and to signpost people towards using building based NHS services. People experiencing homelessness frequently get stuck in the “revolving door”, perpetually falling through the safety net of health and social care, and accessing one specialist service after another. Timely treatment of conditions can support the efficacy of other interventions in stabilising an individual’s progress out of homelessness, and into accessing mainstream services. The individual in the following excerpt, after a period in a hostel where he relapsed, was evicted and returned to sleeping rough. Once he was able to return to an assessment centre, he experienced successful treatment and is now in stable accommodation. “*I am just talking personally – there are some mornings you wake up and you don’t feel you want to get out of bed, you don’t want to get up and get dressed. You don’t want to even face anyone in the hostel, you don’t even want to step outside. And by having somebody come in, park up there, it would be great.”* Focus Group Participants [Quote: p.12] Consistency in Services A key topic throughout all focus groups was how participants valued consistency in service delivery. Specifically: staffing and routine visits to homelessness services. The opportunity to see the same GP, who an individual already had a relationship with and with whom they had begun to build trust, made successful engagements more achievable. It also avoided the need for participants to have to ‘explain themselves’ repeatedly. Consistency was a topic that spanned all NHS services including specialist homelessness services, where despite the benefits offered by having expertise and tailored services to homelessness people it can be undermined by irregular service provision. For example, some participants who had used a specialist homelessness GP found that the high rate of locum staff that worked in the service meant that they did not feel they were receiving a consistent service. *“There is no communication between the person that you go to because you have no constant doctor. You have a locum who reads and it’s his perception of what is written on the computer. You have got 12 minutes with somebody that you have never seen before. Over on-going stuff that you have to have continuity with. And that is my be all and end all.”* Focus Group Participant [Quote: p.13] Migration and Healthcare While participants’ nationality was not recorded in this study, we can be sure that a large proportion of participants were not originally from the UK – due to the topics discussed and the way that some participants were engaged through specific services for people with no recourse to public funds. Migrants, refugees and asylum seekers are more vulnerable to homelessness than people with long-standing residency in the UK. This is partly due to structural issues like a lack of familiarity with the British social system and not being entitled to benefits and services. It can also be due to personal reasons, such as limited social support networks and difficulties with language. It is clear from the discussions in the focus groups that this brings a further set of difficulties when trying to access and make use of healthcare. Generally in focus groups non-UK origin participants expressed a lack of knowledge around how and where to access healthcare. Language barriers and a distrust of healthcare were also highlighted as a key barrier. For participants who had refugee status, or who were in the process of applying, there was a mixed response around access to healthcare. For some they were relatively happy about primary care that was free at the point of access and

	were aware of how to use this system. However, the complex cases that some refugees are currently involved in can make it very difficult to understand how and where to access services, or to make sense of the entitlements that people had. For some this resulted in a fear of using healthcare, as it was believed that this might have a negative impact on their immigration cases. Wider concerns were raised around healthcare moving beyond primary care and including secondary care and mental health support. Here it was felt that it was counter-intuitive to only provide primary and emergency care, as underlying issues would eventually develop into more serious conditions and the ensuing increased usage of emergency care. “T*he time I came to this country I was happy with GP and he provided for me. […] And they provided GP. At that time, GP was free, the service free. When I apply for asylum as a refugee, they provide free dentist for treatment and also free eye glasses or check-up eyes. So I am happy with healthcare because I have HC1 or HC2. It is a certification of asylum. So right now I don’t have problems.*” Focus Group Participant “*One of the conversations I had with the Home Office official, he said to me I am not allowed to use the hospital. I said what do you mean, I am not allowed? He said you are not allowed. If you are sick you go to the pharmacy. I said I don’t have the money to go to the pharmacy. He said to me you are not allowed to use our NHS, if you are sick you go to the pharmacy and get access there. I don’t have the money. I mean I have been living rough for eight weeks and you expect me to have money.”* Focus Group Participant “*The gentleman that raised the issue of mental health has something that most of us here are dealing with. People do not have papers, they have no status to work, they have no house, no shelter. They cannot access the facilities in this country. They are living on the fringes of society and I have been coming here since December and I have run into so many people that I suspect need help. Nobody is coming here to offer any kind of help. So many people here – sorry –so many people have serious issues, I know that.”* Focus Group Participant [Quotes: p.14] <u>Access to Mental Health Services</u> Most participants believed that mental health support does not meet the needs of people experiencing homelessness. Many participants spoke of the issues that they had personally faced when trying to access support. Many of the issues that participants had faced in accessing mental health support related to concurrent substance misuse issues. The result of this often being that people in need are bounced between services, unable to fulfil the access criteria for a service due to a competing support need. The dilemma of dual diagnosis is that substance misuse is often a catalyst for mental ill health and vice versa. Often an individual’s access to most therapeutic interventions, while dependent on substances, is restricted until the individual can demonstrate a period of stability and henceforth access therapy. A key and common problem, as highlighted throughout the focus groups, is that people reach stability, but then have to wait until funding is put in place – the result often being that people return to the chaos of addiction and mental distress while waiting for support. This is not only damaging to the individuals involved, but results in them using expensive services without long term benefit to the patients’ health. Waiting times were a common topic of discussion and, a significant frustration for participants in the focus groups. Some participants indicated that, frustrated by difficulty in accessing mental health provision to address long standing issues, they increased their use of drugs and alcohol to mask the distress they experienced from underlying mental health needs. For some participants this had resulted in greater use of alcohol or illicit substances as a means of ‘coping’ with mental health issues, leading to a further decline. Participants highlighted that an earlier intervention would have avoided a mental health decline and subsequent

increased substance misuse. However, it was felt by participants that as they stood, they were left with little support. *“Again, my story – mental health and substance misuse went hand in hand. I don’t think I was alone in that one. And the frustration for me was I couldn’t talk to the psychiatrist and stuff until I was sober for at least a year almost. That’s ridiculous. […] But… but I could have had other interventions that could have helped me. Like CBT or something. Or just awareness training or basic interventions that could have tried to convince me to build my own motivation up to do something about my situation. When I say situation, I mean housing, homeless, drinking, everything. And self-esteem, confidence the lot.”* Focus Group Participant [Quote: p.16]

Mental Health Support for All

Poignant discussions occurred in three of the focus groups indicating a need for mental health support to be available to everyone experiencing homelessness, not just those with a diagnosed condition. Participants recognised both the generally high occurrence of mental ill health in the lead up to homelessness, and the negative impact of homelessness on an individual’s mental health. It was felt that a blanket approach to mental health support would mean that people don’t ‘fall through the net’ and that issues were dealt with early, thus preventing issues becoming very serious and more complex to treat. For some participants they felt they were receiving any support in terms of their mental wellbeing. Some even indicated that they felt that they were forced to over play their mental health issues in order to access support. *“But I feel like some people here… most of us –even myself – as if like they want to push me towards that…say I have got mental issue. So I will be…better classified, better help with that. Which is a bit sometimes wrong. I mean like the gentleman here said – anxiety. I’ve got anxiety, I have got depression. I have been through this kind of issue; stress. But they want you to be… say that you have got mental issue because if you don’t have mental issue you will be not helped. Because this is what happen. […] So people be pushed towards this side saying I have got mental issue, so they could get [support] – and I have seen it in places where I have been."* [Quote: p.17]

Training for staff: Information and Understanding

Participants universally believe that NHS staff are, in the main, not equipped with sufficient knowledge of homelessness and the associated health needs in order to effectively work with this population. It was felt that it would be advantageous for both clinical and non-clinical staff to participate in training on homelessness, as many participants had negative experiences of unhelpful attitudes expressed by frontline staff, which had deterred them from accessing services. There was enthusiastic discussion amongst many groups in terms of the potential content and delivery of training. For many, the breach in understanding could be bridged by creating opportunities for staff to meet, or at least hear the stories of, people who have experienced homelessness and the issues they face. Another key training need highlighted was the need for improved knowledge of existing provision available to people experiencing homelessness, so that NHS staff can better signpost to available support. In particular, knowing who to contact and having an established connection will aid this process. “*They should know… how they can help… or… better know the right place. Where to send the person, the person in crisis. They should know where to send this person. I mean I meant the right place or the right contact. Things should be more efficient than taking long time.”* Focus Group Participant [Quote: p.18]

	Engaging in a hospital setting For many participants in this study the hospital setting was reported to be an intimidating place to engage with. This was identified as a key barrier and an explanation as to why hospital appointments are often missed. Waiting times & methods of communication Many participants found the time spent waiting to be seen in health settings problematic. Some experienced this as evidence of being judged, overlooked and misunderstood. While others recognised this as common experience for all patients, waiting is especially troubling for people experiencing homelessness. Another common experience was a lack of awareness around when appointments were likely to be. One participant who was currently 'sofa surfing' reported how, due to his movement between different friends' places, he had not received any letters informing him of appointments. "*They have got all your details, they can email you or phone you. Everyone has a phone these days. Everyone, so it's nothing for them to look on computer… and yet it's very rare because they have their number anyway. It doesn't take long to get on the phone and phone us up… It takes a couple of minutes…"* [Quote: p.20] Independent Peer Support Across all focus groups there was recognition that support to access health care from someone who had shared lived experience of homelessness is valuable. All of the participants who had been supported by a peer advocate or care navigator reported having a positive experience, indicating that it had helped them to gain a sense of control over their health needs. A discussion in one focus group highlighted the need for peers to be well trained and well supported in their work, as well as maintaining independence from homelessness and health services. The discussion touched on the complexity of the role, the 'not professional, professional'. Decision Making & Accountability Participants were asked to explore whether they felt that they were in control of their healthcare, whether they felt fully informed and could make choices about their care. Commonly participants felt that they were not given their options or opportunities to shape their own care. A common discussion around this related to participants feeling that if they were feeling undervalued generally, and as a result were less likely to feel that 'figures of authority' like doctors and nurses listened to their opinions. A proactive approach is needed to involve people experiencing homelessness in shaping their own care. This is particularly so in terms of providing feedback on the care process. Participants felt that feedback processes were not always accessible. Despite many negative experiences of healthcare, few participants had any experience feeding back on their care. For some participants, not having an outlet for their frustration had resulted in negative consequences. When well informed and supported, individuals (whether homeless or not) can have more

	control over their care. If they can feel confident to feedback on their care, the level of service is ultimately improved. For this participant they had a positive experience of feeding back on their care. “*Yeah choice. That would be nice. If you can – because you know yourself much better what is your condition and what affects you, what… where your pains are. So choice is sometime helps yeah. It’s a good idea. But I think you feel that you don’t really get asked, you get told.”* Focus Group Participant *Interviewer: “So have either of you ever fed back about your experiences?” Focus Group Participant: “Yeah I have stood there and shouted and screamed. That’s happened a few times. And I have certainly had bad [experiences]….And then you just get yourself kicked out. Yeah and you get banned from the place.”* [Quotes: p.21] Reliance on Emergency Care A lack of access to primary care, or a feeling that primary care was not meeting the needs of homeless individuals, was an influencing factor. In this sense, emergency care was seen as a way to have multiple needs addressed in one visit in a streamlined and immediate fashion. For others the key element was that it was an open access service where care could be provided for physical health issues as well as other needs, including shelter and respite. Emergency care can often be depended on by people experiencing homelessness, but an effective intervention will reduce this dependency in the long run. When an individual accesses emergency care it offers an opportunity to tackle issues beyond just the immediate health needs, a chance for a more holistic intervention. While the individual accessing emergency care might be presenting with a specific ailment – it could be the route towards a life changing intervention. “*The last time I was in hospital – well, the only time I would go to hospital is in the back of ambulance. Because I wouldn’t go and sit in a waiting room. I would rather get knocked down. Which is what happened to me the last time*.” Focus Group Participant [Quote: p.24] Respite care The idea of respite care was welcomed as an opportunity to stabilise and recuperate. It was felt that this was particularly the case with people who were ‘entrenched’ and unwilling to move off of the street, or people who lived chaotic lives and were unable to sustain accommodation. However, many participants also responded that they felt that this was only a ‘sticking plaster’ when people would be discharged to the streets or back into temporary accommodation. Hospital discharge Focus group participants shared many stories of going through hospital discharge processes. Negative experiences were widespread, with one of the key issues highlighted having been discharge to the street without any sign posting to relevant services. This was particularly so with ‘frequent flyers’ who, due to their regular attendance can sometimes have their medical needs overlooked by staff at the hospital. This can mean that people are caught in a cycle of using hospitals for respite, but without a decisive intervention regarding their discharge. For others, while written information on services was provided, it didn’t help them to avoid moving to the streets. In one case, a participant who had just

	been thrown out of his parent's home attended A&E to get support Importantly, for some participants a decisive intervention at the point of discharge had been a turning point in their lives. Well informed staff, who had identified an accommodation situation early and had taken the time for a stable exit route from hospital to be identified, can be key to changing an individuals' lives. Health Services as a route to accommodation & Support A theme that was highlighted is the key role that healthcare staff can have in supporting individuals to access secure, appropriate accommodation. Whether this is through facilitating bed spaces, effectively sign posting, or adding 'weight' to applications for accommodation with the local authority – healthcare staff can play an important role in improving access to appropriate support. When meeting with patients, healthcare professionals may be privy to personal information about unstable housing even before individuals have engaged with support services. At times of crisis they may also be best placed to support individuals to find relevant support before situations deteriorate further. Medical professionals identifying unstable accommodation statuses and linking up with local non-medical services, and primary care services offering a 'social prescription' to sources of support within the community, can offer an important intervention. One participant explained how "joined up" services, with clear communication between them, led to them being placed in more stable accommodation by the local authority. Data Recording and Sharing The topic of data recording and sharing was addressed in all of the focus groups. Data collection was generally seen as a positive, with participants seeing a link between well-informed records accessible across NHS services, and service quality. A common rationale was that it meant that patients do not have to 'explain themselves' to medical staff repeatedly, particularly around accommodation and substance misuse. Participants were also asked whether they would be happy for their information to be shared more widely beyond NHS services to relevant support services (services discussed included homelessness, drug and alcohol and mental health services). Again, there was agreement across focus groups that this was a good idea, if done with consent from the patient. Participants also felt that it was important for people's accommodation status to be recorded on their NHS records so that medical staff could be aware of this support need at an earlier stage, and therefore plan treatment and discharge appropriately. It was also highlighted in two focus groups that this could add to the accountability of health services, and help services to understand how homeless people may have been treated in medical settings. The risk of being held to account could also lead to better quality of care for homeless people. Although some participants did have concerns around data security, it was generally felt that as long as the purposes of the data collection were for support, and systems used were secure, then it would not be a problem. A question was raised on two focus groups over when people had moved away from homelessness and whether being 'homeless' would continue to 'follow them around'. *"The NHS is computerised so everyone's notes are online. So anyone should be able to access them if they are within the NHS system. I think it's brilliant. Because the doctor doesn't have to go. Ask you a thousand questions, he's got it all on hand. I see you are this, you*

have been suffering from that for a while, you are on that medication. Let it go on from there." Focus Group Participant [Quote: p.26]

Substance Misuse

As discussed in relation to mental health support, the dislocation caused by dual-diagnosis is a key issue for people attempting to access drug and alcohol support. However, for some participants for whom mental health issues were not immediately an issue, they still faced significant waiting times and requirements for access to detox. For this participant, and many others who shared their stories, the delays in getting support had led to what they felt was a decline in their physical and mental health conditions.

Smoking Cessation

Awareness of smoking cessation services, and knowledge about how to access support, was a key issue, with many participants feeling that they were unsure of their options for quitting. This was both within services and in wider healthcare. In one focus group there was an example where some of the participants were aware of a smoking cessation project in their hostel, while others weren't. The reality for people experiencing homelessness is that smoking is a widespread and hugely damaging practice that could be preventable with tailored support. However, whether for a lack of information or services not meeting the needs of individuals, this is an area where an intervention tailored to the needs of homeless people could not only improve health but save considerable money in the long term around treating health conditions.

Providing Information for Patients

A key issue raised in focus groups was the need for information on healthcare and wider support services to be not only readily available, but be proactively provided for people with experience of homelessness. It was acknowledged, however, that communicating through conventional mediums would be difficult for people experiencing homelessness. This was both in terms of paper and online information and literature. The same limited availability of relevant and helpful information was also held by healthcare and support staff, who could be in a prime position to direct people to appropriate support. This highlights the need for both better information on healthcare and on homeless services. A number of participants highlighted how it was other people who were homeless who were the best source of information, as they had already used services and could communicate it in a way that people could understand. This raises the need for information to be delivered in a way that is clear and easily understood. While information on which services are available and how to access them was key, many participants felt that they simply did not know their rights around healthcare. All focus groups were asked the question 'are you aware of your rights around healthcare': few could answer this question. There was a sense that while participants felt that they could access emergency care, many were unsure of their rights around accessing primary care, around making choices about their own care, and about other rights such as accessing healthcare records. All the focus groups welcomed the opportunity to have a better understanding of their rights to healthcare. As this conversation from a focus group illustrates, some participants felt that having a better knowledge of these entitlements would immediately lead to a better use of healthcare. Participants were asked whether a ‘rights to access healthcare’ card specifically designed for homeless people would be a useful tool. *Interviewer: “Do you feel like that would be helpful, to know your rights [around healthcare]?” Focus Group Participant: “Yes.” Interviewer: “How would that help you?” Focus Group Participant: “So I could change… you know, my situation if I know more about or was aware of services and rights. I know where to go and I know I can perhaps change things quickly for me or the need to go to the right person to start the right conversation and say the right things.”* [Quote: p.31]

On-going engagement with People Experiencing Homelessness

Many participants felt that their opinions and choices were not ordinarily valued – and that the opportunity provided by the London Homeless Health Programme systematic consultation was a chance to begin to communicate and influence service provision in a meaningful way.

Social Exclusion & Isolation in final Days

Palliative care was a topic discussed with participants in focus groups. Perhaps understandably not one of the participants we spoke to had personal experience of using end of life care. However, it was common for participants to have had experiences where fellow residents in homelessness support services had passed away, either as an unexpected incident or following a protracted bout of illness. The participant felt that there was a need for more support, particularly as the staff at the hostel were unprepared (or unable) to offer emotional support to the individual who was passing away, or to the other residents in the hostel. In another case a participant had seen the benefit of palliative care with a fellow resident in a hostel. Generally, participants saw the merit of specialist palliative care for people experiencing homelessness, with the key motivation being that there was recognition that homelessness involves elements of isolation and social exclusion, support networks tending to be fragmented or unavailable. For this reason, more proactive support is needed to fill this gap. However, for some participants the discussion around palliative care sparked a debate on how an individual’s paths to death had occurred. For some, it was felt that a lack of support from mainstream healthcare had resulted in people passing away. There was a feeling that if individuals were better supported to address health needs, there would not be a need for a specialist palliative care service for homeless people.

Giving choice for a final decision

Throughout all of the focus groups where palliative care was discussed it was highlighted that whether there was a specialist palliative care service for people experiencing homelessness or not, the key is that people are given the choice to make decisions about where they pass away and how they are supported.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report any details on potential biases arising during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not provide any details on how ethical issues have been considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not report on how the data was analysed in this study.)*

Critical appraisal

Section	**Question**	**Answer**
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers do not report the findings of this study in relation to current practice or policy. There is some discussion of how the results contribute to existing knowledge. The researchers do not identify new areas where research is necessary and do not discuss the generalisability of the findings.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Groundswell, 2017

Bibliographic Reference	Groundswell; Healthy Mouths: a peer-led health audit on the oral health of people experiencing homelessness; 2017

Study Characteristics

Study type	General qualitative inquiry Mixed methods approach was used.

Country/ies where study was carried out	UK
Setting	Focus groups were conducted in homelessness hostels and day centres.
Data collection and analysis	Focus groups were used to explore in-depth the experiences of service users relating to oral health. Questions in the focus groups were deliberately broad allowing participants to discuss their perceptions, opinions and attitudes towards homelessness and healthcare services. Focus Groups were recorded and then audio recordings were transcribed, coded and analysed.
Recruitment strategy	Research participants were engaged through homelessness services across London including day centres, hostels and winter night shelters. Research visits were advertised by hostel staff and incentives were offered to participants to say thank you for their time.
Study dates	Not reported
Sources of funding	Groundswell's Insight and Action work, including this study, has been funded by Trust for London, an independent charitable foundation who aim to tackle poverty and inequality in London.
Inclusion criteria	• Participants were either currently homeless or had recent experience of homelessness.
Exclusion criteria	Not reported
Sample size	N=47 homeless people (forming 7 focus groups)
Participant characteristics	Not reported for the focus group participants
Results	<u>Difficulties Registering</u> We asked all participants whether at any point since they had been homeless they had attempted to register with a dentist. 31% had made an unsuccessful attempt to register with a dentist with the main reason being that they were told they were not entitled to NHS treatment (33%) or the practice list was full or there was a waiting list (24%). <u>Attending the dentist</u>

All participants were asked if there was anything that prevented them from attending the dentist, common factors were cost (23%), 'fear' (24%) and previous negative experiences of treatment (12%). Comparing this to Pathway's research which also asked those who were not registered with a dentist what the reasons were. Only one participant in their research gave cost as a reason, however, believing they were not entitled to treatment (13%) and previous negative experiences and fear (7%) were found to be common barriers to registering with a dentist along with other higher priorities (9%) and lack of perceived need (9%).

Missed Appointments

Groundswell Peer Advocates have had difficulties in the past with signing up clients from particular hostels with some dental practices. In these cases the explanation is often given that residents have a poor rate of attendance for dental appointments. Both private and NHS dentists are self-employed and when people don't show up to appointments dentists go unpaid but still incur costs. An NHS practice can lose significant amounts of money due to undelivered treatment under the NHS contract. *"I had a problem with my tooth and I spoke to a few of the residents in my hostel. And I said 'where is the closest dentist?' There is a dentist like four doors down from our hostel. I spoke to a few people and they said no they don't take people on from this hostel, we've got a bad name. And a lot of people said the same thing. I went in there and they just wouldn't take me."* – Focus Group Participant [Quote: p.24]

Access to Dental Care in Homelessness Services

Mobile services were universally seen as a key tool in treating people's oral health. 14% of participants reported to have used a mobile dentist since they had been homeless, with the mobile dental units playing an important role in providing treatment and signposting people towards using building based dental services. A quarter (26%) of participants told us they had seen a Crisis at Christmas dentist since they had been homeless.

Trust in Dentists

In the focus groups, participants overall had positive feelings about dentists. However there were those that had a negative experience in the past who reported negative opinions of dentists overall. *"They make a hell of a lot of money. Because when you go to the dentist the first they see you, its ching, ching, ching, money, money. Especially if your teeth are bad. You know, but… it's like with anything, a lot of people would rather go to a private dentist because they know what they are doing. You go to a public dentist they aint got a clue, and if you've got someone that's young and hasn't got a clue and ends up taking the wrong tooth out, what do you do?"* – Focus Group Participant

Focus Group Participant: "I just cannot stand dentists. Because they are the lowest… obnoxious people that you can meet." Groundswell: "What makes you think that?" Focus Group Participant: "Well sometimes you go to the dentist and they will take the wrong tooth out." Groundswell: "Take the wrong teeth out?" Focus Group Participant: "The last time I went to the dentist was…. it

	weren't my fault, it's what he actually done. He never told me he was going to use a needle. He just went straight into the wrong tooth." [Quotes: p.26] <u>Communicating During Appointments</u> Focus group participants discussed how it was important for dentists to communicate fully with those who are receiving treatment. Due to mental health and drug and alcohol issues that are common among homeless people it was felt that additional attention needed to be given to making sure that information is conveyed fully and completely understood. A participant from another focus group explained his perception of good and bad practice. Participants felt that there is a fine balance to strike between conveying a message clearly and treating people as more than just a 'homeless person'. <u>Treatment as a 'Homeless Person'</u> A common topic discussed in focus groups was how stigma could be a barrier to accessing dentistry and healthcare more widely. Participants felt that being homeless automatically set them behind people who were 'homed' and this was not only off putting but prevented participants from going to the dentist all together. It is also important to note that over a quarter of participants (28%) told us that they feel judged when they go to see a dentist. In the general population, 97% of people who have attended a dentist report that they were treated with respect and dignity. Some participants reported that due to being homeless they felt the treatment that was on offer was 'lesser' than the general population. Only liable to have teeth pulled out and not repaired whereas others who were not homeless may be offered a higher quality service. Often this was associated to the cost of treatment. *"My experience… the stigma is straight away as soon as you walked in… as soon as you walked into the practice, the stigma is you were ill-treated by the receptionist for a start. Oh it's him from the hostel, just sit over there. And we will get round to you … you know. And you could actually feel the tension in the room – or I could – in the room. I have always felt that the receptionist of any practice, whether it be a GP, whether it be dentist it's your first line of contact, your first point of call.*" - Focus Group Participant [Quote: p.27] <u>Motivation and Competing Priorities</u> We found that many participants had given up hope with ever having good oral health. 33% of survey participants reported that their 'teeth were beyond repair'. 17% of participants told us they can't get the courage to get to a dentist without a drink. For others it set them at an automatic disadvantage in terms of treatment from a dentist and practice staff. <u>Dental Anxiety and Phobia</u> Commonly a reason for being anxious in dental appointments is the feeling of a lack of control. Research reveals that providing clear information about treatment increases patient's sense of control and is key to relieving dental anxiety. The 'stop' signal in which patients are encouraged to tell health practitioners if they feel uncomfortable has been shown to help those anxious about treatment in general to engage.

	Costs & Entitlement Cost was commonly explained as an issue that had prevented people from attending the dentist both in terms of signing up and also seeking check-ups and treatment on an ongoing basis. One focus group participant explained how he was unable to receive care due to cost until the problem had become a more serious issue. A clear issue that arose in both qualitative and quantitative data was that there was a lack of information around what people are entitled to when it comes to treatment with an NHS dentist. 58% of participants either agreed or strongly agreed that they were 'unclear what they were entitled to regarding NHS Dentists'. There was a call from focus group participants to receive more information about entitlement particularly around how entitlements to care are affected by different benefit payments. One participant told us that she was unaware about being entitled to dental care until she received the HS2 card for free prescriptions and read the entitlement on the card itself. "*Years ago I got a very big tooth problem. I go to the dentist and they give to me the price list. And so to take off this tooth I must pay a lot of money. They want £25. Excuse me I am homeless, I've not got money. Then a bigger problem, because I have got a big infection... they take off my tooth for free.*" – Focus Group Participant [Quote: p.30]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on any potential biases arising during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report information on whether ethical issues have been considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not provide any details about how to data was analysed in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is not valuable *(The researchers do not discuss the results of this study within the context of broader existing literature. There is no discussion surrounding new areas of research, nor is there any information given on the generalisability of the findings.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Groundswell, 2020

Bibliographic Reference	Groundswell; Women, homelessness and health: a peer research project; 2020

Study Characteristics

Study type	General qualitative inquiry Mixed methods
Country/ies where study was carried out	UK
Setting	The fieldwork took place in hostels, drop-in and day centres across London.
Data collection and analysis	**1 to 1 survey based interviews** All data collection was completed on tablet computers with 77 delivered face-to-face at a range of services in London. Surveys typically lasted 30 minutes. Many participants agreed to be audio recorded, which were listened to and transcribed by a professional transcriber. The qualitative interviews were analysed in NVivo 11. **Focus groups** All focus groups were audio-recorded and transcribed, then coded using NVivo. Focus groups last around 90 minutes.
Recruitment strategy	Not reported
Study dates	February to September 2019
Sources of funding	Greater London Authority (GLA).

Inclusion criteria	• Women over the age of 18 years • Women with current or previous experience of homelessness • Those who were currently accessing support services that support homeless people in London
Exclusion criteria	Not reported
Sample size	N=104 homeless women n=77 survey based interviews n=87 participants in focus groups Note: it is unclear whether the same participants were involved in the interviews as the focus groups.
Participant characteristics	Average age (years)- 43 years Age range (years)- 19 to 75 years
Results	<u>Healthcare service usage</u> Two of the most common barriers were waiting lists and being unable to get an appointment; some participants also highlighted a lack of support to get to the medical appointment. This participant explained that they did not have the money for travel to get to an appointment. Other participants spoke of how it was difficult to access services as they were moved around from place to place. This participant explains the challenges she had with getting to appointments, mainly around being able to afford transport, but that through support from Groundswell she was able to attend them, get diagnosed quicker and avoid using secondary care services. Some women spoke of how they felt that services did not understand the specific issues they experience as homeless women and/or that services did not take their issues seriously. This participant makes an important point about the need for awareness of the issues amongst staff and volunteers and for reactions not to make the participant feel they are doing badly. Participants felt that NHS services did not understand the practicalities of being homeless: “and they don’t understand that you are homeless, you haven’t got an Oyster, or it took you time to get here”. This woman spoke of how her GP didn’t understand that despite having temporary accommodation, she couldn’t work because of her health. Many spoke about how the specialist services were supportive because they understood the issues homeless people face. Participants frequently told us that being

	able to get lots of medical services under one roof, either in a homelessness day centre or at an NHS centre, was highly beneficial to their health and wellbeing. Specialist surgeries, because they work with people experiencing homelessness, do not ask for ID. Participants also spoke of how services working together was supporting their health and wellbeing. We also found that participants greatly benefited from women only services or women only drop-ins in mixed services. Many services had sessions and organised activities where participants could get something to eat, receive support and talk to fellow clients, staff or volunteers. For those who had experienced domestic and/or sexual violence, the support they received varied considerably. While some of them received support, others either did not receive any, the support was not enough or had not told anyone about what happened in order to be able to receive it. One woman spoke of how she was unable to get mental health support for the violence she had experienced because she was living in a squat (see section below on mental health). Another woman spoke of how she is on the waiting list to get support but while she is waiting, she told us she is suffering significantly. Many women who had been affected by violence were either too scared to talk about it with a professional or to report it to the police, and/or felt it would again be re-traumatising to get help. This woman described the help she received and the challenges she had faced talking about it. *"They have been very good because they have had experience with people in my situation. And the majority of clients - they are now patients, sorry - of my situation, so they can help you.*" [Quote: p.56] The Mental Health Catch-22 Women spoke of not being able to receive the full support they needed for their mental health because of their housing situation or other issues they were experiencing. One woman spoke of how her mental health issues were dismissed and put down to her immigration issues. Women spoke of how they could not get support for their mental health unless they controlled their addiction. When access was possible, participants spoke of how it took a considerable time, in many cases over nine months, from an initial appointment with a GP to getting support from a counsellor and/or psychiatrist. As mentioned previously, since people experience homelessness can be moved around a lot, referrals that are made are not always followed through correctly. In some cases, participants explained how they felt that they had to talk about self-harm and/or suicide or enact on it in order to get support. This quote also echoes feelings among other participants in this research that there is a tendency among health professionals to favour medication rather than other forms of therapy. Another participant describes how not having a front door that shut properly in the hostel she was living in made her anxious. However, instead of fixing the problem of her door – her key workers felt she should be sectioned.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers do not provide any details on how the participants were selected. There is no information around recruitment.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not provide any details on approval of the research from the ethics committee.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not report how data was analysed in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Gunner, 2019

Bibliographic Reference	Gunner, E.; Chandan, S. K.; Yahyouche, A.; Paudyal, V.; Marwick, S.; Saunders, K.; Burwood, S.; Provision and accessibility of primary healthcare services for people who are homeless: A qualitative study of patient perspectives in the UK; British Journal of General Practice; 2019; vol. 69 (no. 685); E526-E536

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	The interviews took place in private rooms to maintain confidentiality, with the exception of two interviews that were conducted in communal areas at the participants’ request.

Data collection and analysis	A convenience sampling method was used based on the availability of participants at each site. Interviews were audio-recorded, transcribed verbatim, and analysed through a thematic framework approach by two researchers and checked by a third researcher before discussion in the team.
Recruitment strategy	Posters were made available in the public areas of the shelters to advertise the researchers' visit. Owing to variable literacy levels among the study population, staff at the study sites also verbally communicated details of the project to potential participants. Individuals were approached by staff at the study sites and referred to the research team if they expressed an interest to participate.
Study dates	Not reported
Sources of funding	The University of Birmingham
Inclusion criteria	• Participants who were homeless • Participants who were aged ≥18 years • Participants with the capacity to provide informed consent. • Participants who can communicate in English (or otherwise who had access to an interpreter on site)
Exclusion criteria	Not reported
Sample size	N=22 homeless people
Participant characteristics	Age range: 24-70 years Length of time experiencing homeless: <6 months to ≥5 years
Results	Organisation and delivery Most participants identified the absence of a 'fixed abode' as the largest barrier to registering at a mainstream general practice where both proof of address and photo identification were often requested by the frontline staff. Those using mainstream practices were either registered before becoming homeless or through a mutual agreement between the shelter and the local general practice. Some participants relied on help from friends or relatives to assist with supplying proof of address by allowing utility bills to be addressed in their names. Some mentioned that there was 'no way' of

	getting a general practice registration when sleeping rough. This was described in the context of signposting, and patient use of mental health and substance misuse services in the community. Participants described a lack of signposting to appropriate services. Despite participants being refused registration at local mainstream practices, they mentioned that they were not signposted to alternative services. This resulted in a patient having no access to a general practice for several months. The lack of service integration was also described in the context of mental health and substance misuse services, which were deemed to exclude those with the greatest need. Entry thresholds to such services were said to actively obstruct those patients who were self-harming, including those with recent suicide attempts, despite these incidents often being precipitated by poor mental health. Some participants with mental health conditions and concomitant substance misuse mentioned not being able to receive mental health support until they addressed their substance misuse issue despite their perception that these were interrelated, thus placing them in a vicious cycle. Themes around continuity of care were identified in the context of transition of care across services and sharing of patient medical records. Transition of care between secondary and primary health care and onto social services were often deemed to be suboptimal in practice. Variation in hospital discharge pathways for patients who were homeless was reported by those who had been admitted to hospital while homeless. One hospital was aware of the participant's homeless status and discharged them only once accommodation had been arranged. However, the accommodation was unsuitable as it had no fridge to store their insulin. Alternatively, another participant was discharged onto the streets despite making staff aware of their living circumstances. Participants also gave accounts of how poor transition of care between health and social services can perpetuate the cycle of homelessness. Failure of hospital staff to notify the city council regarding a participant's need for housing on discharge led to a participant being refused accommodation on arrival at the council despite their assumption of eligibility. Though the health of the participant had improved, they were forced to return to rough sleeping. Staff at the centre also undertook outreach services on the streets and at a local homeless shelter, used a patient's social network in order to contact them, provided opportunistic interventions, and initiated follow-up. The sense of reliance on the staff at the practice, however, posed a barrier to the patients relocating to a mainstream general practice. Given the multitude of healthcare problems they were facing, several participants described the long waiting lists for an appointment as a barrier to accessing care. Participants explained that they often experienced a rushed appointment in mainstream practices that limited their opportunity to fully discuss the multiple health issues they faced. Participants alluded to the disservice the 'one appointment, one problem' policy was causing them. Half of participants reported attending A&E in the 12 months preceding interviews. Participants described long waiting times and difficulty travelling to the general practice as reasons for presentation at A&E. Long waiting times at A&E itself were also a barrier and led to non-use of 'any' healthcare services by some participants. "*Getting proof of address when you're on the streets you don't have an address so it does get quite difficult and like I managed to get erm my uncle to let me stay with him for a while, get some bills sent there er like my bank statements stuff like that so I could actually get a GP … I know several people who have been coughing up blood and all that kinda stuff but they can't get in to see a GP coz they can't register.*" (male [M], aged 24 years, shelter A [SA]) "*Since we've come [here], I'm not registered, she's [daughter] not registered [because] I can't find [a] GP.*" (female [F], aged 32 years, shelter B [SB]) [Quotes: p.530]

Patient-related factors

Some participants mentioned that they were aware of the mainstream general practices that existed in their local area. A few, however, explained that finding a local practice was not easy given their lack of access to the internet and their unstable living arrangements. Most had attempted to register with a mainstream practice in the recent past, with varying degrees of success. Some participants felt confident in registering at a mainstream practice as they were able to complete application forms and understand the processes involved. However, others mentioned that they had struggled because of learning difficulties or being unable to comprehend the system. Some participants described having to walk to services, which was restricted by existing health issues and disabilities. After becoming homeless, one participant was forced to stop attending counselling sessions for depression and anxiety as they could not afford to pay for transport. One participant explained how severe pain further restricted service access as, on arrival at the practice, the participant no longer felt well enough to interact with staff. Resources were also described in the context of managing prescribed medicines. Participants reported having a large pill burden. A former rough sleeper explained that shelter and food were prioritised above medication when living on the streets. Medicines were often distributed or stolen within social circles. One participant described the difficulty they faced in storing insulin as there was no fridge in the temporary accommodation. A person’s emotional state was identified as a barrier to accessing primary health care. Feelings of embarrassment and depression were examples of emotions that deterred people who are homeless from seeking health care. "*They had no err fridge for my insulin right so I was putting my insulin in cold water in the sink and they was coming in, cleaning my room and leaving my insulin out of the water, so my insulin’s going warm*." (M, aged 50 years, SC) [Quote: p.532]

Social exclusion and stigma

While accounts of good relationships between participants and healthcare providers were described by some, others perceived themselves as being victims of discrimination and stigmatisation by HCPs due to their living circumstances, immigration status, and health issues. Some participants recounted mistrust between themselves and the HCPs. The influence of staff attitude on a patient’s health-seeking behaviour was emphasised by several participants and said to be a ‘decider between life and death’ for some patients who are homeless. Some participants also described the experience of facing stigma and exclusion from other service users at mainstream practices, which led them to exhibit poor behaviour and be de-registered from services.

GP awareness of the complex healthcare needs of people who are homeless

While some GPs would provide additional support to patients who are homeless, other GPs were perceived to have failed to tackle their complex healthcare needs. For example, a patient who was registered at a mainstream practice received delayed support when GPs failed to signpost him to mental health services for 6 months after his diagnosis of depression and anxiety. Some mainstream GPs were also reported to lack awareness of the impact of homelessness

	on health. Further training for mainstream HCPs to raise awareness of such issues was suggested by several participants in order to improve primary care provision. "*I think they probably need to be made more aware of [homelessness] because there's a lot of erm things that you can face on the streets, you can face a lot of illness more than you would do in like a house.*" [Quote: p.533]

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not give any information on whether or not they critically examined their own role, potential bias and influence during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval (Ref: 2017-50) was granted by the University of Birmingham School of Pharmacy Research Ethics Committee.)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Interviews were audio recorded, transcribed verbatim, and analysed through a thematic framework approach by two researchers and checked by a third researcher before discussion in the team.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Hauff, 2014

Bibliographic Reference	Hauff, A. J.; Secor-Turner, M.; Homeless health needs: shelter and health service provider perspective; Journal of community health nursing; 2014; vol. 31 (no. 2); 103-117

Study Characteristics

Study type	General qualitative inquiry

	Mixed methods
Country/ies where study was carried out	US
Setting	Interviews were conducted in a private location selected by participants
Data collection and analysis	Data from this study were collected in two phases. In phase one, 10 individual interviews were conducted with local shelter staff. In phase two, 14 individual interviews were conducted with health service providers. All interviews lasted from 20 min to 90 min and were digitally recorded. Descriptive content analysis methods were used to identify themes and patterns among interview data.
Recruitment strategy	Convenience sampling was used to recruit staff from five area shelters, two permanent supportive housing establishments, two area hospitals, a homeless health clinic, and public health departments. Participants were recruited via e-mail invitation with information about the project
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=24 n=10 shelter staff n=14 health service staff
Participant characteristics	Not reported
Results	<u>Barriers to care</u>

	Many of the health care needs reported by shelter staff members were tied to barriers to access or fulfilment of needs, such as lack of insurance and inability to afford care. Medications are often lost, stolen, or unaffordable. Shelter staff members discussed the difficulty diabetic residents have in regulating blood sugars due to lack of supplies and a clean space in which to use them, as well as barriers to proper nutrition. All shelter staff members cited transportation as a common barrier. One shelter staff participant remarked on the difficulty of navigating the health care system among multiple barriers presented with homelessness. Three shelter staff members also discussed a high incidence of unreported sexual assault among female residents and difficulty connecting with appropriate care while avoiding retraumatisation. They described a lack of established medical care and appropriate counselling for such residents. Because many residents do not report the assaults, staff members provide support without adequate training and debriefing. Assaulted residents turn to shelter staff for support, and staff struggle to advocate for them. Some shelter staff members also described perceived barriers such as resistance to seek health care due to lack of trust in providers or the health care system. One shelter staff member described a homeless patient who experienced significant pain and was not prescribed pain medication because the physician feared the homeless patient would sell his medication. Medical respite and support service needs Most shelter staff members stated that medical respite is a frequent need among the residents they encounter. Health needs and barriers to care management Some health service providers described homeless health needs as similar to those of the general population, but with significantly more barriers to management. One participant described that homelessness, itself, is an unmet health need, and health is not a priority if a person does not have a home. Medical needs of homeless patients were described as complex and increasing with limited ability to treat co-morbid issues. Homeless persons are often offended by providers or fear judgment, and some lose trust in providers to the point of unwillingness to return for care. Some participants said that it takes weeks to establish trust with homeless patients or residents at a minimum. Discharge planning Health service providers collectively voiced that discharge planning for homeless patients is difficult. Homeless patients were said to be medically stable to leave the hospital, but still in need of basic medical care that is not available in shelters or on the street. Some providers voiced concerns about homeless patients' ability to access appropriate resources after discharge, as well as the scarcity of appropriate places for discharge. Other participants said that hospital discharge may be delayed if an appropriate place is not available, and length of hospital stay would be longer. Medical respite and support service needs

	Health service providers corroborated the need for a medical respite facility in the community. Relationships were reportedly strained among hospital and shelter staff members because of the lack of a post-acute level of care for homeless persons.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers have not discussed how they decided on the method used in this study.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Institutional Review Board approval was obtained through North Dakota State University and other participating agencies as necessary.)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not provide enough information on how the data was analysed in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Health Scotland, 2004

Bibliographic Reference Health Scotland; Delivering health care to homeless people: an effectiveness review (Research in brief no 13); 2004

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	UK
Setting	Interviews were held in three locations in Scotland: an urban area (Edinburgh), a smaller town with a rural hinterland (Perth) and a rural location (Argyll and Bute).
Data collection and analysis	Not reported
Recruitment strategy	In each area, a small number of key professionals working for both statutory and voluntary sector organisations were either invited to a group discussion, or interviewed over the telephone.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	Not reported
Results	Mental health and drug and alcohol services As one focus group participant commented, delays in accessing services could be a particular issue when homeless people sought to end a drug dependency. PAM services Professions Allied to Medicine (PAM) services include dentistry, opticians, physiotherapy and podiatry (chiropody). These services are important to people experiencing homelessness. "*...podiatry is actually quite a big issue for basic foot care to be honest and you can understand why that would be for a population group that's transient, that's going to walk around, maybe their shoes are ill-fitting, they're not actually buying things themselves anyway, they're relying on things for handouts...Another thing is glasses for eye care, access to opticians for, I mean you can get a, you can get an eye test I'm sure through Section 12 money through*

	Social Work, I think you can access them through there but it's quite hard to immediately get, to get, to get replacement glasses. I know we've had problems with this." (Health service administrator). [Quote: p.20] Locality issues The dispersal of homelessness across a wide area makes the delivery of services expensive and logistically difficult. Attitudes towards homelessness As one participant in a focus group reported, the potential for miscommunication between homeless people and those providing or administering healthcare is considerable, when both parties start to interact with preconceived ideas of how the other will behave. Popular attitudes to homelessness and the experience of homelessness itself also form a barrier to health services through undermining the self esteem of homeless people. Mental health and drug and alcohol dependency As one focus group participant noted, the extent to which a dependency can dominate a homeless person's life may also mean that they can lose focus on other issues. Young People Participants in the focus groups also noted a tendency not to prioritise health among young homeless people. Young people who have been in care, or perhaps run away from home, may be ill equipped in terms of knowing where to find and how to access services. While they are not children, they may nevertheless be no better equipped than a child when it comes to day to day living and using services. Comprehensive services The importance of an outreach facility as part of a comprehensive primary health care response was also stressed by the focus group interviewees. One respondent was disappointed that a fixed site service could not presently offer this outreach facility. Nursing, facilitator services Continuity of care when people are rehoused was also stressed by study interviewees. Overall principles for primary care health service delivery for homeless people Effective services could have an open access system, although some services find that a combination of open access and appointments can also be effective. With both comprehensive and primarily nurse-led primary health care services, the

	relationship between the health professional and homeless person appears to be key to the successful delivery of healthcare. A socially orientated approach to healthcare is needed that allows a conversation between the homeless people and the health professional that extends further than a focus on medical problems. Effective joint working and, where possible, full integration of health services with social services and housing is also of paramount importance. *"....being able to develop a relationship, a professional relationship that gives them unconditional respect, you know that they let you down yesterday but you're still here for them today. And it doesn't happen overnight, its maybe 2, 3, 4 meetings before the actual stories start to appear."* (Healthcare professional) [Quote: p.41] Services addressing multiple needs One interviewee considered that an institutionalised 'mono- problem' culture within the health service was a real issue in terms of developing services for people with multiple needs, whilst a couple of people warned against a situation where people potentially ended up with too many workers in their lives. "*...because of the isolated or specialist nature of the services provided what I will do in practice is that I will go to the service that will deal with the problem that I think is my most serious problem at the moment, namely my broken arm, and I will turn up at A&E who will set the bones, put a plaster on it, and discharge me, the fact that I have a serious alcohol problem, no home, no job and the fact that I've just been thrown out of the house by my partner, is not addressed.... what we've got is structural isolation of services and problems, where the reality is that many of these people have multiple problems, and they as I say require multiple and long term solutions".* (Health professional) *"..it just becomes so big, suddenly people have got five or six health care workers in their lives now and before they had none, do you know what I mean, so you have to keep an eye on it in terms of, you know, how specialists are becoming."* (Health provider) [Quotes: p.49]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not give any details on how they decided which research design method to use.)*

Critical appraisal		
Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(The researchers do not report details on how the participants for this study were selected. From the information given, it is evident that the participants are appropriate for the research aims.)*
Data collection	Was the data collected in a way that addressed the research issue?	No *(The researchers do not not provide any details on why the methods chosen to collect data were selected.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on any potential biases arising throughout the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report how ethical issues were considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not report on how data was analysed in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution of the findings of this study to existing knowledge, however there is no discussion of new areas where research is necessary or the transferability of findings.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Relevant

Healthwatch, 2015

Bibliographic Reference Healthwatch, England; Safely home: what happens when people leave hospital and care settings?; 2015; 59

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	People's views were collected through focus groups, surveys, and visits to services. Data was reviewed and themes were drawn out. A survey of frontline staff was undertaken to elicit their perceptions.
Recruitment strategy	Not reported
Study dates	Not reported

Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	Not reported
Participant characteristics	Not reported
Results	<u>Delays and a lack of effective coordination between different services</u> Participants reported problems they experienced as a result of poor coordination between different parts of the health system, and between health services and community support. People also told us that information is not always being passed on to their GPs as quickly as it should be, leading to delays in receiving aftercare treatment, or medication once they return back to the community. Co-ordination between hospitals and housing services was identified as a significant issue affecting homeless people's recovery after discharge. We learnt that local authorities can be slow or unwilling to respond to hospital requests for assistance with people who are homeless, and when they do respond, individuals can find that they do not meet the criteria for housing. <u>People feel left without the services and support they needed after discharge</u> Individuals told us that they had been discharged from hospital before they were ready and without the right support in place. People told us about finding themselves in a vicious cycle, repeatedly going in and out of hospital because they were continually not being given the care and support they needed to recover in the long term. We heard about a lack of follow-up care, with individuals not being given enough information about their medication when discharged, and not being told where to go in the community for help when they need it. Those who have been homeless told us that accessing community support - such as rehabilitation to regain strength, movement and stability following injury or illness could be extremely difficult. This was particularly the case if someone was rough sleeping or in a low support hostel. This problem is particularly acute for homeless people as they are less likely to be registered with a GP than those who are not homeless. Homeless people told us about being discharged without support – often straight back to the street without accommodation in which to recover. "*They discharged me and I was back on the streets. They could have kept me in there longer and made sure I was full recovered before being discharged. They don't care; I don't have anywhere to stay to fully recover*." [Quote: p.42]

People feel stigmatised and discriminated against

Those with experience of being homeless told us they often felt discriminated against and judged by health workers and not treated with kindness or respect during their stay. Others said that they felt unwanted in hospital and perceived that they were discharged too early as a result of this stigma. “*They cleaned me up overnight and discharged me the next day. I didn’t feel ready to leave." “They always get you out as fast as they can. I never get a treatment plan. I get treated as fast as possible and no follow-up." “After being beaten up with a crow-bar I got x-ray and stayed overnight and had a headache when they discharged me but got no plan or support.*” [Quotes: p.17]

People feel they are not involved in decisions about their care or given the information they need

Homeless people said they felt rushed through hospital and sent back to the streets without being advised where they might seek further support to recover or manage their condition. We heard from many homeless people that, when in hospital, were not involved in decisions about their treatment or discharge. Individuals we spoke to often believed this was due to stigma and discrimination.

People feel that their full range of needs is not considered

This was a particular issue reported by those with experience of homelessness. Individuals said that often only the immediate physical problem they’d presented would be treated. Wider needs – especially mental health conditions – were often ignored. People felt their treatment was rushed rather than used as an opportunity to ensure that they had all of the support they needed.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers did not provide any details.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers did not provide any details.)*
Data collection	Was the data collected in a way that addressed the research issue?	No *(The researchers did not provide any details.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers did not provide any details.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers did not provide any details.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The researchers did not provide any details.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge but they did not identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Relevant

Homeless Link, 2012

Bibliographic Reference	Homeless Link; Improving hospital admission and discharge for people who are homeless; 2012

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	A series of peer-led interviews were conducted with homeless people. Additionally, the researchers held a meeting with experts involved in hospital admission and discharge of homeless people across England to gather their experiences and recommendations for change. 28 of these professionals were interviewed by telephone and 10 provided information through written case studies or feedback.
Recruitment strategy	Not reported

Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=95 n=57 homeless people n=38 members of staff from homelessness organisations, Local Authorities, and hospital trusts.
Participant characteristics	Not reported
Results	On admission: identifying homelessness The reaction many clients received on mentioning their homelessness is likely to make many unwilling to flag up their homelessness for fear of being discriminated against. There were countless examples given where the mention of homelessness on admission had triggered prejudice among hospital staff. On admission: identifying support agencies In addition to housing need, interviewees discussed the importance of identifying the support agencies a homeless person might be engaged with at the earliest opportunity- including substance misuse services, GPs, and outreach projects. Traditionally, one of the key challenges from members who manage accommodation based projects has been that they are not notified if their clients present at A&E or are admitted to hospital. This can not only lead to tenancies being terminated (as staff assume the client has abandoned) but can prevent necessary measures being put in place to support a client when they leave hospital. Building and maintaining relationships Good relationships were not shared across the board. In some areas agencies felt there was a poor attitude towards joint working meaning it was rarely a priority. Even where relationships did exist, there was concern about how easily they could be lost with the high turnover of staff, and variation between wards within the same hospital. In some areas agencies

	continued to feel isolated and would welcome the opportunity to extend communication links, particularly within hospital settings. "*There are so many staff changes and a high turnover of staff…we've told them about good practice but once staff changes started to be so frequent it's got harder for the message to get through.*" Hospital link worker [Quote: p.15] Ensuring a safe discharge The findings suggest that many clients are still being discharged before wider health needs are being met, and without consideration of the likely conditions people are returning to. Our findings also suggest that too many patients are being found as 'fit for discharge' without their housing wider support needs being taken into account. Many clients reported leaving hospital in a poor state of health. Many people said they did not get support with wider needs, particularly mental health and substance misuse, even if their 'primary' injury had been treated. Ten clients reported that they had left hospital before being formally discharged, and failure to take wider needs – particularly relating to substance misuse- was seen as a major contributor to this. Several clients were unable to attend follow up care due to their homelessness or severity of health problems – for example attending appointments, storing medication, or dressing wounds can be difficult if living on the streets or in a chaotic environment. Poor communication also led to late notifications of discharge, or in some cases no notification at all. The co-ordinator of a night shelter told us about examples when homeless people have turned up straight from the hospital with nowhere to go. Outreach teams and hostel managers also shared frustrations about receiving no information about their clients, or receiving it too late, leaving them unable to put in enough support for often very vulnerable clients. Clients also stressed the lack of practical support they were given on the day of discharge. We heard many examples of where poorly planned discharge was compounded by lack of consideration for a client's clothing, or how they would leave the hospital, many of which were a long way from town centres. Many people volunteered that they would have liked support with transport – many were told that if they had no resources they would need to walk back. Continuous improvement: quality and monitoring Despite these different levels of demand, many staff would like further support and training. They also wanted processes to be simpler so that all ward staff could be confident about using them. There was also demand, particularly from the homelessness sector, for training to address some of the discriminatory attitudes which persist in health settings. On the whole, hospital staff did not monitor data about the outcomes for their clients and were not aware there were systems in place to do this. Prejudice Many clients felt poorly treated by hospital staff because of their homelessness, or because of substance misuse problems. Others also felt that medical staff denied them access to treatment because they were homeless.

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researches have not discussed how they decided which method to use.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers do not explain how the participants were selected, however it is clear that the most appropriate participants were included in this study. The researchers do not provide details around recruitment.)*
Data collection	Was the data collected in a way that addressed the research issue?	No *(The researchers did not justify the setting for the data collection or the methods chosen for data collection. The researchers do not provide details on how the interviews were conducted.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report on how ethical considerations were taken into account during this study.)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	No *(The researchers do not report on how the data was analysed in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and but they do not identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Hudson, 2010

Bibliographic Reference	Hudson, A. L.; Nyamathi, A.; Greengold, B.; Slagle, A.; Koniak-Griffin, D.; Khalilifard, F.; Getzoff, D.; Health-seeking challenges among homeless youth; Nursing Research; 2010; vol. 59 (no. 3); 212-218

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	US
Setting	Not reported
Data collection and analysis	A total of five focus group sessions were conducted, with 4 to 6 participants in each group. The focus groups, each lasting 1 hour, were conducted by two facilitators. Focus groups were audio recorded and content analysis was performed to analyse the data.
Recruitment strategy	Recruitment was encouraged by posting the colourful art flyers at the a homeless shelter.
Study dates	Not reported
Sources of funding	Support for this research was provided by Grant DA023521 from the National Institute on Drug Abuse.
Inclusion criteria	• 18-25 years old • Self-reported as street youth • Reported use of drugs over the last 30 days
Exclusion criteria	Not reported
Sample size	N=24 homeless youth
Participant characteristics	**Gender** Male: 18/24 Female: 6/24

Results	<u>Failing Access to Health Care</u> Homeless young adults revealed that accessing health care was challenging due to scarcity of service sites. Homeless young adults revealed that accessing health care was challenging due to generally long waiting times for services. For general health care, participants reported a few drop-in sites that provided free medical services. Although these young persons knew where medical care was provided and the times services were offered, receiving care was problematic. In addition, two homeless young adults (23 years old, White man, 20 years old, African American woman) were concerned about the long hours spent in emergency rooms. Many homeless young adults revealed that another serious barrier to health care was discrimination expressed by health care providers toward young adults who were homeless or used illegal drugs. Perceived rules and hidden agenda of support institutions often were perplexing for participants and served as barriers to seeking health care and other services. For example, length of time participants were homeless was a policy that one community agency had to enforce prior to the release of services. This was frustrating for participants because other states did not have such policies. *"Good luck…they make you wait for hours and they send you home right away with bunch of Tylenol." "They help you, and once they give you the right resources they tell you, you can't come here no more." "You have to be homeless for a year in order to get a shelter…that is why people are heading out to San Francisco and northern California because they have services available…the youth out there, within a month of being homeless, they find you a job and give you a place…the law there is that youth cannot be on the street."* [Quotes: p.6] <u>Needing More Help</u> Homeless young persons experienced a number of unmet needs. For one woman (23 years old, Hispanic), "how to take the damn shower…that's the biggest thing… clothing to change into and somewhere to keep the clothing…" For two men, dental care was an unmet need. For the same woman (23 years old, Hispanic) who had mental health problems, receiving mental health treatment was a critical unmet need not only because of lack of services but also because young adults often do not realise that they were mentally ill. <u>Perceiving Stigma</u> The youth were most frustrated by the discrimination they experienced from passers-by and law enforcement. Rather than provide resources for homeless youth, youth frequently were confronted with unforgettable comments that were full of judgment. Moreover, in Los Angeles, young adults perceived that police were discouraging homeless young adults to be on the street, regardless of whether resources were not being provided.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report how they considered ethical issues in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The investigator oversaw transcription and content analysis of the focus group recordings as performed by trained research assistants. Categories and accompanying data were reviewed between two research staff and an experienced qualitative researcher for agreement.)*

Critical appraisal		
Section	**Question**	**Answer**
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Jagpal, 2019

Bibliographic Reference	Jagpal, Parbir; Barnes, Nigel; Lowrie, Richard; Banerjee, Amitava; Paudyal, Vibhu; Clinical Pharmacy Intervention for Persons Experiencing Homelessness: Evaluation of Patient Perspectives in Service Design and Development; Pharmacy (Basel, Switzerland); 2019; vol. 7 (no. 4)

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK

Setting	The focus group was conducted in a communal area within the temporary shelter for people experiencing homelessness.
Data collection and analysis	Participants were provided with an information sheet in advance through postage or in person when invited to the event. The focus group was recorded and transcribed verbatim and analysed using thematic coding. Data were analysed using thematic coding of the focus group transcript and notes taken during one to one engagement. The focus group and street engagement lasted approximately 1 hour and 20 minutes, respectively.
Recruitment strategy	A total of ten registrants of a specialist homeless healthcare centre who had four or more prescribed medications were identified and invited by clinical staff at the specialist centre and were sent a letter of invitation to participate in the focus group. In addition, participants with multiple long-term health problems were also invited from the temporary shelter where the focus group took place.
Study dates	Not reported
Sources of funding	The National Institute of Health Research (NIHR) Research Design Service at University of Birmingham
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=9 homeless people
Participant characteristics	**Gender** Male: 7/9 Female: 2/9
Results	<u>Acquaintance with pharmacy services</u> Participants described using community pharmacy services for collecting their prescribed medicines. However, most of them described having a very low or no interaction with a community pharmacist when collecting their prescription.

	This lack of interaction was related to the busy environment of a community pharmacy. Minimal experience of pharmacist service in general practice was mentioned. Perceived feasibility and benefits of a clinical pharmacy service Participants described their experience of visiting their doctor, nurse practitioners, substance misuse nurse and charity workers at the specialist healthcare centre, but not a pharmacist. Participants involved in the discussion mentioned that a clinical pharmacy service based at the specialist homeless healthcare would address many of the barriers homeless persons were facing around access to medicines and healthcare in general. Facilitating access to medicines Participants described that they face a physical inability to visit a pharmacy, due to their multi-morbidities and illnesses and, hence, would often miss the collection of prescriptions. They would value clinical pharmacists' help in facilitating timely collection of medicine at the specialist healthcare centre, as this was close to their temporary shelters. Understanding Prescribed Treatments Participants described that they often lacked understanding about their prescribed medicines. They would value somebody with expertise in medicine to 'listen' and develop a 'rapport' with them. One person described that often patients did not understand what was prescribed to them and there was not enough opportunity to query prescribing decisions by the doctors, due to lack of time. A clinical pharmacist based at the specialist primary healthcare centre would facilitate discussion of medicine-related issues. This would aid patient understanding of reasons for prescribing medication and its potential side-effects or interactions, and support better management of health conditions. References were also made to the side effects of the medicines and potential role of pharmacists in preventing and managing the side effects. Better Integration across Services One participant also described a lack of liaison between primary and secondary care and prison services, which often lacked an effective transition of care, particularly with regards to prescribed medicines. A clinical pharmacist would be able to bridge such barriers. Referral and Liaison with Other Services Participants also mentioned that pharmacists would be ideal in facilitating their access and engagement with mental health services, as they had an expert understanding of medicines for mental health conditions and the negative impact of a disjointed approach towards the health and well-being of a patient. One of the persons sleeping rough mentioned that many homeless people were often reluctant to be admitted to hospitals, as many hospitals do not offer

	substance misuse services to inpatients. Clinical pharmacists would hence be effective in their referral process, by identifying and liaising with the ‘right’ hospitals and making sure that patients do not miss their prescribed treatments while in hospital. Minimising Misuse of Prescribed Medicines Participants described that misuse of prescribed medicines was often common amongst persons experiencing homelessness, as many of them had substance misuse problems. A pharmacist, as an expert in medicines who is based at the specialist centre, would be able to help address substance misuse by diagnoses, advice and referral to substance misuse services. Screening, Diagnosis of Health Conditions and Prescribing of Medicines Participants mentioned that they would trust pharmacists with screening for diseases, diagnostic skills and prescribing medicine and provided examples of their previous experience of pharmacists’ diagnostic skills. One rough sleeper mentioned that his blood pressure or any form of cardiovascular risk assessment was not done ‘for years’ as nobody had ‘come to’ him and that they were not registered with any general practice. One of the participants of the focus groups currently living in an emergency shelter also said that persons sleeping rough would most benefit from outreach visits. "*Sometimes pharmacists are better at diagnosis than doctors, in my eyes."* (M (age not known)) "*I have one doctor saying I’ve got osteoarthritis, but my pharmacist said no, no, it’s rheumatoid, it is the other one, yeah...and the doctor said, no, it’s rheumatoid arthritis, you know, cause I worked in water, I was a plasterer by trade, so work in water over the years, hands shrank*." (M, 50a) [Quotes: p.5] Prospect of outreach visits by pharmacists Participants suggested that pharmacists could visit persons experiencing homeless in temporary shelters, emergency accommodation and streets during outreach. They mentioned that some patients may be unable to walk to the specialist primary healthcare centre or make appointments and hence outreach would ensure continuity of care. "*They (persons experiencing homelessness) don’t go to a doctor...so, if you went out to them...they would probably open up to you."* [Quote: p.6] Peer support and social influences in engaging with services Participants mentioned that social influences were key in encouraging people sleeping rough to engage with outreach services by pharmacists. One participant suggested that a peer support network would facilitate engagement with the outreach services. Addressing challenges in following up homeless persons

	Participants were requested to suggest ways to address the challenges to follow up people experiencing homelessness during their care. They mentioned that building trust and rapport means participants were more likely to agree a mutual meeting point either at the specialist homeless healthcare centre, at the temporary shelter or at a natural venue.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not provide any details on potential bias and influence throughout the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study was approved and funded by the National Institute of Health*

Critical appraisal

Section	Question	Answer
		Research (NIHR) Research Design Service at University of Birmingham as a public involvement event, hence ethical approval was not required.)
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not report details on how the analysed was analysed.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Kachingwe, 2019

Bibliographic Reference	Kachingwe, Olivia N.; Anderson, Kent; Houser, Carla; Fleishman, Jamie L.; Novick, Julia G.; Phillips, Danielle R.; Aparicio, Elizabeth M.; "She was there through the whole process:" Exploring how homeless youth access and select birth control; Children & Youth Services Review; 2019; vol. 101; 277-284

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	US
Setting	Not reported
Data collection and analysis	Each focus group interview and in-depth interview used a semi structured interview guide, were on average 37 min in length, and were facilitated by an external program evaluator. Data were analysed using Interpretative Phenomenology Analysis (IPA).
Recruitment strategy	Not reported
Study dates	Not reported
Sources of funding	Grant Number TP2AH000046 from the HHS Office of Adolescent Health as part of the Innovative Teen Pregnancy Prevention Programs (iTP3) project.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=11 homeless young females
Participant characteristics	Age range: 14 to 18 years Mean age: 15.6 years
Results	<u>Becoming close and building trust: connecting with peers and staff</u> Participants derived great meaning from being close to their peers and to interdisciplinary staff as part of the process of accessing and selecting birth control. What entailed "being close" varied for participants. Some participants

	experienced their bond with staff as characteristic of a mother-daughter relationship. Participants also expressed an ability to trust and rely on staff. Making the choice: medical knowledge Once interested in exploring the possibility of acquiring birth control, participants' interaction with the medical provider played an integral role in their willingness to follow through. Participants described broadly fearing medical professionals and struggling to overcome their fear in order to receive sexual health services during adolescence.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes

Critical appraisal

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(All procedures were approved by the University of Hawai‘i’s and Texas A&M University's Institutional Review Boards.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Data analysis followed interpretative phenomenological analysis and steps were conducted by the first author and verified by the senior author for quality assurance.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Relevant

Kennedy, 2014

Bibliographic Reference	Kennedy, Sara; Grewal, Mandeep; Roberts, Elizabeth M.; Steinauer, Jody; Dehlendorf, Christine; A Qualitative Study of Pregnancy Intention and the Use of Contraception among Homeless Women with Children; Journal of Health Care for the Poor & Underserved; 2014; vol. 25 (no. 2); 757-770

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	US
Setting	Not reported
Data collection and analysis	Interviews were conducted, audio-recorded and transcribed verbatim. Analysis was informed by grounded theory.
Recruitment strategy	Study subjects were recruited using a consecutive, convenience sampling method from a family shelter placement agency.
Study dates	September 2010 and April 2011
Sources of funding	This paper was developed with Dr. Dehlendorf's K23 award (K23HD067197), both from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health.
Inclusion criteria	Women were eligible if they were: • between the ages 18 and 45 • either English- or Spanish-speaking • currently housed or seeking housing in a family shelter • in custody of at least one minor child • sexually active with at least one man in the past year
Exclusion criteria	• If women were pregnant, deaf , unable to consent for any reason (including psychosis or current intoxication from drugs or alcohol)

	- If they had hysterectomy or tubal ligation - Primary partner with vasectomy
Sample size	N=22 homeless women
Participant characteristics	**Age** Mean age: 32 years
Results	Barriers to contraceptive use and reproductive health care Many reasons given for not using contraception consistently by the homeless women in our sample mirror the barriers to using contraception reported by the general population, such as fear of side effects, fear of health problems, and partner dislike of condoms. One barrier to contraceptive use and reproductive health care reported by homeless women was an inability to prioritise health due to competing demands. Women described feeling overwhelmed by the stresses caused by being homeless, resulting in a decreased priority placed on their own personal health. Women reported their time was consumed by trying to secure housing, food, employment, and health care for their children. Personal health care appointments were frequently not made or skipped. Provider practices Women frequently reported feeling that they were treated differently when their provider learned they were homeless. Some women stated that they never disclose to their provider that they are homeless, for fear of substandard care or judgment. Restrictive prescribing practices by health care providers was another barrier to using contraception reported by the homeless women in our sample, including lack of quick-start methods and not providing adequate numbers of refills. In addition, women reported barriers to obtaining birth control in one visit, including a lack of trained individuals to insert an intrauterine device (IUD) or implant and requirement of two visits prior to starting a method for reasons such as obtaining sexually transmitted infection (STI) or Pap smear results. Positive provider practices reported by our participants that facilitated contraceptive use included being given samples of contraception to start immediately. *"I can't just walk up and say, "Hey, I need this [contraceptive method], I need that." They want you to go through a process . . . but at times I be needing it at that moment." "On one occasion she had the birth control pills right then and there and she was able to start me on birth control pills. That's one of the things I really, really liked. Even though it might have not been the one that I absolutely wanted, but I needed it at that time, and they had them on hand."* [Quotes: p.764]

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethics approval was granted by the University of California at San Francisco Committee for Human Research.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis was conducted by two researchers and discrepancies were resolved by consensus.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Kerman, 2019

Bibliographic Reference	Kerman, Nick; Gran-Ruaz, Sophia; Lawrence, Madalynne; Sylvestre, John; Perceptions of Service Use Among Currently and Formerly Homeless Adults with Mental Health Problems; Community Mental Health Journal; 2019; vol. 55 (no. 5); 777-783

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting	Not reported
Data collection and analysis	Semi-structured, audio-recorded interviews were conducted in-person with each participant. The interviews lasted approximately 75 min, on average. Audio recordings of the interviews were transcribed verbatim. Data were analysed using thematic analysis.

Recruitment strategy	A convenience sample of participants who were recruited through three service agencies (an emergency shelter, a supportive housing program, and an intensive case management team).
Study dates	Not reported
Sources of funding	Mental Health Research Canada (MHRC)
Inclusion criteria	• Participants were either currently or formerly homeless (that is, one or more nights spent on their own in an emergency shelter or on the street) • self-reported having a mental illness or substance use problem • were 18 years or age or older • spoke English
Exclusion criteria	Not reported
Sample size	N=52 participants n=26 currently housed with a history of homelessness n=26 currently experiencing homelessness
Participant characteristics	**Gender** Male: 23/52 Female: 28/52 Transgender female: 1/52 Average age of participants who were formerly homeless: 47.62 years (SD=10.73) Average age of participants who are currently homeless: 41.85 years (SD=8.80)
Results	<u>Accessibility of services</u>

	Decisions to ban or refuse service to participants were often seen as one-sided, unfair, or discriminatory. Though both groups described being refused or banned from services, currently homeless participants were most concerned as it left them few to no options of where else to go to meet their basic needs. Service refusals could also yield a sense of hopelessness, abandonment, and other negative internalisations. Lack of identification was an issue when accessing services. Services that offered information and direction about other services increased accessibility and helped to reduce feelings of being “lost” within service systems. This required service providers who were not only knowledgeable about their own programs but other available services as well. Wait times affected participants’ perceptions of treatment and care for better or worse. Further, actions taken by service providers to expedite care were seen positively. Participants also appreciated service providers who provided sufficient face-to-face time to discuss problems, efficiently responded to meet needs, and followed-up as needed. However, comparisons with other service users appeared to affect participants’ perceptions of service providers. With regard to proximity, services that were nearby or would physically come to service users (for example, outreach programs, community-based mental health teams) were perceived positively, especially by currently homeless participants. Similarly, many participants appreciated when service providers would coordinate and accompany them to programs as it reduced the likelihood of missed appointments or not seeking needed treatment and care. Affordability was also identified by participants, with services that were free or covered by provincial health insurance being described positively and services that were unaffordable being discussed unfavourably. *“You feel like you have nobody and nobody wants to help you. That’s why I just kept going on like, ‘What is wrong with me that the shelter can’t even take me?’” “I don’t have a family doctor so I can’t get the forms done through [social assistance] and I don’t have identification so I can’t get a family doctor.” "The receptionist … will know that it’s me crying and literally just transfer me right through to [the counsellor] rather than waiting on hold."* [Quotes: p.779] <u>Humanity in Approach to Care</u> Participants placed great emphasis on their perceptions of services’ approach to care. Many currently and formerly homeless participants shared their views of the organisational rules and policies guiding service provision. Service rigidity was identified as contributing to negative experiences. This included inflexible prescribing practices by physicians, strict rest times within the shelter system, organisational prioritisation of the views of service providers over service users in response to disagreements, and lack of integration of service users’ feedback into service delivery. Other rules and policies described by participants that could lead to a negative experience included: lack of confidentiality; insufficient training of staff, especially in conflict resolution; and a general inconsistent application of the rules between staff members. In contrast, when programs had qualified, “specialised” staff; “reasonable policies”; and minimal hierarchies, these contributed to a positive service experience. The characteristics and approach of service providers was also widely discussed by participants. Participants described their interactions, observations, and views of the individuals involved in the delivery of services. Service providers who were “disrespectful”, “judgmental”, “impersonal”, “unapproachable”, and “lacking compassion” were perceived negatively, whereas participants described

	more positive experiences and relationships with providers who were "considerate", "nonjudgmental", "friendly", "welcoming", "smiling", "caring", and "understanding". Perceptions and Relationships with Other Service Users Participants described how their service experiences were influenced by others who were also using the services. Other service users affected participants' perceptions of safety and security. Female participants felt safer in women only groups and programs. Conflict among service users led to participants feeling unsafe. Reports of conflict included: bullying, arguments, physical altercations, being "ripped off" financially, and thefts of personal possessions. Relatability was characterised by participants having an 'us' or 'them' mindset. Participants described a sense of solidarity and connection with other service users who had similar backgrounds, traits, and experiences ('us'). Outcomes of Service Use Feelings of distrust and helplessness following service use were notable negative outcomes.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the Research Ethics Board of the authors' institution (Reference Number: #H06-16-06). All procedures performed in this study were in accordance with the ethical standards of the Tri-council Policy Statement 2: Ethical Conduct for Research Involving Humans by the Panel on Research Ethics of the Government of Canada.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The lead author performed the coding from interview transcripts. Coded data were collated separately by the first three authors into potential themes. The final results were reviewed as a team through consensus to identify similarities and discrepancies.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Minor concerns

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Highly relevant

Kesia, 2018

Bibliographic Reference	Kesia, Reeve; et, al.; The mental health needs of Nottingham's homeless population: an exploratory research study. Final report; 2018; 146

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Most (21) interviews were conducted on the telephone while two were conducted face-to-face.
Data collection and analysis	A flexible interview tool was employed. Interviews took a 'biographical' approach. All interviews were recorded, subject to consent (only one respondent refused), and transcribed. Transcripts were then coded thematically using NVivo 11 but each individual transcript was also analysed whole as a 'biography'. Interviews were conducted with strategic and policy leads for relevant fields, stakeholders working with or managing services for specific client groups (for example, people with mental health issues, younger people, people with dual diagnosis, and people complex needs), and with both clinical and non-clinical staff.

Recruitment strategy	Participants were recruited through the survey conducted in the quantitative part of this study and through the organisations that had participated in the survey and other housing services in contact with people with mental ill health (to ensure certain groups and experiences were represented in the sample). The latter recruitment strategy relied on staff within services to identify people who met the criteria of being homeless and having mental health issues.
Study dates	May and September 2017
Sources of funding	The Big Lottery Funded 'Fulfilling Lives' programme
Inclusion criteria	• Participants were homeless at the time of interview • Participants met researchers inclusive definition of mental ill health (ranging from mental disorder to poor mental wellbeing) • Only people within the Nottingham City boundary
Exclusion criteria	No other exclusion criteria were employed
Sample size	N=60 participants n=37 homeless people n=23 stakeholders
Participant characteristics	**Gender** Male: 21/37 Female: 16/37 **Age range:** Under 25 years: 4/37

	25 to 34 years: 8/37 35 to 49 years: 16/37 50+ years: 9/37
Results	Patterns of service use The support and treatment interviewees received after a mental health crisis – for example, suicide attempt, hospital admission, hospital or police detention under the Mental Health Act - was very variable. Some interviewees appeared to have received no follow-on support whatsoever, while others were referred for regular psychiatric input, prescribed much needed medication, Crisis Team, or CPN support. This will partly reflect differential needs at the point of assessment / discharge, the severity of the crisis, and the varying obligations and responsibilities of statutory services depending on the situation. There were no instances of interviewees rejecting support when assessed during or following such crises. Although most interviewees had received support or treatment from mental health services in Nottingham, this was sporadic, uneven, and did not always align with respondents' needs. Experiences of trying to access support and treatment Just over half of survey respondents with mental health issues reported that on at least one occasion in the past 12 months they had needed, but not received an assessment, treatment, or support for a mental health issue. Stakeholders confirmed that they were finding it increasingly difficult to help their clients to access mental health services. To access appropriate mental health services, people must first be recognised as having mental health issues. Several respondents described times when they had fallen at this first hurdle. There was evidence that homeless people can encounter difficulties having their mental health issues - or the severity of their mental ill health - acknowledged. Leona reported that her 'anger' issues were frequently interpreted as a behavioural choice or the consequence of drug use and, by implication, something she could readily change. Stakeholders made similar points, citing examples of clients whose behaviour was not recognised as related to mental health needs. Although this did not emerge as a significant issue for interview respondents, a small number of respondents had negative perceptions of accessing care at doctor's surgeries - of how they had been spoken to and treated by frontline staff; of the discomfort of being in the waiting room; and of others' perceptions. These participants had experienced a sense of intolerance of mental health conditions, homelessness or behaviour that is different from the 'norm'. Falling between service thresholds

	Across all stakeholders, thresholds for services were raised as an issue in relation to homeless people accessing support and treatment. This manifests with thresholds being too high, and being too low, and is complicated further by respondents' other support needs. In addition, stakeholders reported that non-standard behaviour that does not fit a clear diagnosis means some people slip through the net. There were difficulties getting recognition for mental health issues, and many respondents found they did not meet thresholds for mental health services despite having significant mental health needs. Jasmine found that, moving from child to adult mental health services, the professional assessment of her mental health changed, despite no change in her mental health. As a child, she met the threshold for psychiatric services but as an adult she did not. *"In terms of the threshold, there are people who want services but when they get assessed, usually by a crisis team, there's a feeling that they don't meet that threshold. There's lots of people that display bizarre behaviour that would want services but they don't meet the criteria."* (General needs hostel) *"We have got a number of families who we are working with where we think they should be with a mental health service but they kind of don't fit anyone's criteria, so there's no assessments being done and so we're sticking with them cos we're the only service they're with."* (Supported housing) *"They just couldn't find evidence of serious mental health issues. The only problem was I was suicidal, very emotional, anxiety attacks, depression obviously."* (Vin, aged 50) [Quotes: p.78] *"I had her [psychiatrist] for two years and she was nice but then when I hit 18 and I went to see the adult ones they basically said I wasn't ill enough to have a psychiatrist."* (Jasmine, aged 28) [Quote: p.79] <u>Dual Diagnosis</u> In some cases, drug and/or alcohol abuse was a key factor rendering them ineligible, or 'too complex' for mental health services. Yet dual diagnosis was very common amongst survey and interview respondents. At times this left respondents caught between health services and drugs services as each deemed the other to be the primary need requiring treatment. Respondents reported the view that their presenting mental health issues were sometimes interpreted as the result of drug use and, therefore, not properly the concern of mental health services. There was a dual diagnosis team operating in Nottingham during the fieldwork period but they were only mentioned by one respondent. When Rosie (see above) had her self-referral to talking therapies rejected she reported contacting the dual diagnosis team and being turned down but she could not recall the reasons why. Dual diagnosis as a barrier to accessing services was an issue raised by several stakeholders, who confirmed that it could be very difficult to access mental health services whilst abusing drugs or alcohol, but also difficult to access dual diagnosis support. "[*I would like] people to be a bit more understanding about your mental health, and try and work with you and help you, cos I don't think there's much help out there for people that's got mental health issues. People put it on the drugs and stuff, but there's a reason why people smoke the drugs, cos they're not getting the right help in the first place. Some people have suffered before they smoked the drugs and they haven't had the help […] people think cos you're on drugs it's [mental health issues] come from there but I suffered before I smoked anything for a long while…but drugs have just made it worse*" (Lisa) [Quote: p.80] <u>Waiting lists</u>

	Homeless people and stakeholders alike reported long delays between referrals and the start of support or treatment, particularly in relation to secondary mental health services. It is, therefore, likely that some of those survey respondents who reported needing, but not receiving support or treatment, may well have been referred for appropriate support, but were still waiting for it to materialise. As indicated by Ray's experience, during a period of time on a waiting list, mental health could rapidly exacerbate with respondents reaching crisis point. Ray was not the only respondent to attempt suicide while waiting for an appointment with secondary mental health services. And it need not be a particularly lengthy wait for people's mental health to deteriorate to the point of crisis. Freddie, aged 24, who was one of the few respondents with very regular, consistent support and treatment from the same professionals described what happened when he could not get an urgent appointment with his CPN. Inappropriate or 'dead-end' referrals There were examples where respondents had been referred to services (or health professionals informed them about, or offered to refer them to a service) but this did not translate into effective support or treatment. For the homeless people we interviewed, rejection from a service usually left them back at square one (although not necessarily in Ross's case, now he is in contact with professionals in adult mental health services). There appeared to be little tracking of referrals, or follow-up, or signposting on to another more relevant service. One stakeholder reported that GPs receive little information from secondary health services about the outcome of referrals, which may help explain this result. The onus is therefore on the patient to re-present to their GP, or actively seek out alternative services, which can be particularly difficult for homeless people. Many respondents had been offered a referral to counselling or some form of talking therapy, had refused this, and no other suggestions had been forthcoming for alternative support or treatment. From the homeless person's perspective, they had been offered inappropriate or ineffective intervention. One stakeholder articulated well the multiple barriers facing homeless people in accessing forms of talking therapies. She pointed to restricted access to these services because of complex needs, but questioned how appropriate they were, in any case, for people in unstable situations.

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers have not reported on whether there was any critical examination of potential biases that may arise during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers have not given any details on how ethical issues were considered.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not provide any details on how the data was analysed.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Klop, 2018

Bibliographic Reference	Klop, H. T.; van Dongen, S. I.; Francke, A. L.; de Veer, A. J. E.; Rietjens, J. A. C.; Gootjes, J. R. G.; Onwuteaka-Philipsen, B. D.; The Views of Homeless People and Health Care Professionals on Palliative Care and the Desirability of Setting Up a Consultation Service: A Focus Group Study; Journal of Pain and Symptom Management; 2018; vol. 56 (no. 3); 327-336

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	The Netherlands
Setting	Focus groups (duration 1.5 hours) with professionals were held at a central location. Focus groups (duration 1 hour) with homeless people were conducted in the nursing homes where they were staying at that time.
Data collection and analysis	All focus groups were conducted and moderated by the same female researcher, trained in both qualitative and quantitative research. Transcripts were analysed following the principles of thematic analysis.

Recruitment strategy	Professionals were recruited by telephone and email using purposive sampling. Recruitment was through relevant health care organisations and existing professional networks of the project team using the snowball method. Homeless people were recruited using opportunity sampling. In a specialised nursing home for homeless people and a homeless shelter providing medical respite care, staff were asked to distribute an information letter.
Study dates	October 11th to November 30th 2016
Sources of funding	This work was supported by a grant from The Netherlands Organisation for Health Research and Development (ZonMw) (grant number: 844001205) for the focus groups.
Inclusion criteria	**Healthcare professionals** • Participant is currently working in a shelter for homeless people (day or night care), respite care, nursing home ward, other facility aimed at homeless people, or palliative care facility. • Participant works in one of the four major Dutch cities, which are Amsterdam, Rotterdam, The Hague, and Utrecht. • Participant is a physician, nurse, social worker, and policy maker or has a related profession. • Participant is available on selected moments for the focus groups. **Homeless participants** • Participant is currently homeless. • Patient is currently seriously ill. • Participant is being cared for in the nursing unit, nursing home, or outreach home care provided by the nursing home. • Participant is willing to talk about palliative care or care when being seriously ill. • Participant is older than 18 years.
Exclusion criteria	**Healthcare professionals** • Participant is not currently working in a facility for (care for) the homeless.

	Homeless participants - Participant is not able to talk or is not understandable. - Participant does not understand Dutch or English and/or is not able to communicate in one of those languages. - Participant is younger than 18 years.
Sample size	N=34 n=15 homeless people n=19 service providers
Participant characteristics	**Homeless participants** Gender: Male: 11/15 Female: 4/15 Age range: 40-82 years **Healthcare professionals** Gender: Male: 9/19 Female: 10/19 Age range: 36-69 years
Results	Complexity of palliative care Both professionals and homeless people thought palliative care needs for the homeless population are much greater than regular palliative patients, largely due to the possibility of multi-morbidities combined with substance abuse/mental health issues. ‘‘*I regularly have contact with homeless people who are extremely ill and highly vulnerable, and increasing*

	numbers are dying when with us. Then you come up against all kinds of things that are never in the picture for a GP, because you aren't familiar with the severe psychiatric issues and you don't see the addiction either.'' (Professional, FG 2) [Quote: p.332] <u>Behaviour of homeless people</u> The challenging behaviour of homeless people can be distressing to the health care providers, which complicates the care. '*'It's often awkward enough already for ordinary people in society to deal with the palliative phase properly, but with a target group like this it's even more so, because if they are admitted to whatever setting, they start behaving in highly inappropriate ways.''* (Professional, FG 1) [Quote:p.332] <u>Lack of expertise</u> Given the various problems homeless people experience, it is almost impossible for professionals or even specialists to have sufficient expertise in all aspects. Services are unequipped to meet the needs of homeless people. According to homeless participants, palliative care in nursing home departments now focuses mainly on providing physical care, whereas social and psychosocial care is very important to them. <u>Sharing of knowledge</u> Professionals also expressed a desire to share existing knowledge with professionals from different disciplines and cities. <u>Variety of palliative care</u> Although participants indicated that palliative care for homeless people has received more attention during the last few years, most pointed out that the quality and knowledge of palliative care still varies greatly among professionals, organisations, and cities. Opportunities for professionals to consult someone often appear to depend on available knowledge, experience, and funding regarding palliative care for homeless people. <u>Self-determination</u> Homeless participants wanted to become more involved in decisions about health or treatment, even in cases of limited mental capacity. <u>Different perceptions</u> Homeless participants' perceptions were that there is too little staff time available, among nurses in particular. This is in turn related to the limited availability and frequently changing staff. They mentioned that professionals need to pay attention to, for example, their life story and psychological needs (without immediately referring them to a psychologist) and need to be more open about palliative care.

	Trusting relationships According to both professionals and homeless participants, homeless people are often distrustful and need time and attention to build a trusting relationship. Homeless participants provided specific suggestions for establishing trusting relationships: they are more positive about professionals who pay attention and have more time available, and who have sincere interest in them. Flexible care In addition, homeless people mentioned a need for care beyond the usual opening hours and possibilities.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*

Critical appraisal		
Section	**Question**	**Answer**
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The Ethics Review Committee of VU University Medical Center provided a waiver as ethical approval was not needed under Dutch law.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis was conducted by two researchers. Themes and interpretations were regularly discussed with the project team.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Krakowsky, 2013

Bibliographic Reference	Krakowsky, Y.; Gofine, M.; Brown, P.; Danziger, J.; Knowles, H.; Increasing Access-A Qualitative Study of Homelessness and Palliative Care in a Major Urban Center; American Journal of Hospice and Palliative Medicine; 2013; vol. 30 (no. 3); 268-270

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting	Not reported
Data collection and analysis	The interviews lasted approximately an hour. Each interview was audiotaped and transcribed by the interviewer. Following the transcription of the interview, it was read a total of 4 times by the interviewer. Thematic analysis was used in recognising themes that unified the 7 different transcripts.
Recruitment strategy	Not reported
Study dates	Not reported
Sources of funding	The authors received no financial support for the research, authorship, and/or publication of this article.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=7 n=3 registered nurses n=4 outreach workers
Participant characteristics	Not reported
Results	<u>Increasing positive interaction between the health care system and the homeless</u> The homeless are reluctant to access palliative services because of previous negative experiences with the health care system. It was clear throughout the interviews that a strong, sensitive health care system would be

accommodating and inviting to all populations, including the severely marginalised. The system, as a whole, must work on increasing trust between provider and patient, increase awareness regarding harm reduction strategies, and work to act as an advocate for marginalised individuals.

Training staff to deal with the unique issues confronting the homeless

Health care workers that are confronted with palliative issues in homeless population need to be trained to deal with them. The training can be divided into 2 specific areas: (1) talking about death and dying and (2) the unique needs of the homeless population. An individual trained in providing care to the homeless is not necessarily equipped with the tools needed to discuss death and dying in a sensitive, meaningful way. Training is central in providing care providers with these tools, as experience alone is not sufficient. The homeless population has unique needs in end-of-life situations. They are more likely to be estranged from family members, they may have friends or families that are difficult to contact on short notice, and they may have addiction and mental health issues that complicate an already difficult situation. Care providers must be equipped and comfortable in comforting those issues. Without the proper training and support, many of the unique needs of the homeless population will not be addressed.

Providing patient-centred care

People prefer to die the way they lived. Previous attempts at palliative care for the homeless involved facilities that were dissimilar to anything the individual had experienced throughout his or her life. It is important to appreciate the desire of an individual to die in a familiar, comfortable environment. Palliative care providers must provide care in a patient-centred approach. Each individual has his or her own end-of-life priorities.

Diversifying the methods of delivery

Individuals may want to access palliative care in a spectrum of different settings. Therefore, patient-centred approaches must not only focus on the content of the interaction but the context as well. Some individuals are more comfortable spending their end of life in a hospital, with 24-hour nursing care and access to physicians. Other individuals prefer a shelter-based or palliative care institution where they have more control over their environment while still having access to staff trained in easing terminal illness and death. These individuals appreciate the comfort and flexibility of shelter or institution-based approaches. For a variety of reasons, some individuals are uncomfortable being institutionalised and have had negative experiences in homeless shelters. These individuals may recognise that they are currently near their death but are unwilling to enter any form of institution for care. Street-based palliative care would serve this population and provide flexible, patient-centred care.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not report details on how they decided which method to use when collecting data for this study.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers do not report how the participants were selected.)*
Data collection	Was the data collected in a way that addressed the research issue?	No *(The researchers do not justify the setting for data collection. The researchers report how data were collected but do not provide justification for the methods chosen. There is some detail provided for the interview method.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the Research Ethics Boards at St Michael's Hospital in Toronto, Canada, and the University of Toronto)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Data analysis was conducted by the lead researcher who conducted the interviews and carried out thematic analysis.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is not valuable *(The researchers do not discuss the contribution the study makes to existing knowledge, nor do they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Relevant

Leggio, 2020

Bibliographic Reference	Leggio, William J.; Giguere, Anthony; Sininger, Carissa; Zlotnicki, Nicole; Walker, Samuel; Miller, Michael G.; Homeless Shelter Users and Their Experiences as EMS Patients: A Qualitative Study; Prehospital Emergency Care; 2020; vol. 24 (no. 2); 214-219

Study Characteristics

Study type	Phenomenological

Country/ies where study was carried out	US
Setting	Homeless shelters
Data collection and analysis	One on one interviews were conducted. All interviews were transcribed then compared to the original audio word-for-word by a researcher. Transcripts from the recorded audio were analysed using NVivo 12. Thematic analysis was performed and codes were assigned utilising NVivo.
Recruitment strategy	The homeless shelter identified individuals through their outreach and social work who previously experienced emergency medical services as a homeless shelter user.
Study dates	Two separate dates in September 2017 and two separate dates in November 2017.
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=18 homeless people
Participant characteristics	**Gender** Male: 12/18 Female: 6/18
Results	<u>Perceived positive experiences</u> Participants reporting a positive experience with emergency medical services attributed this to their professionalism and quick response times. The participants elaborated on professionalism by focusing on the EMS providers being polite, concerned, and non-judgmental towards them. They attributed EMS providers asking questions about their condition as a

	sign of being concerned or worried about their condition or complaint. Participants discussed quick EMS response times as being part of their positive experiences. Perceived negative experiences Participants that reported having a negative experience with EMS connected this to their interactions with the providers and feeling like they were not taken seriously. Examples were EMS providers acting aggravated or judgmental towards the participants. Participants remembered feeling ashamed, awful, and judged by EMS providers when recalling their negative experiences. Participants described how these interactions did not align with what they expected from any healthcare provider. Also reported were negative experiences of having to walk to the ambulance and being told to only sit on the seat and not on the ambulance cot. Also recalled by some participants was EMS attempting to talk participants out of being transported, EMS providers listening to others rather than the participant about their condition, and assuming the participants were under the influence of drugs or alcohol. Perceived views of emergency medical service providers towards users of homeless shelters Similar to the negative experiences reported, participants described how they witnessed and perceived EMS providers arriving at homeless shelters with bias and judgments against them.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Institutional Review Board at Creighton University in Omaha, Nebraska (#1044148-2).)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Data was analysed by thematic analysis by the authors. A final review was conducted by the primary and supervising researchers.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Lester, 2001

Bibliographic Reference	Lester, H.; Bradley, C. P.; Barriers to primary healthcare for the homeless: The general practitioner's perspective; European Journal of General Practice; 2001; vol. 7 (no. 1); 6-12

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	UK
Setting	Interviews were conducted in GP surgeries
Data collection and analysis	Data were collected using a topic guide developed from discussions with GPs at a local medical unit for homeless people and from a systematic review of the relevant literature. Interviews lasted between 30-60 minutes and were audiotaped and fully transcribed. The interviews were analysed using the Framework method of manual analysis developed by Social and Community Planning Research
Recruitment strategy	A table was therefore constructed of the 350 GP principals in the Birmingham Family Health Authority Area stratified by variables potentially relevant to the study, such as age, gender, years in practice, practice list size and Townsend score. GPs were then randomly selected from within each group. Letters inviting GPs to take part.
Study dates	August 1995-April 1996
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=25 general practitioners with experience dealing with people experiencing homelessness

Participant characteristics	**Gender** Male: 18/25 Female: 7/25 **Race** White: 21/25 Non-white: 4/25 **Age** Average age: 44 years (range: 30-62 years)
Results	Commonly held views about barriers HCPs reported that there was no training given during UG and PG training, creating a perceived barrier of a lack of factual knowledge about homelessness. Homeless people were also often perceived as costly in terms of practice time. There was also a general consensus that barriers were created by poor communication between health and social services, particularly in terms of difficulty in contacting people out of hours. Barriers to providing primary health care, such as a lack of practice flexibility and practice finances, were however rarely mentioned as barriers to care. In further contrast to previous studies, all general practitioners said their receptionists would not be involved in the decision to register or refuse registration to a new patient. Some general practitioners did however mention the need for practice and receptionist training to ensure that receptionists did not make value judgements on appearances. *"When I was at medical school there was no specific teaching about homelessness It was mentioned in the context of TB and that was it."* (AP3) [Quote: p.8] Descriptions of homeless people Positively disposed general practitioners emphasised the human qualities and commented that it was possible for anyone to become homeless. In contrast, negatively disposed general practitioners appeared to view homeless people as difficult, untrustworthy time wasters. Most also made a distinction between the ‘deserving’ and the ‘undeserving’ homeless, the latter being primarily the younger homeless and those with addiction problems, whose homelessness was perceived as self-inflicted. Perceptions of power

Most positively disposed general practitioners described the homeless as powerless people. Demanding behaviour was viewed as an extension of their life circumstances. Many described homeless people as having low expectations within the consultation and of being grateful for treatment. If they were demanding about the need for an immediate appointment, this was perceived as secondary to their inability to access the health service in the usual way, for example by telephoning to make an appointment, or because they were in crisis. Negatively disposed general practitioners often saw homeless people as more powerful than other patients and as sometimes having the ‘upper hand’ in the doctor-patient relationship. They knew what they wanted and were perceived as demanding in terms of their prescription requests, often did not comply with treatment, and on occasions left the practice area after the doctor had spent some time and effort on their care.

<u>Consultation style</u>

The most consistent contrast between positively disposed and negatively disposed general practitioners appeared to be in their individual consultation style. Positively disposed general practitioners enjoyed the consultation. Negatively disposed general practitioners, in contrast, had few expectations of success in either medical or social terms. Within the consultation, positively disposed general practitioners stressed their role in making the consultation work, aimed to practise proper medicine despite the restrictions imposed by homelessness and tried to help with access to the social aspects of care. They acknowledged the uncertainty that can be associated with caring for homeless people, and accepted a long-term view of modifying health-seeking behaviour. There was also general agreement among the positively disposed general practitioners on the need for a firm and consistent approach. In contrast, the negatively disposed general practitioners felt their role should be restricted to physical problems, and that health education and social problems such as issuing housing letters were outside their remit. Many also found the uncertainty of providing healthcare for homeless people difficult. Their actions also tended to fall into one of two categories, either being overly prescriptive or ‘giving in’ to demands that they felt compromised their professional role.

<u>The origins of attitudes</u>

The positively disposed GPs cited parental and other familial influences, and medical role models who influenced them to provide primary healthcare for homeless people. Extracurricular activities before and during medical school such as voluntary work with a housing organisation and helping out at Christmas projects were mentioned more frequently by positively disposed GPs than negatively disposed GPs. The majority of positively disposed general practitioners also had postgraduate psychiatry experience and experience of working with homeless people. However, half of the negatively disposed general practitioners also had training posts which involved working with the homeless, suggesting that experience alone, while valuable, is not the main determining factor in a general practitioner’s disposition.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report details on how ethical issues were considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The grounded theory analysis was conducted by the first author and two other researchers.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

MacKenzie, 2019

Bibliographic Reference	MacKenzie, M.; Purkey, E.; Barriers to end-of-life services for persons experiencing homelessness as perceived by health and social service providers; Journal of the American Board of Family Medicine; 2019; vol. 32 (no. 6); 847-857

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Canada
Setting	Not reported

Data collection and analysis	In-depth interviews with participants occurred either in-person or by telephone and explored emerging themes from the surveys using a semistructured research guide. Interviews lasted between 30 and 90 minutes. Interviews were audio-recorded and transcribed verbatim. Analysis was informed by a phenomenological approach.
Recruitment strategy	Health professional participants were recruited through mass emails, as well as targeted emails sent out to key partners.
Study dates	January to August 2018
Sources of funding	South East Local Health Integration Network (SELHIN) in Ontario, Canada
Inclusion criteria	• Informed consent • Employment in their position for at least 1 year • Employed in the specific community for at least 1 year • Provided front-line services directly to clients/patients (currently or in the past).
Exclusion criteria	Not reported
Sample size	N=10 service providers (same population as reported in Purkey 2019, different outcome data reported)
Participant characteristics	Not reported
Results	Structural Barriers to Care Outside of the Health Care System The lack of a permanent home or address was the biggest barrier to accessing palliative care. the current structure of the shelter system, in which residents are requested to leave often for most of the day, renders it inappropriate for someone at the end of life. Additional barriers to accessing services identified by respondents included lack of identification, lack of an Ontario Health Insurance Plan card, lack of a phone with which to receive calls about appointment times, and lack of transportation to make it to appointments. Systemic Barriers to Care Within the Health Care System

Barriers included the requirement that one have a family physician as a conduit to a referral to palliative care services, and the lack of continuity in the system for this population for whom trust is particularly important and difficult to establish. The geographic location of services, often far from the places where people live, was another barrier. An overall paucity of palliative care services, not specific to the homeless population, including a lack of sufficient hospice beds was identified. Finally, the rigidity of the existing system, the lack of a harm reduction approach or services, and the stigma with which people are treated, were the most important barriers.

Care Avoidance

Clients avoided seeking care until very late in their disease, often when they were past the point of having choices around their palliative care. The struggles of day-to-day life for people experiencing homelessness often took precedence over seeking out palliative care. Care avoidance also related to extremely negative experiences of the health care system related to stigma that clients had experienced in the past. Another cause for service avoidance was substance use.

Stigma as a Barrier

Stigma manifested in health care providers not taking into account patients' lived realities when considering recommended courses of action; in overt discrimination, rude or thoughtless behaviour toward their clients; and finally resulted in care avoidance due to negative past experiences on the part of service users. Stigma was worse in the context of a client with a substance use disorder. The consequences of stigma included the exclusion of support networks for hospitalised patients (support networks, often drawing from similar social situations as the patient, were either made to feel unwelcome or in some cases explicitly asked to leave) resulting in patients having to make the decision to leave or to die alone in hospital; denial of care (for example, patients who “refused” to stop their illicit substance use might have care withdrawn or refused); and could result in patients feeling so frustrated and/or unwelcome that they would leave “against medical advice” even if this meant they were at risk of dying on the street.

Gaps in Health Care Provider Knowledge and/or Attitudes

Clients experienced unacceptable stigma from other health care providers. Many suggested the need for enhanced health care provider training on trauma, addictions and mental health, empathy, and respectful approaches to persons experiencing substance use or homelessness.

Gaps in Available Services and Possible Solutions

Participants cited outreach services in other communities that they perceived could be helpful to their clients, rather than insisting that they fit into the new current ambulatory mould. Finally, and most importantly, a palliative care system that embraced the principles of harm reduction was perceived to be essential to allow clients to enter into care, and to remain in care that preserved their dignity.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role of potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Data analysis was conducted by two researchers who coded transcript data and carried out analysis informed by a phenomenological approach.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Mago, 2018

Bibliographic Reference	Mago, Anjali; MacEntee, Michael I.; Brondani, Mario; Frankish, James; Anxiety and anger of homeless people coping with dental care; Community Dentistry & Oral Epidemiology; 2018; vol. 46 (no. 3); 225-230

Study Characteristics

Study type	Ethnographic Phenomenological

Country/ies where study was carried out	Canada
Setting	The Lookout Emergency Aid Society.
Data collection and analysis	Participants were interviewed, which was audio-recorded. Interviews lasted about 20-45 minutes and were then transcribed verbatim for analysis. Data were analysed inductively.
Recruitment strategy	Participants were recruited using purposive sampling.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	• Participants aged over 19 years • Homeless, whether sheltered or unsheltered
Exclusion criteria	Not reported
Sample size	N=25 homeless people
Participant characteristics	**Gender** Male: 18/25 Female: 7/25 **Age** Mean age: 51 years

	Age range: 25-64 years
Results	Barriers to care Everyone raised concerns about the cost of dentistry. Access experiences by First Nations populations were reported as prejudiced. People faced barriers at community health clinics and some people reported difficulties making an appointment because they had no phone. People reported that getting a medical appointment was easier than a dentist appointment due to the ubiquity of medics. "*The government only allowed three [tooth] extractions a year because I am First Nations."* [Quote: p.226] Service use We heard complaints about dentists being dishonest or disrespectful. An older Indigenous man believed that dentists are cruel and discriminatory against people of colour. Complaints of disrespect, exploitation and stigma permeated the interviews. An Indigenous woman explained that a dentist told her: "*You people only come in when your teeth are hurting. Probably we should pull out all your teeth"*(P10). Another older non-Indigenous woman said that dentists were careless and without compassion There were residual anxieties and fears from previous experiences. [Quote: p.227] Opinions on dental health Descriptions of mouth-care touched only cursorily on the need to brush teeth. Everyone moved rapidly and persistently to the severity and management of toothaches. We heard how teeth were *"so painful that I couldn't sleep. . . eat. . . talk. . . think, the whole pain was just here*"(P15), and that "*there is lot of food that I can't eat because it doesn't digest . . . I can't chew, so it is very bad on my health*"(P14). Home-remedies and over-the-counter medications were identified as effective self-treatments "*if I have really bad pain or. . . abscess. . . I just brush my teeth, take Ibuprofen for couple of days, then the pain goes away*"(P23). When that did not ease the toothache or abscess, there was the perception that hospital emergency departments are "*better than dental offices. . . [because] they have dentists [who] are better than the dentists down here*"(P6). [Quotes: p.228] Improving dental services Another man was well-informed about the cause of dental caries and complained that the staff in homeless shelters "got to stop giving sweets, that's all they do down here, they give out sweets"(P2). There were requests also for better dentist-patient communications and more government-sponsored dental services. "*Before, even when you get teeth cleaned, they should tell you - what they are going to do; how they are going to do it; what procedure they are going to use; the results . . . and also the price. You should tell the powers, like the government, that we need more than $1000 a year. That way, we can look after our teeth better."* [Quote: p.228]

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers do not provide details on how the participants were selected.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Approval was granted from the university's Behavioural Research Ethics Board(H14-01169).)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The four authors read and coded the transcripts independently before reaching a consensus on the interpretation of major themes.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge but they do not identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Masson, 2020

Bibliographic Reference	Masson, Carmen L.; Fokuo, J. Konadu; Anderson, August; Powell, Jesse; Zevin, Barry; Bush, Dylan; Khalili, Mandana; Clients' perceptions of barriers and facilitators to implementing hepatitis C virus care in homeless shelters; BMC Infectious Diseases; 2020; vol. 20 (no. 1); 1-8

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	US
Setting	This study was conducted in a large homeless shelter in San Francisco.
Data collection and analysis	The facilitator used a semi-structured interview guide to conduct focus groups, which included open-ended questions. Each focus group lasted 60 minutes. Focus group discussions were digitally recorded and transcribed verbatim for thematic analysis. Transcribed focus groups were analysed using qualitative thematic analysis
Recruitment strategy	A purposive sample of shelter clients was recruited to qualitatively describe experiences and perceptions related to accessing HCV care. Participants were recruited using flyers posted and distributed by shelter staff.
Study dates	September and October 2018
Sources of funding	This study supported by investigator-initiated grant through Gilead Sciences Inc. (IN-US-342-4531) (to M.K.), National Institutes of Health T32DA007250 (to J.K.F), UG1DA015815, and K24AA022523 (to M.K).
Inclusion criteria	• Participants were over 18 years of age
Exclusion criteria	Not reported
Sample size	N=20 homeless people
Participant characteristics	**Gender** Male: 10/20 Female: 10/20 Age range: 26-69 years
Results	<u>Limited knowledge and misconceptions regarding HCV</u>

	At the individual level of analysis, limited knowledge of the main modes of HCV transmission (for example, sharing needles, blood transfusion), HCV diagnosis, and the availability of treatment for HCV were barriers. Mistrust of healthcare providers Mistrust of health care providers and government institutions was a barrier for treatment. Limited advocacy for HCV services by shelter staff At a system level of analysis, some participants reported the sentiment that there was limited advocacy for HCV services by shelter staff. Motivators for HCV testing and treatment Participants acknowledged the benefits of both HCV testing and treatment. They reported that a strong personal motivator to be tested and treated for HCV was to prevent transmission to others and prevent disease progression. They reported that HCV education as a key factor that may motivate some people to be tested and treated for HCV. Financial incentives Financial incentives was cited as a strong motivator to engage homeless clients in HCV rapid testing and receipt of HCV education. *“People will get it [testing] as long as there is an incentive behind it so if there’s no incentive they won’t get it.”*(African American Woman) [Quote: p.5]

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The institutional review board of the University of California, San Francisco reviewed and approved study procedures.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis was conducted by three authors who coded data and generated themes through an iterative process.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

McNeil, 2012a

Bibliographic Reference	McNeil, Ryan; Guirguis-Younger, Manal; Illicit drug use as a challenge to the delivery of end-of-life care services to homeless persons: Perceptions of health and social services professionals; Palliative Medicine; 2012; vol. 26 (no. 4); 350-359

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting	Interviews were conducted at participants' place of employment or an alternate location of their choosing.
Data collection and analysis	Semi-structured interviews were conducted. Interviews were audio recorded with the consent of participants and ranged in length from 45 to 120 minutes, although the vast majority of interviews were approximately 60 minutes in length. Interviews were transcribed verbatim. Data was analysed by thematic analysis.
Recruitment strategy	Existing relationships with health and homeless service providers in Ottawa and Toronto facilitated recruitment in study cities.
Study dates	April 2007 and June 2008
Sources of funding	Ryan McNeil is supported by a Four-Year Fellowship from the University of British Columbia.
Inclusion criteria	Not reported
Exclusion criteria	Not reported

Sample size	N=50 health and social services professionals
Participant characteristics	Not reported
Results	<u>Competing priorities</u> Participants identified competing priorities among homeless persons, including illicit drug use and its supporting income-generating strategies, to be a barrier to access to end-of-life care services. They believed that homeless persons who use illicit drugs de-prioritised their health needs, leading to decreased contact with healthcare providers. As a consequence of this lack of contact with healthcare providers, participants felt that homeless persons who use illicit drugs were less likely to receive and/or adhere to treatment and, therefore, more likely to experience adverse health outcomes, resulting in emergency room visits or death. Participants felt that many homeless persons who may have benefitted from end-of-life care services were not referred to these services because their competing priorities caused them to lack the most basic level of access to health services. *"If you are worried about where your next fix is going to come from or where your next meal is going to come from and you don't know where you are going to sleep that night, healthcare falls to the bottom of the list."* (Nurse Practitioner) [Quote: p.353] <u>Lack of trust in healthcare providers</u> Participants noted that one of the key barriers to end-of-life care services for homeless persons who use illicit drugs was their lack of trust in healthcare providers, which they attributed to the cumulative impact of the discrimination by this population in healthcare settings. Participants reported that many homeless persons who use illicit drugs were unwilling to be referred to end-of-life care services due to this lack of trust. Participants believed that many homeless persons who use illicit drugs internalised discrimination encountered in healthcare settings and, therefore, did not feel worthy of receiving services. "*There is a lot of shame. My experience has been that many of those I see in the shelter carry a lot of shame. Low self-esteem, horrific histories of trauma and abuse, mistrust of caregivers. They've lived very independent lives. At the end of life, when their needs increase, it's distressing to them because they need to trust when they've never learned to trust. They bring with them experiences that are negative from healthcare providers. It's a challenge*." (Physician) [Quote: p.353] <u>Exclusion from traditional end-of-life care services</u> Participants strongly believed that this population was excluded from mainstream end-of-life care services, such as community hospices and hospitals, on account of illicit drug use. Many participants noted that end-of-life care services providers in their community had zero-tolerance policies toward illicit drug use that automatically excluded this population. In the event that formal zero-tolerance policies did not exist, participants noted that accompanying behavioural problems were cited as a justification for excluding this population. Several participants also remarked that mainstream end-of-life

	care settings were not appropriate for this population due to their structure and incompatibility with lifestyles associated with illicit drug use. Mainstream end-of-life care settings were perceived to be serene, sterile places far removed from the circumstances that this population was accustomed to. Challenges to end-of-life care services delivery A significant challenge to the delivery of end-of-life care services to homeless persons who use illicit drugs was their nondisclosure of active illicit drug use. Participants remarked that punitive approaches to illicit drug use discouraged many clients from disclosing active illicit drug use. Participants identified several challenges that might result due to the non-disclosure of illicit drug use by clients, including but not limited to: (a) increased likelihood that clients would experience adverse drug reactions; (b) challenges in determining the cause of changes in client behaviour; and (c) difficulty in determining whether changes in health status were attributable to illicit drug use or illness progression. These challenges frequently occurred at the same time and negatively impacted client health and workplace safety. Pain and symptom management Many participants acknowledged that they faced difficulties in addressing the pain and symptom management needs of homeless persons who use illicit drugs due to the cumulative effects of drug use on their overall health and opioid tolerance. Participants frequently referenced high levels of opioid tolerance as a concern when administering pain medication, fearing that delivering the level of medication necessary to alleviate symptoms would result in overdose. Although this served as a significant everyday challenge for many participants, it was also identified as a barrier to specialist care. Several participants reported that specialists were unable, or unwilling, to offer support to this population due to fears that they would be liable for adverse reactions. Need for end-of-life care and addictions training Many participants acknowledged that they required addictions training or, if they had worked primarily in this field, further education on end-of-life care. Participants indicated that these areas of study seldom overlapped to the detriment of their clients. For example, participants experienced in end-of-life care services delivery reported feeling unprepared to cope with illicit drug use because they had not received training in that field. Furthermore, a lack of available research on providing end-of-life care services to persons using illicit drugs was identified as a major barrier. Interruptions in care as a result of illicit drug use policies Participants identified low barrier community and shelter-based health and end-of-life care services as having an increased capacity to deliver end-of-life care services to this population due to their abandonment of zero-tolerance, abstinence-only service delivery models. Participants acknowledged that these facilities, which have been developed in several cities with the intention of providing services to homeless, hard-to-serve clients, were better able to engage homeless persons who

	used illicit drugs by not excluding them from services on the basis of continued drug use. However, they believed that policies requiring clients to leave the premises in order to use illicit drugs themselves posed several challenges, including but not limited to interruptions in care, risk of injury, and risk of accidental overdose. Several participants felt that expanding harm reduction policies to include onsite, supervised drug use had the potential to minimise risks and, thereby, improve the quality of care. They believed that, although existing illicit drug use policies were intended to maintain order in the facilities, they had a tendency to penalise clients for continued illicit drug use at end-of-life even as they acknowledged that it was unrealistic to expect changes in behaviour.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*

Critical appraisal

Section	**Question**	**Answer**
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study was approved by research ethics committees at Saint Paul University and the University of British Columbia.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis was conducted by the authors of this study who coded interview data. The emerging themes were discussed and revised during regular meetings between the authors and the final themes and sub-themes were established based on consensus.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

McNeil, 2012b

Bibliographic Reference	McNeil, Ryan; Guirguis-Younger, Manal; Dilley, Laura B.; Recommendations for improving the end-of-life care system for homeless populations: A qualitative study of the views of Canadian health and social services professionals; BMC Palliative Care; 2012; vol. 11 (no. 1); 14-21

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting	Interviews were conducted at participant's workplace or alternate location of their choosing.
Data collection and analysis	Semi-structured qualitative interviews were conducted. Interviews were audio recorded and ranges in length from 45 to 120 minutes, although the majority were approximately 60 minutes in length. Interviews were transcribed verbatim. Data was analysed by thematic analysis to generate themes.
Recruitment strategy	Letters or emails were sent to seventy-three potential participants to provide them with information about the study and invite them to participate.
Study dates	February 2007 to August 2008
Sources of funding	Ryan McNeil is supported by a doctoral award from the Social Science and Humanities Research Council. This research was funded by the Social Sciences and Humanities Research Council (Grant # 410-2006-2050). Saint Paul University provided supplementary funding.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=54 health and social services professionals
Participant characteristics	Not reported
Results	<u>Availability of end-of-life services and supports</u>

Participants noted that, although end-of-life care services struggled to meet local demand, what services were available were generally inaccessible to homeless populations. Participants noted that homeless populations were unable to access end-of-life care services as a result of a lack of caregiver support and/or financial resources. Participants reported that end-of-life care services in their communities assumed that clients were stably housed and supported by caregivers or had the financial resources to pay for care (for example, assisted living facilities). As a consequence, they felt that their clients were unable to access these services.

Operating policies that exclude homeless populations

Participants noted that end-of-life care providers in their communities had largely adopted operating policies that excluded homeless populations from accessing services (for example, anti-drug policies, codes of conduct, and so on). Participants felt that these operating policies privileged ‘normative patients’ (for example, persons who were housed, had family, and conformed to procedures) and excluded homeless persons on the basis of a range of conditions common among this population (for example, mental illness and substance use). In particular, anti-drug policies were identified as a barrier to care and, where formal policies did not exist, participants reported that substance-using homeless persons were identified by intake personnel as disruptive and, on the basis of this, denied services. Participant accounts suggest that these operating policies were perceived as discriminatory because they prevented a particular population (for example, homeless persons) from accessing services, thus reinforcing inequities in access to the end-of-life care system.

Lack of continuity of care

Participants expressed frustration with the lack of continuity of care for this population. They highlighted two particular challenges with implications for the end-of-life care system. First, participants noted that poor continuity of care (for example, lack of follow-up, poor discharge planning, and so on) often precipitated the need for end-of-life care services among homeless persons with chronic diseases (for example, HIV/AIDS). Participants noted that poor discharge planning placed an undue burden on community agencies ill-equipped to provide end-of-life care services. Participants reported that homeless persons were frequently discharged directly to emergency shelters even though these settings could provide only limited care to clients with complex medical needs.

Low-threshold strategies

Participants strongly recommended that the end-of-life care system adopt low-threshold approaches, which have minimal requirements for admission and care. Participants emphasised that conventional approaches requiring drug or alcohol abstinence restricted access to end-of-life care services for substance-using homeless populations. Participants reported that it was important that end-of-life care providers acknowledge that changes to rules and regulations were needed for the purpose of serving this population.

Partnering community agencies with the end-of-life care system

Participants strongly believed that the wide variety of health and social services agencies accessed by homeless persons (for example, shelters, soup kitchens, syringe exchange programs, and so on) should be formally partnered with the end-of-life care system. Participants articulated how the trust developed between these agencies and homeless populations helped to mediate access to a range of other services (for example, primary care, specialists, and so on) and could perform a similar function in the context of end-of-life care. Furthermore, participants reported that these agencies, and especially trusted staff, were able to monitor changes in health status over time due to their sustained contact with this population and mediate access to health and end-of-life care services. "*We work together at three sites. Because many of our patients that we have [in the hospice] have been known to the other two sites, there's kind of a family. In that way, we help each other and we communicate with each other. As far as other facilities go, we use what's out there in the community. Our patients may be known to some community health centres.*" (Nurse) [Quote: p.5]

Strengthening training for end-of-life care professionals

Participants reported that increased training was needed to strengthen the capacity of healthcare professionals to address the complex and diverse needs of homeless populations at end-of-life (for example, pain and symptom management, substance use, and so on). Participants noted that, while they valued the clinical expertise of healthcare professionals, clinicians often lacked experience in areas such as mental health and substance use that limited their effectiveness and openness to best practices.

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study was approved by the research ethics committees at the University of British Columbia and Saint Paul University.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis was conducted by the authors of this study who coded interview data. The emerging themes were discussed and revised during regular meetings between the authors and the final themes and sub-themes were established based on consensus.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

McNeil, 2013

Bibliographic Reference	McNeil, R.; Guirguis-Younger, M.; Dilley, L. B.; Turnbull, J.; Hwang, S. W.; Learning to account for the social determinants of health affecting homeless persons; Medical education; 2013; vol. 47 (no. 5); 485-494

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting	Interviews were conducted with participants in their work settings or in alternative locations of their choosing (for example, public parks, coffee shops, and so on)
Data collection and analysis	Semi-structured, qualitative interviews were conducted to collect data. Interviews were audio-recorded. Each interview lasted 45–120 minutes, although most were approximately 60 minutes in length. Interviews were transcribed verbatim. An inductive and iterative process was used to analyse data.

Recruitment strategy	Participants who worked primarily in settings mandated to provide care to homeless persons were recruited. Additional potential participants were identified through a scoping review of health services for homeless persons.
Study dates	February 2007 and August 2008
Sources of funding	This study was funded by the Social Sciences and Humanities Research Council (SSHRC) (Grant # 410-2006-2050). RM is supported by a doctoral award from SSHRC.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=24 homeless people
Participant characteristics	**Gender** Male: 6/24 Female: 18/24
Results	<u>Need to account for social and structural factors</u> Participants highlighted challenges to providing care to homeless persons, noting that they could not rely on assumptions embedded in their clinical training and reinforced in hospital settings (for example, clients are appropriately housed, have proper nutrition and access to transportation, and are able to pay for care and treatment). Although participants acknowledged that changing these social and structural factors was beyond the scope of their training and professional practice, they reported that it was critical to account for these factors when providing care and developing treatment plans. However, with reference to the lack of emphasis on the social determinants of health in their clinical training, participants expressed their feelings of being ill prepared to cope with these challenges. <u>Acquiring experiential knowledge</u> Participants articulated how they acquired experiential knowledge to address the health needs of homeless persons by being present and identifying ways to respond to these needs within their social and structural contexts. Being present

entailed actively and deeply engaging with this population outside of traditional health care environments in order to foster understanding of how factors exogenous to the individual influence health and health behaviours. Participants noted that, because they had only a limited capacity to visit many settings, they often supplemented direct observation and interactions by liaising with colleagues and community partners. In this context, participants reported that regular contact with community health and social service agencies (for example, emergency shelters, syringe exchange programmes, and so on) was critical to keeping abreast of the health status and needs of individual clients, as well as of homeless persons generally. Participants articulated how doing so allowed them to extend their presence into these settings and consequently increase the responsiveness of clinical care to clients’ circumstances.

Evaluating effectiveness through observation and critical reflection

Participants reported that they evaluated the effectiveness of clinical care and treatment on an ongoing basis through direct observation and critical reflection. Participant accounts indicated that they continued to engage with clients in multiple settings (for example, community clinics, emergency shelters, and so on) to evaluate a range of treatment and health outcomes (for example, treatment adherence, substance use, and so on) in the clients’ natural environments. Participants reported that doing so allowed them to better evaluate any social and structural factors that constrained the efficacy of care and treatment. Participant accounts illustrated that, whether through reflection or journaling, they carefully considered how social and structural factors impacted the delivery of health care services to this population. In this regard, participant accounts indicated that critical reflection involved thoughtful deliberation on their experiences in the field (for example, observed barriers to care or treatment adherence), as well as any feedback they received from clients.

Adjusting clinical strategies

Participants articulated how they had learned to adjust their clinical practice to integrate strategies they felt successfully accounted for social and structural factors that impact on clinical care. Participants emphasised that they made these adjustments on an ongoing basis to reflect their experiences in the field and noted that they applied lessons learned to similar situations. Accordingly, as one participant observed, these adjustments to clinical practice were part of an ongoing process. Participants identified a wide range of changes they had made to their clinical practice that took into account social and structural factors that shape the health of homeless persons, including but not limited to prescribing medication that can be taken without food, dispensing medication via emergency shelters or clinics, and escorting or arranging for someone to escort clients to appointments for X-rays, laboratory tests and specialist consultations. Furthermore, they reported that they had learned to expand the scope of their clinical practice to include advocating for improvements in the material conditions of homeless persons as a means to improving the overall health of this population.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study was approved by the institutional research ethics boards at the University of British Columbia and Saint Paul University.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis was conducted by two research team members. The emerging themes were discussed and revised during regular meetings between the authors and the final themes and sub-themes were established based on consensus. Once the final*

Critical appraisal

Section	Question	Answer
		thematic categories had been established, two research team members independently re-coded sections of the transcripts to ensure the credibility of these categories.)
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Mills, 2015

Bibliographic Reference	Mills, Emma; Burton, Christopher; Matheson, Catriona; Engaging the citizenship of the homeless: a qualitative study of specialist primary care providers; Family Practice; 2015; vol. 32 (no. 4); 462-467

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK

Setting	Interviews were conducted over the telephone.
Data collection and analysis	Semi-structured interviews were conducted and audio-recorded. Interviews followed a topic guide informed by existing literature. Data analysis followed a framework approach. The researcher transcribed all interviews enabling familiarisation, then conducted a preliminary coding.
Recruitment strategy	Participants were recruited through informal professional networks in the UK using purposive sampling in order to include a range of location, practice type and duration of professional experience.
Study dates	Not reported
Sources of funding	No funding was obtained.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=13 healthcare professionals
Participant characteristics	**Gender** Male: 3/13 Female: 10/13 **Average time spent working with homeless people** 11 years (range 2 to 24 years) **Profession** GP: 9/13 Nurse: 3/13 Health visitor: 1/13

Results	Systemic barriers to engagement Several interviewees described the difficulty they perceived for homeless persons in accessing health care even within a universal and free system such as the NHS. In particular, they identified the rigid appointment systems operated by most GP practices, which were at odds with patients' more disordered lives and conflicting priorities. This 'lack of flexibility' was identified as a barrier but also as one which with planning and resources could be overcome. Another suggestion for homeless patients' apparent inability in many cases to navigate health care services effectively was the complexity of the system itself. This complexity was not limited to health care; many interviewees raised the issue of the multiple services homeless patients needed to engage with and stated that their difficulties in engaging would be present across all services. There was the suggestion that some services were not only difficult to navigate, but actively obstructive to those people least able to navigate them. Some services set entry restrictions which meant that some homeless persons were effectively excluded, such as alcohol and drug rehabilitation services that required a stable address. All systems, whether for health or social services such as benefits and housing, were seen as independently claiming priority on people using them. Thus, people with multiple needs often had to prioritise issues other than health care. *"The greatest barrier which people seem to have is finding services that are willing to be flexible enough to deal with the way in which they have their lifestyles. So having to make an appointment for a GP at 8 o clock in the morning is a huge barrier, particularly if you haven't got phones. I'm trying to think what, that services don't start until 9 o clock in the morning so they can't make phone calls until 9 o clock when services are available."* (Nurse, 11) [Quote: p.463] Difficulties engaging with professionals Homeless persons were seen as having difficulties with relationships by some health care professionals. In some cases, this was viewed as a characteristic of individuals which predisposed them to homelessness. However, others saw this less in terms of a lack of innate capacity, and more in terms of limited opportunities to acquire and practice the skills of navigating services. Low self-worth was widely recognised as an important factor in homeless person's non-engagement with health care. It was seen as applying to wariness to embark on new clinical relationships and in a sense of fatalism. Stigma was commonly reported, both in examples of inappropriate treatment by medical staff and in patients fear of stigma, which was enough to prevent homeless patients from seeking treatment. Although many reports of stigmatisation by patients were accepted at face value by clinicians, some interviewees suggested that stigma might in some cases be more perceived than real. Despite perceptions of difficulty engaging with professionals as well as systems, interviewees highlighted the importance homeless patients put on familiarity, continuity or trust with professionals. *"And sometime it's about self-worth, as well, some people I come across will say this is the punishment I have for the life I've had and you know I'm not about to try and fix it yet. And that person a few years down the line will be in a completely different place and say yep, I am ready to turn things around now and I am ready to move on and go through treatment."* (GP, 2) [Quote: p.464] System approaches to facilitate engagement

	The homeless practices represented by the participants strove to provide a service suitable to the needs of their community of marginalised people. When describing the specialist service provided for homeless patients, emphasis was placed on designing services around the particular needs of homeless patients. For some services, this involved premises close to facilities such as homeless centres, outreach sessions in such facilities and hosting specialist outreach teams (for example, for hepatitis C) visiting the practice. Interviewees described steps they had taken to make their services more supportive of patient engagement. One widely used strategy was to offer a balance of drop in sessions with scheduled appointment times. Such combinations allowed patients to initially access care regardless of their abilities to engage, whilst allowing a progression towards attending more structured care. Part of that flexibility came from performing opportunistic medicine whenever the patient engaged, and being flexible about the clinician's role in the practice in order to provide the patient with the most well-rounded care during any attendance. Several participants described seeking to find a balance between making services totally user centred and maintaining some rules and expectations for engagement. This was seen as important both for the functioning of specialist homeless services, but also as a way of preparing patients for life in more mainstream GP practices. Most interviewees spoke very positively about the role multi-agency communication and support had to play in encouraging patients to engage successfully with health care. By communicating and working in partnership with other agencies, improving awareness of the health services provided for homeless patients could be targeted where it was most likely to be required. A consistent theme emerged of helping homeless persons learn to engage with health care and other systems. *"For me one of the really important things is about permeability, so it's about how much services are actually tailored towards meeting the needs of patients who are homeless."* (GP, 2) [Quote: p.464] Relationship approaches to facilitate engagement A trusting relationship, which enabled the patient to feel safe in the health care environment, was seen as key to promoting engagement and the starting point for this. The importance of relationships was seen as being relevant to all members of the primary care team. Relationships were understood as being challenging for patients as well as clinicians. Among the ways of fostering trust, interviewees describe not just listening and understanding, but addressing practical issues. Small suggestions were seen as making a step to securing the patient's confidence not only in their health professional, but ultimately in themselves. "*Generally speaking I think people build up a relationship with everybody in the practice, or certainly a representative of each aspect, so they will have a particular admin person they know, they'll have contact with the nurse practitioner, they'll have contact with one or more of the GPs. And possibly CPN and specialist staff, health visitor as well*." (GP, 5) "*I think a lot of people have really big issues with trust and authority and with anxiety and meeting new people. A huge proportion of the people I see will talk to me about really traumatic childhood experiences… they're just not able to trust anyone or deal with that interaction with people."* (GP, 3) [Quotes: p.465] Practice, patient, community and citizenship An additional aspect of engagement that emerged was the sense of the homeless service becoming a community of engagement in which established service users or formerly homeless people supported current users generating a

	citizenship of service users. Participants described ways in which their services were promoted and advocated by the homeless patients themselves. Networks within the homeless community led to the sharing of information regarding service provision and health literacy. Having developed a trusting relationship with their health professional, several participants reported that patients then brought their peers to services in order that they might benefit too, often commenting on the trustworthiness of staff. The positive influence from engaging successfully with one patient often had widespread results within the homeless community. For some patients, their role in the community went beyond spreading the awareness of services. They sought active roles among homeless people, promoting and assisting in health care provision for their peers. This sharing of information and reciprocity enabled members of the homeless community to present themselves as service users and develop a role with responsibilities in the citizenship of the practice. Through developing relationships with staff and peers, patients were enabled to develop and strengthen this citizenship. Indeed, such was the apparent desirability of the homeless health care community within some practices that non-homeless patients expressed their desire to seek citizenship, requesting access to the services. In turn, this citizenship carried expectations of self-determination and choices over decisions. *"I'll test one person [BBV] and then the following week they come back with their mates, whose been told about me doing the blood borne virus testing and he then will come back a couple of weeks later with his girlfriend or he'll come back the next day to a different venue where he knows I am and he'll bring his girlfriend. So yes, that definitely improves not only engagement with the individual… but also they bring others to the service."* (Nurse, 11) *"It will all just be a breakthrough for them and then they'll end up being able to get involved with volunteer work, and we've got quite a few ex-service users who are volunteers here and I think a lot of them are very stable in their lives."* (Nurse, 9) [Quotes: p.465]

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval was granted by the University's Ethics Review Board (CERB/2014/2/1023) and multi-site National Health Service (NHS) R&D approval was obtained.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(One researcher transcribed all interviews, and two separately investigators coded the interviews and developed a thematic framework by consensus.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Moore, 2011

Bibliographic Reference	Moore, G.; Manias, E.; Gerdtz, M. F.; Complex health service needs for people who are homeless; Australian Health Review; 2011; vol. 35 (no. 4); 480-485

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting	Not reported
Data collection and analysis	Two separate interview schedules were developed: one for homeless people and the other for service providers, based on a literature search and work experience of the research team. Interviews were audio recorded and transcribed verbatim. Thematic analysis was used to analyse the results.
Recruitment strategy	The service providers were purposively sampled due to their involvement in the care of homeless people who accessed a public, teaching hospital. Potential homeless participants were identified when they presented to the ED. A purposive sampling approach was used with participants in an effort to obtain a broad cross-section of people with different demographic profiles.
Study dates	Not reported
Sources of funding	• Financial support was provided through the Australian Research Council Linkage Project Scheme, project number: LP0453587. • Financial support was also provided by St Vincent's Hospital. • Financial assistance was provided by the Australian Research Council and a contribution from Dr Andrew Dent, previous Director of Emergency Department, St Vincent's Hospital

Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=47 n=20 homeless people n=27 service providers
Participant characteristics	**Homeless people** Mean age: 50.5 years (SD 9.4), range 35 to 68 years Gender: Male: 15/20 Female: 5/20 **Service providers** Mean age: 40.2 years (SD 7.9), range 28 to 58 years Mean number of total years of work= 16.4 years (SD 7.9), range 7 to 30 years Mean number of years of experience in working with homeless people= 11.5 years (SD 7.5), range 1 to 28 years
Results	<u>Respect for homeless people and co-workers</u> The need to be treated with respect within the carer-patient relationship and between different staff members either within an organisation or across institutions. Service providers referred to respect as an essential component contributing to the development of trust and improving the engagement with a homeless person. Respect is a word used frequently to mean consideration for someone or holding them in high regard. For service providers, respect extended beyond the word ‘consideration’. It involved acting in ‘good faith’ with a conviction to be truthful and committed to the well being of another person. *"The first thing you need to do is develop a connection and some kind of rapport and some kind of way of getting some understanding of where they are coming from and then you might go down the path of what assessments they need because you need to get a better picture of what they need."* [SP12] (Catrina, hospital social worker) [Quote: p.482]

	Engagement Engagement in service utilisation involved close relationships between homeless people and service providers who continued to maintain an ongoing focus on the health of homeless people. Engagement required the development of a relationship between two people and was crucial to the outreach work for homeless people. Lack of after-hour services The ED was a key service operating 24 h each day for homeless people to access in time of crisis or psychosocial need. Service providers found *‘the whole after-hours thing . . . a nightmare’* [SP19] as there was no ability to refer people until working hours and often the opportunity of engaging with the homeless person was lost when they were asked to wait till morning to find accommodation. It was an added issue to access interpreters after-hours in the hospital setting as *‘we only have phone interpreters then and not everyone has phone interpreter access’* [SP24]. Service providers *‘would like an after-hours referral system’* [SP24] so that they could refer homeless people to the appropriate services in the morning. It was identified that if the homeless person could be flagged in some way the staff in the morning could follow-up the person. [Quotes: p.483] Complexity of services Due to the multiple and diverse needs of homeless people there was an equally diverse service response with specific criteria for selective access to services such as youth and women’s refuges. In addition to the many services supporting homeless people, the way that these services communicated and referred homeless people became a central issue in navigating and negotiating case management. "*Even though there were numerous services supporting homeless people they had specific criteria to deal with selective groups like, women and children and the elderly. Just because there were the services available it did not mean homeless people accessed them...cause if you don’t know you can access...unless you ask for it, you don’t need it or get it"* [HP9] [Quote: p.484].

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethics approval for the conduct of the study was obtained from the institutional review board of the participating hospital, the participating community-based organisation that deals with the needs of homeless people, and the university.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Data analysis was independently conducted by two researchers to check for consistency of themes, and agreement was obtained for all identified themes.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Munoz, 2015

Bibliographic Reference	Munoz, R. T.; Aragon, J. S.; Fox, M. D.; Community-engaged research and homeless adolescents: Capturing perceptions of health care and building lasting relationships with the community; International Public Health Journal; 2015; vol. 7 (no. 1); 155-161

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	US

Setting	Not reported
Data collection and analysis	Focus groups and interviews were conducted for data collection. Focus groups lasted 60-90 minutes and individual interviews ranged from 30-60 minutes. Focus groups and individual interviews were semi-structured to promote conversational, two-way communication. All focus groups and individual interviews were audio-recorded, transcribed, and supplemented by notes taken by the research team. Thematic analysis was done by content analysis.
Recruitment strategy	Participants were identified by the partnering agency as either homeless or "at risk" for homelessness.
Study dates	Not reported
Sources of funding	The National Centre for Research Resources and the National Institute of General Medical Sciences of the National Institutes of Health through Grant Number 8P20GM103447.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=30 homeless adolescents
Participant characteristics	**Gender** Male: 19/30 Female: 11/30 **Age** Mean age: 20.3 years
Results	<u>Lack of respect from health care providers</u> A major theme was homeless adolescents' perceive a lack of respect from health care providers that comes from being poor and homeless.

	Dehumanisation is a systematic: "It's all about the money" Participants were relatively aware of the structural challenges within the health care system associated with financing. A second major theme was profit driven models of care leave no room for the needs of homeless adolescents. The impact of perceptions on health seeing behaviour: "Toughing it out" The perceptions that health care providers in the US dehumanise homeless adolescent because of the financial drivers of health delivery appears to influence homeless adolescent's health seeking behaviours. Further, to reduce the need to seek care from an insensitive, formal health care delivery system, homeless adolescents in our sample reported turning to informal peer networks for alternative care. Solutions from a homeless adolescent perspective: "Be a little more understanding" Although homeless adolescents exhibited distrust of health of the health care system, participants also held hope that health care delivery could be improved. For instance, one female homeless adolescent suggested more egalitarian partnerships with providers that incorporate shared decision making would help increase trust. *"Be a little more understanding…At least consider some of my ideas in the treatment plan instead of shoving me off like I don't know what I'm talking about. I don't know everything just like he don't know everything, you know, but the difference is I can admit it."* [Quote: p.158]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study protocol was approved by the Institutional Review Board of the University of Oklahoma Health Sciences Centre.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not report who analysed the data in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Nicholas, 2016

Bibliographic Reference	Nicholas, D. B.; Newton, A. S.; Kilmer, C.; Calhoun, A.; deJong-Berg, M. A.; Dong, K.; Hamilton, F.; McLaughlin, A. M.; Shankar, J.; Smyth, P.; The experiences of emergency department use by street-involved youth: Perspectives of health care and community service providers; Social work in health care; 2016; vol. 55 (no. 7); 531-544

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	Canada
Setting	Interviews took place in either the target hospitals or community agencies.
Data collection and analysis	Individual and group interviews were scheduled. Interviews were audio recorded and transcribed verbatim, and the analysis of transcript data was supported by computer software NVivo 10. Data were analysed by the grounded theory methodology.
Recruitment strategy	Community and/or ED-based service providers who work with street involved (SI) youth were recruited through a theoretical sampling approach, by email notices sent out by site managers.
Study dates	Not reported
Sources of funding	The Alberta Centre for Child, Family and Community Research. Dr. Newton (author) is supported by a Canadian Institutes of Health Research (CIHR) New Investigator Award.
Inclusion criteria	Not reported
Exclusion criteria	Not reported

Sample size	N=41 service providers n=20 hospital staff n=21 community-based workers
Participant characteristics	Not reported
Results	Experiences in emergency departments Seamless system navigation between health and community services, and positive liaison with hospital staff were exemplified rarely. Policies and procedures Health care providers (HCPs) described accommodating SI youths' lifestyles by altering policies and procedures. One physician described adjusting rules to fit the lifestyle and needs of SI youth, such as with leniency around hours, appointments, and fees. Impact of past experiences on SI youth accessing care Community agency staff reported that past experiences in the ED substantially determine youths' later attitudes and actions regarding seeking ED care. Family experience was also described to play a key role. Participants identified a range of care alternatives for youth beyond an ED (for example, walk-in clinics), although others suggested that there are few viable health care alternatives for SI youth. *"I think that delving into that history … really digs up lots of trauma, and that trauma pushes them out the door."* [Quote: p.534] Health service avoidance Community agency staff reported consequent difficulty convincing youth to access health services. *"There's a time [that] they just avoid it all together and they don't even bother." "We thought that [a youth] might have meningitis … [and] it took probably a good four hours of convincing to get this youth to go [to the ED]."* [Quote: p.535] Unique, but missed needs

	Community agency staff reported instances in which SI youth (under 18 years) were treated as adults in ways that were harmful, noting that SI youth often have unique needs relative to other youth and relative to adults. A lack of money for the daily needs of SI youth was identified as a common issue for SI youth that in turn impeded ED care. Cultural and relational differences between youth and ED staff SI youth were reportedly uncomfortable in the ED often for reasons related to interpersonal relationships and structures in the ED. Another stated that youth have "paranoia" around the medical system due to past abuse, discrimination, and mistrust of systems in general. ED staff shared that hospital processes and culture may cause problems for SI youth. Negative ED staff attitudes and workload issues Imposed stigma and prejudice toward SI youth by ED staff were identified SI youths' reported perceptions of uncaring staff were reinforced by less attention from staff due to high staff workloads. Benefits yet challenges associated with advocates in the ED Participants generally suggested that advocates in the ED can benefit SI youth experience. ED staff similarly valued the presence of advocates in the ED. However, advocates were not valued unless they were viewed by HCPs as, *"… someone who … is in a position of legitimacy in the health care worker's eyes—so either their group home worker or their social worker, but not their friend."* Community workers reported several negative experiences while attempting to advocate for the youth in the ED. [Quote: p.538] Long wait times and a lack of follow-up It was noted that long wait times in the ED exist for all service users. Yet, these extended waits reportedly impose heightened barriers for SI youth. According to one physician, an ideal ED discharge would mean that, *"When you're done in the ED, there needs to be a place perhaps other than the street, if you're going to be discharged, that I can send you to that you can go and sleep till 10 o'clock in the morning or whatever you want to do, and then someone's there in the morning to pick up the pieces and carry on."* Several staff cited a policy that underage individuals must be discharged to the care of a responsible adult. They described struggle in discerning who could be considered a responsible adult, citing concerns about uninvolved or distant family members, or individuals who may be exploiting the youth. Another added that if a youth has arrest warrants, they may be released into police custody. [Quote: p.539] Insufficient mental health services Mental health services were reported to be insufficient to meet the needs of SI youth. Gaps in mental health services reportedly create a cycle of turmoil for these youth.

	Insensitive communication Insensitive communication by staff toward SI youth was commonly reported.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*

Critical appraisal

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study received institutional research ethics board approval prior to commencement.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not provide any details on who analysed the data in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Paisi, 2020

Bibliographic Reference	Paisi, M.; Witton, R.; Withers, L.; Plessas, A.; Burrows, M.; Morrison, S.; McDonald, L.; Kay, E.; Strategies to improve oral health behaviours and dental access for people experiencing homelessness: a qualitative study; British dental journal; 2020

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	Two 45-minute focus groups were conducted with centre residents by a peer researcher. The lead researcher conducted the face-to-face interviews with other stakeholders, which lasted 30-45 minutes. All interviews and focus groups were audio-recorded and transcribed by the lead researcher. The transcripts were uploaded onto NVivo 12 software. Thematic analysis was conducted.
Recruitment strategy	Purposive sampling was used for recruitment. Invitation posters were displayed in a residential homeless centre and information was distributed by a volunteer who acted as a gatekeeper for this study.
Study dates	February to March 2018
Sources of funding	Oral and Dental Research Trust (GSK Research Award)
Inclusion criteria	• ≥18 years old • Living in temporary accommodation (residential homeless centre) • No inclusion criteria applied to those interviewed individuals who worked with homeless people
Exclusion criteria	• Participants experiencing homelessness unable to provide informed consent (for example, due to intoxication) • No exclusion criteria applied to those interviewed individuals who worked with homeless people
Sample size	N=23 n=11 homeless people n=12 stakeholders

Participant characteristics	**Participants** Average age (mean±SD): 34.10±10.59 years Age range: 21.20-55.30 years Gender: Male- 11/11 **Stakeholders** Gender: Male- 5/12 Gender: Female- 7/12 Employment: Dental staff- 3/12 GP and other healthcare staff- 2/12 Community engagement- 1/12 Academic- 1/12 Professionals working with people experiencing homelessness in different capacities (eg support workers, managers)- 4/12 Volunteer- 1/12
Results	Awareness and empowerment The need to raise awareness on the importance of oral health and its impact on overall health was highlighted. Improving and/or updating basic oral health knowledge among people experiencing homelessness (particularly around diet and oral hygiene) was recommended. Empowering support workers to give basic up-to-date dental health advice can enable them to instil oral hygiene in their people's routines in the long term. Staff and volunteers should be encouraged to ask and prompt about oral health, and signpost the people they support to dental services. Thus, knowledge of available services and how

the system works can empower them to provide meaningful support. They are also in an ideal position to remind patients of appointments or attend them with them and thereby improve attendance. Improving understanding of oral health among other healthcare professionals is also seen as important, as is encouraging prevention and targeting people when young, either through the care system or probation services. Provision of care can be enhanced by improving dental practitioners' knowledge of health and social issues commonly affecting this population.

Supportive environment and dental health system

Regular free provision of toothbrushes and toothpaste, particularly in residential and drop-in centres, and drawing attention to the availability of these products can help facilitate routine oral hygiene. Residential services could promote healthy eating through educational activities and by providing healthier meal and snack options. Adequate funding is fundamental for service provision. Redesigning the dental NHS remuneration system or having salaried dental services could encourage more NHS dentists to take on patients experiencing homelessness, who often present with more complex needs and who may require longer courses of treatment. Longer appointments could improve both provision and continuity of care. Having someone accompanying patients to their appointments (particularly volunteers or peers) can help with attendance. *"I think an infinite supply of toothbrushes and toothpaste [is needed]. Never let that be a barrier. Never, ever, ever"* (volunteer) "*You can stay away from grease, sugar, you can choose [if you have your own place]. Here [hostel] you can't*" (participant experiencing homelessness). [Quotes: p.3]

Flexible and holistic care

One size definitely doesn't fit all. Accommodating the local context and incorporating flexibility into service delivery are important, and once patients have been assessed, it is best to offer treatment promptly. Knowing the additional social, financial and health burdens that this population faces and providing training to dental teams on trauma-informed treatment can support the provision of holistic care. Understanding the stage each person is in their life and their dental journey, and that being homeless is not their entire identity, is important and can support service sustainability. "*...tailoring healthcare services to local needs...rolling out national policies, but allowing flexibility within those policies to make necessary changes to help the local community."* (academic) "*So, we initially had only afternoon appointments but we found that quite a lot of the people...might be inebriated by the afternoon. So morning is better for them.*" (dental staff). [Quotes: p.3]

Outreach and community engagement

Academics and support services strongly recommended community outreach activities (promoting prevention and raising awareness about oral health and access to treatment). Such activities are thought to be particularly valuable for people who have a history of marginalisation and may find engagement with services particularly challenging. Enabling dental students to have contact with different groups of people early in their training will also promote understanding of homelessness, the reality of patients' daily lives and their vulnerability, as well as promoting students' communication skills. Healthcare professionals need protected time for outreach activities to happen. *"...allowing healthcare professionals protected time to do*

	that, because...outreach services...that don't directly impact on their clinical practice fall down the prioritisation list' (academic)." [Quote: p.4] Collaboration with other health and social services Establishing relationships with other healthcare professionals (for example, GP outreach) and homeless support organisations can promote a holistic approach to care, help with signposting, and improve attendance and compliance rates. Effective communication The conduct of the dental team, including reception staff, is a crucial element in the dental journey of patients. Training can help increase awareness and understanding among dental teams of the complexities of homelessness and promote patient-centred care. Explaining to patients what the dentist is going to do without the use of jargon, helping them understand treatment options and answering questions can provide reassurance. It is also important to manage expectations and be honest about what is expected from the patients, while being pragmatic and realistic about what they can do in their circumstances. Continuity of care by the same clinician is important in establishing trust and rapport with patients. Important qualities of a dentist as highlighted by people experiencing homelessness and support staff include being non-judgemental, respectful, gentle, empathetic, open-minded, a good listener, not making assumptions about how people arrived at their current situation and not blaming. Not giving up on patients and constant motivation are paramount.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the University of Plymouth Faculty of Health and Human Sciences ethics committee (Ref 17/18–854).)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Two authors independently coded the transcripts, using an inductive approach. They then discussed differences, identified links between the codes and merged them into agreed themes. Any disagreements were resolved by consensus.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Highly relevant

Patient and Client Council, 2015

Bibliographic Reference	Patient and Client Council; Issues faced by people who are homeless in accessing health and social care services: report of an initial scoping exercise; 2015

Study Characteristics

Study type	General qualitative inquiry Stakeholder consultation
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	The consultation process involved face to face conversations which lasted up to one hour, except one stakeholder which was a group discussion. Each interview was digitally recorded and fully transcribed. The interviews were then analysed to identify key themes and issues regarding access to services for the homeless population.

Recruitment strategy	The researchers consulted with stakeholders who either worked directly with people who were homeless, belonged to organisations with the direct aim of working with and helping homeless people, or people who had an interest or portfolio which included working in this area within a particular organisation.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=18 stakeholders
Participant characteristics	**Organisations consulted** • Council for the Homeless NI- Chief executive • Belfast Metropolitan College- Social work lecturer • Public Health Agency- Health & Social Wellbeing Improvement Senior Officer • Extern homeless support team- Manager, co-ordinator, homeless support workers • Homeless public health nursing team- Advanced nurse practitioner and independent prescriber • ECHO steering group • Simon Community- Homeless prevention coordinator
Results	<u>GP access</u> The two keys issues with GP access are registering with a GP (difficulties due to identification requirements) and due to feelings of embarrassment when having to explain they do not have a fixed address. Due to the layout of surgeries, others often overhear conversations which can cause further embarrassment. Limited consultation times often do not allow for a

	full assessment to determine how best to respond to a person with multiple and complex needs. Some stakeholders reported that other health and social care services are accessed through the GP, therefore if the homeless population cannot get access to a GP they are more likely to struggle to get access to other services. *"Homeless people will very often move and it's that kind of continuity of care that they need. It's not like these people are not capable of going and getting a doctor but they may have left one area to go to another area and may not know how to register."* (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues) *"They [GP] just get them in, give them what they need and let them go again. I'm concerned that a real assessment of their health needs isn't carried out at the beginning. GPs need to be more caring to that individual rather than just writing them a script."* (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues) [Quotes: p.30 & 32] Geographical location of services Gaining access to services due to their location, was also an issue which increased the difficulty of accessing health care and made some services inaccessible for homeless people. For example, due to the distant location of one Sexually Transmitted Disease (STD) screening clinic, transport was needed to access it. As the majority of people who are homeless do not own a car, these services were not accessible to them. Difficult and chaotic life circumstances Problems with not being able to access services can often come as a result of individuals not being able to manage their appointments. When an appointment is made for a GP or a specialist service such as mental health or addiction services, often this group of individuals cannot keep the appointment. If an appointment is made the individual needs to be at an address to receive the letter, be able to read it and attend the appointment. Some stakeholders indicated that if a homeless person receives a letter and cannot read, as a result, they may miss the appointment. They also stated that, in some instances, services work on the "three strikes and you're out" policy where if you miss three appointments you are removed from the service, resulting in the person being back at the start of the process and possibly on a waiting list for the service again. *"The big thing is people having the capacity to keep their appointments. If someone is referred to the community addictions team, they've got to be able to open the letter, read it, ring through and say they are going to keep the appointment, remember to keep the appointment and go on the day. That is actually quite difficult if you've got addiction problems or mental health illness."* (Stakeholder – working directly with homeless) *"One of the big things for homeless people is that a lot of services at the minute like mental health are appointment based services, they don't prioritise that and won't. If you get an appointment for a community mental health team in three weeks' time, you need somebody there that is going to make sure you go."* (Stakeholder – Working directly with homeless) [Quotes: p.33] Mental Health A number of stakeholders also raised the issue of waiting times to be seen by specialist services such as mental health services or getting an appointment to see a GP when newly registered.

Timely access

Waiting lists for services can also cause difficulty for the homeless population. Due to their transient nature they may move out of one area and into another. This can mean they are put to the bottom of the waiting list for services within the new Trust as there is no joined up approach when moving across the Trusts. Stakeholders also indicated that when a homeless person approaches a professional with a desire to stop drinking or taking drugs they need help at that particular point in time. If they have to wait weeks or months for support it may be too late. One stakeholder reported that if a homeless person goes for a mental health assessment and turns up intoxicated they send them away and tell them to come back when they have detoxed. This means they are put back at the beginning of the process again and more time passes before they are seen. *“When someone wants to come off alcohol or come off drugs that isn’t something that can wait until three months down the line. That is something that when your mind is set on doing that, you need to do it, you want to do it now. So very often there is a window of opportunity that is missed because you can’t get services for those people at that time.”* (Stakeholder interviewee – Working directly with homeless) [Quote: p.37]

Stigma, low self-esteem and discrimination

One stakeholder found that one of the biggest complaints from service users they work with was the attitude at A&E, particularly for those who have alcohol or drug problems. Stakeholders reported that stigmatisation can be an issue but they were more aware of a stigmatisation around chronic alcoholics or street drinkers who continue to drink no matter how much help they receive. These individuals may present to health services frequently and health professionals can feel exhausted trying to help them as they may present back again a few days later. One stakeholder emphasised that these individuals are unwell whether, mentally, or through addiction or physical health and they deserve the same health care as anyone else.

Fear and denial

Stakeholders believed that often people who are homeless have so many other issues going on in their life that their health is not a priority. Often they will not seek assistance until their health is critical. Stakeholders felt the reason for people who are homeless not wanting to go to hospital could be due to the fact they would be “different” to everyone else on the ward. Others on the ward would have friends and family coming to visit them every night and they would have no-one. Alternatively, they may have an addiction problem and they know that if they go into hospital they won’t be able to satisfy their addiction needs.

Learning disabilities

A number of stakeholders raised the issue of learning disabilities and access to services after the age of 18. It was highlighted that young people are often diagnosed as having a learning disability however, in the transition period to adulthood, reference to their ‘learning disability’ often changes to ‘learning difficulty’. The consequences of this change in reference from ‘disability’ to ‘difficulty’ often means the level of support they receive is reduced compared to what they received in adolescence when they were diagnosed as having a learning disability. This transition period can cause difficulties for people who are homeless in particular as they may lose some of the support they had. *“There’s not the same statutory responsibility and support for learning difficulties.”* (Stakeholder Interviewee – Role in providing policy/strategy/direction in relation to homeless issues) *“They were maybe in children’s learning disability services as well and once they turn 18 they’re not [in that service any longer]. We’ve had some horrendous situations where people have been assessed at a certain level and all of a sudden when they turn 18 their IQ or whatever system they use, they go up and they are no longer available for services.”* (Stakeholder interviewee – Working directly with homeless) [Quotes: p.40]

Dual diagnosis & need for coordinated care

Stakeholders reported that often being homeless can mean an individual may have a mental health illness and an addiction at the same time (a dual diagnosis). Homelessness may also mean there is a higher chance that you will be unable to access the services you need. People who are homeless need coordinated help from different aspects of the health and social care system. For example, GPs, hospitals, hostels, drug and alcohol detoxification programmes, psychiatric help, social services and dentists. As a result of their dual diagnosis people who are homeless need access to a number of different services and with the many issues that are going on in their lives, they may not turn up for appointments, or if they do turn up, they might not engage with the service. A number of stakeholders highlighted that dual diagnosis causes difficulty in accessing services as it is often hard to know which problem should be treated first. For example, it can be difficult to distinguish whether the mental health issue is caused by the addiction or if the addiction is caused by the mental health issue. *“If someone has a drug and mental health problem which do you work on first? That’s where you find people fall between services or don’t engage in services.”* (Stakeholder interviewee – Working directly with homeless) [Quote: p.42]

Lack of long-term care provision

There is a lack of long term nursing care and end of life care for the homeless population. There is a need for better provision of nursing care services for those with addiction problems as nursing homes are not suitable. Those who have been in hospital for a period of time and have detoxed, are likely to return to their old habits if they go back to the environment they came from. However, if they were moved to accommodation where they could recover and detox fully they may have a better chance of making a full recovery.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(The researchers did not explain how the participants were selected. However, the researchers did report where the participants were recruited from.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers have not reported on any potential biases arising throughout the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report on how ethical issues have been considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(The authors report that data was analysed to identify key themes and issues. There are no further details provided about the analysis process, however the data presented support the findings.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to current practice/policy. The researchers do not identify new areas where research is necessary and do not discuss the transferability of the results to other populations. This may not be relevant in the context of this study.)*
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Pendyal, 2021

Bibliographic Reference	Pendyal, Akshay; Rosenthal, Marjorie S.; Spatz, Erica S.; Cunningham, Alison; Bliesener, Dawn; Keene, Danya E.; "When you're homeless, they look down on you": A qualitative, community-based study of homeless individuals with heart failure; Heart & lung : the journal of critical care; 2021; vol. 50 (no. 1); 80-85

Study Characteristics

Study type	Grounded theory

Country/ies where study was carried out	US
Setting	Interviews were conducted in settings of participants' choosing, including public spaces such as the city library and municipal park, hospital rooms (with participants that were hospitalised at the time of interview), homeless shelters, and, for participants who had successfully transitioned from homelessness to stable housing, in their own residences.
Data collection and analysis	The lead author conducted every interview. Interviews averaged 57 minutes in length. All interviews were digitally recorded and transcribed by a professional transcription service. All transcripts were coded independently by two team members. Data were analysed by a multidisciplinary team using a grounded theory approach.
Recruitment strategy	The researchers used purposive sampling techniques to recruit participants from a variety of settings. Flyers were posted throughout the city of New Haven. In addition, the researchers engaged key stakeholders within the New Haven community to recruit participants.
Study dates	May 2018 to June 2019
Sources of funding	This work was supported by CTSA Grant Number TL1 TR001864 from the National Center for Advancing Translational Science (NCATS), a component of the National Institutes of Health (NIH).
Inclusion criteria	• Participants were included in this study if they had experienced homelessness at any time following heart failure diagnosis
Exclusion criteria	Not reported
Sample size	N=19 homeless people
Participant characteristics	**Gender** Male: 14/19 Female: 5/19

	Age Mean: 56 years Range: 34 to 72 years
Results	Instability Due to Homelessness Impedes Successful Heart Failure self management Behaviours and Routines Day to day instability/a chaotic lifestyle lead to difficulties in successful self management behaviours. In particular, medication routines were reported as challenging. *"I was missing appointments because I had no transportation. I was missing appointments because I had nowhere to sleep at night-. . .Wherever [I am] I carry a [tote bag] with my medicine in it. . .I'll leave my tote bag there...I won't come back for three, four days. . .Then when I go back, 'Oh man, my medicine'. . .All my possessions got sold from the eviction warehouse. All my possessions got sold. Sleep apnea machine. . .Medicines, clothes, everything."* (Participant 2, male, age 52) *"It's hard to take the medication when you're out there. . .You can't make it to pharmacies. . .I take 12 different types of medications. Seven of them you have to have with food. So hence, the other four or five, I won't even take. . .Actually, the only ones I would take is the torsemide and spironolactone so I can get...the [fluid] off of me. But the rest I won't even take."* (Participant 5, male, age 51) [Quotes: p.82] Homelessness Creates Difficult Tradeoffs Between Basic Necessities and Heart Failure Self Management Participants described difficult trade-offs between basic necessities and health needs. Another way in which participants described tradeoffs was by prioritising "short-term thinking," as opposed to planning for the future and making durable investments in their well-being. Stigmatisation by Healthcare Providers Influences the Experiences of Homeless Individuals With heart failure Within the Healthcare System Several participants described homelessness as a source of stigma that informed their interactions with the healthcare system. Even when participants were able to recognise symptoms of worsening HF, concerns about how they would be perceived by medical staff often prevented them from seeking timely HF care. When they did seek care, participants reported that they were treated without dignity. Stigma also made some participants hesitant to divulge their housing status to healthcare providers, out of fear that it would result in incomplete or inadequate care. In contrast, other participants reported that when healthcare providers used non-stigmatising language and actively inquired about their housing status, it elicited a sense of hope and greater self-efficacy.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The Yale University Institutional Review Board approved this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Two authors independently coded the interview transcripts. Through multiple group sessions, in order to ensure scientificrigour, the research team discussed applications of codes in an ongoing manner, reconciling differences in coding via negotiated consensus and checking the interpretations against other researchers and the data.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Relevant

Pleace, 2020

Bibliographic Reference	Pleace, Nicholas; Bretherton, Joanne; Health and care services for people sleeping rough: the views of people with lived experience; 2020; 23

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Focus groups were conducted in 4 areas in England, nominated by the Department of Health and Social Care.

Data collection and analysis	Four focus groups were conducted and each one lasted approximately one hour.
Recruitment strategy	Not reported
Study dates	July and August 2019
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=23 people with lived experience of sleeping rough
Participant characteristics	**Age range** 19 to 63 years **Gender** Female: 4/23 Male: 19/23 **Number of participants sleeping rough at the time of participation** 17/23
Results	<u>Homelessness services and access to health and care services</u> Homelessness services acted as a conduit to health and social care in all four areas. This is not a surprising finding as the core function of most daytime and emergency accommodation, as well as supported housing services, is to provide some form of case management, or at least act as a referral and information point for people needing assistance with accessing required care and support. In Site A, where there was not the same degree of development of specialist health services

	designed to work with people sleeping rough and the wider homeless population, this role appeared to be particularly important, with services acting as a referral point to mainstream NHS services. Knowledge of the presence of specialist health services in the other three areas was universal. However, the presence of these specialist services did not necessarily mean that people sleeping rough would make use of them in preference to mainstream NHS services. Experience of referral from homelessness services to the NHS and care services was not always positive. Sometimes a referral would receive no response, an issue with respect to mental health services which is explored in more depth below, or there could be a sense of being referred to one service after another, without necessarily getting the support, care or treatment needed from any of them. *"I think the most favourite word of services at the moment is, we'll refer you. You go to them and they say, 'We'll refer you to them.'"* [Quote: p.11] Flexibility in the mainstream NHS Respondents were using ordinary GP services, attending A&E and making use of other mainstream NHS services. In Site A, there was not really an alternative, mainstream NHS services were the ones available, but while specialist services were available elsewhere, this was not the route that people with experience of sleeping rough always took when seeking health and care. If certain visual cues were not present and someone reported having an address, the NHS reacted the same way as it would with anyone else. In essence, many people sleeping rough do not look like, or present themselves, in the way that mass and social media tends to present a 'homeless person'. When someone is not differentiated in terms of dress or manner or other signifiers, passing as an ordinary citizen might mean a better response, rather than being processed as a stereotypical 'homeless' person who might be assumed to be intoxicated, criminal or even dangerous because of mental health problems. Some of the answers given by the respondents showed this perceived risk of being identified as 'homeless'. A few of those using ordinary GP surgeries reporting that they had retained their doctor, by using the address they had possessed when they originally registered and subsequently lost A&E departments were quite often referred to as neutral spaces, in which the sheer volume meant that people tended to all be processed in a very similar way. There was not necessarily time to recognise someone might be 'homeless' and respond differently than to another patient, or these hospital departments just saw a lot of variety of need and simply had an operational ethos that meant equal treatment for all. Some respondents reported a sense that presentation was important, that how someone behaved in a given situation would influence the kind of support they received. People sleeping rough seeking to present themselves sympathetically, as 'service worthy' individuals, across a range of services. Experience was varied, however, with a few of the people with lived experience of sleeping rough and homelessness reporting that an ordinary GP had registered them even though they had reported themselves as being homeless. Barriers to mainstream NHS services Where registration with an ordinary GP was retained, physical distance and one other logistical challenge, having to have a phone/internet to make appointments, could be barriers to access. Where outpatient and other services involved homeless people travelling, homelessness services were reported as being able to offer assistance, paying for bus tickets and taxi

	fares, or sometimes using worker time to help people attend appointments. No issues were reported with respect to ambulance services, when they were called for people sleeping rough, the ambulances always came. A sense of stigma and associated problems with GP registration were reported by several focus group respondents. A few respondents were retaining registration with GPs although they were outside the practice boundary area or lacked a fixed address within the area. However, a GP telling someone to register elsewhere because they were now living outside their area was only reported in one instance. In a few cases, respondents felt that they had been treated differently because of their characteristics, but this appeared to be more associated with drug and alcohol use than with their position as someone sleeping rough. Access to dentistry was variable, those living in areas with specialist service provision could get access to treatment but finding an NHS dentist and then registering with that dentist could be problematic. "*On a bus, it's about 40 minutes, half an hour. No, no, from X, it's about 40 minutes from X, it's about an hour on a bus, X, from here, isn't it, but, first of all, I've got to ring up at eight o'clock in the morning to get an appointment. My phone got nicked; I've got no phone. How do I go about doing that?"* [Quote: p.14] *"…my GP was saying I've got to find another GP in [neighbouring borough], but I'm used to them because I've been with them 21 years, so I'm not going to leave them."* [Quote: p.15] Using specialist NHS services A few respondents reported that they did not wish to use specialist services, the reason being that there were other people sleeping rough and street-using populations there who were active drug users, while they were not. Where there was an established relationship with a GP in an ordinary surgery, a few respondents expressed a preference for maintaining that relationship, rather than changing to seeing a GP in a specialist homelessness service. Experience of treatment in specialist NHS services was reported in uniformly positive terms across the three groups in the sites where these services were present. Mental health services There was evidence from the four focus groups with people with lived experience of sleeping rough that mental health services were hard to access, uncoordinated with other services and were perceived by people sleeping rough as being under resourced.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes *(The aim or the importance of the research is not explicitly stated but can be inferred from the information provided.)*
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers have not justified research design. There is no discussion given in the study to deduce why the study method was chosen.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(There is no detail on how the participants were selected and no discussion around recruitment.)*
Data collection	Was the data collected in a way that addressed the research issue?	No *(There is some information provided about the setting for data collection and how the data were collected. No information is available for justification of method and no detail is given on how the focus groups were conducted. There is no discussion of data saturation.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The authors have not provided any details on whether they examined their own role, potential bias, or influence during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval was secured via the independent review processes for both health care and social care research at the University of York.)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	No *(There is no information given for the analysis process. The researchers have not critically examined their own roles, potential bias, and influence during the study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable *(There is some discussion about the contribution of this study to existing knowledge and the transferability and generalisability of results. There is no detail provided on new areas of research.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Relevant

Pleace, 2000

Bibliographic Reference	Pleace, Nicholas; Jones, Anwen; England, Jude; Access to general practice for people sleeping rough; 2000

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	Data were collected through interviews. Securing cooperation from GPs not working with people sleeping rough proved problematic and not all the planned interviews were conducted. The focus groups also proved difficult to organise in London.
Recruitment strategy	Not reported
Study dates	Not reported
Sources of funding	The Centre for Housing Policy- The University of York
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=112 people interviewed n=12 GPs n=7 health authority workers n=6 health workers n=19 homelessness workers n=4 representatives from the Royal College of General Practitioners, Health Action for Homeless People, and the Community Practitioners' and Health Visitors' Association Special Interest Group on Homelessness n=64 people sleeping rough

Participant characteristics	**Characteristics of people sleeping rough** **Age range** 18-24 years: 18/64 25-34 years: 20/64 35-44 years: 16/64 45-54 years: 5/64 55+ years: 5/64 **Gender** Male: 52/64 Female: 12/64
Results	<u>Accessing GPs: the views of general practitioners, health authorities and health professionals</u> Overall GPs and other health professionals felt that permanent registration was preferable for their patients for a number of reasons including continuity and quality of care, preventative health care and access to secondary care. Although permanent registration was generally favoured, there was sometimes confusion about who was entitled to it. Some GPs who did not work regularly with homeless people believed that patients had to have a permanent address to be permanently registered for example, although other GPs suspected that this sometimes was used as an excuse not to permanently register people sleeping rough. There were other problems for GPs with regard to permanent registration related to financial arrangements. Some doctors believed that they would not get paid for registering patients without an address, others worried that they would leave the area or not attend appointments and affect their targets, for example for immunisation. The reason given most often for some GPs' reluctance to register patients who were sleeping rough was that they feared they would be drug users and would abuse prescriptions. GPs were also concerned that they would become a target for other drug users if they were known to prescribe Valium, benzodiazepines or methadone. Without an accurate record of the patient's history GPs found it difficult to discern genuine cases and as a consequence some doctors would never prescribe drugs which might be misused. GPs who worked regularly with people who were sleeping rough thought that they could sometimes be difficult, but no more so than many other patients. Often these doctors worked in practices in socially and economically deprived areas and were very concerned that all their patients were treated equally. GPs who worked with people sleeping rough had felt threatened 'once or twice' by homeless patients, usually drug users, who

	wanted treatment or a service which the doctor thought inappropriate. This behaviour was attributed to the addiction or to mental health problems or the patient's poor communication skills. Another concern which GPs repeatedly voiced was that they did not possess the necessary skills or knowledge to deal with patients with complicated health problems, addictions and mental health problems. Many of the GPs who worked with people sleeping rough had 'inherited' the work from a predecessor and learned from experience, none said that they had any training which related to homelessness. *"We keep sending out information to GPs in the area and keep on trying to make it very clear that you do not need an address, the message has not got across. You absolutely do not need an address to register, it can be care of wherever. I think it may be 'We don't want to do it' and 'this is why we don't do it."* GP, Lambeth [Quote: p.31] *"I don't think there's anything different, just more, and frequently multiple problems in one person. Because there may have not been good access to health care previously, quite a lot of things may have become symptomatic and quite a lot of things may require attention at once, so you may have to deal with quite a lot of multiple health problems, many inadequately assessed and treated previously."* GP, Lambeth. [Quote: p.32] *"I used to go out with an outreach team and I used to feel really awkward as I didn't know whether I was doing a good job, a bad job, there is no measure, no follow up."* GP, Westminster "*I feel very vulnerable in the sense that I don't feel able to follow up a problem that I've unearthed. OK the responsibility is partly with the patients to chase up the result, but legally as well there is also an onus on the doctor to chase up the patient.*" GP, Westminster. [Quote: p.34] Accessing GPs: the views of people sleeping rough and project workers Some project workers reported that they always used the Health Authority's allocation procedure, this was not something they liked having to do and people sleeping rough did not want a doctor who they felt had been forced to register them. In some cases, people sleeping rough had been told that they could not register without an address, many others reported being told that the list was full. In other cases people sleeping rough were able to register with GPs but only on a temporary basis, which could in fact, last for many years. A number of respondents said that they invented an address in order to register with a doctor, others remained permanently registered with their family GP or their previous doctor. In some cases the practice was in the locality but, as earlier research has found, it was not uncommon for people to have a GP in another town or city. Sometimes this meant that people had not seen a GP for years but a few people travelled to see their doctor. This was inconvenient and expensive and meant that they were not able to receive a full service, but some people preferred to see their own GP. A few respondents said that they 'saw doctors all over' and were registered temporarily in a number of practices or saw different doctors in various projects. This was usually for convenience and to ensure that they would be able to access a doctor. Most people who needed medical attention when sleeping rough said that they had felt very embarrassed because they were dirty and unkempt. They were conscious of the reaction of doctors, receptionists, nurses and of other patients in the waiting room. Those who were able to access day centres would have a shower and change their clothes before visiting the doctor, even if this meant delaying treatment for a few days. Many homeless people and project workers complained that doctors and other health professionals had been rude, unsympathetic or even abusive because they were homeless. Some people thought that health professionals assumed that all people sleeping rough had alcohol and drug addictions and that this affected attitudes towards them. In some cases people felt that they did not deserve treatment and that health professionals would blame the individual for his or her poor health. Some people

sleeping rough felt that they would not receive sympathetic treatment, in many cases because of past experience, and this made them reluctant to approach health services unless they had to.

Quality of care

People who were sleeping rough did not receive the same quality of care as other patients. There were a number of reasons for this including the use of temporary rather than permanent registration. Another major problem was trying to ensure continuity of care, this was not only an issue for patients but also for doctors who felt deskilled or demoralised when they could not provide a full service for their patients. A particular problem in providing continuity of care for GPs was the difficulty of trying to work without detailed medical records, which made all aspects of diagnosis and treatment more difficult. This was often coupled with a patient who perhaps had poor communication skills or who had little recollection of what other doctors had said. There were also many difficulties around compliance and appointment keeping, especially when people had to wait weeks or months for an appointment. *"Just because you are homeless, it doesn't make you any more expensive to treat than anybody else, I mean anybody who gets a lymphoma or anybody who has MS or something. RCGP representative. Temporary registration means funding for three months. Many people have acute health needs, often due to lifestyle, they are going to get immediate treatment but other services, check ups, smears etc just won't kick in with temporary registration. Dr X. registers all his patients, but that means that people have come in and used up loads of resources and then gone again and he doesn't get any payment for them, so that is a disincentive."* Health Authority representative "*We don't like GPs registering anyone temporarily because we don't feel that they're actually getting the proper care, there's not the same requirement on the GP to immunise, do cervical smears..."* GP Contracts Manager [Quotes: p.37]

Access to other health services

A common complaint was the length of waiting times in A&E, but this was generally seen as a simple fact of life in a busy A&E department rather than as something to do with homelessness. The main concerns that people sleeping rough and project workers had were that sometimes the receptionists, doctors or nurses had negative attitudes towards homeless people, particularly if they had a drug or alcohol related problem. There was also a feeling that A&E would sometimes 'patch up' someone sleeping rough and then discharge them without much thought about their continuing need for care.

Mainstream or targeted services

Many homeless people lead chaotic lives and often lack the necessary skills or motivation to seek health care and almost everyone felt that on site services and outreach teams had an essential role in ensuring that people took an interest in their health and in providing a service which was more responsive to the needs of the most marginalised rough sleepers. Another commonly held view among all respondents was that mainstream services should be more flexible and responsive to the needs of people who were sleeping rough, in some cases this benefited other patients, doctors and surgery staff. Some people who had used targeted services, usually in London, thought the doctors there were more sympathetic and understanding than ordinary GPs and many said they preferred to use these services. In the other areas respondents felt

	that they should be able to register at an ordinary general practice and that they should be treated the same as any other patient. Although the majority of people who had accessed GPs in ordinary practices complained either of feeling embarrassed, or about their treatment, some interviewees were very happy with the treatment they received. It was often easier for people to register with a general practice when they had an advocate.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on any potential biases arising throughout the study.)*

Critical appraisal

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report on how ethical issues were considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The researchers do not report any details on the how the data was analysed.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable *(The researchers discuss the findings of this study within the context of existing literature. The researchers identify new areas where research or change in policy is necessary. However, the researchers do not discuss whether the findings from this study can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Purkey, 2019

Bibliographic Reference	Purkey, Eva; MacKenzie, Meredith; Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care; International Journal for Equity in Health; 2019; vol. 18 (no. 1); N.PAG-N.PAG

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting	Focus groups and interviews with homeless people were conducted at Street Health Centre in Kingston.
Data collection and analysis	**Health providers** In-person or telephone semi-structured interviews were conducted using an interview guide. Interviews lasted approximately 60 minutes. **Homeless people** Six focus groups were held with 2 to 7 participants, along with 4 in-depth interviews. The sessions lasted between 2 and 3 hours. Transcripts and survey responses were reviewed, analysed and coded. The analysis was informed by directed content analysis.
Recruitment strategy	**Service providers** Community agencies identified key informants who had been employed by their organisation for at least 1 year and had provided front line services. **Homeless people** Persons with experience of homelessness were recruited from agencies mandated to provide services to those who are vulnerably housed. Snowball sampling was used to recruit further participants.
Study dates	January and August 2018
Sources of funding	The South East Local Health Integration Network (SELHIN) in Ontario, Canada.
Inclusion criteria	Homeless participants

	- Those with a past or present history of homelessness
Exclusion criteria	Not reported
Sample size	N=41 n=10 health service providers n=31 homeless people
Participant characteristics	Not reported
Results	Experience of stigma and shame when interfacing with the healthcare system The experiences of stigma among PWLE were overwhelming. In some cases, the stigma was so painful that it superseded any health complaints, previous trauma, or other concerns a patient might have. Stigma was by far most pronounced in the context of current or documented history of substance use, even if substance was remote, compounding the sense of shame and stereotyping. PWLE were often isolated from support networks when in care because their support networks, coming from the same social contexts, were equally stigmatised and occasionally overtly excluded by healthcare providers. PWLE lacked trust towards healthcare providers due to past experiences which had significant impacts on their care seeking behaviour and likelihood of following through on provider recommendations. The presence of an advocate from outside of their social network (eg. a social services worker or pastoral care worker), had a significant impact on the care patients received. While this was more likely to enable them to receive care in a respectful and appropriate manner, it further highlighted the stigma they experienced when their advocate was not present. Lack of accountability of the healthcare system towards equity-seeking populations Participants felt that the healthcare system was not accountable to the people it served. Participants articulated the responsibility of healthcare providers to provide excellent, empathic care to everyone who presents, regardless of their socioeconomic status, substance use history, or life circumstances. Healthcare providers were felt to have a lack of understanding of the impact of social determinants of health, ongoing trauma and past adversity on people's health and healthcare presentations. Examples were given of clients asked to leave the hospital because of the way they dressed or smelled. Participants felt that healthcare providers lacked knowledge around harm reduction, around the root causes of substance use and adversity, and that they appeared to lack empathic or compassionate curiosity towards patients and the difficulties they encountered. Respondents wanted to see medical practitioners whose priority were their patients rather

	than status, job security, or finances. They also felt that having peers with lived experience of substance use, homelessness, or other equity-related challenges operating within the healthcare system would help make care more accountable and acceptable for them and others. Inflexibility of the system HSSPs described a healthcare system that was not tailored to meet the needs of their clients. The system was described as designed by middle class people for middle class clients, expecting conformity to the system rather than tailoring the system to the differing needs, desires and challenges of patients. Examples included the requirement that housing be obtained before treatment could be initiated when housing was not an option; a lack of flexibility for patients who might show up late or miss appointments; and a lack of openness to a harm reduction approach that might allow patients to receive a tailored form of treatment in the context of substance use rather than being dismissed out of hand. Positive experiences healthcare experiences where providers upheld dignity, autonomy and choice for patients, where they provided flexible, non-judgemental services in spaces where clients felt welcomed. Participants used terms such as “trust” and “compassionate” to describe these positive experiences of care. “*She’s a nurse here yes. I adore her. I adore her. I respect her and I trust her and she’s the sweetest girl that. I’ve ever had – the sweetest medical care person I’ve ever had take care of me. She’s just amazing […] Yeah. like she’s very very thorough and she’s very compassionate. I just, oh my heart’s with her, I love her. Yeah.”* (FG9BRM1) *“They are really like, hey we like the atmosphere of this place. We like that people here treat us really nice and we’re people. We feel loved. There are paramedics here who are, you know, assisting us. Um we really feel safe in this space and like there’s no judgement and we want to keep coming back here.”* (KI9) [Quotes: p.5]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethics approval was obtained through Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Transcripts and survey responses were reviewed, analysed and coded as one data set by 2 independent researchers. Themes were then reviewed collaboratively by the 2 researchers to ensure consensus.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge*

Critical appraisal

Section	Question	Answer
		and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Rae, 2015

Bibliographic Reference	Rae, Bernadette Emma; Rees, Sharon; The perceptions of homeless people regarding their healthcare needs and experiences of receiving health care; Journal of Advanced Nursing (John Wiley & Sons, Inc.); 2015; vol. 71 (no. 9); 2096-2107

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	UK
Setting	Not reported

Data collection and analysis	Open ended questions were used in one-to-one semi-structured interviews, with prompt questions to explore what had been said or to encourage expansion. All the audio-recorded interviews were downloaded and transcribed verbatim. The transcribed interviews were uploaded into NVivo10 to organise the significant statements into meaningful clusters. Colaizzi's method for data analysis was used.
Recruitment strategy	The convenience sample was recruited from two local homeless services; one hostel for men and one non-residential facility for male and female homeless, providing drug and alcohol rehabilitation and structured programmes to return clients to domiciled status.
Study dates	September 2012 to May 2013
Sources of funding	Any expenses incurred in the process of this research were funded solely by the author (Bernadette Rae). No funding was received by any agencies.
Inclusion criteria	• Homeless defined as living on the street; living in sheltered, temporary or hostel accommodation or sofa-surfing without knowledge of when or if permanent housing will be available. • Willingness to participate and have their voices recorded. • Ability to understand and speak English. • Not previously known to the researcher. • 18 years or older. • Free from uncontrolled psychotic illness and not intoxicated during the interview.
Exclusion criteria	Not reported
Sample size	N=14 homeless people
Participant characteristics	**Gender** Male: 12/14 Female: 2/14

	Age range Age range (years): 29 to 53 years **Ethnicity** Irish: 1/14 Mixed British: 2/14 White British: 5/14 Asian: 2/14 Afro-Caribbean: 4/14 **Current accommodation** Street: 2/14 Shelter: 0/14 Temporary accommodation: 3/14 Hostel: 9/14 **Previously street-homeless**: 11/14
Results	<u>Expressed health need- priorities</u> Throughout the interviews it was explicit that the priorities of the homeless in their daily life altered the importance they attached to their health and well-being and therefore their healthcare seeking behaviour. When they had fewest resources (shelter, money, food) they frequently neglected themselves until crisis point. Their reasons for not prioritising health are multiple and are not just about being homeless; it is what effect that has, as well what has preceded the homelessness. One man commented on the fact that getting a roof after being street-homeless does not suddenly change the psychology or habits of the person overnight. <u>Healthcare experiences- access to healthcare</u>

Six of the participants said they had been obliged to move to an area they didn’t know, which meant losing their own GP and then having difficulty in registering elsewhere. Several participants had been refused registration with a practice because they had no fixed abode and none had been offered the surgery address as a ‘care of’ address (Crisis 2002). Some were able to use a day centre address as a ‘care of’ address and day centres know which GP practices will welcome homeless patients. None of the participants reported having zero healthcare encounters, needs or not seeking health care.

Healthcare experiences- positive experiences

Flexibility from the GP was valued and helped to keep patient engagement. This was not about absolving the patient from responsibility, but understanding their circumstances *"And they knew, right, because I was sleeping rough, I ain’t going to get there at a certain time. I turn up and they say ‘Yes, alright fair enough, sit down, you might be an hour."* (M49) [Quote: p.2101]

Healthcare experiences- negative experiences

In this study being given technically correct but unrealistic advice made the participants feel unwelcome and uncared for. Five participants mentioned that they had been released from prison with no fixed abode. The responses to being asked how they feel about seeking medical help now were mixed. Some who currently had a GP and had felt they had received good care didn’t foresee any problems asking for healthcare. Those who felt they had been treated badly and one was currently registered with a GP, said they did not trust they would be listened to and preferred to go to A&E if they felt they really had to. Poor discharge planning from hospital resulted in substandard care and highlights the lack of communication between services. Two participants mentioned that they had been given the details of night shelters by police while they were on the street, but none had been given such details in A&E.

Attitudes

Across the interviews participants talked about how they felt about themselves and their situation and their values. The sense of responsibility was an unlooked for response but clearly showed that there is a population in great need of health and social care that can respond to positive regard, being listened to and appropriate care. Not being listened to or treated as an individual also blocks engagement.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study was approved by a university Ethics Committee.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The first author conducted data analysis by coding data from transcripts and sorting into themes following phenomenological analysis.)*
Findings	Is there a clear statement of findings?	Yes

Critical appraisal

Section	Question	Answer
Research value	How valuable is the research?	The research has some value *(The researchers do not discuss whether the findings from this study can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Ramsay, 2019

Bibliographic Reference	Ramsay, Natalie; Hossain, Rahat; Moore, Mo; Milo, Michael; Brown, Allison; Health Care While Homeless: Barriers, Facilitators, and the Lived Experiences of Homeless Individuals Accessing Health Care in a Canadian Regional Municipality; Qualitative Health Research; 2019; vol. 29 (no. 13); 1839-1849

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada

Setting	Interviews were held on-site at familiar environments including shelters and social service organisations. Interviews were held in private rooms for confidentiality; however, shelter staff were present in adjacent rooms for support if needed.
Data collection and analysis	Face-to-face, semi-structured interviews were conducted following an interview guide. Interviews ranged from 15 to 90 minutes, were audio recorded, and transcribed verbatim. Inductive thematic analysis was used to analyse the data.
Recruitment strategy	Purposeful sampling strategies were used to identify participants for this study, including criterion and maximum variation sampling.
Study dates	Not reported
Sources of funding	This work was supported by the Niagara Community Foundation and McMaster University, Michael G. DeGroote School of Medicine—Niagara Regional Campus
Inclusion criteria	Participants who: • self-identified as experiencing homelessness • were aged 18 years or older • have had an interaction with a health care provider within the health care system during the time they were experiencing homelessness
Exclusion criteria	Participants who: • were younger than 18 years of age • did not identify as an individual struggling with homelessness, • did not have a health care interaction during the time they were experiencing homelessness, • only had interactions within the health care system which occurred 5 or more years prior • were unable to provide informed consent.
Sample size	N=16 homeless people

Participant characteristics	**Gender** Male: 13/16 Female: 3/16 **Age** Mean age: 42.9 years Age range: 18 to 65 years
Results	Affordability Healthcare costs not covered by provincial health insurance was a significant barrier. Challenges finding a family physician Family physicians unable to accept more patients into their practice was a barrier to accessing healthcare. This was made harder if substance use problems were disclosed. Inadequacy of the psychiatric model of care The current model of psychiatric care was identified as an issue leading to isolation and avoidance of the health care system. Current procedures and protocols used by the health care system when hospitalising those with psychiatric conditions, such as isolation, mandatory assessment, and the imposition of curfews on hospital passes, posed a significant barrier to accessing treatment. Participants also found medications to be inadequate, with difficulty tolerating side effects, and questioned the diagnoses that they had received. Patients thought providers only wanted to prescribe medication and patients preferred non pharmacological treatments. Inappropriate management Multiple issues were reported with regard to discharge from hospital for individuals struggling with homelessness. Participants reported being discharged without information regarding community supports or programs, and being lost to follow-up despite plans for care as outpatients. Mental health follow-up and transitioning between providers was also found to present a barrier to continuity of care.

Loss/lack of trust in health care providers and health care system

Negative experiences among participants, their friends, and acquaintances, contributed to a distrust of the health care system alongside the perception that health care providers are only interested in their own personal financial gain. *"I think that some doctors can be pretty ignorant. They're just more interested in getting you out of there instead actually taking the time enough to actually see if there's something actually wrong . . . if you've got an issue they're supposed to look into it, not just take the cash, see you later. I've seen that."* [Quote: p.1844]

Poor therapeutic relationships

Participants described experiences of mistreatment and a failure to provide appropriate and patient-centred care by health care providers. When participants sought health care, they felt as though providers were dismissive of their issues, including those related to mental health, and were ineffective at listening to patients' concerns and experiences. To participants, the therapeutic relationship was eroded when they felt dismissed or there was a lack of communication and collaborative decision-making.

Systemic issues

A lack of health care resources, manifest as expressions of frustration with emergency department wait times and the paucity of accessible mental health care services. Participants perceived that this lack of resources negatively impacted their ability to access health care.

Transportation and accessibility

Lack of support for transportation in the region was another significant barrier for individuals experiencing homelessness. Being unable to attend appointments or travel to laboratories and imaging facilities significantly impacted their ability to access care. This appears to have curtailed their continuity of care, as this transient population may not always be close to their usual sources of care.

Understanding and empathy of homelessness

Participants endorsed the feeling that physician prejudice and lack of empathy toward their situation alienated them from seeking care. Participants perceived that judgmental behaviours and attitudes from physicians toward individuals experiencing homelessness directly led to the denial of care. "*Some of the guys may not say too much because they got pushed in the system, knocked down and everything else and now made them feel like [curse word] [. . .] we're all treated like a piece of garbage. And that's [the problem] of being homeless [. . .] I am beginning to think it has a lot to do where I lived too, being homeless and stuff, "Why should we give a [curse word] about him? He's only going to go out and screw up again anyways . . ." they've got to trust* *somebody and they are not very trusting because they've been kicked around and put down so much, finger pointed at*." [Quote: p.1845]

Accessibility of services

The centralisation of services, including health care providers, laboratory, and imaging services was seen as a facilitator in accessing healthcare. "*Yeah. Usually I'll go see the doctor, from there he gives me the prescription. I go downstairs and everything's right in the same building. It's fast.*" [Quote: p.1845]

Community health care outreach

Organisations and outreach programs which provide mobile health care support greatly improved access and the experience of healthcare. Initiatives such as the provision of immunisations at shelters, nursing outreach visits, and harm reduction strategies were cited by participants as greatly improving their health care. *"They actually have somebody who comes here every third Friday, I believe, who does that. They'll come, and they'll give you your shots and make sure you're up to health and all that [. . .] It was good, because the person came here, and they explained why they're here and what they're doing. Literally, as they went along, they showed me what they were doing and whatever."* [Quote: p.1845]

Positive relationships

Although negative past experiences with health care services presented a barrier, positive experiences and relationships were very beneficial for promoting health care utilisation. Participants stated that effective communication skills, empathetic listening, and no perceived judgment from physicians, especially primary care physicians, provided continuous support and improved their overall health care experiences.

Shelter coordinating health care

Social and health care agencies in the community were shown to be an invaluable asset to accessing health care. Organisations familiar with health care and community resources and supports were found to help facilitate access and improved health care experiences for this population.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the Hamilton Integrated Research Ethics Board at McMaster University (HIREB #1267).)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Each transcript was reviewed by a member of the research team. Inductive thematic analysis was used to analyse the interview data. Four investigators independently conducted line-by-line coding, describing the data using initial codes. The research team*

Critical appraisal

Section	Question	Answer
		then, through consensus, developed a coding scheme. Any disagreements in coding scheme were addressed through group discussions.)
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Reid, 1999

Bibliographic Reference	Reid, P.; Klee, H.; Young homeless people and service provision; Health & Social Care in the Community; 1999; vol. 7 (no. 1); 17-24

Study Characteristics

Study type	General qualitative inquiry

	Mixed methods study design. Qualitative component very small.
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	A semi-structured interview schedule was employed with a mixture of closed and open questions. All interviews were tape recorded and transcribed to provide additional qualitative data.
Recruitment strategy	A non-random sampling procedure ensured adequate representation of homeless individuals. Interviewees were contacted through homelessness agencies or by networking from key informants.
Study dates	Not reported
Sources of funding	The Economic and Social Research Council
Inclusion criteria	• Participants aged 14-25 years • Participants using some type of illicit drug on average on 2 or more days a week
Exclusion criteria	Not reported
Sample size	N=200 homeless youth
Participant characteristics	**Gender** Male: 143/200 Female: 57/200
Results	<u>Health service- Physical health</u>

	Often, the GP was based in a different part of Greater Manchester to that which the homeless person was currently living. This was sometimes an area they were unwilling to revisit because of family problems that had led to their homelessness, or one that was too far for them to travel on a limited income. Health service- Psychological health The transitory nature of the homeless lifestyle meant that some were unaware of the location of local health care services.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Can't tell *(The researchers employed a mixed-methods design and the qualitative component was small.)*
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not report details on how they decided which method to use.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on any potential biases arising during this study.)*

Critical appraisal

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report how ethical issues have been considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The researchers do not provide details on how the data analysis was conducted.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is not valuable *(The researchers do not report on the contribution this study makes to existing knowledge, new areas where research is necessary, or the generalisability of findings from this study.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Relevant

Salem, 2015

Bibliographic Reference	Salem, B. E.; Ma-Pham, J.; Understanding Health Needs and Perspectives of Middle-Aged and Older Women Experiencing Homelessness; Public Health Nursing; 2015; vol. 32 (no. 6); 634-644

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	US
Setting	Focus groups took place in a private area of the homeless facility.
Data collection and analysis	Each focus group lasted around an hour. In total, 4 focus groups were conducted followed by a survey. The focus groups were audio-recorded, transcribed, and content analysis was conducted.
Recruitment strategy	Not reported
Study dates	May to June 2013
Sources of funding	The National Institute of Health (NIH)/Nursing Research (NINR) T32 NR007077
Inclusion criteria	• ≥40 years of age • Homeless • Pre-frail or frail as determined by two structured instruments* • Free of evidence of acute, psychotic hallucinations • English speaking *the Tilburg Frailty Instrument (TFI) and the SHARE-FI
Exclusion criteria	Not reported
Sample size	N=20 homeless women

Participant characteristics	**Age** Mean age (SD): 53.45 years (5.2) Age range: 43 to 62 years
Results	Health and healthcare needs Homeless women described several areas of need which included vision, dental care and managing pain. Two women were concerned that they had not received information about Hepatitis C virus. Another woman shared the need for practitioners to take certain types of insurance. Length of time getting to the right person Homeless women described wait times and getting to the right person. One homeless woman explained the challenges of being referred. "*Getting to the people that you need to see right away is key and it seems that you have to go through a big rigmarole to get to them."* Participant 13 [Quote: p.6] Knowledge of access, paperwork and provider access Homeless women shared that they felt that they do not get proper medical attention and that they lacked paperwork to have access to health insurance resources. "*I believe you need a birth certificate, ID. I don't have all that."* Participant 19 [Quote: p.7] Being fearful of having certain tests done or medical procedures Homeless women also shared that they were fearful of having certain tests done or medical procedures. Past experience of providers One woman described healthcare providers attitude towards her when they found out she was homeless. Another homeless woman shared that she perceived that the healthcare provider had an attitude and wouldn't be of assistance to her.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers do not provide any details on how the participants were selected.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study was approved by the University of California, Los Angeles Human Subjects Protection Committee.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Audio files were transcribed by an independent transcriptionist, and content analysis was conducted with transcripts initially coded line by line. The PI and another senior researcher met and reviewed the codes, categories, subcategories, themes and*

Critical appraisal

Section	Question	Answer
		diagrams, exploring the data and discussing the findings. The PI also reviewed the findings with the partner and stakeholder at the community-based site.)
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Relevant

Shulman, 2018

Bibliographic Reference	Shulman, C.; Hudson, B. F.; Low, J.; Hewett, N.; Daley, J.; Kennedy, P.; Davis, S.; Brophy, N.; Howard, D.; Vivat, B.; Stone, P.; End-of-life care for homeless people: A qualitative analysis exploring the challenges to access and provision of palliative care; Palliative Medicine; 2018; vol. 32 (no. 1); 36-45

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	UK
Setting	Data collection with professionals was conducted at their place of work. Data collection with currently homeless people occurred at the hostels or day centres they were recruited from, while data collection with formerly homeless people took place at the offices of a charity with which all were familiar.
Data collection and analysis	Focus groups lasted for 1 h with homeless people, health- and social-care providers and 3 h for all other groups. Data collection was audio recorded and transcribed verbatim. Thematic analysis was used to identify, analyse and report themes from the data.
Recruitment strategy	Participants were recruited using opportunistic sampling across three London boroughs, selected for their high numbers of both homeless people and homelessness services. Formerly homeless people felt it would be most appropriate for hostel and day centre staff to identify and invite potential participants, rather than using posters to advertise the research.
Study dates	October 2015 to October 2016
Sources of funding	This research was funded by a grant from The Oak Foundation (OCAY-14-574).The researchers were supported by Marie Curie (grant numbers: 509537; 531645 and 531477). Initial seed funding and support was provided by Coordinate My Care to facilitate in the development of this research.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=127 n=99 healthcare workers n=28 homeless people
Participant characteristics	**Gender** Male: n=68

	Female: n=59
Results	Challenges in the provision of palliative care for homeless people in London Challenges included supporting people with complex trauma and substance misuse in mainstream services, uncertainty around prognosis and complexity associated with homelessness. Gaps and fragmentation in existing systems meant there was often very little choice regarding place of care for homeless people. Complex behaviours in mainstream health and social services Health and social services have difficulty supporting the complicated requirements of some homeless people due to their often chaotic lifestyles and addictions. During hospital admissions, it was common for addiction-driven behaviours to cause homeless people to frequently leave the ward to obtain substances or alcohol. This made it difficult for already stretched hospital staff to engage with the person and deliver the care required. Furthermore, homeless people were avoidant of many mainstream facilities, which seemed alien to them. A preference to remain in the familiar environment of the hostel was described. The inexperience of many professionals alongside the difficulties of working with people with challenging behaviours in mainstream settings was sometimes translated into a perceived prejudice and lack of compassion towards homeless people. This complexity negatively affected the way that homeless people were able to access services, meaning assessments and the delivery of services were challenged. "*I think there's a stigma … and professionals see it as a choice, you choose to pick the can up and put it to your mouth, rather than you being mentally and physically sick… So they just think 'You're wasting our time, you didn't have to pick up that drink', but there's so much more behind it than just picking up the drink.*" (Formerly homeless person – Borough B) "*Social services say 'they're still drinking, so we're not going to give them a package of care'. Even if they're drinking, they still need to get in and out of a bath, or use a commode. Their drinking doesn't mean they're not entitled to services.*" (Drug and alcohol worker – Borough B) [Quote: p.41] Gaps in existing systems Homeless people often present with high support needs with advanced ill health and/or cognitive impairment at a young age (young olds). The lack of facilities providing palliative care, including respite and a place to die in comfort, were the most significant gaps described. Homeless people do not fit the profile of the majority of care home patients where one of the admission criteria is usually to be over 65 years of age. Behaviours associated with substance misuse also pose a challenge for hospices and care homes, where many residents are frail and vulnerable. Thus, access to these services is uncommon for this population. Frustration was expressed regarding the fragmentation and lack of joint approach between health, housing and social services which prevented a person-centred approach to care. Assessments by social services only took the individual's current situation into account. They were often conducted in hospitals, following detox from alcohol (or stabilisation on methadone), were often inaccurate and did not represent that person's needs back in the community. When support from social services was obtained, it was often inadequate. Concerns from hostel staff were often not

	listened to by professionals and a lack of continuity in carers meant trust did not develop between the carer and the homeless person. Where the focus of support and interactions between professionals and homeless individuals changed from an aim to reduce or stop substances, to an improvement in quality of life, care was person-centred and compassionate. Storing and administering medication within a hostel was also problematic. Hostel staff are not trained or licensed to administer medication. In an environment in which many residents have substance misuse issues, the safe storage of medications such as opiates is an issue. Furthermore, some participants felt dying in a hostel may be an isolated, unpleasant experience that could be disturbing for other residents. The burdens of caring for dying homeless people fall on hostel staff, despite often having no medical training or experience. Many participants emphasised that hostels are not, and perhaps should not become care homes. While hostel staff did all they could to support dying residents, this was a very difficult position for them, emotionally and logistically. With the focus of palliative care being quality of life, for some, the benefits of enabling dying persons to remain in hostels outweighed the challenges. Arguments for people remaining in the hostel centred around choice and compassion. Some hostel residents perceived the hostel as ‘home’. As such, if a desire to remain there until death was expressed, some felt this should be honoured. While hospitals may better serve the physical needs of dying homeless people, some felt hostels were best placed to meet their emotional needs. Furthermore, hospitals were often thought of as ‘places of death’ by homeless people and were thus avoided. Uncertainty and complexity For illnesses such as cancer, with more predictable trajectories, professionals reported more success in accessing services including hospice support. However, even for homeless cancer patients who were not misusing substances, placement within a care home or hospice remained challenging, due to young age and previous experiences that hospices had with supporting homeless people Advance Care Planning [or discussions regarding goals of care] rarely occurred with our group of homeless individuals. In addition to a lack of options to offer, professionals often lacked confidence in having such conversations and expressed concerns regarding the fragility and vulnerability of many homeless people. Many homeless people are using substances to block out past trauma, so the potential of negatively impacting on their emotional well-being by discussing future health and options was voiced as a major concern. Other professionals feared discussions about future care needs and preferences may represent removal of hope and be interpreted as staff ‘giving up on them’. Transient relationships were often cited by medical staff as conversation barriers. Avoidance of discussing future preferences was echoed by homeless people. The combination of apprehension from professionals and avoidance from homeless people challenged the exploration of future wishes and preferences. "*The last time I tried to get a [homeless] patient a bed at a hospice, they [the hospice] interrogated me. They wanted a very clear prognosis and it was because the woman I had sent there before, who we thought was dying … was there for months because she had nowhere else to go.*" (Hospital palliative care nurse specialist – Borough B) [Quote: p.42] "*A lot of people are frightened to think about it. Most people won’t talk about it, they won’t entertain talking about it. They see it as so far away, you know? Why bother now, let’s wait until nearer the time.*" (Hostel resident – Borough C) [Quote p.43]

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethical approval was obtained from the University College London research ethics committee (reference no.6927/001).)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis was used to identify, analyse and report themes from the data. Line-by-line coding was undertaken by one author, and consensus was achieved through discussion by the same author and another author. Higher level candidate themes and sub-themes were developed and discussed with a wider group of healthcare professionals, researchers and formerly homeless people.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

St. Mungos, 2009

Bibliographic Reference	St. Mungos; Happiness Matters: Homeless people's views about breaking the link between homelessness and mental ill health; 2009

Study Characteristics

Study type	General qualitative inquiry

	Mixed methods
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	Individual, face-to-face interviews were undertaken with four groups of homeless people at different stages of recovery and with a range of diagnoses, known and unknown. The interviews were held in private, on a one-to-one basis with the interviewee and the peer researcher, who noted the answers which were then passed to the report author.
Recruitment strategy	Not reported
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=103 homeless people
Participant characteristics	**Gender** Male: 72/103 Female: 31/103 **Type of accommodation** Street: 9/103 Shelter: 17/103

	Hostel: 51/103 Mental health/complex needs project: 18/103 Living independently or semi-independently having experienced mental health problems: 8/103
Results	Mental health services for homeless people Most participants had had negative experiences of mental healthcare and discussed that they felt no one would listen to their problem and only hand out medication. Interviewees were asked if they were getting enough support for their mental health needs. Opinion was split exactly down the middle – 50% felt they were and 50% said not. Barriers to access A frequent theme (mentioned by 14%) was an increase in either the quantity or level of services available – ‘more trained staff', 'more funding’, ‘more one-to-one services’, ‘would like to meet with him more often’. Another very prominent theme was better communication with professionals and staff. A strikingly common theme was, once again, the lack of accessible, available, good quality services offering a personalised, positive response many of our interviewees said they wanted a walk-in style of service and why, in general, open access services work better. Rough sleepers The problem of dual diagnosis seems to be even worse for rough sleepers, who typically find it even more difficult to keep appointments and are frequently described as especially hard to engage. All the outreach workers we interviewed mentioned how difficult it is to access services for their clients with drink/drug use and mental health problems. ‘Listen to people rather than empty promises’ Homeless people want to be listened to. ‘Listening’ also came up as a significant theme when interviewees were asked what they would change or improve about mental health services. "*My doctor doesn’t listen but if I had someone who would listen I would be comfortable" "Doctor needed to interact more and listen more. Made me feel frustrated and angry" "More funding and more professionals that have the understanding and the TIME to listen" "[Best bit of support was] being really listened to" "Need someone to talk to like a counsellor. No faith in my doctor" "Get to the roots of people’s problems"* [Quotes: p.10] Getting to the root of people's problems Interviewees made repeated references to what can be described as a ‘holistic’ approach to meeting homeless people’s needs.That is, they wanted to be seen as a whole person, not just a set of discrete needs to be addressed separately *"I do best in holistic services that consider the whole person, that can see how my practical issues relate to my deeper emotional/*

	psychological issues and will work with both at once" "Get to the roots of people's problems. Don't just put an Elastoplast on a gaping wound. Early stuff can affect people through their lives." [Quotes: p.26] Person-centred care These interviewees comments show that for these people, not infrequently, person-centred care was not on offer. Training for frontline housing/homelessness staff Many of our interviewees mentioned staff training as a key area for improvement of services, and some mentioned how much they valued the support from former homeless people who have been trained as support workers (in fact one of the interviewees was a trainee project worker himself). Complex needs involving drink or drugs and mental health problems Many of our interviewees spoke about encounters with services where they felt their real needs were not addressed, and even if they didn't actually say so, they very probably did not go back.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not report how they decided which method to use.)*

Critical appraisal		
Section	**Question**	**Answer**
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(The researchers do not report how the participants were selected for this study. However, since the participants were selected from services aimed towards the target population, it is clear that an appropriate population was recruited.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on any potential biases arising during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report on details of how ethical issues were considered in this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The authors do not provide any details on how data was analysed or who conducted the data analysis in this study.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the findings from this study in relation to current practice/policy. The researchers do not identify news areas where research is necessary, nor do they discuss the generalisability of the results to other populations.)*

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Relevant

Stajduhar, 2019

Bibliographic Reference	Stajduhar, K. I.; Mollison, A.; Giesbrecht, M.; McNeil, R.; Pauly, B.; Reimer-Kirkham, S.; Dosani, N.; Wallace, B.; Showler, G.; Meagher, C.; Kvakic, K.; Gleave, D.; Teal, T.; Rose, C.; Showler, C.; Rounds, K.; "Just too busy living in the moment and surviving": barriers to accessing health care for structurally vulnerable populations at end-of-life; BMC palliative care; 2019; vol. 18 (no. 1); 11

Study Characteristics

Study type	Ethnographic
Country/ies where study was carried out	Canada

Setting	Observation occurred in homes, shelters, transitional housing units, community-based service centres, on the street, and at healthcare appointments
Data collection and analysis	Data collection included repeated participant observation over a 30 month timespan. 300 hours of observation were conducted. Observations were conducted by research staff, around-the-clock and throughout the week. Field notes were recorded by hand and then transcribed. In-depth interviews were conducted to supplement observational data. Interviews were recorded digitally and transcribed verbatim. The interview transcripts and the observational field notes were analysed by thematic analysis in NVivo.
Recruitment strategy	Recruitment was done in collaboration with two community-based organisations who work closely with structurally vulnerable populations, by inviting them to participate via pamphlets, posters, and presentations at their places of employment. Recruitment was also done by referrals from clinicians within community based healthcare.
Study dates	Not reported
Sources of funding	This research is supported by funds from the Canadian Institutes of Health Research (MOP 133578).
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	**Number of people who were observed** N=119 n=25 homeless people n=25 support persons n=69 formal service providers **Number of people who were interviewed** N=58 n=19 homeless people

	n=16 support persons n=23 service providers
Participant characteristics	**Participant characteristics for those who were observed** **People experiencing homelessness** Gender: Male: 16/25 Female: 9/25 Average age: 59 years Age range: 19-81 years **Support persons** Gender: Male: 11/25 Female: 14/25 Average age: 50 years Age range: 35-71 years **Service providers** Gender: Male: 25/69 Female: 41/69 Other (gender queer, two-spirit, trans): 3/69 Average age based on 44 participants: 44 years

	Age range based on 44 participants: 24-67 years
Results	<u>The survival imperative</u> People experiencing homelessness prioritised shelter and food over accessing palliative care services. Awareness of advance care planning, palliative care, etc was minimal/non-existent. Some healthcare professionals thought that these social care needs fell outside their scope of practice. *“It became clear that her [Amber’s] focus all day, every day, was simply on finding food”.* [Quote: p.7] <u>The normalisation of dying</u> People experiencing homelessness may have long histories of surviving social disadvantage and may have witnessed people in their social networks dying as a result of their 'lifestyle'. This can lead to a normalisation of dying. <u>The problem of identification</u> Identifying those who require palliative care is difficult in a population whose care is typically provided by workers outside the formal medical system. When identified, care was regarded as 'top rate'. They experienced care in ways they never had, including feeling believed, getting their pain needs met, having access to additional income and services, and being surrounded by care providers who were compassionate, kind and invested in their care. <u>Professional risk and safety management</u> National and local policies can impact access to palliative care services. <u>The cracks of ‘silo-ed’ care systems</u> Health and social service systems in Canada operate within defined boundaries regarding roles and responsibilities, which results in ‘cracks’ between these systems through which those who are structurally vulnerable fall. Homeless people have to navigate through multiple departments/services/organisations, which can be challenging. Also, can lead to lack in continuity of care.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Research ethics approval was granted from university and health authority ethics committees.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Analysis of the data was conducted by the entire research team who met repeatedly throughout the data collection process to identify emerging themes and issues to consider for further investigation.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Strange, 2018

Bibliographic Reference	Strange, C.; Fisher, C.; Arnold-Reed, D.; Brett, T.; Ping-Delfos, W. C. S.; A general practice street health service: Patient and allied service provider perspectives; Australian journal of general practice; 2018; vol. 47 (no. 12); 44-49

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	Australia
Setting	Not reported
Data collection and analysis	A generic qualitative study using semi-structured interviews was undertaken. Open-ended questions prompted participants to describe experiences and perspectives. Interviews were audio-recorded and transcribed verbatim. Analysis of the interview transcripts was assisted by NVivo. A thematic analysis was undertaken using Braun and Clarke's six phases.
Recruitment strategy	Purposeful sampling provided a range of different ages, gender, cultural background, housing status and length of attendance at the Freso Street Doctor service.
Study dates	April 2016 to September 2016
Sources of funding	The study was funded by a research grant from Spinnaker Health Research Foundation, Fremantle, Western Australia. The General Practice and Primary Health Care Research Unit is partly funded by the University of Notre Dame Collaborative Research Network (CRN) program from the Australian Government.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=32 n=27 homeless people n=5 allied service staff
Participant characteristics	**Participant characteristics for people experiencing homelessness** **Gender** Male: 20/27 Female: 7/27

	Age group 23-45 years: 12/27 46-84 years: 15/27 **Ethnicity** Aboriginal and Torres Strait Islander: 5/27 Non-Indigenous: 22/27
Results	Doctor-patient empathy Attending mainstream general practice usually meant repeating their history and social circumstances with GPs who tried to address everything at once and left patients feeling overwhelmed. Some patients described feeling rejected from the broader community and alienated from mainstream healthcare services. Allied service providers also reported disconnection between patients and the community, which made attendance at mainstream primary healthcare difficult. Although some mainstream GPs empathised well with people who were homeless and marginalised, some patients reported feeling stigma from reception staff and other patients in practice waiting rooms. Better understanding of patient circumstances Patients and service providers talked about how homelessness and mental ill health impaired their ability to do practical and simple things, such as attend appointments, complete forms or apply for a Health Care Card. Normally, they would have done these themselves when their circumstances and health were better. Service providers reported how patients were often unable to produce Medicare and Health Care Cards when needed for mainstream services. By contrast, the drop-in, relaxed triage system of the FSD service suited their health issues and informal and often chaotic nature of their lives. The FSD clinic locations were convenient for patients as they often co-located with other services, such as food and laundry programs, housing and mental health services. The rotation of street health clinics to different sites improved potential access and helped to link patients to services. Facilitating referral pathways They reported many patients having long histories of disengagement, distrust and poor experiences in the public healthcare system. A trusting relationship with the patient took time to build but once established enabled a transfer of trust to other services.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(Ethics approval was obtained from the University of Notre Dame Human Research Ethics Committee (Project ID: 015154F).)*

Critical appraisal

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Two authors identified themes and patterns independently for cross-validation. Findings were reviewed by all authors.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations, which considering the specific population group may be a reason why.)*
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Relevant

Sturman, 2020

Bibliographic Reference	Sturman, N.; Matheson, D.; 'I just hope they take it seriously': homeless men talk about their health care; Australian health review : a publication of the Australian Hospital Association; 2020; vol. 44 (no. 5); 748-754

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting	An 80-bed Brisbane homeless men's hostel
Data collection and analysis	Sampling was driven by convenience and was non-purposive. There were four participants in each focus group. The facilitator took brief handwritten notes during the groups and the sessions were audio recorded, professionally transcribed and coded using ATLAS.ti software. The transcript data were initially inductively coded by one of the authors using descriptive and in vivo coding.
Recruitment strategy	A recruitment flyer was displayed at the hostel medical centre reception on the day of a group, headed 'Are you interested in talking to researchers about your experience of healthcare systems and services?' Participants who indicated their interest to the hostel nurse were given written participant information and invited to attend.
Study dates	October 2017 to September 2018
Sources of funding	The Health Alliance, a joint initiative of Brisbane North Health and Hospital Services, and Brisbane North Primary Health Network
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=20 homeless men
Participant characteristics	**Accommodation at time of focus group** Homeless hostel at which focus groups were held: n=14/17 Sleeping rough: n=1/17 Boarding house: n=1/17

	Supported accommodation: n=1/17 *participant characteristics only available for 17 participants
Results	Dismissive care Several participants in all groups reported experiences of healthcare providers discounting their need for help. Waiting times of several hours in emergency departments (EDs) were commonly reported, and often experienced as discriminatory, although a few participants acknowledged workload pressures, including the need to prioritise critically ill patients and a lack of in-patient beds. In one group, caring and compassion were explicitly discussed. In two groups participants reported that inaccurate, outdated or prejudicial information in medical records (for example, previous drug use or confrontational incidents) appeared to compromise their current care. Participants in all groups reported avoiding medical care unless their situation was critical. *"I don't really trust hospitals or doctors unless I'm really dying."* (FG4P4) [Quote: p.751] Fragmented care In all groups some participants described fragmented, even chaotic, care. Participants in two groups reported positive experiences of case workers who were 'a single point of contact', 'someone who can vouch for you' and/or someone to wake them for, and transport them to, appointments. Participants tended to talk more about ED than out-patient or general practice experiences, but several commented that general practice experiences improve once they 'get to know the doctor'. Although most participants agreed that comprehensive medical records should be readily available, some were suspicious of electronic information Inconsistent medical management of pain. Inadequate acknowledgement of psychological distress Participants in four groups described inconsistent prescribing for pain. One participant described 'walking through an imaginary door' and having his painkillers confiscated during his mental health admission from the ED. General practitioners (GPs) were also reported to have inconsistent approaches to pain management, ranging from liberal prescribing on patient request to a blanket refusal to prescribe 'anything strong'. Several participants appeared to be bemused by this inconsistency. A few other participants commented that GPs could be worried about previous addiction issues relapsing, and that it could be difficult for GPs to know whether to trust patients. Participants reported turning to the ambulance service or 'mates' to obtain pain relief that was not forthcoming elsewhere. Participants in four groups described difficulty communicating with mental health services, sometimes presenting only as a last resort, or involuntarily, and harbouring misgivings and resentment based on previous negative experiences. Several participants reported 'clamming up', having to 'swallow your pride a little bit as a man' and other difficulties in communicating their distress, including having to 'prove' that they were very unwell.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study had full ethics approval from the University of Queensland Human Research Ethics Committee (2017001368).)*

Critical appraisal		
Section	**Question**	**Answer**
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The transcript data was coded by one of the authors using descriptive and in vivo coding. Both authors discussed, compared and contrasted focus group transcripts and/or verbatim excerpts when considering categories and themes to ensure that these were grounded in the data. The authors reached a consensus on conceptual categories and key themes.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Sznajder-Murray, 2011

Bibliographic Reference	Sznajder-Murray, Brittany; Slesnick, Natasha; 'Don't Leave Me Hanging': Homeless Mothers' Perceptions of Service Providers; Journal of social service research; 2011; vol. 37 (no. 5); 457-468

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	US
Setting	Interviews were administered within a private office at the homeless shelter.
Data collection and analysis	The focus groups were semi structured and lasted between 1.5 to 2 hours. Each group was audio-recorded and transcribed in full detail. Thematic analysis was conducted to generate themes from the data.
Recruitment strategy	Women were recruited to participate in the focus groups through a local homeless family shelter.
Study dates	July to August 2009
Sources of funding	Not reported
Inclusion criteria	• They had physical custody of a biological child between the ages of 2 and 6 years • They met *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR) criteria for a substance use or alcohol use disorder • They were currently residing in a local family emergency shelter and met the federal definition of homelessness
Exclusion criteria	Not reported
Sample size	N=28 homeless women
Participant characteristics	**Age** Mean age: 29.2 years (SD=6.4) Age range: 18 to 40 years

Results	Perception That Service Providers Do Not Understand Mothers’ perception that service providers did not understand them was influenced by their reports of feeling disrespected and judged by service providers. Many mothers described service providers with “nasty attitudes”. Several mothers reported that rude behaviours and disrespect discourage them from wanting to work with service providers. Feeling judged also added to mothers’ perception of lack of understanding by service providers. Many mothers reported that service providers, including medical professionals, “looked down” on them. Women described experiences of being looked at like “we are nothing.” Several women also noted that they felt some service providers judged them because of their drug use. Perception of Service Providers as Unsupportive Most mothers reported that service providers were not providing sufficient assistance. Many mothers noted that they felt they are given long lists of things to do but are not provided with enough guidance to complete the tasks. Some women reported that service providers intentionally did not provide them with enough assistance. Fear of Service Providers Many mothers reported some feelings of fear in regards to service providers, but the particular fear differed among mothers. One mother reported having an overall fear of those in authority, while other mothers reported fear of certain agencies or particular service providers. The fear of losing their children was common, and many mothers said their children were all that they had. In particular, several mothers reported fear of the state’s children’s services department. Women’s fears appeared to be a barrier to communication with service providers. For example, many mothers withheld information about their substance use, because they feared that: a) substance use information would be reported to government agencies, b) they would lose their public assistance, or c) their children would be taken away. While many of the mothers experienced generalised fear and distrust in regards to sharing information with service providers, in some instances, specific experiences with service providers caused fear and distrust. One mother said that in the past, a case manager told her that if she had one more baby, the case manager would transfer her case. Because of this, the mother did not tell the case manager that she was pregnant until late in her pregnancy. The case manager transferred her case, and consequently, the process of adding the baby to the health insurance card was delayed. Desire to Be Understood When discussing desirable qualities among service providers, many mothers expressed a strong desire to be understood. Mothers noted that they wanted someone who would listen to them. The mothers said they felt like they had gone through so much in life that it would be helpful to have someone understand their unique situation. Some mothers expressed gratitude and relief because they were able to discuss their problems during the assessment interviews and focus groups. Mothers wanted to work with service providers who could relate to their experiences so that they would be more

	understanding. Some mothers said they thought it was difficult to relate to college-educated service providers because they did not have a lot of education themselves. Past experiences with service providers who were not empathetic led some mothers to believe it was impossible for anyone to understand them unless the service provider had been in their situation. Therefore, some mothers wanted service providers who had previously been homeless. *“I would want somebody to actually sit down and listen to me and basically let them know my side of the story instead of them jumping down my throat talking about ‘you need to do this, that, and the third.’” "We need somebody on our level, and I’m pretty sure we ain’t had 20 years of college in our pocket, but it should be somebody who could relate to us, who you know, would not make us feel so bad for being in this situation or make us feel so ugly about ourselves.*" [Quotes: p.7] Desire for Support Many of the mothers spoke of how difficult it was to be a single mother and to not have anyone to help or talk with; therefore, many mothers reported a strong desire for extra support. Women reported wanting service providers to acknowledge the positive steps they are taking and to have a positive attitude. They wanted service providers to provide them with more guidance and assistance. Many mothers said it is important that when service providers set goals with them, they also need to help them meet their goals. Trust The mothers stressed it was very important that they be able to trust their service provider and that they be assured that everything they discuss would be confidential. Mothers said they would only be able to talk with their service provider about personal problems if they were able to trust the provider. Mothers said they wanted to be able to build a trusting relationship with service providers, but they also acknowledged that it takes time. One mother noted that she had previously been able to build a trusting relationship with her substance abuse counsellor with whom she had worked for 8 years. Some women noted that they do not trust anyone, and others noted that no matter how much they trust someone, there were still things, such as their childhood, that they would not feel comfortable discussing.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The Ohio State University's Institutional Review Board approved all research procedures prior to beginning the study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Two undergraduate research assistants transcribed the focus group interviews in full detail. The first author then read the transcripts from each interview in their entirety and developed codes and themes.)*
Findings	Is there a clear statement of findings?	Yes

Critical appraisal

Section	Question	Answer
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

The Queen's Nursing Institute, 2015

Bibliographic Reference	The Queen's Nursing Institute; What community nurses say about hospital discharge for people who are homeless; 2015

Study Characteristics

Study type	General qualitative inquiry Mixed methods
Country/ies where study was carried out	UK
Setting	Not reported

Data collection and analysis	Nurses working directly with people who are homeless were interviewed.
Recruitment strategy	Not reported
Study dates	2014
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	Over 180 nurses were interviewed
Participant characteristics	Not reported
Results	Transition of care Nurses reported that improvements were required during transition of care or when a person is discharged from hospital. This was due to poor communication, inappropriate/unsafe discharge access to appropriate accommodation/step-down care, and other problems. *"Discharge information is not communicated, there's no forward planning, and patients are subsequently discharged to no fixed abode"* [Quote: p.2] Reasons for challenges Nurses reported that there were several reasons for challenges when discharging homeless people from hospital, including poor joint working between organisations, lack of local supported housing, inadequate health service resources, lack of awareness of community services among hospital staff, improvement in professional skills, limited resources. Nurses thought that NHS systems are not designed for homeless people. "*People move from borough to borough and so care is fragmented- NHS IT and the transfer of health notes are not designed with a mobile population in mind."* [Quote: p.5]

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not provide any details.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No *(The researchers do not provide any details.)*
Data collection	Was the data collected in a way that addressed the research issue?	No *(The researchers do not provide any details.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not provide any details.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not provide any details.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The researchers do not provide any details.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	No *(The researchers do not provide any details.)*
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge but they do not identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Ungpakorn, 2020

Bibliographic Reference	Ungpakorn, R.; Rae, B.; Health-related street outreach: Exploring the perceptions of homeless people with experience of sleeping rough; Journal of advanced nursing; 2020; vol. 76 (no. 1); 253-263

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	UK
Setting	A semi-structured interview schedule was used. Interviews were conducted in drop-in centres.
Data collection and analysis	All interviews were conducted face-to-face in a private room and were audio recorded. Thematic analysis was conducted using an inductive approach. Mind maps and manual coding was used to develop an initial list of codes and coding was completed using NVivo version 11.
Recruitment strategy	Purposive opportunistic sampling was used to recruit participants from 3 drop-in centres.
Study dates	4th June 2018 to 28th June 2018
Sources of funding	This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.
Inclusion criteria	• Aged 18 years and over • Currently homeless with experience of sleeping rough • Able to speak English
Exclusion criteria	• Previous interaction with the researcher in the role of nurse practitioner • No capacity to give informed consent, including temporary loss of capacity due to alcohol or drug intoxication • People who did not speak English
Sample size	N=10 homeless people
Participant characteristics	**Gender** Female: 1/10 Male: 9/10

	Age range 26-56 years **Ethnicity** White Latvian: 1/10 White British: 5/10 White Polish: 1/10 Black Ghanaian: 1/10 White Bulgarian: 1/10 Mixed Caribbean Cuban: 1/10 **Duration of homelessness (range)** 9 days-7 years
Results	<u>A human connection</u> Participants said that healthcare professionals visiting them on the street would make them feel cared for. PM52 described the effect of knowing that someone is concerned for your welfare as a ‘psychological boost’. CM34 talked about how it would reduce his sense of exclusion. The two participants who had personal experience of health-related street outreach described their interactions with the healthcare workers in terms of a human connection. An emphasis on common humanity through the mutual sharing of personal information was felt to reduce the power imbalance between the housed professional and the homeless patient. CM44H gave details of how he was made to feel more comfortable. In direct contrast to this, several participants gave examples where healthcare encounters lacked any human connection. These included being asked a long list of questions by 999 call-operators (CM34) and being made to feel unwelcome and rushed by staff in emergency departments (WM56). There were some negative perceptions of street outreach. PM30 described being approached by a police officer during his experience with the multi-agency street outreach team. The healthcare workers did not speak to him directly, leading him to believe that they were only there to ‘to tick a box’. CM44 said he thought that the idea of health-related street outreach was ‘great’ and ‘really useful’. However, he also said that outreach teams would be unable to find him in the hidden locations where he was sleeping and expressed in negative terms how he would feel about being approached.

	Street outreach as a bridge People with experience of sleeping rough in this study said that health-related street outreach could act as a bridge to health care, by overcoming access barriers. Many examples of barriers were given. CM34 and CM44H spoke about the practical challenges of life on the street and shame related to this as obstacles to attending fixed site services. CM44 also felt street outreach could overcome lack of knowledge about available healthcare services and entitlement to them. Participants were concerned that health often deteriorates on the street and said that healthcare workers could provide advice and assess people on the street to prevent this. Health-related street outreach was also perceived as a way to build rapport and encourage people to use fixed-site services in future. Most participants said that access barriers were significant but there was one exception. CM56 did not recognise any obstacles to accessing health care for people experiencing homelessness. For this reason his perception of health-related street outreach was that it was unnecessary and a waste of resources. The right approach To achieve a human connection and for health-related street outreach to work effectively as a bridge to health care, participants in this study said the right approach was essential. They defined the right approach in terms of the location and timing of street outreach, people included in the street outreach team and first impressions made by the outreach workers through the verbal and non-verbal styles adopted by them. Several examples of the wrong approach were given and the likely result of these was felt to be significant: alienation of people experiencing homelessness and long-term negative effects on their use of healthcare services. Waking people was felt to be unhelpful. PM30 said he would be ‘annoyed’ if he were approached while asleep for this reason. First impressions of healthcare workers providing street outreach were felt to be very important. Due to concerns about safety on the street, healthcare workers should be recognisable by their appearance. However, uniforms were perceived as maintaining hierarchy and creating distance. A less formal way of achieving a recognisable appearance was recommended. Health-related street outreach should be a gradual process that allows the person experiencing homelessness to set the agenda by asking them what they need and allowing them to decide whether they want to accept help or not. Demanding personal information and coercive methods should be avoided as this risks alienating people. Non-verbal interaction styles were also perceived as very important. CM44H recommended being ‘open with your body language’ to avoid intimidating people on the street. Respecting personal space and coming down to the same level were defined as the right approach by several participants, CM44 described ways for healthcare workers to make themselves more ‘friendly and approachable. Employing the wrong approach in health-related street outreach was perceived as potentially having negative impacts on people experiencing homelessness, both in relation to their immediate emotions and to their use of healthcare services in future.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(A university ethics committee approved this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The lead researcher completed the six phases of thematic analysis using an inductive approach and a rich description of the entire data set.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Vasillou, 2006

Bibliographic Reference Vasillou, Christina; Ryrie, Iain; Someone there to talk to; Mental Health Today; 2006; 23-26

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Not reported
Data collection and analysis	Staff from 123 randomly selected services working in the field of housing and youth homelessness across all London boroughs were interviewed. Staff from these services were asked to contact potential interviewees from among their clients to elicit young people's views.

Recruitment strategy	Not reported
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=182 n=123 services working in the field of housing and youth homelessness n=59 homeless youth
Participant characteristics	**Young people's characteristics** **Marital status** Single: 50/59 Other: 9/59 Asylum seekers or refugees: 9/59
Results	Researching the problem Staff felt that stigma was a major obstacle with respect to mental health. They said many young people did not want to accept a referral for counselling because of the stigma or the damage it would do to their credibility. Some young people were also reportedly uncertain about the benefits of counselling. Services described how young people equate mental health problems with long term incarceration, straight jackets or padded cells. Struggles to access appropriate support for mental health, particularly for young people without a diagnosis were an issue. Delays in mental health assessment, support and diagnosis were commonly cited and many respondents felt that this might be linked to the reluctance of the mental health teams to diagnose young people. Dual diagnosis of mental health and drug/alcohol problems was regarded as a major challenge in meeting the mental health needs of service users. Linked to this was a perception by some that

	mental health services could be poor communicators and reluctant to include housing workers or other non-clinical professionals in multi disciplinary meetings. Staff described how some service users lack insight owing to the nature of their mental health problems, which can make engagement very difficult. Efforts to de-stigmatise mental health emerged as a priority in participants' suggestions for ways to resolve these difficulties. The majority of service workers felt that training for staff in mental health users should be easily accessible and free so that it would be possible for all workers to take it up. The call for better service integration across the mental health and housing sectors was a consistent request. *"…sometimes people fall between the cracks… the mental health services are saying "Well, it's a drugs issue", and the drugs sort of services are saying"Well, it's a mental health issue" and this young person is left in the middle with, like "Which way do I go?".'* (manager, Quick access hostel) [Quote: p.24] <u>Young people's views</u> The young people described problems with accessing support and welfare services at every level. Problems finding a GP were reported by some, as were long waiting lists to gain a mental health assessment. The voluntary sector was praised by many for the ability to meet emotional needs as well as housing, benefit, education and employment needs. Voluntary sector organisations were reported as responding more rapidly than statutory services and if they were unable to help with a specific need they would support the young person to find a suitable service. Many young people appreciated being managed by the same key workers in the voluntary sector, particularly those key workers who were empathic, supportive and consistently available to them. Emotional support was an important need expressed by those interviewed. A common request was for access to services around the clock. Many proposed 24-hour drop in centres with readily available trained staff and counsellors where young people in their situation could be listened to and talk through difficulties. The young people wanted counselling and therapy to be offered at the first point of contact when a young person is experiencing any mental health problem. They said that services should take a young person friendly approach and ensure the environment is non intimidating to encourage young person to attend. Services should employ staff and mentors who have been through similar experiences so young people can be understood and their circumstances appreciated. In particular, it was felt that GPs should be more proactive during the earlier stages of a mental health problem. Young people also said that they wanted to be referred to counselling services rather than simply prescribed medication. More information on homelessness and mental health should be available to young people at a younger age. Young people also felt that more specialist support was required, particularly to manage the combination of mental health and drug and alcohol problems. Fast track referral systems and more detoxification and rehabilitation programmes were seen as necessary. Young people also felt that life skills and coping strategies should be more widely taught in schools.

Critical appraisal		
Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers have not reported on the justification of the research design. There is no detail provided on how they decided which method to use.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	No *(The researchers do not justify the setting or the methods chosen for data collection. The researchers do not report on the methods used to collect data. The form of data collection is unclear and there is no discussion about the saturation of data.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they considered any potential biases arising throughout the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	No *(The researchers do not report on how ethical issues have been considered throughout this study.)*
Data analysis	Was the data analysis sufficiently rigorous?	No *(The researchers do not provide a description of the analysis process.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge or understanding. The researchers do not identify new areas where research is necessary and they do not discuss whether the results can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	Serious concerns
Overall risk of bias and relevance	Relevance	Partially relevant

Wille, 2017

Bibliographic Reference	Wille, Stephanie M.; Kemp, Katherine A.; Greenfield, Brenna L.; Walls, Melissa L.; Barriers to Healthcare for American Indians Experiencing Homelessness; Journal of social distress and the homeless; 2017; vol. 26 (no. 1); 1-8

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	US
Setting	Interviews were conducted individually in private settings. Participant interviews took place at service agencies and service provider interviews took place at the University or in providers' offices.
Data collection and analysis	Interviews lasted from 12 to 66 minutes with an average length of 37 minutes. Research staff electronically transcribed all audio-recorded interviews verbatim. Data analysis was performed using qualitative data software NVivo10. A general inductive approach to analysis was used.
Recruitment strategy	Recruitment of homeless adults was possible with the assistance of multiple local service agencies using convenience and purposive sampling methods. Recruitment of healthcare/social service providers occurred via snowball sampling.
Study dates	2013-2014
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=28 n=16 homeless people n=12 service providers
Participant characteristics	**Characteristics of homeless participants** **Gender** Male: 8/16 Female: 8/16

	Age Mean age: 37 years (SD 13.1) Age range: 19-57 years **Characteristics of service providers** **Gender** Male: 4/12 Female: 8/12 **Age** Mean age: 45 years (SD 9.9) Age range: 26-57 years
Results	Transportation Homeless participants reported lack of transportation to healthcare facilities as a frequent barrier to care. For many, walking was their predominant form of transportation given the financial burden associated with other modes of transport. Phone Accessibility If transportation falls through and individuals do not have phones to cancel their appointments, they often experience even less access to care as a result of these missed appointments. The homeless participants frequently discussed a lack of consistent telephone access and the negative impact this had on making and keeping physical and mental health appointments. Barriers as a result of limited phone access ranged from difficulty scheduling appointments to not receiving reminder calls to being unable to cancel appointments when needed. *"When you're homeless on the streets it's kinda hard for them to call you and remind you of your appointments and stuff 'cause you know you never know where you're at and a lot of the time you don't have a phone or access to a phone"* (Male Homeless 3) [Quote: p.5] Discrimination Homeless participants identified discrimination during visits to healthcare stemming from several factors including ethnicity, gender, socioeconomic status (including homelessness), (perceived) substance use, and appearance. Most homeless

	participants reported experiencing discrimination on some level, with a majority recounting discriminatory experiences because they were American Indian. Cold and Bureaucratic Culture This theme emerged from stories about discourteous and undignified treatment from healthcare providers. This theme encompassed discrimination and yet was broader in nature. Participants in this study felt misunderstood by healthcare providers and a lack of connection when asked why they were seeking care. One such negative experience can have a major impact on patient perceptions of care. Access to Care Providers discussed how access issues led to urgent or emergency care visits. Discrimination and Mistrust Responses from service providers, like homeless participants, also revealed discrimination and mistrust as a problem in the healthcare system. Restrictive Policies Service providers in this study expressed frustration with rules and regulations that made it challenging for them to meet the needs of their clients. Many facilities have missed appointment policies that can prevent individuals from seeking care at that specific clinic. "*Missed appointments a lot of times, there's like a rule, three strikes you're out type of thing, so if somebody either pulls a no-call or no-show, or tries to show up intoxicated sometimes they're asked not to come back, so we're left searching for a different provider for them"* (Female Service Provider 5) [Quote: p.8]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes

Critical appraisal

Section	**Question**	**Answer**
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	No *(The researchers do not provide any details on why they chose interviews as the research design.)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No *(The researchers do not report on how they assessed their own role or potential bias during the study.)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The study protocol was IRB approved.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Three coders were assigned transcripts so that each interview was independently read and analysed by two members of the team, by a general inductive approach. The two coders assigned to each transcript met to compare thematic results; overall, identified themes were highly consistent between coders. In the few cases where inter-rater agreement was not achieved, a third researcher familiar with the data provided input on final theme identification.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Wise, 2013

Bibliographic Reference	Wise, Caitlin; Phillips, Kenneth; Hearing the Silent Voices: Narratives of Health Care and Homelessness; Issues in Mental Health Nursing; 2013; vol. 34 (no. 5); 359-367

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	US

Setting	Interviews were conducted in a quiet, private office at the ministry because it was a familiar and comfortable place to the participants.
Data collection and analysis	Interviews ranged in length from 9 minutes to 75 minutes. The principal investigator conducted and audio-taped all interviews and took field notes to ensure the most accurate depiction of each interview. The audio tapes were transcribed verbatim by a professional transcriptionist. Data was analysed by phenomenological analysis.
Recruitment strategy	The purposive sample for this study included 11 currently homeless men and women. Participants were recruited through a homeless ministry.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	• An adult, greater than 18 years old • Either homeless or formerly homeless, which is assumed in this study to be the physical, emotional, and social experience of living without a home or permanent place of residence • Willing to participate in a private audio-taped interview.
Exclusion criteria	Not reported
Sample size	N=11 homeless people
Participant characteristics	**Gender** Male: 6/11 Female 5/11 **Age** Age range: 21 to 54 years
Results	<u>Same/Different: “Second Class Citizens”</u>

	Within the world of homelessness, the participants identified a hyperawareness of other people. They seemed to form their own society full of “second class citizens,” sometimes glared at, often ignored, and always distinctly separate from mainstream society. They seemed to develop an “us/them” mentality that pervaded every aspect of their lives and, especially, their experiences with health care. Fair/Unfair: “On the Back Burner” Often intertwined with relational separation from mainstream society, came a protest against injustice. It seemed that no matter where the participants went to receive health care, they reported being faced with unfair treatment and forced to endure unendurable waits, unmerited arrests, and groundless accusations. Freedom/Barriers: “Playing the Game” The homeless population must struggle through a maze of bureaucracy, paperwork, and physical barriers that prevent them from getting the care that they seek. These barriers are perceived as specific to the homeless society as compared with the freedom of the rest of society. They seem to see this mainly as an insurance barrier: They do not have a way to pay, so they do not receive the care that they need. Choice/No Choice: “What Kind of Choice is That?” Homelessness forces people into situations they otherwise would never encounter. Mothers are forced to sleep out in the cold with their babies, and each person must look out for him or herself before anything else. Homeless individuals must also make many tough choices: Camp outside or get bedbug bites inside? Brush my teeth or eat a meal? Get health care or shelter? Many of the participants cited such choices as their reason for not seeking health care.

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(This study was approved by the Institutional Review Board at the University of Tennessee prior to data collection.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(The principal investigator, who completed interview training with an experienced phenomenological researcher, read and analysed the transcripts. A portion of the transcripts were read and analysed by members of a phenomenology group that met weekly at the University of Tennessee's College of Nursing.)*

Critical appraisal

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value *(The researchers discuss the contribution the study makes to existing knowledge and they identify new areas where research is necessary. The researchers do not discuss whether or how the findings can be transferred to other populations.)*
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Woith, 2017

Bibliographic Reference	Woith, Wendy M.; Kerber, Cindy; Astroth, Kim S.; Jenkins, Sheryl H.; Lessons from the Homeless: Civil and Uncivil Interactions with Nurses, Self-Care Behaviors, and Barriers to Care; Nursing Forum; 2017; vol. 52 (no. 3); 211-220

Study Characteristics

Study type	Phenomenological

Country/ies where study was carried out	US
Setting	Ministry for homeless people
Data collection and analysis	Interviews consisting of open-ended questions were conducted. Interviews typically took between 30 and 60 minutes. The researcher kept records during the interview. Tapes and field notes were transcribed verbatim by the interviewer. Data were analysed through content analysis identification of themes
Recruitment strategy	A convenience sample of homeless adults who visit a drop-in ministry for the poor and homeless.
Study dates	September 2014 to May 2015
Sources of funding	Not reported
Inclusion criteria	• Aged 18 or older • Homeless as defined by Nickasch and Marnocha (2009) • English speakers
Exclusion criteria	• People who demonstrated overt cognitive impairment
Sample size	N=15 homeless people
Participant characteristics	**Gender** Male: 10/15 Female: 5/15 **Age** Age range: 18 to 53 years

	Mean afe: 34.3 years
Results	<u>Nurses Should be Civil</u> Civility was an important issue for our participants. They believed that nurses should take patients seriously and demonstrate compassion, attentiveness, and fairness. They wanted nurses to be nonjudgmental and to enjoy what they do. Although they acknowledged that nursing work is difficult, stressful, and at times dangerous, they repeatedly emphasised that an attitude of civility is necessary when nurses care for the homeless. *"I was trying to explain my situation and how serious it might be. My head was throbbing really, really hard . . . While I was talking, [my nurse] was looking at the other nurse like I'm a joke." "It's nice to be treated like somebody cares. That they really care about how you feel and if you're getting the right kind of care." "Some [nurses] treat their dog better than they treat their homeless patients. . . Treat people as people. Be respectful."* [Quotes: p.215] <u>Self-Care Behaviours</u> Participants said when they become ill, they expect to go through it alone. They reported that when they need healthcare, EDs are their first choice. "*I usually just let it go by. I don't really like hospitals, but if I have to I'll go. But I know that without the medical card, they don't really want to mess with you." "I got a doctor for my asthma, but I don't usually go there. I would have to ride the bus and when I'm feeling poorly, that's hard. I would just go to the ER.*" [Quotes: p.216] <u>Barriers to Good Care for the Homeless</u> Participants described not able to get appropriate care because they cannot afford to pay for it. One asserted that treatment for people who are homeless is inferior because the homeless do not have money. Six participants believed their homeless status prevented them from getting good health care. One woman said because she is homeless, nurses label her rather than treat her as an individual. *"Like, if you're rich . . .you can get the best of everything, if you have money to do so."* [Quotes: p.217]

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes

Critical appraisal		
Section	**Question**	**Answer**
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes *(The researchers received approval from their university's institutional review board.)*
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Two members of the research team read and analysed data from the interviews. They used content analysis to analyse the data and produce themes.)*
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns

Critical appraisal		
Section	**Question**	**Answer**
Overall risk of bias and relevance	Relevance	Highly relevant

Appendix E Forest plots

Forest plots for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

No meta-analysis was conducted for this review question as it was a qualitative review and so there are no forest plots.

Appendix F GRADE-CERQual tables

GRADE tables for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

Table 6: Evidence summary profile for (GRADE-CERQual) theme A1.1 – Access to help/information

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
9 studies Ake 2018 General qualitative inquiry with focus groups. N=26 homeless women. Asgary 2015 Grounded theory with interviews. N=50 people experiencing homelessness. Batterham 2007 Phenomenological with interviews. N=6 young people experiencing homelessness. Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Groundswell 2017 Mixed methods with focus groups. N=47	Data from 9 studies suggested that there was a lack of help or information available for people experiencing homelessness. The studies reported that information was needed on topics such as pregnancy education, cancer and screening, prevalent illnesses such as the hepatitis C virus, entitlement to care, and oral health. People experiencing homelessness reported requiring help in making appointments and with accessing support and welfare services. "I wished someone would've been there to help answer questions and explain things." [Quote: Ake 2018, p.40] "There seems to be a lack of education in a lot of the clients, or people who are homeless and somehow we've got to get across to them exactly how to reduce the spread of viruses such as colds and flus and other kinds of ailments that involve the transference of bacteria" (Male client 3). [Quote: Campbell 2015, p.6]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
people experiencing homelessness. Masson 2020 General qualitative inquiry with interviews. N=20 people experiencing homelessness. Paisi 2020 General qualitative inquiry with interviews and focus groups. N= 23 (n=11 people experiencing homelessness, n=12 stakeholders). Salem 2015 General qualitative inquiry with focus groups. N=20 homeless women. Vasillou 2006 General qualitative inquiry with interviews. N=59 (n=59 homeless youth, staff from n=123 services working in the field of housing and youth homelessness).						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 7: Evidence summary profile for (GRADE-CERQual) theme A1.2 – Appointment systems

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
7 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Kerman 2019 General qualitative inquiry with interviews.	Data from 7 studies showed that appointment systems were a perceived barrier to accessing care. People experiencing homelessness described appointment systems as rigid in terms of access regulations, appointment slots and making appointments. Overall, people wanted appointment systems to be more flexible and responsive to the needs of people experiencing homelessness. “I have to ring at 7 am in the morning. And if you miss that time – it’s only 7 till 8. Maybe no one is going to pick up the phone for the rest of the day, at my GP. So you are only going to be able to make a regular appointment. Then you will have to wait a few weeks for an appointment.” [Quote: Groundswell 2016, p.10] “The greatest barrier which people seem to have is finding services that are willing to be flexible enough to deal with the way in which they have their lifestyles. So having to make an appointment for a GP at 8 o clock in the morning is a huge barrier, particularly if you haven’t got phones. I’m trying to think what, that services don’t start until 9 o clock in the morning so they can’t make phone calls until 9 o clock when services are available. (Nurse, 11).” [Quote: Mills 2015, p.463]	Serious concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Pleace 2000 General qualitative inquiry with interviews. N=112 (n=12 GPs, n=7 health authority workers, n=6 health workers, n=19 homelessness workers, n=4 representatives from different organisations, n=64 people sleeping rough).						
Sub-theme A1.2.1 – Communication						
1 study Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported).	Data from 1 study showed that a common experience was not receiving any letters with appointment information due to movement between different shelters or friends' places. People experiencing homelessness reported that an improvement in communication was required to accommodate these needs. Providing information and wider support to people experiencing homelessness may be challenging, since communicating through conventional means such as emails, could be difficult. "I don't know how you are going to [communicate with people experiencing homelessness]. They	Moderate concerns[2]	No or very minor concerns	Minor concerns[3]	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
	are homeless, they don't access the paper and TV and everything. They don't get no proper service, they don't have a phone, most of the homeless. How we can you know. That's going to be difficult." (Focus Group Participant) [Quote: Groundswell 2016, p.20]					
Sub-theme A1.2.2 – Missed appointment policies						
3 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Wille 2017 General qualitative inquiry with interviews. N=28 (n=16 people experiencing homelessness, n=12 service providers).	Data from 3 studies reported the difficulties people experiencing homelessness faced when they missed appointments with health and social services. Many facilities have missed appointment policies that can prevent individuals from seeking care again at that specific clinic. Some services charged penalties for missing appointments, particularly for dental services, where a "Did Not Attend" may result in a charge. "I do try and make an appointment but I always end up missing them. I keep forgetting about them or I won't come in the night before." (Male, London) [Quote: Astra Zeneca 2012, p.45] "Missed appointments a lot of times, there's like a rule, three strikes you're out type of thing, so if somebody either pulls a no-call or no-show, or tries to show up intoxicated sometimes they're asked not to come back, so we're left searching for a different provider for them" (Female Service Provider 5). [Quote: Wille 2017, p.8]	Moderate concerns[2]	No or very minor concerns	Moderate concerns[5]	No or very minor concerns	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sub-theme A1.2.3 – The length of clinical appointments						
4 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Healthwatch General qualitative inquiry with focus groups and survey data. N=Not reported. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders.	Data from 4 studies suggested that short appointment times were a barrier to accessing healthcare. People experiencing homelessness reported that they did not have enough time during appointments to feel comfortable enough to discuss their needs and they felt rushed. This was the case with both GP and dentist appointments. As a result, wider health needs such as mental health issues could not be discussed. One healthcare provider reported that GPs should be notified about the living situation of patients beforehand to allow time for a thorough examination to take place and the individual's needs to be fully assessed. "When they are just saying this is what is wrong with you I will give you this now, you have got to go cos I have got to see the next patient, it's like well wait a minute I haven't even explained what's wrong with me. You are just fobbing me off and giving me this medicine and then letting me go. It's like how am I supposed to make myself feel better." [Quote: Csikar 2019, p.3] "They [GP] just get them in, give them what they need and let them go again. I'm concerned that a real assessment of their health needs isn't carried out at the beginning. GPs need to be more caring to that individual rather than just writing them a script." (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues) [Quote: Patient and Client Council 2015, p.32]	Moderate concerns[2]	No or very minor concerns	Minor concerns[4]	Minor concerns[6]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sub-theme A1.2.4 – Waiting times						
15 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Bhui 2006 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Broadbridge 2018 General qualitative inquiry with interviews. N=23 people experiencing homelessness. Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers.	Data from 15 studies showed that access to health and social care services was hindered by long waiting lists. In one study, a nurse reported that waiting times were unavoidable due to the volume of patients. However, people experiencing homelessness considered long waiting lists as direct contributors to decline in their physical and mental health. Further, both staff and people experiencing homelessness themselves recognised that, in some cases, by the time people experiencing homelessness admit they need help it is normally because they are at crisis point, and so need help immediately. The data also reported on service users' experiences of long waiting times before seeing a healthcare professional, mostly in emergency care. "I had to wait three months for a back doctor. I waited three months and he told me they were still waiting. I waited another four months. It's been two and a half years and I'm still waiting." [Quote: Davis-Berman 2016, p.6] "Good luck…they make you wait for hours and they send you home right away with bunch of Tylenol." [Quote: Hudson 2010, p.6] "When someone wants to come off alcohol or come off drugs that isn't something that can wait until three months down the line. That is something that when your mind is set on doing that, you need to do it, you want to do it now. So very often there is a window of opportunity that is	Moderate concerns[2]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Davis-Berman 2016 General qualitative inquiry with interviews. N=14 (n=4 people experiencing homelessness, n=10 community experts). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Groundswell 2020 Mixed methods with interviews and focus groups. N=104 homeless women. Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Hudson 2010 General qualitative inquiry with focus groups. N=24 homeless youth.	missed because you can't get services for those people at that time." (Stakeholder interviewee – Working directly with homeless) [Quote: Patient and Client Council 2015, p.37] "Getting to the people that you need to see right away is key and it seems that you have to go through a big rigmarole to get to them." (Participant 13) [Quote: Salem 2015, p.6]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Kesia 2018 General qualitative inquiry with interviews. N=60 (n=37 people experiencing homelessness, n=23 stakeholders). Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Salem 2015 General qualitative inquiry with focus groups. N=20 homeless women. Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men.						

1. Serious concerns about methodological limitations as per CASP qualitative checklist
2. Moderate concerns about methodological limitations as per CASP qualitative checklist
3. The study contributing to the theme offers moderately rich data
4. Studies together offered moderately rich data
5. Studies together offered some rich data
6. Some evidence is from a different context to the review question (study population in Healthwatch 2015 includes people experiencing homelessness, older people, and people with mental illnesses)

Table 8: Evidence summary profile for (GRADE-CERQual) theme A1.3 – Availability of services

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
10 studies Asgary 2015 Grounded theory with interviews. N=50 people experiencing homelessness. Bhui 2006 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Davis-Berman 2016 General qualitative inquiry with interviews. N=14 (n=4 people experiencing homelessness, n=10 community experts). De Veer 2018 General qualitative inquiry with interviews. N=64 (n=19 people experiencing homelessness, of which n=12 people who were deceased but included in data analysis, n=13 social workers, n=12 physicians, n=16 registered nurses, n=3	Data from 10 studies reported a general lack of services available to people experiencing homelessness. Service providers felt there were too few general practices that worked with people experiencing homelessness in London. A lack of specialist healthcare providers also seemed to be a problem, especially for palliative care. Studies reported barriers to access, which included the requirement that one have an address to access a GP (who acts a conduit for referrals to specialist care services), rigidity of the healthcare system, and a paucity of palliative care services, amongst many others. Data on palliative care reported that it is neither well developed nor visible for homeless populations. Service providers reported that palliative care needs for homeless populations are much greater than regular palliative patients. ''I regularly have contact with people experiencing homelessness who are extremely ill and highly vulnerable, and increasing numbers are dying when with us. Then you come up against all kinds of things that are never in the picture for a GP, because you aren't familiar with the severe psychiatric issues and you don't see the addiction either.'' (Professional, FG 2) [Quote: Klop 2018, p.332]	Moderate concerns[1]	No or very minor concerns	Minor concerns[2]	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
nurse assistants, n=1 sheltered housing facility coordinator). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Hudson 2010 General qualitative inquiry with focus groups. N=24 homeless youth. Klop 2018 General qualitative inquiry with focus groups. N=34 (n=15 people experiencing homelessness, n=19 service providers). MacKenzie 2019 Phenomenological with interviews. N=10 service providers (same population as reported in Purkey 2019). Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders.						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**

1. Moderate concerns about methodological limitations as per CASP qualitative checklist
2. Studies together offered moderately rich data

Table 9: Evidence summary profile for (GRADE-CERQual) theme A1.4 – Consistency and care continuity

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
1 study Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness).	Data from 1 study reports that a major barrier to access is the lack of continuity between services. People experiencing homelessness reported a lack of efficient information-sharing between the providers due to fragmentation of the services. "[…] it's hard to know who is handling people's cases. And we find out, in a crisis, there are six of us on the case, so maybe we could have collaborated before if there had been a mechanism to know one other. We want to do it, we're able to do it, but we don't know who's involved." (Table 4, Synthesis, World Café) [Quote: Alunni-Menichini 2020, p.9]	No or very minor concerns	No or very minor concerns	No or very minor concerns	Minor concerns[1]	HIGH

1. Some evidence is from a different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)

Table 10: Evidence summary profile for (GRADE-CERQual) theme A1.5 – Cost of services

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
10 studies Canavan 2012 General qualitative inquiry with interviews. N=28 experts in mental healthcare for people experiencing homelessness. Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Hauff 2014 Mixed methods with interviews. N=24 (n=10 homeless	Data from 10 studies reported on how the cost of services was a barrier to accessing care. People experiencing homelessness reported there was limited availability of low-cost dental health care for people experiencing homelessness. Some people wanted more clarity regarding the costs of treatments. One participant who had refugee status or was in the process of applying for it in the UK, expressed happiness about primary care being free at the point of access. "And then I got a letter through saying that I owed seventy-five pound for work that they had done. And I erm, you know, I explained to them and said look I am on benefits this that and the other, and they weren't having any of it and eventually people came knocking on my door to take stuff out of my flat, you know. And that put me off as well." [Quote: Csikar 2019, p.3] "The time I came to this country I was happy with GP and he provided for me. […] And they provided GP. At that time, GP was free, the service free. When I apply for asylum as a refugee, they provide free dentist for treatment and also free eye glasses or check-up eyes. So I am happy with healthcare because I have HC1 or HC2. It is a certification of asylum. So right now I don't have problems." Focus Group Participant [Quote: Groundswell 2016, p.14] "Before, even when you get teeth cleaned, they should tell you - what they are going to do; how they are going to do it; what procedure they are going to use; the results…and also the price. You should tell the powers, like the government, that we need more than $1000 a year. That way, we can look after our teeth better." [Quote: Mago 2018, p.228]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
shelter staff, n=14 health service staff). Mago 2018 Ethnographic, phenomenological with interviews. N=25 people experiencing homelessness. Munoz 2015 General qualitative inquiry with interviews and focus groups. N=30 homeless adolescents. Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Paisi 2020 General qualitative inquiry with interviews and focus groups. N=23 (n=11 people experiencing homelessness, n=12 stakeholders). Salem 2015 General qualitative inquiry with focus groups. N=20 homeless women.						
Sub-theme A1.5.1 – Out of pocket expenses						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
8 studies Bhui 2006 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Glumbikova 2018 Grounded theory with interviews. N=30 people experiencing homelessness. Groundswell 2017	Data from 8 studies reported that out of pocket expenses hindered access to dental treatments, optometry, and mental health. "Years ago I got a very big tooth problem. I go to the dentist and they give to me the price list. And so to take off this tooth I must pay a lot of money. They want £25. Excuse me I am homeless; I've not got money. Then a bigger problem, because I have got a big infection... they take off my tooth for free." – Focus Group Participant [Quote: Groundswell 2017, p.30] "Like, if you're rich . . .you can get the best of everything, if you have money to do so." [Quote: Woith 2017, p.217]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Mixed methods with focus groups. N=47 people experiencing homelessness. Mago 2018 Ethnographic and phenomenological with interviews. N=25 people experiencing homelessness. Woith 2017 Phenomenological with interviews. N=15 people experiencing homelessness.						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 11: Evidence summary profile for (GRADE-CERQual) theme A1.6 Discrimination

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
13 studies Batterham 2007 Phenomenological with interviews. N=6 young people experiencing homelessness. Bhui 2006 General qualitative inquiry with interviews. N=10 people	Data from 13 studies reported that people experiencing homelessness face discrimination, which creates a barrier to accessing healthcare. This was a view expressed by service providers and people experiencing homelessness. Some people reported that due to being homeless they felt the treatment that was on offer was 'lesser' than the general population and other data showed that service providers concur with this. People experiencing homelessness felt that prejudice and lack of empathy toward their situation alienated them from seeking care. A service provider in Canada reported that members of minority communities, such as	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
experiencing homelessness. Biederman 2014 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2013). Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Groundswell 2017 Mixed methods with focus groups. N=47 people experiencing homelessness. Mago 2018 Ethnographic, phenomenological with interviews. N=25 people experiencing homelessness. McNeil 2012a General qualitative inquiry with interviews. N=50 health and social services professionals (same population as McNeil 2012b). Mills 2015 General qualitative inquiry with interviews.	Aboriginal people, feel doubly discriminated by service providers. "Attitude of staff is a barrier. The attitudinal issues that a staff has regarding the nature of who that patient is – that's racism, bias, all that kind of stuff. Discrimination exists for the homeless population in general and the Aboriginal homeless population. I think that's a primary issue that generates how an individual accesses a system or turns away from a system after they've accessed it. The perception that they're not going to be treated well is part of a series of access barriers." (Male provider 1). [Quote: Campbell 2015, p.7] "The government "only allowed three [tooth] extractions a year because I am First Nations." [Quote: Mago 2018, p.226] "Just because you are homeless, it doesn't make you any more expensive to treat than anybody else, I mean anybody who gets a lymphoma or anybody who has MS or something." (RCGP representative). "Temporary registration means funding for three months. Many people have acute health needs, often due to lifestyle, they are going to get immediate treatment but other services, check-ups, smears, and so on just won't kick in with temporary registration. Dr X. registers all his patients, but that means that people have come in and used up loads of resources and then gone again and he doesn't get any payment for them, so that is a disincentive." (Health Authority representative). [Quotes: Pleace 2000, p.37] "Some of the guys may not say too much because they got pushed in the system, knocked down and everything else and now made them feel like					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
N=13 healthcare professionals. Munoz 2015 General qualitative inquiry with interviews and focus groups. N=30 homeless adolescents. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Pleace 2000 General qualitative inquiry with interviews. N=112 (n=12 GPs, n=7 health authority workers, n=6 health workers, n=19 homelessness workers, n=4 representatives from different organisations, n=64 people sleeping rough). Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. Woith 2017 Phenomenological with interviews. N=15	[curse word] [. . .] we're all treated like a piece of garbage. And that's [the problem] of being homeless [. . .] I am beginning to think it has a lot to do where I lived too, being homeless and stuff…". "Why should we give a [curse word] about him? He's only going to go out and screw up again anyways . . ." they've got to trust somebody and they are not very trusting because they've been kicked around and put down so much, finger pointed at". [Quotes: Ramsay 2019, p.1845]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
people experiencing homelessness.						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 12: Evidence summary profile for (GRADE-CERQual) theme A1.7 – Eligibility criteria

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
8 studies Bhui 2006 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Broadbridge 2018 General qualitative inquiry with interviews. N=23 people experiencing homelessness. Kesia 2018	Data from 8 studies reported that there were strict eligibility criteria in place to access healthcare services. Criteria were often considered to be too strict, forcing people experiencing homelessness into crisis situations before help could be provided. Some people reported that to access appropriate mental health services, people must first be recognised as having mental health issues. Some felt they had to lie to get access to support, whilst others felt let down and did not return to seek support. One woman reported that women struggled to access services because they were not always seen as 'homeless' due to often sleeping on other people's floors or staying in relationships that they really wanted to leave, just to be in accommodation. "In terms of the threshold, there are people who want services but when they get assessed, usually by a crisis team, there's a feeling that they don't meet that threshold. There's lots of people that display bizarre behaviour that would want services but they don't meet the criteria." (General needs hostel)	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews. N=60 (n=37 people experiencing homelessness, n=23 stakeholders). MacKenzie 2019 Phenomenological with interviews. N=10 service providers (same population as reported in Purkey 2019). McNeil 2012a General qualitative inquiry with interviews. N=50 health and social services professionals (same population as McNeil 2012b). McNeil 2012b General qualitative inquiry with interviews. N=54 health and social services professionals (same population as McNeil 2012a). Moore 2011 General qualitative inquiry with interviews. N=47 (n=20 people experiencing homelessness, n=27 service providers).	[Quote: Kesia 2019, p.78] "Even though there were numerous services supporting people experiencing homelessness they had specific criteria to deal with selective groups like, women and children and the elderly. Just because there were the services available it did not mean people experiencing homelessness accessed them . . . cause if you don't know you can access . . . unless you ask for it, you don't need it or get it" [HP9]. [Quote: Moore 2011, p.484]					

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme A1.7.1 Conditional treatment rules						
3 studies Kerman 2019 General qualitative inquiry with interviews. N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders.	Data from 3 studies reported that some services set entry conditions which meant that some homeless persons were effectively excluded, for example, to access alcohol and drug rehabilitation services or learning disability services a stable address was required. Decisions to ban or refuse services were often seen as one-sided, unfair, or discriminatory, and could lead to a sense of hopelessness and abandonment. “You feel like you have nobody, and nobody wants to help you. That’s why I just kept going on like, ‘What is wrong with me that the shelter can’t even take me?’” [Quote: Kerman 2019, p.779]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH
Sub-theme A1.7.2 Transition between child and adult services						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
4 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Kesia 2018 General qualitative inquiry with interviews. N=60 (n=37 people experiencing homelessness, n=23 stakeholders). Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders.	Data from 4 studies reported that homeless youth were more vulnerable to 'falling between the cracks' when transitioning between child and adult services. One study reported a participant's professional assessment of mental health changing when they moved from child to adult services. As a child, they met the threshold for psychiatric services but as an adult they did not. Some community-based workers reported that homeless youth often have unique needs relative to other youth and relative to adults. One study from Northern Ireland discussed that young people are often diagnosed as having a learning disability however, in the transition period to adulthood, reference to their 'learning disability' often changes to 'learning difficulty'. The consequences of this change in reference from 'disability' to 'difficulty' often means the level of support they receive is reduced compared to what they received in adolescence when they were diagnosed as having a learning disability. "I had her [psychiatrist] for two years and she was nice but then when I hit 18 and I went to see the adult ones they basically said I wasn't ill enough to have a psychiatrist." (Jasmine, aged 28) [Quote: Kesia 2018, p.79] "They were maybe in children's learning disability services as well and once they turn18 they're not [in that service any longer]. We've had some horrendous situations where people have been assessed at a certain level and all of a sudden when they turn 18 their IQ or whatever system they use, they go up and they are no longer available for services." (Stakeholder interviewee – Working directly with homeless) [Quote: Patient and Client Council 2015, p.40]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

1. Minor concerns about methodological limitations as per CASP qualitative checklist
2. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 13: Evidence summary profile for (GRADE-CERQual) theme A1.8 – Knowledge and awareness

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme A1.8.1 – Awareness about rights to healthcare						
1 study Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported).	Data from 1 study suggested that many people experiencing homelessness simply did not know their rights around healthcare. There was a sense that while people felt that they could access emergency care, many were unsure of their rights around accessing primary care, around making choices about their own care, and about other rights such as accessing healthcare records. All the people in the focus group welcomed the opportunity to have a better understanding of their rights to healthcare. They felt that having a better knowledge of these entitlements would immediately lead to a better use of healthcare. "Interviewer: 'Do you feel like that would be helpful, to know your rights [around healthcare]?' Focus Group Participant: 'Yes.' Interviewer: 'How would that help you?' Focus Group Participant: 'So I could change… you know, my situation if I know more about or was aware of services and rights. I know where to go and I know I can perhaps change things quickly for me or the need to go to the right person to start the right conversation and say the right things'." [Quote: Groundswell 2016, p.31]	Moderate concerns[1]	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme A1.8.2 – Knowledge and awareness about dental provision						
1 study Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness.	Data from 1 study suggested that one of the major barriers in accessing dental care services was the lack of an appropriate point of contact. This reduced participant's awareness of available high street or community dental services. "You phone someone up for help, right, and by the time they have got round to the third or fourth person you might have got about half the information that you need to be able to go and see them kind of thing. But it's like they make it so complicated." [Quote: Csikar 2019, p.3]	No or very minor concerns	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	MODERATE
Sub-theme A1.8.3 – Knowledge and awareness of issues surrounding homelessness and health						
1 study Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness).	Data from 1 study reported that some practitioners felt they had a lack of knowledge about issues associated with homelessness (for example, mental health and addiction) and of available resources, which can limit access for people experiencing homelessness. "If there's no suicide or just substance use, or even sometimes more of a bipolar crisis, they put you in jail instead of taking you to the hospital. They don't distinguish anything; they aren't trained to. The fact is they're police officers, not social workers. But that's what they should have: better mental health and addiction training, especially in cities like Montreal." (Participant experiencing homelessness and substance use 1) [Quote: Alunni-Menichini 2020, p.9]	No or very minor concerns	No or very minor concerns	Moderate concerns[2]	Serious concerns[3]	LOW
Sub-theme A1.8.4 – Service provider's knowledge and awareness of services						
9 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social	Data from 9 studies suggested that some service providers had a knowledge gap of available services for people experiencing homelessness, which prevented them from accessing healthcare. Some service providers reported it was difficult to stay up to date on the full range of healthcare services available and as such found it difficult to signpost to relevant services.	Minor cncerns[4]	No or very minor concerns	No or very minor concerns	Minor concerns[3]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
services professionals, n=8 people experiencing homelessness). Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Davis-Berman 2016 General qualitative inquiry with interviews. N=14 (n=4 people experiencing homelessness, n=10 community experts). Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Gunner 2019 General qualitative inquiry with interviews. N=22 people	"We need access to more information. We need to know what services exist and how to make referrals to them. Many nurses don't know and so people are falling through the net. Maybe a telephone Information Line would help." (A&E nurse) [Quote: Croft-White 2004, p.28] "I've been here six years, and I still get people, they're saying, 'I didn't even know it was a clinic in here.'… So that's the main thing, just letting them know." (P15, healthcare [HC]) [Quote: Gallardo 2020, p.4]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
experiencing homelessness. Kerman 2019 General qualitative inquiry with interviews. N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). Masson 2020 General qualitative inquiry with interviews. N=20 people experiencing homelessness. Paisi 2020 General qualitative inquiry with interviews and focus groups. N= 23 (n=11 people experiencing homelessness, n=12 stakeholders).						
Sub-theme A1.8.5 – Service user's knowledge and awareness of services						
4 studies Batterham 2007 Phenomenological with interviews. N=6 young people experiencing homelessness. Groundswell 2015 General qualitative inquiry with focus groups. N=44 people	Data from 4 studies suggested that people experiencing homelessness were not aware of services and did not have knowledge about how to access support, with many people feeling that they were unsure of their options. This was particularly the case for smoking cessation services. Service providers reported that young people experiencing homelessness may be ill equipped in terms of knowing where to find and how to access services. "The fact that they haven't got access to information to tell them about what is available	Moderate concerns[1]	No or very minor concerns	Minor concerns[5]	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported) Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported.	and where to go and things like that. Because you are in such a bubble when you are in that life, when you are on the streets. It really is and you withdraw from quite a lot of agencies that can help you. So it's about having the information in the first place as to where to go to get help with this and where to go to get help for that. And when you don't know you tend to withdraw even more and then just sit and suffer in silence." (Focus Group Participant) [Quote: Groundswell 2015, p.25]					

1. Moderate concerns about methodological limitations as per CASP qualitative checklist
2. The study contributing to the theme offers some rich data
3. The evidence is from a substantially different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)
4. Minor concerns about methodological limitations as per CASP qualitative checklist
5. Studies together offer moderately rich data

Table 14: Evidence summary profile for (GRADE-CERQual) theme A1.9 – Literacy

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
4 studies Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Csikar 2019 General qualitative inquiry with focus	Data from 4 studies suggested that low levels of literacy contributed to difficulties in accessing care. This included people with learning difficulties who needed support with correspondence and attending appointments. "A number of our patients are illiterate. A lot of our patients would just collapse with any forms, even if they can read and write." [Quote: Clark 2020, p.6]	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
groups. N=16 people experiencing homelessness. Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders.	"The big thing is people having the capacity to keep their appointments. If someone is referred to the community addictions team, they've got to be able to open the letter, read it, ring through and say they are going to keep the appointment, remember to keep the appointment and go on the day. That is actually quite difficult if you've got addiction problems or mental health illness." (Stakeholder – working directly with homeless) [Quote: Patient and Client Council 2015, p.33]					

Table 15: Evidence summary profile for (GRADE-CERQual) theme A1.10 – Local services

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sub-theme A1.10.1 – Single point of contact for a range of services						
2 studies Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Pleace 2020 General qualitative inquiry with interviews. N=23 people with	Data from 2 studies reported that the lack of a single access point made it hard for people experiencing homelessness to obtain support for the full range of needs. "How wonderful would it to have a podiatrist, an optician, and someone who does dental health. It would be wonderful to have those things here under one roof." [Quote: Clark 2020, p.7]	No or very minor concerns	No or very minor concerns	Moderate concerns[1]	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
lived experience of sleeping rough.						
Sub-theme A1.10.2 – Availability of allied health services						
3 studies Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Jagpal 2019 General qualitative inquiry with focus groups. N=9 people experiencing homelessness.	Data from 3 studies reported that other than care from medical doctors, people experiencing homelessness have an unmet need to access allied health services. These include: nursing, dentistry, optometry, pharmacy, physiotherapy, and rehabilitation. One study reported on the merits of having a specialised pharmacist available for a wide range of issues, including access to mental health services and screening for diseases. “...podiatry is actually quite a big issue for basic foot care to be honest and you can understand why that would be for a population group that's transient, that's going to walk around, maybe their shoes are ill-fitting, they're not actually buying things themselves anyway, they're relying on things for handouts...Another thing is glasses for eye care, access to opticians for, I mean you can get a, you can get an eye test I'm sure through Section 12 money through Social Work, I think you can access them through there but it's quite hard to immediately get, to get, to get replacement glasses. I know we've had problems with this.” (Health service administrator) [Quote: Health Scotland 2004, p.20] ‘Sometimes pharmacists are better at diagnosis than doctors, in my eyes.’ M (age not known) [Quote: Jagpal 2019, p.5]	Moderate concerns[2]	No or very minor concerns	Minor concerns[3]	No or very minor concerns	MODERATE

1. Studies together offer some rich data
2. Moderate concerns about methodological limitations as per CASP qualitative checklist
3. Studies together offered moderately rich data

Table 16: Evidence summary profile for (GRADE-CERQual) theme A1.11 – Location of services

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
6 studies Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Pleace 2020 General qualitative inquiry with interviews. N=23 people with lived experience of sleeping rough. Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. Reid 1999 General qualitative inquiry with interviews. N=200 homeless youth.	Data from 6 studies suggested that the location of services is an environmental barrier, which limits access to healthcare. Service users felt less willing to go to a clinic located in an area with which they were unfamiliar, saying they feel uncomfortable in clinics located far away. People preferred if services were located in one place or close together. "On a bus, it's about 40 minutes, half an hour. No, no, from X, it's about 40 minutes from X, it's about an hour on a bus, X, from here, isn't it, but, first of all, I've got to ring up at eight o'clock in the morning to get an appointment. My phone got nicked; I've got no phone. How do I go about doing that?" [Quote: Pleace 2020, p.14] "Yeah. Usually I'll go see the doctor, from there he gives me the prescription. I go downstairs and everything's right in the same building. It's fast." [Quote: Ramsay 2019, p.1845]	Serious concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

1. Serious concerns about methodological limitations as per CASP qualitative checklist

Table 17: Evidence summary profile for (GRADE-CERQual) theme A1.12 – Mental health support

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
2 studies Batterham 2007 Phenomenological with interviews. N=6 young people experiencing homelessness. Broadbridge 2018 General qualitative inquiry with interviews. N=23 people experiencing homelessness.	Data from 2 studies suggested that people experiencing homelessness had poor access to mental health support. One person reported having to go to extreme lengths to access mental health services. Others, who could access mental health services said they found the format of therapies unhelpful. "It was difficult when I was homeless, I had to go to an extreme which was breaking the law before I got help. I was living homeless under a bridge for about three/four months and it come to one day where, thinking about suicide, I was gonna do it. I went into a shop and I went to rob it, it was a cry for help really and I accessed MH through the crisis team. It took the extreme of doing something silly, and putting other people in danger, to get help." "There was a lot of things, group therapy and that…I don't like talking in large groups I can't deal with like loads of people, and it didn't seem like enough support, like once a week" [Quotes: Broadbridge 2018, p.4 & 5]	Moderate concerns[1]	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	LOW
Sub-theme A1.12.1 – Support for dual diagnosis						
7 studies Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing	Data from 7 studies suggested that access to combined support for substance use and mental health problems was very poor for homeless populations. Some people said their mental health issues were sometimes interpreted as the result of drug use and, therefore, not properly the concern of mental health services. The complexity of dual diagnosis in the homeless population causes difficulty in accessing services as it is often hard to know which problem should be treated first. For example, it can be difficult to distinguish whether the mental health issue is caused by the addiction or if the addiction is caused by the mental health issue. This often leads to people falling through the gaps. Some service users indicated that, frustrated by	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
homelessness and service providers not reported). Groundswell 2020 Mixed methods with interviews and focus groups. N=104 homeless women. Kesia 2018 General qualitative inquiry with interviews. N=60 (n=37 people experiencing homelessness, n=23 stakeholders). Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. St. Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness. Vasillou 2006 General qualitative inquiry with interviews. N=59 (n=59 homeless youth, staff from n=123 services working in the field of housing and youth homelessness).	difficulty in accessing mental health provision to address long standing issues, they increased their use of drugs and alcohol to mask the distress they experienced from underlying mental health needs. “Again, my story – mental health and substance misuse went hand in hand. I don’t think I was alone in that one. And the frustration for me was I couldn’t talk to the psychiatrist and stuff until I was sober for at least a year almost. That’s ridiculous. […] But… but I could have had other interventions that could have helped me. Like CBT or something. Or just awareness training or basic interventions that could have tried to convince me to build my own motivation up to do something about my situation. When I say situation, I mean housing, homeless, drinking, everything. And self-esteem, confidence the lot.” (Focus Group Participant) [Quote: Groundswell 2016, p.16] “[I would like] people to be a bit more understanding about your mental health, and try and work with you and help you, cos I don’t think there's much help out there for people that's got mental health issues. People put it on the drugs and stuff, but there's a reason why people smoke the drugs, cos they're not getting the right help in the first place. Some people have suffered before they smoked the drugs and they haven't had the help […] people think cos you're on drugs it's [mental health issues] come from there but I suffered before I smoked anything for a long while…but drugs have just made it worse.” (Lisa) [Quote: Kesia 2018, p.80] “If someone has a drug and mental health problem which do you work on first? That’s where you find people fall between services or don’t engage in services.” (Stakeholder interviewee – Working directly with homeless) [Quote: Patient and Client Council 2015, p.42]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
	"…sometimes people fall between the cracks… the mental health services are saying "Well, it's a drugs issue", and the drugs sort of services are saying "Well, it's a mental health issue" and this young person is left in the middle with, like "Which way do I go?"." (Manager, Quick access hostel) [Quote: Vasillou 2006, p.24]					

1. Moderate concerns about methodological limitations as per CASP qualitative checklist
2. Studies together offer some rich data

Table 18: Evidence summary profile for (GRADE-CERQual) theme A1.13 – Opening hours

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
6 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Gallardo 2020	Data from 6 studies showed that limited opening hours made access to services very difficult. Some people reported that, other than emergency care, there was not an accessible healthcare facility open 24 hours to accommodate those who get sick on the weekends or after hours. Service providers reported wanting an after-hours referral system so that they could refer people experiencing homelessness to the appropriate services for the following morning. No supporting quote.	Minor concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Hudson 2010 General qualitative inquiry with focus groups. N=24 homeless youth. Klop 2018 General qualitative inquiry with focus groups. N=34 (n=15 people experiencing homelessness, n=19 service providers). Moore 2011 General qualitative inquiry with interviews. N=47 (n=20 people experiencing homelessness, n=27 service providers).						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

2. Some evidence is from a substantially different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)

Table 19: Evidence summary profile for (GRADE-CERQual) theme A1.14 – Prioritisation

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sub-theme A1.14.1 – Attitudes toward help seeking						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
2 studies Glumbikova 2018 Grounded theory with interviews. N=30 people experiencing homelessness. Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers).	Data from 2 studies reported that service users experiencing mental health issues reported these as reasons for avoiding healthcare services or lacking the motivation to seek care. Community agency staff reported consequent difficulty convincing them to access health services. Service users only go to a doctor when they have an acute health problem and so there is no or little concept of prevention. "I don't use preventive examinations unless I'm completely K.O., so no... Because I don't even care... I'm not active, I always start becoming interested only when something starts to hurt…" (Male CP 7, 51 years old) [Quote: Glumbikova 2018, p.319] "There's a time [that] they just avoid it all together and they don't even bother." [Quote: Nicholas 2016, p.535]	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH
Sub-theme A1.14.2 – Competing priorities						
18 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Canavan 2012	Data from 18 studies reported that health needs, particularly physical health conditions, were not a high priority when compared to food and shelter. The studies reported that the lifestyle of people experiencing homelessness was too stressful and chaotic to prioritise health issues. Some people reported that when they sought care, it was for acute health issues rather than preventive or screening procedures. Although some needs could be met (for example, shelter), one man commented on the fact that getting a roof does not suddenly change the psychology or habits of the person overnight. Data from some studies reported that people experiencing homelessness prioritised other needs over palliative care needs. Difficulties accessing palliative care arose from lack of services, lack of support/signposting to services and lack of awareness. Many service users reported it was common to have had experiences	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews. N=28 experts in mental healthcare for people experiencing homelessness. Chaturvedi 2016 General qualitative inquiry with interviews. N=7 homeless youth. Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Dickins 2020 General qualitative inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers). Groundswell 2015 General qualitative inquiry with focus groups. N=44 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported).	where fellow residents had passed away unexpectedly. “To be honest, I ain’t got time to worry about my health, have I? No money, no roof over my head, no job, no girlfriend and no fags”. [Quote: Astra Zeneca 2012, p.33] “If you have got loads of other stuff going on in your life, dental hygiene is probably down there until obviously it becomes painful and then it goes up there...” [Quote: Csikar 2019, p.2] “If you are worried about where your next fix is going to come from or where your next meal is going to come from and you don’t know where you are going to sleep that night, healthcare falls to the bottom of the list.” (Nurse Practitioner) [Quote: McNeil 2012a, p.353] “It became clear that her [Amber’s] focus all day, every day, was simply on finding food”. [Quote: Stajduhar 2019, p.7]					

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Kennedy 2014 Grounded theory with interviews. N=22 homeless women. MacKenzie 2019 Phenomenological with interviews. N=10 service providers (same population as reported in Purkey 2019). McNeil 2012a General qualitative inquiry with interviews. N=50 health and social services professionals (same population as McNeil 2012b). Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Pendyal 2020 Grounded theory with interviews. N=19 people experiencing homelessness. Rae 2015 Phenomenological with interviews. N=14						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
people experiencing homelessness. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). Stajduhar 2019 Ethnographic with participant observation and interviews. Number of people who were observed: N=119 (n=25 people experiencing homelessness, n=25 support persons, n=69 formal service providers). Number of people who were interviewed: N=58 (n=19 people experiencing homelessness, n=16 support persons, n=23 service providers). Wise 2013 Phenomenological with interviews. N=11 people experiencing homelessness.						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 20: Evidence summary profile for (GRADE-CERQual) theme A1.15 – Registration for GP services

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
12 studies Broadbridge 2018 General qualitative inquiry with interviews. N=23 people experiencing homelessness. Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Glumbikova 2018 Grounded theory with interviews. N=30 people experiencing homelessness. Groundswell 2015 General qualitative inquiry with focus groups. N=44 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Groundswell 2017	Data from 12 studies reported that there were many hurdles for people experiencing homelessness when registering for healthcare services. Service providers reported that many local GPs refused to register people experiencing homelessness without proof of address or proof of identity, although evidence from some studies reported that this should not be the case. There was also the issue with 'practice boundary areas', which posed another barrier to people experiencing homelessness who frequently move location. As a result, service users reported it was helpful to be able to access GPs in more than one location. Some people experiencing homelessness found themselves making use of emergency service departments for a variety of medical problems, and often to overcome the problem of not being able to register with a GP. "If they are local, they may have had a GP. But usually there is a substance misuse problem and therefore they have been struck off. So we act as a GP – and we are prepared to do this. We don't turn people away. This is the policy agreed by our consultant." (Senior staff nurse at an A&E department) [Quote: Croft-White 2004, p.18] "Getting proof of address when you're on the streets you don't have an address so it does get quite difficult and like I managed to get erm my uncle to let me stay with him for a while, get some bills sent there er like my bank statements stuff like that so I could actually get a GP … I know several people who have been coughing up blood and all that kinda stuff but they can't get in to see a GP coz they can't register." (male [M], aged 24 years, shelter A [SA]) [Quote: Gunner 2019, p.530]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Mixed methods with focus groups. N=47 people experiencing homelessness. Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Pleace 2000 General qualitative inquiry with interviews. N=112 (n=12 GPs, n=7 health authority workers, n=6 health workers, n=19 homelessness workers, n=4 representatives from different organisations, n=64 people sleeping rough). Pleace 2020 General qualitative inquiry with interviews. N=23 people with lived experience of sleeping rough.	"We keep sending out information to GPs in the area and keep on trying to make it very clear that you do not need an address, the message has not got across. You absolutely do not need an address to register, it can be care of wherever. I think it may be 'We don't want to do it' and 'this is why we don't do it'." GP, Lambeth [Quote: Pleace 2000, p.31] "…my GP was saying I've got to find another GP in [neighbouring borough], but I'm used to them because I've been with them 21 years, so I'm not going to leave them." [Quote: Pleace 2020, p.15] A knock on effect of being unable to register for GP services was being unable to also access other health and social care services, which people tended to do through their GP.					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Rae 2015 Phenomenological with interviews. N=14 people experiencing homelessness. Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness.						
Sub-theme A1.15.1 – Requirements around identification and paperwork						
4 studies Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Kerman 2019 General qualitative inquiry with interviews. N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness).	Data from 4 studies reported that services had numerous documentation requirements for service eligibility, which created a barrier for access. “One of the things I just thought of that could be a potential barrier is missing or stolen ID.” (male client 1) [Quote: Campbell 2015, p.7] “I believe you need a birth certificate, ID. I don't have all that.” Participant 19 [Quote: Salem 2015, p.7]	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Salem 2015 General qualitative inquiry with focus groups. N=20 homeless women.						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 21: Evidence summary profile for (GRADE-CERQual) theme A1.16 – Role of technology

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
3 studies Adkins 2017 Grounded theory with focus groups. N=24 homeless youth. Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men.	Data from 3 studies showed that evidence about the role of technology in enabling access to healthcare was mixed. Some service users considered mobile phone applications to be useful for things like general support and information. When it came to information available through search engines, although it was considered useful and handy to be able to get information quickly, there was some distrust in the credibility of the source. No supporting quote.	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH
Sub-theme A1.16.1 – Lack of internet and phone access						

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
4 studies Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. MacKenzie 2019 Phenomenological with interviews. N=10 service providers (same population as reported in Purkey 2019). Mago 2018 Ethnographic, phenomenological with interviews. N=25 people experiencing homelessness. Wille 2017 General qualitative inquiry with interviews. N=28 (n=16 people experiencing homelessness, n=12 service providers).	Data from 4 studies showed that a few service users had difficulty finding a local GP practice due to their lack of access to the internet. People experiencing homelessness who did not have a phone experienced difficulties in accessing healthcare. This included difficulties making or cancelling an appointment and not receiving appointment reminders. "When you're homeless on the streets it's kinda hard for them to call you and remind you of your appointments and stuff 'cause you know you never know where you're at and a lot of the time you don't have a phone or access to a phone" (Male Homeless 3). [Quote: Wille 2017, p.5]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

1. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 22: Evidence summary profile for (GRADE-CERQual) theme A1.17 – Service providers' views and experiences

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
7 studies Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Hauff 2014 Mixed methods with interviews. N=24 (n=10 homeless shelter staff, n=14 health service staff). Klop 2018 General qualitative inquiry with focus groups. N=34 (n=15 people experiencing homelessness, n=19 service providers). Lester 2001 Grounded theory with interviews. N=25 general practitioners with experience with people experiencing homelessness. McNeil 2012b General qualitative inquiry with interviews. N=54 health and social services professionals (same population as McNeil 2012a). Mills 2015	Data from 7 studies reported on the experiences of healthcare professionals when providing services to people experiencing homelessness. Overall, there were mixed opinions from service providers. Some reported the challenging behaviour of people experiencing homelessness as distressing and complicating the provision of care, particularly in specialist care settings such as palliative care. Others, who worked regularly with people experiencing homelessness, thought that they could sometimes be difficult, but no more so than many other patients. ''It's often awkward enough already for ordinary people in society to deal with the palliative phase properly, but with a target group like this it's even more so, because if they are admitted to whatever setting, they start behaving in highly inappropriate ways.'' (Professional, FG 1) [Quote: Klop 2018, p.332] "I don't think there's anything different, just more, and frequently multiple problems in one person. Because there may have not been good access to health care previously, quite a lot of things may have become symptomatic and quite a lot of things may require attention at once, so you may have to deal with quite a lot of multiple health problems, many inadequately assessed and treated previously." GP, Lambeth. [Quote: Pleace 2000, p.32]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
General qualitative inquiry with interviews. N=13 healthcare professionals. Pleace 2000 General qualitative inquiry with focus groups. N=23 people with lived experience of sleeping rough.						
Sub-theme A1.17.1 – Managing medication						
11 studies Broadbridge 2018 General qualitative inquiry with interviews. N=23 people experiencing homelessness. Dickins 2020 General qualitative inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers). Groton 2020 General qualitative inquiry with focus groups. N=18 people experiencing homelessness. Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Hauff 2014	Data from 11 studies reported on a range of issues faced when managing medication. Ten studies reported service providers' views and 1 study reported the view's of both service providers and service users. A few studies reported provider experiences of people experiencing homelessness managing medication. Overall, service providers highlighted two problems with medication management. The first, management concerns regarding their ability to independently adhere to a prescribed treatment regimen. The second, once medication is prescribed is the issue of storing medication in hostels where other residents may have substance misuse issues. Some studies described people's difficulties managing their own medication and their perceptions of prescribing practices. Overall, people experiencing homelessness had negative experiences of managing their medication. Many people described not being able to obtain their medication due to other access issues, which sometimes resulted in self-"medication" (drink and drug use). Some people reported difficulties around the storage of specific medication, for example, insulin requiring refrigeration. In general, they wanted more information about their medication, including information about side effects and how to manage them.	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Mixed methods with interviews. N=24 (n=10 homeless shelter staff, n=14 health service staff). Jagpal 2019 General qualitative inquiry with focus groups. N=9 people experiencing homelessness. Kennedy 2014 Grounded theory with interviews. N=22 homeless women. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Pendyal 2020 Grounded theory with interviews. N=19 people experiencing homelessness. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men.	Overall, people had negative experiences of prescribing practices and wanted more information about why prescriptions and dosages change. Many people described prescribing practices as restrictive and inconsistent. This was particularly the case for contraceptives and pain medication. Some people reported problems with getting a new prescription if their medication had been lost or stolen, the latter being commonly reported in shelters. If prescriptions required filling more frequently, this was reported as an issue due to other access issues such as transport. Often, they reported going to emergency care as the only way of guaranteeing getting their prescription filled. "So, I had just got my medication, and I put it in my book bag. I sat my book bag next to me and fell asleep. Somebody tap on my shoulder and say, "Are you here?" I jumped up and took off without my book bag [nonverbal indicating it was gone]. All the medications, gone. How can I go back to my doctor and say, "Hey, you know my book bag was stolen with my medications…"? [Quote: Groton 2020, p.3] "They had no err fridge for my insulin right, so I was putting my insulin in cold water in the sink and they was coming in, cleaning my room and leaving my insulin out of the water, so my insulin's going warm." (M, aged 50 years, SC) [Quote: Gunner 2019, p.532] "I can't just walk up and say, "Hey, I need this [contraceptive method], I need that." They want you to go through a process . . . but at times I be needing it at that moment." [Quote: Kennedy 2014, p.764]					

1. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 23: Evidence summary profile for (GRADE-CERQual) theme A1.18 – Service users' views and experiences

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
12 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Bhui 2006 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Biederman 2014 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2013). Broadbridge 2018 General qualitative inquiry with interviews. N=23 people	Data from 12 studies reported the experiences of service users in relation to access difficulties. Overall, people experiencing homelessness reported that service providers did not understand the practicalities of being homeless and their specific needs. They reported a lack of specialist care, emotional support, and kind interactions. Examples of negative experiences included one participant who said healthcare professionals did not trust him and accused him of lying. One participant perceived the positive and engaging behaviour of a service provider as suspicious, as they experienced positive behaviour so rarely. However, some studies reported positive experiences of services that had specialised staff, reasonable policies, and minimal hierarchies. "…she asked me loads questions and seemed to be really interested but then at the end she gave me a form to fill in on how well she had treated me! That made me very suspicious that she had only done it to get good marks!" [Quote: Astra Zeneca 2012, p.47]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
experiencing homelessness. Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Greysen 2012 General qualitative inquiry with interviews. N=98 people experiencing homelessness. Groundswell 2020 Mixed methods with interviews and focus groups. N=104 homeless women. Kerman 2019 General qualitative inquiry with interviews. N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). Mago 2018 Ethnographic, phenomenological with interviews. N=25 people experiencing homelessness. Pleace 2020 General qualitative inquiry with interviews. N=23 people with						

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
lived experience of sleeping rough. Vasillou 2006 General qualitative inquiry with interviews. N=59 (n=59 homeless youth, staff from n=123 services working in the field of housing and youth homelessness).						
Sub-theme A1.18.1 – Crisis response						
1 study Broadbridge 2018 General qualitative inquiry with interviews. N=23 people experiencing homelessness.	Data from 1 study described a lack of crisis response. People experiencing homelessness reported that they wanted someone to talk to, that sleeping rough and living in insecure accommodation and experiencing mental distress is lonely and they would like to have more people to talk to, and more time with people in support roles, and a free phone number for support. Overall, they had a negative experience of crisis services, which made them feel even worse and led to relapse. Although some people had positive experiences, they noted that they accessed emergency services to bypass crisis services entirely. “There should be a free number so you don’t annoy the 999 people looking, we don’t want to sit in waiting rooms, we want to speak to someone, the right professional - there should be an emergency line for mental health not just the NHS, people on 999 don’t see mental health as an emergency.” “I can never knock the staff at that hospital, but that first port of call was the crisis team, I won’t ring them, I don’t think I probably ever will, I’d go straight to A&E”	Moderate concerns[1]	No or very minor concerns	Minor concerns[3]	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
	"I've got the crisis team, they've been good, Step Up team helped us and referred us to a CPN Nurse and talking therapies, but they said I could be waiting a while" [Quotes: Broadbridge 2018, p.6 & 7]					
Sub-theme A1.18.2 – Counselling around screening						
1 study Asgary 2015 Grounded theory with interviews. N=50 people experiencing homelessness.	Data from 1 study reported that there was a lack of screening counselling and opportunities, as well as a lack of information and guidance about cancer screening and its importance. "Awareness, a lot of people don't know" [M50] "Fear. I mean, there is the logical and there's the illogical. Logically, I know I should have all these tests, but emotionally…I don't want to deal with it now" [M61] [Quotes: Asgary 2015, p.1433]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE
Sub-theme A1.18.3 – Relationship between service user and service provider						
8 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing	Data from 8 studies suggested that acceptability was modulated by the nature of the relationships between users and providers. A relationship of trust, civility, and a strength-based approach with the providers encourages the use of services. It was easier to form trusting relationships with professionals who pay attention and have more time available, and who have sincere interest in them. Ease of access was improved by staff being more tolerant of the difficult behaviour of some people experiencing homelessness in the waiting room. This put other service users at ease. "A couple of times, you have had people that are cantankerous, that are difficult, that raise their voices … But the guys here seem to know exactly what to do and seem to be on top of that." [Quote: Clark 2020, p.6]	No or very minor concerns	No or very minor concerns	No or very minor concerns	Minor concerns[2]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
homelessness, n=4 service providers). Kerman 2019 General qualitative inquiry with interviews. N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). Klop 2018 General qualitative inquiry with focus groups. N=34 (n=15 people experiencing homelessness, n=19 service providers). Sznajder-Murray 2011 Phenomenological with interviews. N=28 homeless women. Ungpakorn 2020 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Wise 2013 Phenomenological with interviews. N=11 people experiencing homelessness. Woith 2017 Phenomenological with interviews. N=15 people experiencing homelessness.	"It's nice to be treated like somebody cares. That they really care about how you feel and if you're getting the right kind of care." "Some [nurses] treat their dog better than they treat their homeless patients…Treat people as people. Be respectful." [Quotes: Woith 2017, p.215]					

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

2. Some evidence is from a different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)
3. The study contributing to the theme offers moderately rich data

Table 24: Evidence summary profile for (GRADE-CERQual) theme A1.19 – Stigmatising attitudes

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
10 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Bhui 2006 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Biederman 2014 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2013). Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness.	Data from 10 studies reported that people experiencing homelessness face stigma when accessing healthcare. The data reports that this stigma is heightened when the person also has mental health issues. Several service users in these studies reported feeling judged, stereotyped, and being disrespected in healthcare settings such as GP practices, emergency care, and dental surgeries. Service users reported feeling offended by providers or fearing their judgment, which led them to lose trust in providers to the point of unwillingness to return for care. Services users reported this behaviour as the main reason for not seeking regular care. In some cases, service providers justified this behaviour when they felt threatened by people experiencing homelessness who had a dual diagnosis. Data from 1 study reported on dental practices not taking on more people experiencing homelessness due to their poor rate of attendance among some existing patients. Both private and NHS dentists are self-employed and when people don't show up to appointments dentists go unpaid but still incur costs. An NHS practice can lose significant amounts of money due to undelivered treatment under the NHS contract. "A lot of people have the idea that our patients are drug addicts and have mental health issues. That's the case for some, but we're seeing a different face of homeless now. We have patients in the clinic who have doctoral degrees that lost their jobs and they just can't find work. So, to be judgmental with the perceptions of homelessness compared to what it really is, I think people need to be more educated."	Minor concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Davis-Berman 2016 General qualitative inquiry with interviews. N=14 (n=4 people experiencing homelessness, n=10 community experts). Groundswell 2017 Mixed methods with focus groups. N=47 people experiencing homelessness. Hauff 2014 Mixed methods with interviews. N=24 (n=10 homeless shelter staff, n=14 health service staff). Hudson 2010 General qualitative inquiry with focus groups. N=24 homeless youth. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Pleace 2000 General qualitative inquiry with interviews. N=112 (n=12 GPs, n=7 health authority workers, n=6 health	[Quote: Davis-Berman 2016, p.6] "I had a problem with my tooth and I spoke to a few of the residents in my hostel. And I said 'where is the closest dentist?' There is a dentist like four doors down from our hostel. I spoke to a few people and they said no they don't take people on from this hostel, we've got a bad name. And a lot of people said the same thing. I went in there and they just wouldn't take me." – Focus Group Participant "My experience… the stigma is straight away as soon as you walked in… as soon as you walked into the practice, the stigma is you were ill-treated by the receptionist for a start. Oh it's him from the hostel, just sit over there. And we will get round to you … you know. And you could actually feel the tension in the room – or I could – in the room. I have always felt that the receptionist of any practice, whether it be a GP, whether it be dentist it's your first line of contact, your first point of call. "- Focus Group Participant [Quotes: Groundswell 2017, p.24 & 27]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
workers, n=19 homelessness workers, n=4 representatives from different organisations, n=64 people sleeping rough).						

1. Minor concerns about methodological limitations as per CASP qualitative checklist
2. Some evidence is from a different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)

Table 25: Evidence summary profile for (GRADE-CERQual) theme A1.20 – Transport

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
7 studies Ake 2018 General qualitative inquiry with focus groups. N=26 homeless women. Glumbikova 2018 Grounded theory with interviews. N=30 people experiencing homelessness. Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Hauff 2014	Data from 7 studies reported on transport being a barrier to accessing healthcare. This included the lack of availability of transport to healthcare settings and the cost associated with the transport. Many service users reported that walking was their main mode of getting to an appointment, which could be difficult for those people with existing health issues and disabilities. No supporting quote.	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Mixed methods with interviews. N=24 (n=10 homeless shelter staff, n=14 health service staff). Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. Wille 2017 General qualitative inquiry with interviews. N=28 (n=16 people experiencing homelessness, n=12 service providers).						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 26: Evidence summary profile for (GRADE-CERQual) theme B1.1 – Appointment systems

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence

3 studies Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. St Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness.	Data from 3 studies reported on what worked well about appointment systems. People experiencing homelessness reported different facilitators to help them attend medical or dental appointments, including a single appointment for consultation and treatment or an open access service, such as walk-in centres. "I would like to go there and get seen straight away and get what you need to get pulled out of your mouth straight away. Instead of having to make another appointment and going back and then making another appointment and going back, do you know I mean? I would just like to go to a dentist explain what happened and get it pulled out and there you're done. You don't have to mess about." [Quote: Csikar 2019, p.3]	Serious concerns[1]	No or very minor concerns	Minor concerns[2]	No or very minor concerns	LOW

1. Serious concerns about methodological limitations as per CASP qualitative checklist
2. Studies together offered moderately rich data

Table 27: Evidence summary profile for (GRADE-CERQual) theme B1.2 – Service users' views and experiences

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme B1.2.1 – Receiving prompt care						
1 study Kennedy 2014 Grounded theory with interviews. N=22 homeless women.	Data from 1 study reported on positive provider practices that facilitated contraceptive use, including being given samples of contraception to start immediately. "On one occasion she had the birth control pills right then and there and she was able to start me on birth control pills. That's one of the things I really, really liked. Even though it might have not been the one that I absolutely wanted, but I needed it at that time, and they had them on hand."	No or very minor concerns	No or very minor concerns	Minor concerns[1]	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
	[Quote: Kennedy 2014, p.764]					
Sub-theme B1.2.2 – Relationship between service user and service provider						
4 studies Batterham 2007 Phenomenological with interviews. N=6 young people experiencing homelessness. Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Kachingwe 2019 Phenomenological with interviews and focus groups. N=11 homeless young females. Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals.	Evidence from 4 studies reported that some people experiencing homelessness experience high quality care from staff, who went ‘above and beyond’. They spoke positively about those service providers with whom they had formed a strong and trusting bond. Often when people spoke about a positive experience with a service provider, this encouraged other people experiencing homelessness to access that service. “Yeah, the text messages show they care about you. It’s only a little text but things like that, the food vouchers. Things like that. They care about you.” [Quote: Clark 2020, p.6] “I’ll test one person [BBV] and then the following week they come back with their mates, whose been told about me doing the blood borne virus testing and he then will come back a couple of weeks later with his girlfriend or he’ll come back the next day to a different venue where he knows I am and he’ll bring his girlfriend. So yes, that definitely improves not only engagement with the individual… but also they bring others to the service.” (Nurse, 11) [Quote: Mills 2015, p.465]	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

1. The study contributing to the theme offers moderately rich data

Table 28: Evidence summary profile for (GRADE-CERQual) theme B1.3 – Role of technology

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
1 study Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders.	Data from 1 study reported that the introduction of texting services to remind individuals about their appointment at health services received positive feedback from service users. No supporting quote.	Moderate concerns[1]	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	LOW

1. Moderate concerns about methodological limitations as per CASP qualitative checklist
2. The study contributing to the theme offers moderately rich data

Table 29: Evidence summary profile for (GRADE-CERQual) theme B1.4 – Transport

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
3 studies Ake 2018 General qualitative inquiry with focus groups. N=26 homeless women. Groundswell 2020 Mixed methods with interviews and focus groups. N=104 homeless women. Pleace 2020 General qualitative inquiry with interviews. N=23 people with	Data from 3 studies suggested solutions to lessen the impact of transport as a barrier to healthcare. Some people experiencing homelessness reported that they found community resources such as, free bus passes or taxi vouchers helpful. Service users also appreciated support from organisations, including someone assisting them to get to their appointments. No supporting quote.	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
lived experience of sleeping rough.						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 30: Evidence summary profile for (GRADE-CERQual) theme B1.5 – Waiting time

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
1 study Kerman 2019 General qualitative inquiry with interviews. N= 52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness).	Data from 1 study reported that waiting times affected people experiencing homelessnesss' perceptions of treatment and care for better or worse and in turn made them more or less likely to access the care. Actions taken by service providers to expedite care were seen positively. "The receptionist … will know that it's me crying and literally just transfer me right through to [the counsellor] rather than waiting on hold." [Quote: Kerman 2019, p.779]	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Table 31: Evidence summary profile for (GRADE-CERQual) theme A2.1 – Communication

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
4 studies Adkins 2017 Grounded theory with focus groups. N=24 homeless youth. Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Chaturvedi 2016 General qualitative inquiry with interviews. N=7 homeless youth. Rae 2015 Phenomenological with interviews. N=14 people experiencing homelessness.	Data from 4 studies reported that improved communication could help with health service engagement. Both services users and providers thought clear communication would significantly improve the care experience. Service users reported that using simple language and explanations, instead of jargon, would help engagement. For some, the service provider's communication style was important in creating a sense of comfort. For example, one person talked about how it would help for the counsellor to be informal and not too distant. "When I listen to that word, I think "nah, I don't need a psychologist. I just need someone to talk." And after they explain in simpler way like "it's for talking, talking what you want. It's not because you look crazy or something." (Robin) [Quote: Chaturvedi 2016, p.59]	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH
Sub-theme A2.1.1 – Respect						
2 studies Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals.	Data from 2 studies emphasised the importance of respect within the carer-patient relationship and between different staff members either within an organisation or across institutions. Service providers referred to respect as an essential component contributing to the development of trust and improving the engagement with a homeless person.	No or very minor concerns	No or very minor concerns	Minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Moore 2011 General qualitative inquiry with interviews. N=47 (n=20 people experiencing homelessness, n=27 service providers).	A trusting relationship enabled the patient to feel safe in the healthcare environment and was seen as key to promoting engagement. Good relationships were seen as important to both service users and service providers. "Generally speaking I think people build up a relationship with everybody in the practice, or certainly a representative of each aspect, so they will have a particular admin person they know, they'll have contact with the nurse practitioner, they'll have contact with one or more of the GPs. And possibly CPN and specialist staff, health visitor as well." (GP, 5) [Quote: Mills 2015, p.465] "'The first thing you need to do is develop a connection and some kind of rapport and some kind of way of getting some understanding of where they are coming from and then you might go down the path of what assessments they need because you need to get a better picture of what they need." [SP12] (Catrina, hospital social worker) [Quote: Moore 2011, p.482]					

Table 32: Evidence summary profile for (GRADE-CERQual) theme A2.2 – Fear, apprehension, and trust

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sub-theme A2.2.1 – Feelings of apprehension						
9 studies Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers).	Data from 9 studies reported that people experiencing homeless often experience feelings of apprehension in disclosing that they are homeless to healthcare professionals. Many people experiencing homelessness with multiple health needs feared that their 'label' impacted on the response they received and made them fearful of accessing their services.	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Chaturvedi 2016 General qualitative inquiry with interviews. N=7 homeless youth. Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Pleace 2000 General qualitative inquiry with interviews. N=112 (n=12 GPs, n=7 health authority workers, n=6 health workers, n=19 homelessness workers, n=4	Some people reported feeling that others would judge them for using mental health services. Some people on a journey of recovery reported feeling nervous about bumping into old acquaintances in waiting rooms. “The psychological barrier of having to walk in and say that you're homeless. Part of it is our fault, part of it is us turning around and feeling uncomfortable and projecting that when it happens. The other half is a definite, darker side of the medical community that turns around and goes ‘oh, is that what you are?” (Male client 1) [Quote: Campbell 2015, p.5] “It’s a bit of a bummer bumping into the odd person. And they are still using [drugs] or whatever and it’s like ‘‘get away from me''. But that’s the only difficulty.” [Quote: Clark 2020, p.5]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
representatives from different organisations, n=64 people sleeping rough). Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). Strange 2018 General qualitative inquiry with interviews. N=32 (n=27 people experiencing homelessness, n=5 allied service staff).						
Sub-theme A2.2.2 – Feelings of fear						
14 studies Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Chaturvedi 2016 General qualitative inquiry with interviews. N=7 homeless youth. Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers).	Data from 14 studies highlighted that people experiencing homelessness are often fearful of service providers and tests, and fearful of being perceived negatively and repeating previous negative experiences of services. Most people recalled feeling some degree of anxiety when attending dental clinics. One person indicated that his fear stemmed from the noise of the hand piece he heard as a child. Some women described a general fear of medical professionals and struggles to overcome their fear and attend sexual health services. "Most of our people have a fear of authority. Medical systems are structured to represent that. They're incredibly hierarchical and even physically they're set up to be daunting to get through… a lot of our clients will hide ailments and I think that just comes from a lifetime of fear of authority." (Female provider 1) [Quote: Campbell 2015, p.5]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Groundswell 2017 Mixed methods with focus groups. N=47 people experiencing homelessness. Kachingwe 2019 Phenomenological with interviews and focus groups. N=11 homeless young females. Kennedy 2014 Grounded theory with interviews. N=22 homeless women. Kerman 2019 General qualitative inquiry with interviews. N=52 (n=26 currently housed people with a history of homelessness, n=26	"…when I was … younger … my family would take me to the dentist. As soon as I'd hear the drill, I'd be off! They'd have to physically restrain me! To… get owt done!" [Quote: Csikar 2019, p.2] "A lot of people are frightened to think about it. Most people won't talk about it, they won't entertain talking about it. They see it as so far away, you know? Why bother now, let's wait until nearer the time." (Hostel resident – Borough C) [Quote: Shulman 2018, p.43]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
currently experiencing homelessness). Mago 2018 Ethnographic, phenomenological with interviews. N=25 people experiencing homelessness. Salem 2015 General qualitative inquiry with focus groups. N=20 homeless women. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). Stajduhar 2019 Ethnographic with participant observation and interviews. Number of people who were observed: N=119 (n=25 people experiencing homelessness, n=25 support persons, n=69 formal service providers). Number of people who were interviewed: N=58 (n=19 people experiencing homelessness, n=16 support persons, n=23 service providers).						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sznajder-Murray 2011 Phenomenological with interviews. N=28 homeless women.						
Sub-theme A2.2.3 – Self-esteem						
11 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Barker 2018 General qualitative inquiry with interviews. N=57 (n=29 people experiencing homelessness, n=28 peer supporters). De Veer 2018 General qualitative inquiry with interviews. N=64 (n=19 people experiencing homelessness, of which n=12 people who were deceased but included in data analysis, n=13 social workers, n=12 physicians, n=16 registered nurses, n=3 nurse assistants, n=1	Data from 11 studies reported that people experiencing homelessness often have very low self-esteem or low feelings of self-worth, which affect the likelihood that they will seek help, sometimes feeling that they are not worth it, or that no one will listen to them. "There is a lot of shame. My experience has been that many of those I see in the shelter carry a lot of shame. Low self-esteem, horrific histories of trauma and abuse, mistrust of caregivers. They've lived very independent lives. At the end of life, when their needs increase, it's distressing to them because they need to trust when they've never learned to trust. They bring with them experiences that are negative from healthcare providers. It's a challenge." (Physician) [Quote: McNeil 2012a, p.353] "And sometime it's about self-worth, as well, some people I come across will say this is the punishment I have for the life I've had and you know I'm not about to try and fix it yet. And that person a few years down the line will be in a completely different place and say yep, I am ready to turn things around now and I am ready to move on and go through treatment." (GP, 2) [Quote: Mills 2015, p.464]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
sheltered housing facility coordinator). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Groundswell 2017 Mixed methods with focus groups. N=47 people experiencing homelessness. Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. McNeil 2012a General qualitative inquiry with interviews. N=50 health and social services professionals (same population as McNeil 2012b). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Patient and Client Council 2015 General qualitative inquiry with interviews and one group						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
discussion. N=18 stakeholders. Rae 2015 Phenomenological with interviews. N=14 people experiencing homelessness. Strange 2018 General qualitative inquiry with interviews. N=32 (n=27 people experiencing homelessness, n=5 allied service staff).						
Sub-theme A2.2.4 – Trust in service providers						
9 studies Biederman 2014 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2013). Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Hauff 2014 Mixed methods with interviews. N=24 (n=10 homeless shelter staff, n=14 health service staff). Jagpal 2019	Data from 9 studies described the lack of trust that people experiencing homelessness have in service providers or in the healthcare system. Reasons for distrust ranged from previous negative experiences to difficulties forming new bonds with service providers. Both service users and service providers said that building trustworthy relationships was important to maintain engagement in health and social care service. "I think a lot of people have really big issues with trust and authority and with anxiety and meeting new people. A huge proportion of the people I see will talk to me about really traumatic childhood experiences… they're just not able to trust anyone or deal with that interaction with people." (GP, 3) [Quote: Mills 2015, p.465] "I don't really trust hospitals or doctors unless I'm really dying." (FG4P4) [Quote: Sturman 2020, p.751]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with focus groups. N=9 people experiencing homelessness. Masson 2020 General qualitative inquiry with interviews. N=20 people experiencing homelessness. Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Strange 2018 General qualitative inquiry with interviews. N=32 (n=27 people experiencing homelessness, n=5 allied service staff). Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men.						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 33: Evidence summary profile for (GRADE-CERQual) theme A2.3 – Identifying groups for whom engagement is particularly challenging

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
4 studies Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Dickins 2020 inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Stajduhar 2019 Ethnographic with participant observation and interviews. Number of people who were observed: N=119 (n=25 people experiencing homelessness, n=25 support persons, n=69 formal service providers). Number of people who were interviewed: N=58 (n=19 people	Data from 4 studies reported different groups who were most likely to disengage from health and social care services. Examples include those with repeating patterns of substance use, migrants, refugees, asylum seekers, sex-workers, and those who require palliative care. "The attitude of hospital staff affects the service. Many of them look down on sex workers and think of them as 'dirty women'. There is a lot of buck-passing, and there is no-one there to advocate for them." [Quote: Croft-White 2004, p.23] "The gentleman that raised the issue of mental health has something that most of us here are dealing with. People do not have papers, they have no status to work, they have no house, no shelter. They cannot access the facilities in this country. They are living on the fringes of society and I have been coming here since December and I have run into so many people that I suspect need help. Nobody is coming here to offer any kind of help. So many people here – sorry – so many people have serious issues, I know that." (Focus Group Participant) [Quote: Groundswell 2016, p.14]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
experiencing homelessness, n=16 support persons, n=23 service providers).						

Table 34: Evidence summary profile for (GRADE-CERQual) theme A2.4 – Lack of care continuity

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
2 studies Batterham 2007 Phenomenological with interviews. N=6 young people experiencing homelessness. Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers).	Data from 2 studies suggested that if care continuity was interrupted, this could lead to disengagement with services. "I am comfortable here, I know everyone. I hate change. When change happens, the way I deal with is to walk away from it. Which isn't always good I know." [Quote: Clark 2020, p.5]	No or very minor concerns	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	MODERATE

1. *Minor concerns about methodological limitations as per CASP qualitative checklist*
2. *Studies together offered some rich data*

Table 35: Evidence summary profile for (GRADE-CERQual) theme A2.5 – Sustaining ongoing engagement and active participation

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme A2.5.1 – Flexibility						
1 study Dickins 2020 General qualitative inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers).	Data from 1 study reported people experiencing homelessness due to rigid treatment plans. Service providers reported the importance of adapting plans to accommodate patient capacities as key to facilitating improved engagement. "I was very much more rigid in my treatment plans until I came here . . . I figure out . . . how much they can engage . . . I also realize they have less energy, mental room to devote to keeping track of their meds, and did they run-out of their prescription, or can they take a TID [three times per day] regimen?" (Nurse Practitioner) [Quote: Dickins 2020, p.343]	No or very minor concerns	No or very minor concerns	Moderate concerns[1]	No or very minor concerns	MODERATE
Sub-theme A2.5.2 – Information giving						
2 studies Chaturvedi 2016 General qualitative inquiry with interviews. N=7 homeless youth. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported).	Data from 2 studies reported that giving more information to people experiencing homelessness made them feel in control of their healthcare, allowing them to make choices about their care. Commonly, they felt they were not given options or opportunities to shape their own care. "Yeah choice. That would be nice. If you can – because you know yourself much better what is your condition and what affects you, what… where your pains are. So choice is sometime helps yeah. It's a good idea. But I think you feel that you don't really get asked, you get told." (Focus Group Participant) [Quote: Groundswell 2016, p.21]	Moderate concerns[2]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme A2.5.3 – Ongoing support						
4 studies Biederman 2013 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2014). Chaturvedi 2016 General qualitative inquiry with interviews. N=7 homeless youth. Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals.	Data from 4 studies suggested that people who feel overwhelmed by an offer of support or resistant to accessing support might feel more motivated if the support was made available on an ongoing basis, over time. Attempts to engage them should be made repeatedly but without placing pressure on people. Treatment providers should be patient and consistent in offering treatment since this would increase engagement with health services "I don't know…like…Give them time you know? Like even me…at the start I was not ready for the support because I just wasn't…uh…I wasn't in a good place and didn't want to meet anyone or talk to anyone…. but with time I became more open to it." (Bobbi) "Just keep at it…that's what I would say to staff and whoever is supporting a young person. Keep letting them know that the help is there." (Bobbi) Bobbi: "In the first session or like the first two sessions I didn't really feel good. I wanted to run away and like not go. . . because that's just how I was feeling then you know? But then it became easier. I didn't feel like that. . . so much anymore and I was more open and sharing." Interviewer: "So what do you think made it easier for you?" Bobbi: "I don't know really. . . just keeping on going I guess." [Quotes: Chaturvedi 2016, p.58]	No or very minor concerns	No or very minor concerns	Moderate concerns[3]	No or very minor concerns	MODERATE
Sub-theme A2.5.4 – Provision of incentives						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
4 studies Asgary 2016 Grounded theory with interviews. N=50 people experiencing homelessness. Biederman 2013 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2014). Masson 2020 General qualitative inquiry with interviews. N=20 people experiencing homelessness. Paisi 2020 General qualitative inquiry with interviews and focus groups. N= 23 (n=11 people experiencing homelessness, n=12 stakeholders).	Data from 4 studies suggested that people experiencing homelessness considered incentives to be a strong motivator to engage with health and social care services. This included things like transport money cards, clothes and toiletries, and food. Service providers reported these incentives increased hepatitis C virus rapid testing and improved oral hygiene. "People will get it [testing] as long as there is an incentive behind it so if there's no incentive they won't get it." (African American Woman) [Quote: Masson 2020, p.5] "I think an infinite supply of toothbrushes and toothpaste [is needed]. Never let that be a barrier. Never, ever, ever." (Volunteer) [Quote: Paisi 2020, p.3]	Minor concerns[4]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH
Sub-theme A2.5.5 – Service feedback						
1 study Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and	Data from 1 study reported that a proactive approach is needed to involve people experiencing homelessness in shaping their own care. This is particularly so in terms of providing feedback on the care process. People felt that feedback processes were not always accessible. Despite many negative experiences of healthcare, few people had any experience of feeding back on their care. For some people, not having an outlet for their frustration had resulted in negative	Moderate concerns[2]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
service providers not reported).	experiences and lack of engagement. When they felt well informed and supported, individuals experienced more control over their care. If they can feel confident to feedback on their care, the level of service is ultimately improved. Interviewer: "So have either of you ever fed back about your experiences?" Focus Group Participant: "Yeah I have stood there and shouted and screamed. That's happened a few times. And I have certainly had bad [experiences]…. And then you just get yourself kicked out. Yeah and you get banned from the place." [Quote: Groundswell 2016, p.21]					
Sub-theme A2.5.6 – Shared decision making						
2 studies Klop 2018 General qualitative inquiry with focus groups. N=34 (n=15 people experiencing homelessness, n=19 service providers). Munoz 2015 General qualitative inquiry with interviews and focus groups. N=30 homeless adolescents.	Data from 2 studies suggested that people experiencing homelessness wanted to become more involved in decisions about health or treatment. For instance, one person suggested that a more egalitarian partnership with providers which incorporates shared decision making would help increase trust. "Be a little more understanding…At least consider some of my ideas in the treatment plan instead of shoving me off like I don't know what I'm talking about. I don't know everything just like he don't know everything, you know, but the difference is I can admit it." [Quote: Munoz 2015, p.158]	Minor concerns[4]	No or very minor concerns	Minor concerns[5]	No or very minor concerns	HIGH

1. The study contributing to the theme offers some rich data
2. Moderate concerns about methodological limitations as per CASP qualitative checklist
3. Studies together offered some rich data
4. Minor concerns about methodological limitations as per CASP qualitative checklist
5. Studies together offered moderately rich data

Table 36: Evidence summary profile for (GRADE-CERQual) theme A2.6 – The role of user led models built on trust between people with common experiences

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme A2.6.1 – Challenges faced by peer supporters						
1 study Barker 2018 General qualitative inquiry with interviews. N=57 (n=29 people experiencing homelessness, n=28 peer supporters).	Data from 1 study suggested that some peer supporters experienced numerous obstacles and challenges in fulfilling their role, including specific service policies, their clients, maintaining their own recovery, and certain professionals. Peer supporters reported that if there weren't these obstacles to fulfilling their role they'd be more effective in encouraging engagement. "Knowing your limitations for yourself … it's just knowing what you can do and what you can't do. Yeah, it's just them being aware of their own triggers … it's a hard one because you … you never … you don't know who you're going to meet." (Jamie, peer support provider only) [Quote: Barker 2018, p.222]	No or very minor concerns	No or very minor concerns	Moderate concerns[1]	No or very minor concerns	MODERATE

1. The study contributing to the theme offers some rich data

Table 37: Evidence summary profile for (GRADE-CERQual) theme A2.7 – The skills, training and values of practitioners

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
23 studies Adkins 2017 Grounded theory with focus groups. N=24 homeless youth. Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth.	Data from 23 studies showed that increased training was needed to strengthen the capacity of healthcare professionals to address the complex and diverse needs of homeless populations. The majority of the service providers reported that they were not equipped with sufficient knowledge of homelessness and the associated health needs for complicated health problems, such as substance addictions and mental health problems. Healthcare providers reported that there was no training given during undergraduate and postgraduate training, and no reference to the effects of the social determinants of health.	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
N=5 focus groups with 4-10 participants in each focus group. Barker 2018 General qualitative inquiry with interviews. N=57 (n=29 people experiencing homelessness, n=28 peer supporters). Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Dickins 2020 General qualitative inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported).	Some service providers felt that given the various problems people experiencing homelessness experience, it was almost impossible to have sufficient expertise in all aspects. However, all service providers said they wanted more training to raise their awareness, improve their knowledge in this area, improve sensitivity and understanding for this population, and overcome preconceived ideas and judgemental behaviour towards people experiencing homelessness. Another key training need was improved knowledge among staff of existing services for people experiencing homelessness. Staff wanted to be better able to signpost to available support. In particular, they though that knowing who to contact and having an established connection would aid this process. "It is not the role of nurses to be judgmental. Let's face it; we all do risky things in our lives. But I cannot guarantee that some are not judgemental. We have not had any training in this area and none of us are involved in any forums." (Senior staff nurse, A&E) [Quote: Croft-White 2004, p.28] "They should know… how they can help… or… better know the right place. Where to send the person, the person in crisis. They should know where to send this person. I mean I meant the right place or the right contact. Things should be more efficient than taking long time." (Focus Group Participant) [Quote: Groundswell 2016, p.18] "I think they probably need to be made more aware of [homelessness] because there's a lot of erm things that you can face on the streets, you can face a lot of illness more than you would do in like a house." [Quote: Gunner 2019, p.533]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Groundswell 2020 Mixed methods with interviews and focus groups. N=104 homeless women. Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Hauff 2014 Mixed methods with interviews. N=24 (n=10 homeless shelter staff, n=14 health service staff). Homeless Link 2012 General qualitative inquiry with interviews and stakeholder meeting. N=95 (n=57 people experiencing homelessness, n=38 members of staff from homelessness organisations, Local Authorities, and hospital trusts). Kesia 2018 General qualitative inquiry with interviews. N=60 (n=37 people experiencing homelessness, n=23 stakeholders). Klop 2018 General qualitative inquiry with focus						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
groups. N=34 (n=15 people experiencing homelessness, n=19 service providers). Krakowsky 2013 General qualitative inquiry with interviews. N=7 service providers (n=3 registered nurses, n=4 outreach workers). Lester 2001 Grounded theory with interviews. N=25 general practitioners with experience with people experiencing homelessness. McNeil 2012a General qualitative inquiry with interviews. N=50 health and social services professionals (same population as McNeil 2012b). McNeil 2012b General qualitative inquiry with interviews. N=54 health and social services professionals (same population as McNeil 2012a). McNeil 2013 General qualitative inquiry with interviews. N=24 people experiencing homelessness.						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Paisi 2020 General qualitative inquiry with interviews and focus groups. N= 23 (n=11 people experiencing homelessness, n=12 stakeholders). Pleace 2000 General qualitative inquiry with focus groups. N=23 people with lived experience of sleeping rough. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). St. Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness. Vasillou 2006 General qualitative inquiry with interviews. N=59 (n=59 homeless youth, staff from n=123 services working in the field of housing and youth homelessness).						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 38: Evidence summary profile for (GRADE-CERQual) theme B2.1 – Care continuity improves engagement

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
1 study Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers).	Data from 1 study reported that continuity of care had benefits and facilitated patient engagement. "I have been coming here that long, my doctor gets me, knows where I am at, when I am going off at the deep end and when I am doing well. So she has insight into that. And that's built up over time." [Quote: Clark 2020, p.5]	No or very minor concerns	No or very minor concerns	Minor concerns[1]	No or very minor concerns	HIGH

1. The study contributing to the theme offers moderately rich data

Table 39: Evidence summary profile for (GRADE-CERQual) theme B2.2 – The role of user led models built on trust between people with common experiences

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
9 studies Barker 2018 General qualitative inquiry with interviews. N=57 (n=29 people experiencing homelessness, n=28 peer supporters). Biederman 2014 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2013). Groundswell 2016	Data from 9 studies showed that people experiencing homelessness valued care and support from those with a shared, common experience, such as an advocate or a peer supporter. A number of people highlighted that those with experience of homelessness were the best source of information, as they could communicate it in a way that people could understand. People experiencing homelessness said that the presence of an advocate or a peer supporter helped them to gain confidence and a sense of control over their health needs, which improved their engagement with services. Some people often found it easier to register with a general practice when they had an advocate. "Just to hear somebody else's story and they were there in your shoes, it's like, wow! And lookin' at 'em now and they succeeded and it's good. It gives me a positive outlook that I'll be	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Moore 2011 General qualitative inquiry with interviews. N=47 (n=20 people experiencing homelessness, n=27 service providers). Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Paisi 2020 General qualitative inquiry with interviews and focus groups. N= 23 (n=11 people experiencing homelessness, n=12 stakeholders). Pleace 2000 General qualitative inquiry with interviews.	there one day. Because there's days that I'm like, no I'm gonna just give up, quit, say I'm done, but then I think, you know, I can't, I've got two kids to live for. I need to get goin'." [Quote: Biederman 2014, p.44] "Sometimes they [youth workers/advocates] also provide some information which may be pertinent." [Quote: Nicholas 2016, p.538] "It will all just be a breakthrough for them and then they'll end up being able to get involved with volunteer work, and we've got quite a few ex-service users who are volunteers here and I think a lot of them are very stable in their lives." (Nurse, 9) [Quote: Mills 2015, p.465]					

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
N=112 (n=12 GPs, n=7 health authority workers, n=6 health workers, n=19 homelessness workers, n=4 representatives from different organisations, n=64 people sleeping rough). Purkey 2019 General qualitative inquiry with interviews. N=41 (n=31 people experiencing homelessness, n=10 health service providers) (same population as reported in MacKenzie 2019).						
Sub-theme B2.2.1 – Peer support						
3 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Astra Zeneca 2012	Data from 3 studies reported the benefits of peer supporters when people experiencing homelessness accessed health and social care services. Peer supporters can build a strong and unique relationship with clients, which becomes an important factor in helping people move on from homelessness. Peer supporters come to the relationship as an equal to their client and help to counter people's mistrust of healthcare professionals, defuse tense situations, and improve the overall care experience. Peer supporters considered themselves to be role models, by breaking boundaries and providing individualised treatment and social support. Peer supporters help by representing someone who has gone through a similar situation and grown	Minor concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Barker 2018 General qualitative inquiry with interviews. N=57 (n=29 people experiencing homelessness, n=28 peer supporters).	from that experience. Most peer supporters saw themselves positively as role models, able to “inspire” and model a life without the everyday struggles of being homeless. Peer supporters felt that acting as role models might inspire clients to do better, or to feel that their goals are achievable, and that there is hope. Peer supporters reported deriving a number of psychological benefits, which ranged from a general feeling of being “happy to help” to feeling that they are making a difference in someone's life. “Yes it would be good (peer mentoring) having advice from someone who has been through what I have been through and come out ok on the other side.” “I'd prefer someone a bit older really who has more experience and some training to talk to, who understands from the inside.” [Quotes: Astra Zeneca 2012, p.27] “Someone coming alongside, you know shoulder to shoulder, there's no kind of hierarchy, so to speak.” (Rick, peer support recipient and now peer support provider) “There are a couple of people that, you notice are paying attention and they might feel stuck where they are at and they might start saying well you know. He was, like, in my position and he's moved on and he's moved on pretty quickly so maybe that could happen for me.” (Rick, peer support recipient and now peer support provider) “So, what I have learned from being homeless and what I've learned from here, I apply to myself and then it helps me to, uh, make sure that when I apply this knowledge that I help other people as well.” (Muhammad, peer support recipient and now peer support provider)					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
	[Quotes: Barker 2018, p.220, 220 & 223]					

1. Minor concerns about methodological limitations as per CASP qualitative checklist
2. Some evidence is from a different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)

Table 40: Evidence summary profile for (GRADE-CERQual) theme A3.1 – Quality of the relationship between provider and person using services

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
9 studies Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Greysen 2012 General qualitative inquiry with interviews. N=98 people experiencing homelessness. Kerman 2019 General qualitative inquiry with interviews.	Data from 9 studies suggested that service users wanted to receive more compassionate care from healthcare providers and for providers to be more relatable. Service users also wanted providers to demonstrate interest in their living situation and be more invested in them as people. "They [hospital providers] should be more worried about whether people have a safe place to stay beyond just physical or medical needs." [Quote: Greysen 2012, p.1487] "We need somebody on our level, and I'm pretty sure we ain't had 20 years of college in our pocket, but it should be somebody who could relate to us, who you know, would not make us feel so bad for being in this situation or make us feel so ugly about ourselves." [Quote: Sznajder-Murray 2011, p.7]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
N= 52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). Kesia 2018 General qualitative inquiry with interviews. N=60 (n=37 people experiencing homelessness, n=23 stakeholders). Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. St. Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness. Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men.						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sznajder-Murray 2011 Phenomenological with interviews. N=28 homeless women.						
Sub-theme A3.1.1 – Care experiences						
22 studies Adkins 2017 Grounded theory with focus groups. N=24 homeless youth. Bhui 2006 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Biederman 2014 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2013). Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Chaturvedi 2016	Data from 22 studies highlighted negative experiences of healthcare. There were several such descriptions of, including seeing different doctors every time (for example, locum GPs), being given inconsistent information, poor communication or feeling unheard, and a lack of shared decision making. Service users reported negative experiences with dentists, GPs, hospice care, mental health services, and paramedics. Most service users reported that these experiences led to feelings of mistrust and reluctance to share personal information with health professionals or stopped them from accessing that service. These experiences were to some extent corroborated by service providers who felt they lacked the specialist knowledge required to help people experiencing homelessness, which inevitably affected care experiences. "We don't have a great sense of understanding about this population or their needs and so they either get under served or inappropriately served" (female provider 1) [Quote: Campbell 2015, p.7] "They make a hell of a lot of money. Because when you go to the dentist the first they see you, its ching, ching, ching, money, money. Especially if your teeth are bad. You know, but… it's like with anything, a lot of people would rather go to a private dentist because they know what they are doing. You go to a public dentist they aint got a clue, and if you've got someone that's young and	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews. N=7 homeless youth. Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Groton 2020 General qualitative inquiry with focus groups. N=18 people experiencing homelessness Groundswell 2017 Mixed methods with focus groups. N=47 people experiencing homelessness. Kerman 2019 General qualitative inquiry with interviews. N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). Kesia 2018 General qualitative inquiry with interviews. N=60 (n=37 people experiencing homelessness, n=23 stakeholders).	hasn't got a clue and ends up taking the wrong tooth out, what do you do?" (Focus Group Participant) [Quote: Groundswell 2017, p.26] "I think that delving into that history … really digs up lots of trauma, and that trauma pushes them out the door." [Quote: Nicholas 2016, p.534] "I think that some doctors can be pretty ignorant. They're just more interested in getting you out of there instead actually taking the time enough to actually see if there's something actually wrong…if you've got an issue they're supposed to look into it, not just take the cash, see you later. I've seen that." [Quote: Ramsay 2019, p.1844] "The last time I tried to get a [homeless] patient a bed at a hospice, they [the hospice] interrogated me. They wanted a very clear prognosis and it was because the woman I had sent there before, who we thought was dying … was there for months because she had nowhere else to go." (Hospital palliative care nurse specialist – Borough B) [Quote: Shulman 2018, p.42]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Krakowsky 2013 General qualitative inquiry with interviews. N=7 service providers (n=3 registered nurses, n=4 outreach workers). Leggio 2020 Phenomenological with interviews. N=18 people experiencing homelessness. Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Pleace 2000 General qualitative inquiry with interviews. N=112 (n=12 GPs, n=7 health authority workers, n=6 health workers, n=19 homelessness workers, n=4 representatives from different organisations, n=64 people sleeping rough). Purkey 2019 General qualitative inquiry with interviews and focus groups. N=41 (n=31 people						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
experiencing homelessness, n=10 health service providers) (same population as reported in MacKenzie 2019). Rae 2015 Phenomenological with interviews. N=14 people experiencing homelessness. Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). St. Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness. Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men.						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sznajder-Murray 2011 Phenomenological with interviews. N=28 homeless women Ungpakorn 2020 General qualitative inquiry with interviews. N=10 people experiencing homelessness.						
Sub-theme A3.1.2 Trauma informed care						
1 study Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers).	Data from 1 study reported that social service providers expressed that some providers lack a deeper awareness of the impact that trauma has on a young person's life and how it may manifest in their behaviour. Providers who do not operate from a trauma-informed care approach may inadvertently serve as a barrier. "They have a different expectation for behaviour than we do. We understand our kids are traumatized and it affects behaviour, and how kids think, and that they are in survival mode, and they've been told their whole lives that they are not worth living or caring for. And when we start to show them that we do care for them, sometimes they will do everything they can to show us that they are not worthy of that. So that's how we see behaviour as separate from the person and that behaviour is the result of something that's happened to them. It's not who they are (P2, SS)." [Quote: Gallardo 2020, p.5]	No or very minor concerns	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	MODERATE

1. Moderate concerns about methodological limitations as per CASP qualitative checklist
2. The study contributing to the theme offers some rich data

Table 41: Evidence summary profile for (GRADE-CERQual) theme A3.2 – Responses to complex healthcare needs

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
3 studies De Veer 2018 General qualitative inquiry with interviews. N=64 (n=19 people experiencing homelessness, of which n=12 people who were deceased but included in data analysis, n=13 social workers, n=12 physicians, n=16 registered nurses, n=3 nurse assistants, n=1 sheltered housing facility coordinator). Dickins 2020 General qualitative inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers). Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers).	Data from 3 studies suggested that health and social services have difficulty supporting the complicated requirements of some people experiencing homelessness. In the opinion of practitioners, this can, in part, be due to their behaviour which can be challenging and difficult to handle. Service providers described how mental health disorders can contribute to difficulties establishing and maintaining primary care relationships. Other challenges included supporting people with complex trauma and substance misuse in mainstream services, uncertainty around prognosis, and complexity associated with homelessness. "He behaved very pettishly, very badly. He let happen what had to happen, but he was absolutely condescending…He could not accept authority at all." (Nurse) [Quote: De Veer 2018, p.6] "Psychiatric disorders is a big one . . . there's such a range . . . they're maybe avoidant in a lot of ways . . . they might not get care until they're in a really major crisis . . . mental illness has a lot to do with the really hard to get people." (Nurse Practitioner) [Quote: Dickins 2020, p.340]	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Table 42: Evidence summary profile for (GRADE-CERQual) theme A3.3 – Consistency and care continuity

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
15 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Bhui 2006 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of	Data from 15 studies demonstrated a lack of consistency and care continuity in service delivery. Many service users reported having multiple GPs, counsellors, and social workers. They said it was difficult to form a trusting relationship if they had to keep repeating their story and starting from the beginning with a new provider every time. Service providers discussed the difficulties of providing consistent care or follow-up with patients who do not have stable housing. Overall, service users wanted to have continuity of care to develop a trusting bond with the service provider. Service providers agreed and thought this improved compliance with treatment and medication. "One of our young people, when she decided yes I'm going to go for counselling, she saw three different people, every time she went back there was a different somebody to assess her so she had to go through all her painful story again and then she said I'm not doing it anymore and she just walked out." (Depaul UK Staff member) [Quote: Astra Zeneca 2012, p.46] "There is no communication between the person that you go to because you have no constant doctor. You have a locum who reads and it's his perception of what is written on the computer. You have got 12 minutes with somebody that you have never seen before. Over on-going stuff that you have to have continuity with. And that is my be all and end all." (Focus Group Participant) [Quote: Groundswell 2016, p.6] "People experiencing homelessness will very often move and it's that kind of continuity of care that they need. It's not like these people are not capable of going and getting a doctor but they may have left one area to go to another area and	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
people experiencing homelessness and service providers not reported). Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Healthwatch 2015 General qualitative inquiry with focus groups and survey data. N=Not reported. McNeil 2012b General qualitative inquiry with interviews. N=54 health and social services professionals (same population as McNeil 2012a). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Patient and Client Council 2015	may not know how to register.” (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues) [Quote: Patient and Client Council 2015, p.30]					

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Pleace 2000 General qualitative inquiry with focus groups. N=23 people with lived experience of sleeping rough. Pleace 2020 General qualitative inquiry with interviews. N=23 people with lived experience of sleeping rough. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men.						
Sub-theme A3.3.1 – Data recording and sharing						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
4 studies De Veer 2018 General qualitative inquiry with interviews. N=64 (n=19 people experiencing homelessness, of which n=12 people who were deceased but included in data analysis, n=13 social workers, n=12 physicians, n=16 registered nurses, n=3 nurse assistants, n=1 sheltered housing facility coordinator). Glumbikova 2018 Grounded theory with interviews. N=30 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Pleace 2000 General qualitative inquiry with focus groups. N=23 people with lived experience of sleeping rough.	Data from 4 studies reporting practitioner views suggested that people experiencing homelessness often have gaps in or no recorded medical history and this was attributed to ‘chaotic’ lifestyles. Missing or incomplete documentation is often a major problem. Service users were mostly in favour of data sharing, as they thought this would mean they didn’t have to explain themselves repeatedly. “They couldn’t find that card. They called an archive, and they found nothing at all. So I have had no doctor ever since. Nobody at all” (Male CP 12, 40 years old). [Quote: Glumbikova 2018, p.320] “The NHS is computerised so everyone’s notes are online. So anyone should be able to access them if they are within the NHS system. I think it’s brilliant. Because the doctor doesn’t have to go...Ask you a thousand questions, he’s got it all on hand. I see you are this, you have been suffering from that for a while, you are on that medication. Let it go on from there.” (Focus Group Participant) [Quote: Groundswell 2016, p.26]	Minor concerns[3]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

2. Some evidence is from a different context to the review question (study population in Healthwatch 2015 includes people experiencing homelessness, older people, and people with mental illnesses).
3. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 43: Evidence summary profile for (GRADE-CERQual) theme A3.4 – Holistic responses to complex needs

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
4 studies Asgary 2015 Grounded theory with interviews. N=50 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Paisi 2020 General qualitative inquiry with interviews and focus groups. N=23 (n=11 people experiencing homelessness, n=12 stakeholders). St. Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness.	Data from 4 studies reported that service providers needed to deliver a more holistic approach to health and social care for people experiencing homelessness. Service users wanted to be seen as a whole person and not just a set of discrete needs to be addressed separately. "You can't just help people with a portion of their lives, you have to help them wholly. Most people don't have the knowledge of outside resources. Some people don't even know what their needs are. They always put medical needs last, especially if someone is mentally ill and doesn't know what their needs are, so make it part of a protocol." [F43] [Quote: Asgary 2015, p.1435] “I do best in holistic services that consider the whole person, that can see how my practical issues relate to my deeper emotional/ psychological issues and will work with both at once.” “Get to the roots of people’s problems. Don’t just put an Elastoplast on a gaping wound. Early stuff can affect people through their lives.” [Quotes: St. Mungos 2009, p.26]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Table 44: Evidence summary profile for (GRADE-CERQual) theme A3.5 – Individualised care and support

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
10 studies Biederman 2013 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2014). Clark 2020 General qualitative inquiry with interviews. N=15 (n=11 people experiencing homelessness, n=4 service providers). Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported.	Data from 10 studies reported that people experiencing homelessness wanted more individualised care and support from service providers. Service users reported that service providers should listen actively, show interest in them, show humanity, and provide non-judgemental care. A socially orientated approach to healthcare allows a conversation that extends further than a focus on medical problems. ".... being able to develop a relationship, a professional relationship that gives them unconditional respect, you know that they let you down yesterday but you're still here for them today. And it doesn't happen overnight, its maybe 2, 3, 4 meetings before the actual stories start to appear." (Healthcare professional) [Quote: Health Scotland 2004, p.41] "For me one of the really important things is about permeability, so it's about how much services are actually tailored towards meeting the needs of patients who are homeless." (GP, 2) [Quote: Mills 2015, p.464]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Krakowsky 2013 General qualitative inquiry with interviews. N=7 service providers (n=3 registered nurses, n=4 outreach workers). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). St. Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness. Strange 2018 General qualitative inquiry with interviews. N=32 (n=27 people experiencing homelessness, n=5 allied service staff).						
Sub-theme A3.5.1 – Specialist services						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
3 studies Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Groundswell 2020 Mixed methods with interviews and focus groups. N=104 homeless women. McNeil 2012a General qualitative inquiry with interviews. N=50 health and social services professionals (same population as McNeil 2012b).	Data from 3 studies suggested that people experiencing homelessness wanted more specialist services. They considered specialist services to have expert knowledge into the needs of people experiencing homelessness, which led to better care. For example, more time for consultation and follow-up, a range of support beyond physical health needs, and access to a range of support services. One study reported the benefits of women only services or women drop-ins. "That's why I go to [Specialist Homelessness GP Service] for 20 years because she knows what people experiencing homelessness need and you know you are going to get sorted. Rather than go to a doctor who just refers you on. Every single person in that building that I am aware of is actually trained around homelessness. And they have experience. And it kind of gels and it works. […] I mean I know a lot of people that go just to talk to some of the staff or whatever." (Focus Group Participant) [Quote: Groundswell 2016, p.12] "They have been very good because they have had experience with people in my situation. And the majority of clients - they are now patients, sorry - of my situation, so they can help you." [Quote: Groundswell 2020, p.56]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 45: Evidence summary profile for (GRADE-CERQual) theme A3.6 – Language and communication

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
7 studies Groundswell 2017 Mixed methods with focus groups. N=47 people experiencing homelessness. Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Paisi 2020 General qualitative inquiry with interviews and focus groups. N=23 (n=11 people experiencing homelessness, n=12 stakeholders). St. Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness. Sznajder-Murray 2011	Data from 7 studies suggested that effective communication between service providers and service users would improve the care experience. Service providers discussed that it was important to communicate clearly, avoid using technical jargon, and provide additional attention to people experiencing homelessness. Insensitive communication and closed body language were common experiences of service users. Service providers reported that the potential for miscommunication was considerable when both parties interact with preconceived ideas of how the other will behave. People experiencing homelessness wanted to be listened to and to be better understood. "My doctor doesn't listen but if I had someone who would listen I would be comfortable." [Quote: St. Mungos 2009, p.10] "I would want somebody to actually sit down and listen to me and basically let them know my side of the story instead of them jumping down my throat talking about 'you need to do this, that, and the third.'" [Quote: Sznajder-Murray 2011, p.7]	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Phenomenological with interviews. N=28 homeless women. Ungpakorn 2020 General qualitative inquiry with interviews. N=10 people experiencing homelessness.						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 46: Evidence summary profile for (GRADE-CERQual) theme A3.7 – Mental health support

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
6 studies Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Hudson 2010 General qualitative inquiry with focus groups. N=24 homeless youth. Kesia 2018 General qualitative inquiry with interviews. N=60 (n=37 people	Data from 6 studies showed that there is a need for mental health support to be available to everyone experiencing homelessness, not just those with a diagnosed condition. Service users reported feeling that their mental health needs were unmet and that mental health services were insufficient, hard to access, and uncoordinated with other services. For some, they felt they were not receiving any support at all and a few even indicated that they felt that they were forced to over play their mental health issues in order to access support. Service providers recognised both the generally high occurrence of mental ill health in the lead up to homelessness, and the negative impact of homelessness on an individual's mental health. It was felt that a blanket approach to mental health support would mean that people don't 'fall through the net' and that issues were dealt with early, thus preventing issues becoming very serious and more complex to treat. "But I feel like some people here… most of us – even myself – as if like they want to push me	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
experiencing homelessness, n=23 stakeholders). Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Pleace 2020 General qualitative inquiry with interviews. N=23 people with lived experience of sleeping rough. Vasillou 2006 General qualitative inquiry with interviews. N=59 (n=59 homeless youth, staff from n=123 services working in the field of housing and youth homelessness).	towards that…say I have got mental issue. So I will be…better classified, better help with that. Which is a bit sometimes wrong. I mean like the gentleman here said – anxiety. I've got anxiety, I have got depression. I have been through this kind of issue; stress. But they want you to be… say that you have got mental issue because if you don't have mental issue you will be not helped. Because this is what happen. […] So people be pushed towards this side saying I have got mental issue, so they could get [support] – and I have seen it in places where I have been." [Quote: Groundswell 2016, p.17] "I was begging for help for two years, every week I was in the doctors crying, saying to them 'I don't know what's wrong with me', I'm either up here or down there and there's never any in between. I don't know what it feels like to feel normal." (Jess, aged 35) [Quote: Kesia 2018, p.72]					

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 47: Evidence summary profile for (GRADE-CERQual) theme A3.8 – Navigating complicated care and support systems

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
9 studies Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Davis-Berman 2016 General qualitative inquiry with interviews. N=14 (n=4 people experiencing homelessness, n=10 community experts). Dickins 2020 General qualitative inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers). Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers,	Data from 9 studies showed that service providers recognised the current service system was complex, segregated, and difficult to navigate. This presented as substantial service delivery barrier for those who are unable or unaware of how to advocate for themselves to receive the care they require. Service providers discussed the importance of providing navigation assistance, such as accompanying people to healthcare appointments or helping them fill out paperwork. "[T]he hoops that we need to jump through in order to navigate healthcare, even as providers is extremely difficult, so I can understand what participants must go through . . . because of all the moving parts of healthcare makes it really difficult for people to navigate and I think that scares people off." (Nurse Practitioner) [Quote: Dickins 2020, p.344]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
n=10 healthcare providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Hauff 2014 Mixed methods with interviews. N=24 (n=10 homeless shelter staff, n=14 health service staff). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers).						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 48: Evidence summary profile for (GRADE-CERQual) theme A3.9 – Service policies

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
9 studies Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Groundswell 2020 Mixed methods with interviews and focus groups. N=104 homeless women. Hudson 2010 General qualitative inquiry with focus groups. N=24 homeless youth. McNeil 2012a General qualitative inquiry with interviews. N=50 health and social services professionals (same population as McNeil 2012b). McNeil 2012b General qualitative inquiry with interviews. N=54 health and social services professionals (same population as McNeil 2012a).	Data from 9 studies reported that national and local policies could sometimes overlook the needs of people experiencing homelessness and by doing so, exclude them from certain services. Services users experienced rules and hidden agendas that prevented them from accessing care or using shelters. For example, this was reported in mental health care where, if a person goes for an assessment and turns up intoxicated they are sent away and told to come back when they have detoxed. This means they are put back at the beginning of the process again and more time passes before they are seen. "You have to be homeless for a year in order to get a shelter…that is why people are heading out to San Francisco and northern California because they have services available…the youth out there, within a month of being homeless, they find you a job and give you a place…the law there is that youth cannot be on the street." [Quote: Hudson 2010, p.6]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders. Stajduhar 2019 Ethnographic with participant observation and interviews. Number of people who were observed: N=119 (n=25 people experiencing homelessness, n=25 support persons, n=69 formal service providers). Number of people who were interviewed: N=58 (n=19 people experiencing homelessness, n=16 support persons, n=23 service providers). Wise 2013 Phenomenological with interviews. N=11 people experiencing homelessness.						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

Table 49: Evidence summary profile for (GRADE-CERQual) theme A3.10 – Service delivery and organisation

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
7 studies Davis-Berman 2016 General qualitative inquiry with interviews. N=14 (n=4 people experiencing homelessness, n=10 community experts). Kerman 2019 General qualitative inquiry with interviews. N= 52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). Paisi 2020 General qualitative inquiry with interviews and focus groups. N= 23 (n=11 people experiencing homelessness, n=12 stakeholders). Purkey 2019 General qualitative inquiry with interviews and focus groups. N=41 (n=31 people experiencing homelessness, n=10 health service providers) (same	Data from 7 studies reported that healthcare systems were not designed for people experiencing homelessness. Service providers reported that it was not tailored to meet the needs of people experiencing homelessness. The system was described as "designed by middle class people for middle class people". People experiencing homelessness were expected to conform to the system rather than receive tailored care according to their differing needs, desires and challenges. Service users reported wanting flexible and tailored services that incorporated user feedback. "...tailoring healthcare services to local needs...rolling out national policies, but allowing flexibility within those policies to make necessary changes to help the local community." (Academic) [Quote: Paisi 2020, p.3] "And they knew, right, because I was sleeping rough, I ain't going to get there at a certain time. I turn up and they say 'Yes, alright fair enough, sit down, you might be an hour." (M49) [Quote: Rae 2015, p.2101] "People move from borough to borough and so care is fragmented- NHS IT and the transfer of health notes are not designed with a mobile population in mind." [Quote: The Queen's Nursing Institute 2015, p.5]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
population as reported in MacKenzie 2019). Rae 2015 Phenomenological with interviews. N=14 people experiencing homelessness. Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. The Queen's Nursing Institute 2015 General qualitative inquiry with interviews. N>180 nurses.						
Sub-theme A3.10.1 – Availability of resources						
10 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness).	Data from 10 studies described higher than expected caseloads, lack of staff and time, lack of funding, and limited resources. Service users reported that there is too little staff time available and a high turn-over, especially amongst nurses. "It's the resources. Everybody is busy, too busy to have the time to do what needs to be done. The funding pressures are also… some programs end after 12 sessions and then you closed, then you move on too, and it's not really built into programs to allow the transitions. And I think that's what	Minor concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Davis-Berman 2016 General qualitative inquiry with interviews. N=14 (n=4 people experiencing homelessness, n=10 community experts). Elder 2014 General qualitative inquiry with focus groups. N=18 (n=7 people experiencing homelessness, n=6 social service providers, n=5 medical providers). Klop 2018 General qualitative inquiry with focus groups. N=34 (n=15 people experiencing homelessness, n=19 service providers). Mago 2018	needs to happen, people pick up the phone and ring the other agencies and talk about the young people, and help with those transitions, get in the car and take those young people to appointments, literally. More client focused services rather than statistical, funding-type stuff. (Participant #20, homelessness sector) [Quote: Black 2018, p.9]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Ethnographic, phenomenological with interviews. N=25 people experiencing homelessness. Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. St. Mungos 2009 General qualitative inquiry with interviews. N=103 people experiencing homelessness.						
Sub-theme A3.10.2 – Emergency care						

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
7 studies Groundswell 2015 General qualitative inquiry with focus groups. N=44 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Patient and Client Council 2015 General qualitative inquiry with interviews and one group discussion. N=18 stakeholders.	Data from 7 studies reported that people experiencing homelessness preferred emergency care to primary because it was a way to have multiple needs addressed immediately in a single and streamlined visit. Emergency care was considered an open access service where care could be provided for physical health issues as well as other needs, including shelter and respite. Most people reported using emergency care due to problems accessing primary care, such as long GP waiting times and difficulties travelling to GP practices. "The last time I was in hospital – well, the only time I would go to hospital is in the back of ambulance. Because I wouldn't go and sit in a waiting room. I would rather get knocked down. Which is what happened to me the last time." (Focus Group Participant) [Quote: Groundswell 2016, p.24] "I got a doctor for my asthma, but I don't usually go there. I would have to ride the bus and when I'm feeling poorly, that's hard. I would just go to the ER." [Quote: Woith 2017, p.216]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Wille 2017 General qualitative inquiry with interviews. N=28 (n=16 people experiencing homelessness, n=12 service providers). Woith 2017 Phenomenological with interviews. N=15 people experiencing homelessness.						
Sub-theme A3.10.3 – Fragmented services						
11 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Broadbridge 2018	Data from 11 studies described complex and fragmented health systems. Staff from all types of agencies recognised that most care is provided in "silos", with minimal coordination between agencies and providers. A more coordinated approach was needed to support them. "Each piece of the jigsaw is like a castle that enjoys the view from it. Some castles don't know that others exist. Each one fights its corner for services and there is no discipline across services. What has been lost is a voice across the city for this client group." (Day centre worker) [Quote: Croft-White 2014, p.26] "...because of the isolated or specialist nature of the services provided what I will do in practice is that I will go to the service that will deal with the problem that I think is my most serious problem at the moment, namely my broken arm, and I will turn up at A&E who will set the bones, put a plaster on it, and discharge me, the fact that I have a serious alcohol problem, no home, no job	Minor concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews. N=23 people experiencing homelessness. Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Elder 2014 General qualitative inquiry with focus groups. N=18 (n=7 people experiencing homelessness, n=6 social service providers, n=5 medical providers). Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Health Scotland 2004	and the fact that I've just been thrown out of the house by my partner, is not addressed.... what we've got is structural isolation of services and problems, where the reality is that many of these people have multiple problems, and they as I say require multiple and long-term solutions." (Health professional) [Quote: Health Scotland 2004, p.49]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews. N=Not reported. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). Stajduhar 2019 Ethnographic with participant observation and interviews. Number of people who were observed: N=119 (n=25 people experiencing homelessness, n=25 support persons, n=69 formal service providers). Number of people who were interviewed: N=58 (n=19 people experiencing homelessness, n=16 support persons, n=23 service providers). Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men.						
Sub-theme A3.10.4 – Hospital discharge procedures						

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
14 studies Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Canavan 2012 General qualitative inquiry with interviews. N=28 experts in mental healthcare for people experiencing homelessness. Davis-Berman 2016 General qualitative inquiry with interviews. N=14 (n=4 people experiencing homelessness, n=10 community experts). Greysen 2012 General qualitative inquiry with interviews. N=98 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported).	Data from 14 studies demonstrated several issues with hospital admission and discharge procedures. Most studies reported that discharge from hospital was abrupt with little explanation and no follow-up or signposting to other services. Many service users reported that they were discharged without receiving adequate care. Some service users were worried about being discharged late at night for fear of their safety when using late night public transport or walking in the dark. In most cases, people were discharged without support and without accommodation, even when service providers were aware of their living situation. In one case, accommodation was identified before transfer from hospital but it was unsuitable as it had no fridge to store the person’s insulin. Overall, service users described being in a vicious cycle, repeatedly going in and out of hospital because they were continually not being given the care and support they needed to recover in the long term. Service providers discussed that there were several reasons for challenges when transferring people experiencing homelessness from hospital, including poor joint working between organisations, lack of local supported housing, inadequate health service resources, lack of awareness of community services among hospital staff, improvement in professional skills, and limited resources. Some reported that discharge planning for people experiencing homelessness was difficult because they might be medically fit to leave the hospital, but still in need of basic medical care that is not available in shelters or on the street. Some homeless shelter staff reported that medical respite is a frequent unmet need. A few service providers thought discharge planning should start at admission. “They should make sure people don’t leave late at night and that they have a safe ride to a safe place to stay.”	Minor concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[3]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Hauff 2014 Mixed methods with interviews. N=24 (n=10 homeless shelter staff, n=14 health service staff). Healthwatch 2015 General qualitative inquiry with focus groups and survey data. N=Not reported. Homeless Link 2012 General qualitative inquiry with interviews and stakeholder meeting. N=95 (n=57 people experiencing homelessness, n=38 members of staff from homelessness organisations, Local Authorities, and hospital trusts). McNeil 2012b General qualitative inquiry with interviews. N=54 health and social services professionals (same population as McNeil 2012a).	[Quote: Greysen 2012, p.1488] "They discharged me and I was back on the streets. They could have kept me in there longer and made sure I was full recovered before being discharged. They don't care; I don't have anywhere to stay to fully recover." [Quote: Healthwatch 2015, p.42] "Discharge information is not communicated, there's no forward planning, and patients are subsequently discharged to no fixed abode." [Quote: The Queen's Nursing Institute, p.2]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Nicholas 2016 Grounded theory with interviews. N=41 (n=20 hospital staff, n=21 community-based workers). Rae 2015 Phenomenological with interviews. N=14 people experiencing homelessness. Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. The Queen's Nursing Institute 2015 General qualitative inquiry with interviews. N>180 nurses.						
Sub-theme A3.10.5 – Referrals between services						
7 studies Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Gallardo 2020 General qualitative inquiry with interviews. N=17 service	Data from 7 studies reported on the challenges of making referrals when supporting people in the homeless population. Service users and providers reported long delays between referrals and the start of support or treatment, particularly in relation to secondary mental health services. People experiencing homelessness preferred to use emergency care since it offered access to more diverse treatment in a single visit. Service providers were aware that providing a referral to a specialist service sometimes did not result in the homeless person attending that appointment due to the logistics involved with	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
providers (n=7 social service providers, n=10 healthcare providers). Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and service providers not reported). Kesia 2018 General qualitative inquiry with interviews. N=60 (n=37 people experiencing homelessness, n=23 stakeholders). Moore 2011 General qualitative inquiry with interviews. N=47 (n=20 people experiencing homelessness, n=27 service providers). Pleace 2020 General qualitative inquiry with interviews. N=23 people with lived experience of sleeping rough. Salem 2015 General qualitative inquiry with focus	planning to attend an appointment in the future. There appeared to be little tracking of referrals to another service. One service provider reported that GPs receive little information from secondary health services about the outcome of referrals, which meant the onus was therefore on the patient to re-present to their GP, or actively seek alternative services, which can be particularly difficult for people experiencing homelessness. There were examples where service users had been referred on, but this did not translate into effective support or treatment. Sometimes a referral would receive no response, an issue with mental health services, or there could be a sense of being referred to one service after another, without necessarily getting the support, care or treatment needed from any of them. "…it's not uncommon for us to try to make four or five referrals for a kid to [agency name] …So we try to work on them—work with them, make them an appointment—so [agency name] is right over there, you can see it across the street and sometimes they don't get there so we'll circle back with them again." (P13, HC). [Quote: Gallardo 2020, p.6] "I think the most favourite word of services at the moment is, we'll refer you. You go to them and they say, 'We'll refer you to them.'" [Quote: Pleace 2020, p.11]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
groups. N=20 homeless women.						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

2. Some evidence is from a different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)

3. Some evidence is from a different context to the review question (study population in Healthwatch 2015 includes people experiencing homelessness, older people, and people with mental illnesses).

Table 50: Evidence summary profile for (GRADE-CERQual) theme A3.11 – Experiences of stigma and discrimination

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
36 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth.	Data from 36 studies showed that people experiencing homelessness experience stigma and discrimination in health and social care. People experiencing homelessness identified stigma and discrimination during visits to healthcare stemming from several factors including complex needs, ethnicity, gender, socioeconomic status (including homelessness), (perceived) substance use, and appearance. Most people experiencing homelessness reported experiencing discrimination on some level, with a majority recounting some form of prejudiced behaviour from service providers. Some people reported that they were not respected, they were treated with a lack of dignity, and excluded from mainstream services due to stigma and discrimination. This led to feelings of hopelessness and distrust and prevented future use of health services. Service users commonly reported that they felt as if service providers thought that their life situation is self-inflicted and there is no influence of structural causes of	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
N=5 focus groups with 4-10 participants in each focus group. Biederman 2014 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2013). Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Broadbridge 2018 General qualitative inquiry with interviews. N=23 people experiencing homelessness. Campbell 2015 General qualitative inquiry with interviews. N=22 (n=11 people experiencing homelessness, n=11 service providers). Canavan 2012 General qualitative inquiry with interviews. N=28 experts in mental healthcare for people experiencing homelessness. Croft-White 2004	homelessness. Most people reported inadequate or incomplete care that was rushed with early discharge and no follow-up. Often, people experiencing homelessness didn't state their living situation for fear of sub-standard care. One study reported service providers thought more training was required to overcome these damaging preconceptions and behaviours. "Nurses shouldn't judge but the staff in one hospital made me feel like dirt on a shoe. They were clearly not interested in me and made me feel as if everything was self-inflicted. But in another hospital, everything was absolutely fine and I felt treated like an equal." [Quote: Croft-White 2004, p.23] A parasite... So, the doctors just look at those people in a certain way... It is sometimes so unpleasant" (Male CP 8, 41 years old) "I've experienced it so many times. Even though I'm not Roma, you can see it right away... even at the doctors, when a Roma woman comes in, the attitude is just different" (Female CP 11, 53 years old). [Quotes: Glumbikova 2018, p.320] "They cleaned me up overnight and discharged me the next day. I didn't feel ready to leave." "They always get you out as fast as they can. I never get a treatment plan. I get treated as fast as possible and no follow-up." "After being beaten up with a crow-bar I got x-ray and stayed overnight and had a headache when they discharged me but got no plan or support." [Quotes: Healthwatch 2015, p.17] "I think there's a stigma … and professionals see it as a choice, you choose to pick the can up and					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Case study and general qualitative inquiry with interviews. N=100 service providers. Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Dickins 2020 General qualitative inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers). Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Glumbikova 2018 Grounded theory with interviews. N=30 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing homelessness and	put it to your mouth, rather than you being mentally and physically sick … So they just think 'You're wasting our time, you didn't have to pick up that drink', but there's so much more behind it than just picking up the drink. (Formerly homeless person – Borough B) [Quotes: Shulman 2018, p.41]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
service providers not reported). Gunner 2019 General qualitative inquiry with interviews. N=22 people experiencing homelessness. Healthwatch 2015 General qualitative inquiry with focus groups and survey data. N=Not reported. Homeless Link 2012 General qualitative inquiry with interviews and stakeholder meeting. N=95 (n=57 people experiencing homelessness, n=38 members of staff from homelessness organisations, Local Authorities, and hospital trusts). Hudson 2010 General qualitative inquiry with focus groups. N=24 homeless youth. Kennedy 2014 Grounded theory with interviews. N=22 homeless women. Kesia 2018 General qualitative inquiry with interviews.						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
N=60 (n=37 people experiencing homelessness, n=23 stakeholders). Leggio 2020 Phenomenological with interviews. N=18 people experiencing homelessness. Lester 2001 Grounded theory with interviews. N=25 general practitioners with experience with people experiencing homelessness. MacKenzie 2019 Phenomenological with interviews. N=10 service providers (same population as reported in Purkey 2019). Mago 2018 Ethnographic, phenomenological with interviews. N=25 people experiencing homelessness. Munoz 2015 General qualitative inquiry with interviews and focus groups. N=30 homeless adolescents. Nicholas 2016 Grounded theory with interviews. N=41						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
(n=20 hospital staff, n=21 community-based workers). Pendyal 2020 Grounded theory with interviews. N=19 people experiencing homelessness. Pleace 2000 General qualitative inquiry with interviews. N=112 (n=12 GPs, n=7 health authority workers, n=6 health workers, n=19 homelessness workers, n=4 representatives from different organisations, n=64 people sleeping rough). Pleace 2020 General qualitative inquiry with interviews. N=23 people with lived experience of sleeping rough. Purkey 2019 General qualitative inquiry with interviews and focus groups. N=41 (n=31 people experiencing homelessness, n=10 health service providers) (same population as reported in MacKenzie 2019).						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Salem 2015 General qualitative inquiry with focus groups. N=20 homeless women. Shulman 2018 General qualitative inquiry with focus groups. N=127 (n=28 people experiencing homelessness, n=99 healthcare workers). Strange 2018 General qualitative inquiry with interviews. N=32 (n=27 people experiencing homelessness, n=5 allied service staff). Sznajder-Murray 2011 Phenomenological with interviews. N=28 homeless women. Vasillou 2006 General qualitative inquiry with interviews. N=59 (n=59 homeless youth, staff from n=123 services working in the field of housing and youth homelessness). Wille 2017 General qualitative inquiry with interviews. N=28 (n=16 people experiencing homelessness, n=12 service providers).						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Wise 2013 Phenomenological with interviews. N=11 people experiencing homelessness.						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist
2. Some evidence is from a different context to the review question (study population in Healthwatch 2015 includes people experiencing homelessness, older people, and people with mental illnesses and the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen).

Table 51: Evidence summary profile for (GRADE-CERQual) theme B3.1 – Quality of the relationship between provider and person using services

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sub-theme B3.1.1 – Positive experiences of care						
13 studies Astra Zeneca 2012 General qualitative inquiry with interviews and focus groups. N=26 homeless youth. N=5 focus groups with 4-10 participants in each focus group. Biederman 2013 Phenomenological with interviews. N=15 homeless women (same population as Biederman 2014). Biederman 2014	Data from 13 studies reported that people experiencing homelessness valued trusting relationships where they could express vulnerability. Positive interactions included being treated with dignity, remembering, acknowledging, listening, talking, giving advice, being available, creating a safe and/or welcoming environment, showing concern, joking, giving tangible aid, and reaching out. This resulted in service users feeling worthy of care, empowered, and recognised as a valid individual. Service users reported positive experiences with dentists, GPs, mental health services, paramedics, and the voluntary sector. A positive experience of healthcare led to an increased chance of using that service again. “I loved [mental health service], I really did. Umm, you know, they help me out through a lot of things, but you know it was that someone I had to talk to, and in that time no matter where I was, like they paid for a taxi to every appointment so I can	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Phenomenological with interviews. N=15 homeless women (same population as Biederman 2013). Black 2018 Phenomenological with interviews. N=30 (n=10 homeless youth, n=20 service providers). Chaturvedi 2016 General qualitative inquiry with interviews. N=7 homeless youth Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Leggio 2020 Phenomenological with interviews. N=18 people experiencing homelessness. Pleace 2020 General qualitative inquiry with interviews. N=23 people with lived experience of sleeping rough. Purkey 2019 General qualitative inquiry with interviews	get to and from every appointment without having to worry… I was always able to access them no matter what. So that was like a one stable place I had from fourteen all the way through to, I was about seventeen. So I was linked in with them and had the same psychiatrist the whole time that never changed on me either, which was good because she knew who I was and then at the end she was starting to come to my DHS things, going [to DHS] 'You've got to do this better, you have to do that better'". (Participant #22, young person) [Quote: Black 2018, p.10] "I was only able to do the second counselling due to the fact that the first counselling was really good." (Mika) [Quote: Chaturvedi 2016, p.58] "She's a nurse here yes. I adore her. I adore her. I respect her and I trust her and she's the sweetest girl that. I've ever had – the sweetest medical care person I've ever had take care of me. She's just amazing […] Yeah. like she's very very thorough and she's very compassionate. I just, oh my heart's with her, I love her. Yeah." (FG9BRM1) [Quote: Purkey 2019, p.5]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
and focus groups. N=41 (n=31 people experiencing homelessness, n=10 health service providers) (same population as reported in MacKenzie 2019). Stajduhar 2019 Ethnographic with participant observation and interviews. Number of people who were observed: N=119 (n=25 people experiencing homelessness, n=25 support persons, n=69 formal service providers). Number of people who were interviewed: N=58 (n=19 people experiencing homelessness, n=16 support persons, n=23 service providers). Sturman 2020 General qualitative inquiry with focus groups. N=20 homeless men. Ungpakorn 2020 General qualitative inquiry with interviews. N=10 people experiencing homelessness.						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Vasillou 2006 General qualitative inquiry with interviews. N=59 (n=59 homeless youth, staff from n=123 services working in the field of housing and youth homelessness).						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

Table 52: Evidence summary profile for (GRADE-CERQual) theme B3.2 – Role and availability of outreach

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
19 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Asgary 2015 Grounded theory with interviews. N=50 people experiencing homelessness. Croft-White 2004	Data from 19 studies showed positive effects of outreach services, including increasing knowledge around health issues, information on the available services (signposting), and healthcare entitlements. Service users appreciated outreach care from: charity workers, GPs, nurse practitioner, pharmacists, and substance misuse nurses. Services users described numerous benefits from outreach services. For example, outreach services eliminate most access barriers faced by people experiencing homelessness, such as transport and psychological barriers. Outreach services bring a level of flexibility that is not possible in traditional healthcare services. The act of coming to the service users also helps to build trust and a strong connection with the service provider and reduces the sense of isolation. Several people reported having a more positive experience with outreach GPs than with GPs in a practice. Service providers also described the benefits of this approach to delivery. Outreach services	Moderate concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
General qualitative inquiry with interviews. N=100 service providers. Csikar 2019 General qualitative inquiry with focus groups. N=16 people experiencing homelessness. Dickins 2020 General qualitative inquiry with interviews. N=26 (n=15 people experiencing homelessness, n=11 service providers). Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social service providers, n=10 healthcare providers). Groundswell 2015 General qualitative inquiry with focus groups. N=44 people experiencing homelessness. Groundswell 2016 General qualitative inquiry with interviews and focus groups. N=91 (breakdown of people experiencing	provided the opportunity for screening and immunisation, and to introduce harm reduction strategies to people experiencing homelessness. Outreach services could help prevent people falling through the safety net of health and social care and were considered more beneficial for those who have a history of marginalisation. Healthcare professionals reported that they need protected time for outreach activities. "We do have a dental unit that goes out. It is a mobile unit that goes out to several locations and is stationed there for a month, until it takes care of the entire community in that area." (P9, HC). [Quote: Gallardo 2020, p.6] "I am just talking personally – there are some mornings you wake up and you don't feel you want to get out of bed, you don't want to get up and get dressed. You don't want to even face anyone in the hostel, you don't even want to step outside. And by having somebody come in, park up there, it would be great." (Focus Group Participants) [Quote: Groundswell 2016, p.12] "They (persons experiencing homelessness) don't go to a doctor...so, if you went out to them...they would probably open up to you." [Quote: Jagpal 2019, p.6] "...allowing healthcare professionals protected time to do that, because...outreach services...that don't directly impact on their clinical practice fall down the prioritisation list' (academic)." [Quote: Paisi 2020, p.4] "They actually have somebody who comes here every third Friday, I believe, who does that. They'll come, and they'll give you your shots and make sure you're up to health and all that [. . .] It was good, because the person came here, and they					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
homelessness and service providers not reported). Groundswell 2017 Mixed methods with focus groups. N=47 people experiencing homelessness. Groundswell 2020 Mixed methods with interviews and focus groups. N=104 homeless women. Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Jagpal 2019 General qualitative inquiry with focus groups. N=9 people experiencing homelessness. Kerman 2019 N=52 (n=26 currently housed people with a history of homelessness, n=26 currently experiencing homelessness). MacKenzie 2019 Phenomenological with interviews. N=10 service providers (same population as	explained why they're here and what they're doing. Literally, as they went along, they showed me what they were doing and whatever." [Quote: Ramsay 2019, p.1845]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
reported in Purkey 2019). Paisi 2020 General qualitative inquiry with interviews and focus groups. N= 23 (n=11 people experiencing homelessness, n=12 stakeholders). Pleace 2000 General qualitative inquiry with focus groups. N=23 people with lived experience of sleeping rough. Ramsay 2019 General qualitative inquiry with interviews. N=16 people experiencing homelessness. Strange 2018 General qualitative inquiry with interviews. N=32 (n=27 people experiencing homelessness, n=5 allied service staff). Ungpakorn 2020 General qualitative inquiry with interviews. N=10 people experiencing homelessness.						

1. Moderate concerns about methodological limitations as per CASP qualitative checklist

2. Some evidence is from a different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)

Table 53: Evidence summary profile for (GRADE-CERQual) theme B3.3 – Service delivery and organisation

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme B3.3.1 – Service collaboration						
11 studies Alunni-Menichini 2020 General qualitative inquiry with interviews and stakeholder meetings. N=47 (n=34 service providers, n=5 health and social services professionals, n=8 people experiencing homelessness). Black 2018 General qualitative inquiry with interviews. N=10 people experiencing homelessness. Croft-White 2004 General qualitative inquiry with interviews. N=100 service providers. Gallardo 2020 General qualitative inquiry with interviews. N=17 service providers (n=7 social	Data from 11 studies reported on the positive effects of collaboration between agencies although there were clear variations in the success of joint working. Service collaboration: delineates roles so each provider knows what their input is, avoids doubling up on information or resources, increases efficiency, increases awareness of what other services provide, increases awareness of patient issues, and provides a consistent response to patients. Service providers reported that interagency partnerships helped streamline the referral process between agencies and also allowed inter-professional relationships to develop, which provided them with direct organisational contacts that helped facilitate the service connection process. Establishing relationships with other healthcare professionals and homeless support organisations can promote a holistic approach to care, help with signposting, and improve attendance and compliance rates. However, good relationships were not shared across the board. In some areas, agencies felt there was a poor attitude towards joint working meaning it was rarely a priority. Even where relationships did exist, there was concern about how easily they could be lost with the high turnover of staff, and variation between wards within the same hospital. In some areas, agencies continued to feel isolated and would welcome the	Minor concerns[1]	No or very minor concerns	No or very minor concerns	Minor concerns[2]	HIGH

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
service providers, n=10 healthcare providers). Health Scotland 2004 General qualitative inquiry with interviews. N=Not reported. Homeless Link 2012 General qualitative inquiry with interviews and stakeholder meeting. N=95 (n=57 people experiencing homelessness, n=38 members of staff from homelessness organisations, Local Authorities, and hospital trusts). Jagpal 2019 General qualitative inquiry with focus groups. N=9 people experiencing homelessness. Klop 2018 General qualitative inquiry with focus groups. N=34 (n=15 people experiencing homelessness, n=19 service providers). McNeil 2012b General qualitative inquiry with interviews. N=54 health and	opportunity to extend communication links, particularly within hospital settings. “Through cooperation and good knowledge of the people in the organizations, we manage to give proper referrals and to have easier access: I know you, you know me, we've done business together, we have a mutual trust. Sometimes, this will allow all the flexibility needed for a client who may not fit perfectly […].” (Table 4, Synthesis, World Café) [Quote: Alunni-Menichini 2020, p.9] “There are so many staff changes and a high turnover of staff…we’ve told them about good practice but once staff changes started to be so frequent it’s got harder for the message to get through.” (Hospital link worker) [Quote: Homeless Link 2012, p.15] “We work together at three sites. Because many of our patients that we have [in the hospice] have been known to the other two sites, there's kind of a family. In that way, we help each other and we communicate with each other. As far as other facilities go, we use what's out there in the community. Our patients may be known to some community health centres.” (Nurse) [Quote: McNeil 2012b, p.5]					

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
social services professionals (same population as McNeil 2012a). Mills 2015 General qualitative inquiry with interviews. N=13 healthcare professionals. Paisi 2020 General qualitative inquiry with interviews and focus groups. N= 23 (n=11 people experiencing homelessness, n=12 stakeholders).						

1. Minor concerns about methodological limitations as per CASP qualitative checklist

2. Some evidence is from a different context to the review question (the study population in Alunni-Menichini 2020 includes service professionals not associated with providing health or social care, for example policemen)

Appendix G Economic evidence study selection

Study selection for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

One global search was undertaken – please see Supplement 2 for details on study selection.

Appendix H Economic evidence tables

Economic evidence tables for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

No evidence was identified which was applicable to this review question.

Appendix I Economic model

Economic model for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

No economic analysis was conducted for this review question.

Appendix J Excluded studies

Excluded studies for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

Excluded qualitative studies

Table 54: Excluded studies and reasons for their exclusion

Study	Reason for exclusion
(2014) Supporting the social networks of homeless people. Housing Care and Support 17(4): 198-207	- No qualitative data on phenomena of interest
(2017) What happens when people leave hospital and other care settings?: findings from the Healthwatch network.	- Incorrect study design
A, Schneider Dana and et, al. (2019) Voices should be heard: what personal stories of homelessness teach us about practice. Families in Society 100(3): 317-327	- No qualitative data on phenomena of interest
Abbott, P., Magin, P., Davison, J. et al. (2017) Medical homelessness and candidacy: Women transiting between prison and community health care. International Journal for Equity in Health 16(1): 130	- Incorrect population
Albanese, F.; Hurcombe, R.; Mathie, H. (2016) Towards an integrated approach to homeless hospital discharge: An evaluation of different typologies across England. Journal of Integrated Care 24(1): 4-14	- No qualitative data on phenomena of interest
Allen, J. and Vottero, B. (2020) Experiences of homeless women in accessing health care in community-based settings: a qualitative systematic review. JBI evidence synthesis 18(9): 1970-2010	- Systematic review, included studies checked for relevance. One new study added
Allen, R.; Sanders, C.; Dawes, J. (2017) A service evaluation of 'A Mile in Her Shoes': The impact of volunteer-led running groups for women affected by homelessness. Physiotherapy (United Kingdom) 103(supplement1): e5	- Conference abstract
Amen, M. M. and Pacquiao, D. F. (2004) Contrasting experiences with child health care services by mothers and professional caregivers in transitional housing. Journal of Transcultural Nursing 15(3): 217-224	- Incorrect population
Anderson, L.; Stuttaford, M.; Vostanis, P. (2006) A family support	- No qualitative data on phenomena of interest

Study	Reason for exclusion
service for homeless children and parents: User and staff perspectives. Child and Family Social Work 11(2): 119-127	
Anderson, Paul (2010) Rethinking homelessness. Connect: 10-11	- Article unavailable
Aparicio, E. M., Phillips, D. R., Okimoto, T. et al. (2018) Youth and provider perspectives of Wahine Talk: A holistic sexual health and pregnancy prevention program developed with and for homeless youth. Children and Youth Services Review 93: 467-473	- No qualitative data on phenomena of interest
Archard, P. J. and Murphy, D. (2015) A practice research study concerning homeless service user involvement with a programme of social support work delivered in a specialized psychological trauma service. Journal of Psychiatric & Mental Health Nursing (John Wiley & Sons, Inc.) 22(6): 360-370	- No qualitative data on phenomena of interest
Arslan, Serdar (2013) "The experiences of professionals working with homeless people in a clinical setting": a qualitative study. Housing, Care & Support 16(34): 145-153	- No qualitative data on phenomena of interest
Asgary, R., Sckell, B., Alcabes, A. et al. (2015) Perceptions, Attitudes, and Experience Regarding mHealth Among Homeless Persons in New York City Shelters. Journal of health communication 20(12): 1473-1480	- No qualitative data on phenomena of interest
Aviles, A. and Helfrich, C. (2004) Life skill service needs: Perspectives of homeless youth. Journal of Youth and Adolescence 33(4): 331-338	- No qualitative data on phenomena of interest
Barker, S. L., Maguire, N., Bishop, F. L. et al. (2019) Expert viewpoints of peer support for people experiencing homelessness: A Q sort study. Psychological services 16(3): 402-414	- Incorrect study design
Beal, Catherine (2014) Insider accounts of the move to the outside: two young people talk about their transitions from secure institutions. Youth Justice 14(1): 63-76	- Incorrect population
Bean, K. F.; Shafer, M. S.; Glennon, M. (2013) The impact of housing first and peer support on people who are medically vulnerable and homeless. Psychiatric rehabilitation journal 36(1): 48-50	- Incorrect study design
Bear, Lauren; Durcan, Graham; Southgate, Jessica (2019) A sense of	- Incorrect population

Study	Reason for exclusion
safety: trauma-informed approaches for women.: 2019	
Begun, S., Combs, K. M., Torrie, M. et al. (2019) "It seems kinda like a different language to us": Homeless youths' attitudes and experiences pertaining to condoms and contraceptives. Social work in health care 58(3): 237-257	- No qualitative data on phenomena of interest
Begun, S. and Massey Combs, K. (2017) An unmet need: Homeless youths' experiences, attitudes and decision making regarding contraception. Contraception 96(4): 274-275	- Conference abstract
Beharry, M. S., Wieseneck, S., Conn, K. et al. (2012) Deserving and designing health care: Suggestions for health care improvement from homeless teens. Journal of Adolescent Health 50(2suppl1): 83	- Conference abstract
Bell, Nick and Lewis, Rosie (2004) Watch this space: young people’s views on writing and designing an effective leaving home guide.: 29p	- No qualitative data on phenomena of interest
Bender, K., Begun, S., Durbahn, R. et al. (2018) My Own Best Friend: Homeless Youths' Hesitance to Seek Help and Strategies for Coping Independently after Distressing and Traumatic Experiences. Social work in public health 33(3): 149-162	- No qualitative data on phenomena of interest
Berends, L. B. (2002) Alcohol and drug supported accommodation for clients with special needs. International Journal of Drug Policy 13(6): 485-493	- No qualitative data on phenomena of interest
Beth, Cummings and et, al. (2000) Young homeless people: speaking for themselves.: 31p	- No qualitative data on phenomena of interest
Bhui, K. (2006) Homelessness and mental illness: A literature review and a qualitative study of perceptions of the adequacy of care - Response. International Journal of Social Psychiatry 52(5): 479-480	- Incorrect study design
Biederman J (2012) Understanding the Experience of Interacting with Service Providers from the Perspective of Homeless Women: A Phenomenological Study.	- Duplicate
Bilton, Helen (2009) Happiness matters: homeless people's views about breaking the link between homelessness and mental ill health.: 43pbibliog	- Duplicate

Study	Reason for exclusion
Bird, Melissa, Rhoades, Harmony, Lahey, John et al. (2017) Life Goals and Gender Differences among Chronically Homeless Individuals Entering Permanent Supportive Housing. Journal of social distress and the homeless 26(1): 9-15	- No qualitative data on phenomena of interest
Bloom, K. C., Bednarzyk, M. S., Devitt, D. L. et al. (2004) Barriers to prenatal care for homeless pregnant women. JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing 33(4): 428-435	- Incorrect study design
Boisvert, R. A., Martin, L. M., Grosek, M. et al. (2008) Effectiveness of a peer-support community in addiction recovery: Participation as intervention. Occupational Therapy International 15(4): 205-220	- Study conducted outside the UK and published before 2010
Borysow, I. C. and Furtado, J. P. (2014) Access, equity and social cohesion: Evaluation of intersectoral strategies for people experiencing homelessness. Revista da Escola de Enfermagem 48(6): 1066-1073	- Not in English language
Bozinoff, N., Small, W., Long, C. et al. (2017) Still "at risk": An examination of how street-involved young people understand, experience, and engage with "harm reduction" in Vancouver's inner city. International Journal of Drug Policy 45: 33-39	- No qualitative data on phenomena of interest
Brinkley-Rubinstein, L. and Turner, W. L. (2013) Health impact of incarceration on HIV-positive African American males: A qualitative exploration. AIDS Patient Care and STDs 27(8): 450-458	- No qualitative data on phenomena of interest
Brown, A., Rice, S. M., Rickwood, D. J. et al. (2016) Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. Asia-Pacific Psychiatry 8(1): 3-22	- Systematic review, included studies checked for relevance. No new studies added
Buckley, K., Tsu, L., Hormann, S. et al. (2017) A health sciences student-run smoking cessation clinic experience within a homeless population. Journal of the American Pharmacists Association 57(1): 109	- No qualitative data on phenomena of interest
Bunce, D. (2000) Problems faced by homeless men in obtaining health care. Nursing standard (Royal College of Nursing (Great Britain) : 1987) 14(34): 43-45	- Incorrect study design

Study	Reason for exclusion
Bungay, V. (2013) Health care among street-involved women: the perpetuation of health inequity. Qualitative health research 23(8): 1016-1026	- Incorrect population
Buu, M. C., Carter, L., Bruce, J. S. et al. (2014) Asthma, tobacco smoke and the indoor environment: A qualitative study of sheltered homeless families. Journal of Asthma 51(2): 142-148	- No qualitative data on phenomena of interest
Cameron, A. (2010) Supporting homeless people living with HIV. Retrovirology 7(suppl1): p161	- Conference abstract
Cameron, A., Abrahams, H., Morgan, K. et al. (2016) From pillar to post: homeless women's experiences of social care. Health & social care in the community 24(3): 345-352	- Study excluded due to thematic saturation for sub-theme A3.10.3 ‘fragmented services’ (this theme is already reported and is judged to be fully adequate and fully coherent). Does not report any other relevant data.
Cameron, A., Lloyd, L., Turner, W. et al. (2009) Working across boundaries to improve health outcomes: A case study of a housing support and outreach service for homeless people living with HIV. Health and Social Care in the Community 17(4): 388-395	- No qualitative data on phenomena of interest
Cameron, Karen L. (2010) Older homeless women with depression. phd: 124 p-124 p	- No qualitative data on phenomena of interest
Campbell, David J. T., Gibson, Katherine, O'Neill, Braden G. et al. (2013) The role of a student-run clinic in providing primary care for Calgary's homeless populations: a qualitative study. BMC health services research 13: 277	- No qualitative data on phenomena of interest
Campbell, R., Saunders-Smith, T., Tibebu, T. et al. (2020) 22 - Patient-Level Barriers to Diabetes Management Among Those With Housing Instability. Canadian Journal of Diabetes 44(7supplement): 10	- Conference abstract
Canham, S. L., Custodio, K., Mauboules, C. et al. (2020) Health and Psychosocial Needs of Older Adults Who Are Experiencing Homelessness Following Hospital Discharge. The Gerontologist 60(4): 715-724	- No qualitative data on phenomena of interest
Canham, S. L., Davidson, S., Custodio, K. et al. (2019) Health supports needed for homeless persons transitioning from hospitals. Health & social care in the community 27(3): 531-545	- Systematic review, included studies checked for relevance. No new studies added

Study	Reason for exclusion
Carpenter-Song, Elizabeth; Whitley, Rob; Hipolito, Maria Mananita S. (2012) "Right Here Is an Oasis": How "Recovery Communities" Contribute to Recovery for People With Serious Mental Illnesses. Psychiatric Rehabilitation Journal 35(6): 435-440	- Incorrect population
Carver, Hannah, Ring, Nicola, Miler, Joanna et al. (2020) What constitutes effective problematic substance use treatment from the perspective of people who are homeless? A systematic review and meta-ethnography. Harm reduction journal 17(1): 10	- No qualitative data on phenomena of interest
Caton, S.; Greenhalgh, F.; Goodacre, L. (2016) Evaluation of a community dental service for homeless and 'hard to reach' people. British dental journal 220(2): 67-70	- No qualitative data on phenomena of interest
Chan, B., Hulen, E., Edwards, S. T. et al. (2018) "It's like riding out the chaos": Perspectives of clinicians and staff on caring for high-utilizer patients in the summit intensive ambulatory care trial. Journal of General Internal Medicine 33(2supplement1): 84-85	- Conference abstract
Chan, Brian, Hulen, Elizabeth, Edwards, Samuel et al. (2019) "It's Like Riding Out the Chaos": Caring for Socially Complex Patients in an Ambulatory Intensive Care Unit (A-ICU). Annals of Family Medicine 17(6): 495-501	- No qualitative data on phenomena of interest
Chau, K. M.; Norris, J.; Heyworth, L. (2018) Advance care planning amongst the homeless: Perceptions of the physician orders for life sustaining treatment (POLST) form and barriers to its usage in the outpatient setting. Journal of General Internal Medicine 33(2supplement1): 107-108	- Conference abstract
Cheryl, F, Jan, R, Grant, M et al. (2013) An Evaluation of The London Community Addiction Response Strategy (London Cares): Facilitating Service Integration Through Collaborative Best Practices.	- No qualitative data on phenomena of interest
Choy-Brown, Mimi (2014) Review of Healing home: Health & homelessness in the life stories of young women. Affilia: Journal of Women & Social Work 29(1): 119	- Incorrect study design
Christiani, Ashley, Hudson, Angela L., Nyamathi, Adeline et al. (2008)	- Study conducted outside the UK and published before 2010

Study	Reason for exclusion
Attitudes of homeless and drug-using youth regarding barriers and facilitators in delivery of quality and culturally sensitive health care. Journal of child and adolescent psychiatric nursing : official publication of the Association of Child and Adolescent Psychiatric Nurses, Inc 21(3): 154-63	
Clifasefi, S. L., Collins, S. E., Torres, N. I. et al. (2016) HOUSING FIRST, BUT WHAT COMES SECOND? A QUALITATIVE STUDY OF RESIDENT, STAFF AND MANAGEMENT PERSPECTIVES ON SINGLE-SITE HOUSING FIRST PROGRAM ENHANCEMENT. Journal of Community Psychology 44(7): 845-855	- No qualitative data on phenomena of interest
Coleman, Mark (2007) Investigating the experiences of professionals working with people who are homeless and in contact with learning disability services. Tizard Learning Disability Review; 12(3): 15-24	- No qualitative data on phenomena of interest
Coles, Emma and Freeman, Ruth (2016) Exploring the oral health experiences of homeless people: a deconstruction-reconstruction formulation. Community Dentistry & Oral Epidemiology 44(1): 53-63	- No qualitative data on phenomena of interest
Collins, P. and Barker, C. (2009) Psychological help-seeking in homeless adolescents. International Journal of Social Psychiatry 55(4): 372-384	- No qualitative data on phenomena of interest
Collins, S. E., Jones, C. B., Hoffmann, G. et al. (2016) In their own words: Content analysis of pathways to recovery among individuals with the lived experience of homelessness and alcohol use disorders. International Journal of Drug Policy 27: 89-96	- No qualitative data on phenomena of interest
Collins, S. E., Orfaly, V. E., Wu, T. et al. (2018) Content analysis of homeless smokers' perspectives on established and alternative smoking interventions. International Journal of Drug Policy 51: 10-17	- No qualitative data on phenomena of interest
Conneely, A., Marshall, S., Bristowe, K. et al. (2018) Qualitative study exploring the experience of homelessness staff working with homeless people with life-limiting illnesses in Dublin, Ireland. Palliative Medicine 32(1supplement1): 88-89	- Conference abstract

Study	Reason for exclusion
Connors, W. J., Hussen, S. A., Holland, D. P. et al. (2017) Homeless shelter context and tuberculosis illness experiences during a large outbreak in Atlanta, Georgia. Public Health Action 7(3): 224-230	- No qualitative data on phenomena of interest
Cormack, Johanna (2009) Counselling marginalised young people: A qualitative analysis of young homeless people's views of counselling. Counselling & Psychotherapy Research 9(2): 71-77	- No qualitative data on phenomena of interest
Cote, P. B. (2019) Sexual Health Services for Homeless Youth: A Qualitative Analysis of their Experiences. Journal of Social Service Research 45(3): 429-443	- No qualitative data on phenomena of interest
Craft-Rosenberg, M.; Powell, S. R.; Culp, K. (2000) Health status and resources of rural homeless women and children. Western Journal of Nursing Research 22(8): 863-878	- Incorrect study design
Crane, M. and Warnes, A. M. (2001) Primary health care services for single homeless people: Defects and opportunities. Family Practice 18(3): 272-276	- Incorrect study design
Crawley, J., Kane, D., Atkinson-Plato, L. et al. (2013) Needs of the hidden homeless - no longer hidden: A pilot study. Public Health 127(7): 674-680	- Incorrect study design
Cream, Julia and et, al (2020) Delivering health and care for people who sleep rough: going above and beyond.: 112	- No qualitative data on phenomena of interest
Da Silva, B. (2002) Young homeless women encountered physical and individual barriers in obtaining health care. Evidence Based Nursing 5(4): 124-124	- Conference abstract
Dang, M. T., Jaime, M. C. D., Akers, M. et al. (2015) The feasibility and acceptability of an electronic personal health record for disconnected youth. Journal of Adolescent Health 56(2suppl1): 122	- Conference abstract
Dasari, M., Borrero, S., Akers, A. Y. et al. (2016) Barriers to Long-Acting Reversible Contraceptive Uptake Among Homeless Young Women. Journal of Pediatric and Adolescent Gynecology 29(2): 104-110	- No qualitative data on phenomena of interest
Davis, D., Hawk, M., Marx, J. et al. (2014) Mechanisms of Adherence in a Harm Reduction Housing Program.	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Journal of Social Work Practice in the Addictions 14(2): 155-174	
Davis, Dana; Hawk, Mary; Winkler, Dana (2017) Because the clients told us so. Housing, Care and Support 20(4): 164-174	- Incorrect study design
Dawes, Jo; Sanders, Charlotte; Allen, Rebecca (2019) "A Mile in Her Shoes": A qualitative exploration of the perceived benefits of volunteer led running groups for homeless women. Health & Social Care in the Community 27(5): 1232-1240	- No qualitative data on phenomena of interest
De Rosa, C. J., Montgomery, S. B., Kipke, M. D. et al. (1999) Service utilization among homeless and runaway youth in Los Angeles, California: rates and reasons. The Journal of adolescent health : official publication of the Society for Adolescent Medicine 24(6): 449-58	- No qualitative data on phenomena of interest
de Vries, Sophia G., Cremers, Anne L., Heuvelings, Charlotte C. et al. (2017) Barriers and facilitators to the uptake of tuberculosis diagnostic and treatment services by hard-to-reach populations in countries of low and medium tuberculosis incidence: a systematic review of qualitative literature. The Lancet. Infectious diseases 17(5): e128-e143	- Incorrect population
Deborah, Kahan and et, al. (2020) Implementing a trauma-informed intervention for homeless female survivors of gender-based violence: lessons learned in a large Canadian urban centre. Health and Social Care in the Community 28(3): 823-832	- No qualitative data on phenomena of interest
Derbyshire, P., Muir-Cochrane, E., Fereday, J. et al. (2006) Engagement with health and social care services: Perceptions of homeless young people with mental health problems. Health and Social Care in the Community 14(6): 553-562	- Study conducted outside the UK and published before 2010
Dickins, K., Buchholz, S. W., Ingram, D. et al. (2019) "Now that you've got that coverage": Promoting use of a regular source of primary care among homeless persons. Journal of the American Association of Nurse Practitioners	- No qualitative data on phenomena of interest
Dixon, Caitlin, Funston, Leticia, Ryan, Catherine et al. (2011) Linking young homeless people to mental health services: An exploration of an outreach clinic at a supported youth	- No qualitative data on phenomena of interest

Study	Reason for exclusion
accommodation service. Advances in Mental Health 10(1): 83-91	
Doran, Kelly M., Ran, Ziwei, Castelblanco, Donna et al. (2019) "It Wasn't Just One Thing": A Qualitative Study of Newly Homeless Emergency Department Patients. Academic Emergency Medicine 26(9): 982-993	- No qualitative data on phenomena of interest
Doroshenko, A., Hatchette, J., Halperin, S. A. et al. (2012) Challenges to immunization: the experiences of homeless youth. BMC public health 12: 338	- No qualitative data on phenomena of interest
Dowrick, C.; Gask, L.; Edwards, S. (2010) Programme to increase equity of access to high quality mental health services in primary care Care (AMP). Journal of Affective Disorders 122(suppl1): S18-S19	- Conference abstract
Drury, L. J. (2003) Community care for people who are homeless and mentally ill. Journal of Health Care for the Poor & Underserved 14(2): 194-207	- No qualitative data on phenomena of interest
Ensign, J. (2001) The health of shelter-based foster youth. Public health nursing (Boston, Mass.) 18(1): 19-23	- Incorrect study design
Ensign, J. (2004) Quality of health care: The views of homeless youth. Health Services Research 39(4i): 695-708	- Study conducted outside the UK and published before 2010
Ensign, J. and Bell, M. (2004) Illness experiences of homeless youth. Qualitative Health Research 14(9): 1239-1254	- Study conducted outside the UK and published before 2010
Ensign, Josephine and Panke, Aileen (2002) Barriers and bridges to care: voices of homeless female adolescent youth in Seattle, Washington, USA. Journal of Advanced Nursing (Wiley-Blackwell) 37(2): 166-172	- Study conducted outside the UK and published before 2010
Ferguson, Kristin M. and Maccio, Elaine M. (2015) Promising programs for lesbian, gay, bisexual, transgender, and queer/questioning runaway and homeless youth. Journal of Social Service Research 41(5): 659-683	- No qualitative data on phenomena of interest
Finfgeld-Connett, D. (2010) Becoming homeless, being homeless, and resolving homelessness among women. Issues in Mental Health Nursing 31(7): 461-469	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Fisher, M.; Florsheim, P.; Sheetz, J. (2005) That's not my problem: Convergence and divergence between self- and other-identified problems among homeless adolescents. Child and Youth Care Forum 34(6): 393-403	- Incorrect study design
Fitzpatrick, Suzanne; Pleace, Nicholas; Bevan, Mark (2005) Final evaluation of the Rough Sleepers Initiative.	- No qualitative data on phenomena of interest
Flick, U. and Rohnsch, G. (2007) Idealization and neglect: Health concepts of homeless adolescents. Journal of Health Psychology 12(5): 737-749	- No qualitative data on phenomena of interest
Fokuo, J. K., Masson, C. L., Anderson, A. et al. (2020) Recommendations for Implementing Hepatitis C Virus Care in Homeless Shelters: The Stakeholder Perspective. Hepatology Communications 4(5): 646-656	- No qualitative data on phenomena of interest
Fordham, Maria (2015) The lived experience of homeless women: insights gained as a specialist practitioner. Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association 88(4): 32-7	- No qualitative data on phenomena of interest
Franco, A. S. and Ngaruiya, C. (2018) Addressing homeless population needs in the emergency department using community-based participatory research. Academic Emergency Medicine 25(supplement1): 206	- Conference abstract
Franco, A. and Ngaruiya, C. (2016) Targeting homeless population needs using community-based participatory research methods in an urban emergency department. Annals of Emergency Medicine 68(4supplement1): S106-S107	- Conference abstract
French, R.; Reardon, M.; Smith, P. (2003) Engaging with a mental health service: Perspectives of at-risk youth. Child and Adolescent Social Work Journal 20(6): 529-548	- Study conducted outside the UK and published before 2010
Freund, P. D. and Hawkins, D. W. (2004) What street people reported about service access and drug treatment. Journal of Health and Social Policy 18(3): 87-93	- Study conducted outside the UK and published before 2010
Gabrielian, S., Young, A. S., Greenberg, J. M. et al. (2018) Social support and housing transitions	- Incorrect population

Study	Reason for exclusion
among homeless adults with serious mental illness and substance use disorders. Psychiatric rehabilitation journal 41(3): 208-215	
Garibaldi, B.; Conde-Martel, A.; O'Toole, T. P. (2005) Self-reported comorbidities, perceived needs, and sources for usual care for older and younger homeless adults. Journal of General Internal Medicine 20(8): 726-730	- Incorrect study design
Garrett, S. B., Higa, D. H., Phares, M. M. et al. (2008) Homeless youths' perceptions of services and transitions to stable housing. Evaluation and Program Planning 31(4): 436-444	- No qualitative data on phenomena of interest
Gazey, Angela, Vallesi, Shannen, Martin, Karen et al. (2019) The Cottage: providing medical respite care in a home-like environment for people experiencing homelessness. Housing, Care & Support 22(1): 54-64	- No qualitative data on phenomena of interest
Gelberg, L., Browner, C. H., Lejano, E. et al. (2004) Access to women's health care: a qualitative study of barriers perceived by homeless women. Women & Health 40(2): 87-100	- Study conducted outside the UK and published before 2010
Gharabaghi, K. and Stuart, C. (2010) Voices from the periphery: Prospects and challenges for the homeless youth service sector. Children and Youth Services Review 32(12): 1683-1689	- No qualitative data on phenomena of interest
Gibbons, Andrea, Madoc-Jones, Iolo, Ahmed, Anya et al. (2020) Rural homelessness: Prevention practices in Wales. Social Policy & Society 19(1): 133-144	- No qualitative data on phenomena of interest
Gomes Lira, Cindy Damaris, Rebouças Justino, Jéssica Micaele, Sarmento de Paiva, Irismar Karla et al. (2019) IS THE ACCESS OF THE STREET POPULATION A DENIED RIGHT?. Revista Mineira de Enfermagem: 1-8	- Not in English language
Gordon, A. C. T., Burr, J., Lehane, D. et al. (2019) Influence of past trauma and health interactions on homeless women's views of perinatal care. British Journal of General Practice 69(688): E760-E767	- No qualitative data on phenomena of interest
Gordon, Anna C. T. and Prasad, Vibhore (2019) Influence of past trauma and health interactions on	- Duplicate

Study	Reason for exclusion
homeless women's views of perinatal care: a qualitative study. British Journal of General Practice 69(688): 548	
Gorton, Sarah (2000) Homeless young women and pregnancy: pregnancy in hostels for single homeless people.	- No qualitative data on phenomena of interest
Grandisson, M., Mitchell-Carvalho, M., Tang, V. et al. (2009) Occupational therapists' perceptions of their role with people who are homeless. British Journal of Occupational Therapy 72(11): 491-498	- Study conducted outside the UK and published before 2010
Grech, E. and Raeburn, T. (2020) Perceptions of hospital-based Registered Nurses of care and discharge planning for people who are homeless: A qualitative study. Collegian	- Study conducted outside the UK and findings do not relate to innovative approaches to health and social care for people experiencing homelessness
Grech, Elizabeth and Raeburn, Toby (2019) Experiences of hospitalised homeless adults and their health care providers in OECD nations: A literature review. Collegian 26(1): 204-211	- Systematic review, included studies checked for relevance. No new studies added
Greenfield, B., Alessi, E. J., Manning, D. et al. (2020) Learning to endure: A qualitative examination of the protective factors of homeless transgender and gender expansive youth engaged in survival sex. International Journal of Transgender Health	- No qualitative data on phenomena of interest
Greysen, S. R., Allen, B., Lucas, G. et al. (2011) Understanding transitions in hospital care for the homeless patient: A mixed-methods, community-based participatory approach. Journal of General Internal Medicine 26(suppl1): 248	- Conference abstract
Groundswell (2020) #HealthNow Literature Review 2020: Trends in patient experience when experiencing homelessness.	- Systematic review, included studies checked for relevance. No new studies added
Guilcher, S. J., Hamilton-Wright, S., Skinner, W. et al. (2016) "Talk with me": perspectives on services for men with problem gambling and housing instability. BMC health services research 16(a): 340	- Incorrect population
Guirguis-Younger, M.; McNeil, R.; Runnels, V. (2009) Learning and knowledge-integration strategies of nurses and client care workers serving homeless persons. Canadian	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Journal of Nursing Research 41(2): 20-34	
Gulland, A. (2016) "I didn't want to be known": Finding healthcare when you are homeless. BMJ (Online) 355: i6511	- Incorrect study design
Gultekin, L., Brush, B. L., Baiardi, J. M. et al. (2014) Voices from the street: exploring the realities of family homelessness. Journal of family nursing 20(4): 390-414	- No qualitative data on phenomena of interest
Gwadz, M. V., Cleland, C. M., Quiles, R. et al. (2010) CDC HIV testing guidelines and the rapid and conventional testing practices of homeless youth. AIDS Education and Prevention 22(4): 312-327	- No qualitative data on phenomena of interest
Gwadz, Marya, Freeman, Robert, Leonard, Noelle R. et al. (2019) Understanding Organizations Serving Runaway and Homeless Youth: A Multi-setting, Multi-perspective Qualitative Exploration. Child & Adolescent Social Work Journal 36(2): 201-217	- No qualitative data on phenomena of interest
Hailes, Amanda and et, al (2018) Hand in hand: survivors of multiple disadvantage discuss service and support.: 40	- Incorrect population
Hakanson, C. and Ohlen, J. (2016) Illness narratives of people who are homeless. International journal of qualitative studies on health and well-being 11: 32924	- No qualitative data on phenomena of interest
Hakanson, Cecilia, Sandberg, Jonas, Ekstedt, Mirjam et al. (2016) Providing Palliative Care in a Swedish Support Home for People Who Are Homeless. Qualitative health research 26(9): 1252-62	- No qualitative data on phenomena of interest
Haldenby, A. M.; Berman, H.; Forchuk, C. (2007) Homelessness and health in adolescents. Qualitative Health Research 17(9): 1232-1244	- Study conducted outside the UK and published before 2010
Haley, R. J. and Woodward, K. R. (2007) Perceptions of individuals who are homeless: Healthcare access and utilization in San Diego. Advanced Emergency Nursing Journal 29(4): 346-355	- Study conducted outside the UK and published before 2010
Hanley, J., Ives, N., Lenet, J. et al. (2019) Migrant women's health and housing insecurity: an intersectional analysis. International Journal of Migration, Health and Social Care	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Hatton, D. C. (2001) Homeless women's access to health services: A study of social networks and managed care in the US. Women and Health 33(34): 149-162	- Study conducted outside the UK and published before 2010
Hatton, D. C. and Fisher, A. (1999) Strategies for managing health problems among homeless women: three case studies. Nursing case management : managing the process of patient care 4(1): 19-24	- Study conducted outside the UK and published before 2010
Hatton, D. C., Kleffel, D., Bennett, S. et al. (2001) Homeless women and children's access to health care: a paradox. Journal of community health nursing 18(1): 25-34	- Study conducted outside the UK and published before 2010
Hawkesford, J. L., Lette, H., Saunders, J. et al. (2020) Oral health perceptions and client satisfaction among homeless adults attending a community-centred dental clinic. Australian dental journal	- No qualitative data on phenomena of interest
Heinze, Hillary J. and Jozefowicz-Simbeni, Debra M. Hernandez (2009) Intervention for homeless and at-risk youth: Assessing youth and staff perspectives on service provision, satisfaction and quality. Vulnerable Children and Youth Studies 4(3): 210-225	- Study conducted outside the UK and published before 2010
Henning, D., Ryan, A., Sanci, L. et al. (2007) Screening for chlamydia trachomatis: Barriers for homeless young people. Australian Journal of Advanced Nursing 24(3): 8-13	- Study conducted outside the UK and published before 2010
Henry, M. L., Lichtman, J. H., Hanlon, K. et al. (2020) Clinical management of Type II Diabetes among the unstably housed: a qualitative study of primary care physicians. Family practice 37(3): 418-423	- No qualitative data on phenomena of interest
Hewett, N. C. (1999) How to provide for the primary health care needs of homeless people: What do homeless people in Leicester think?. British Journal of General Practice 49(447): 819	- Conference abstract
Hill, K. B. and Rimington, D. (2011) Investigation of the oral health needs for homeless people in specialist units in London, Cardiff, Glasgow and Birmingham. Primary health care research & development 12(2): 135-144	- Incorrect study design
Hislop, J. and Newlands, C. (2015) Evaluation of a specialist	- Conference abstract

Study	Reason for exclusion
physiotherapy service for homeless people. Physiotherapy (United Kingdom) 101(suppl1): es574	
Hoffman, Lisa and Coffey, Brian (2008) Dignity and indignation: How people experiencing homelessness view services and providers. The Social Science Journal 45(2): 207-222	- Study conducted outside the UK and published before 2010
Holger-Ambrose, B.; Langmade, C.; Edinburgh, L. (2011) Identifying effective outreach strategies for sexually exploited youth. Journal of Adolescent Health 48(2suppl1): 44	- Conference abstract
Hu, C., Jurgutis, J., Edwards, D. et al. (2020) "When you first walk out the gates...where do [you] go?": Barriers and opportunities to achieving continuity of health care at the time of release from a provincial jail in Ontario. PLoS ONE 15(4): e0231211	- Incorrect population
Hudson, A. L.; Nyamathi, A.; Sweat, J. (2008) Homeless youths' interpersonal perspectives of health care providers. Issues in Mental Health Nursing 29(12): 1277-1289	- Study conducted outside the UK and published before 2010
Hudson, B. F., Shulman, C., Low, J. et al. (2017) Challenges to discussing palliative care with people experiencing homelessness: A qualitative study. BMJ Open 7(11): e017502	- No qualitative data on phenomena of interest
Hudson, Briony F., Flemming, Kate, Shulman, Caroline et al. (2016) Challenges to access and provision of palliative care for people who are homeless: a systematic review of qualitative research. BMC Palliative Care 15: 1-18	- Systematic review, included studies checked for relevance. No new studies added
Huey, L.; Fthenos, G.; Hryniewicz, D. (2012) "I Need Help and I Know I Need Help. Why Won't Nobody Listen to Me?": Trauma and Homeless Women's Experiences with Accessing and Consuming Mental Health Services. Society and Mental Health 2(2): 120-134	- No qualitative data on phenomena of interest
Hwang, C.; Ono Kihara, M.; Kihara, M. (2017) Barriers and facilitators to tuberculosis examination among homeless people in Osaka city, Japan. International Journal of Antimicrobial Agents 50(supplement2): 46	- Conference abstract

Study	Reason for exclusion
Hyde (2010) Where are tomorrow's heartlanders?: unlocking the potential of social housing.: 54pbibliog	- Article unavailable
Iain, Ferguson; Margaret, Petrie; Kirsten, Stalker (2007) With them all the way. Mental Health Today: 28-31	- No qualitative data on phenomena of interest
Ijadi-Maghsoodi, R., Ports, K., Gelberg, L. et al. (2018) "It Can Tear Families Apart:" Understanding the Stressors and Mental Health Needs of Homeless Families With Parental Substance Use Disorders. Journal of the American Academy of Child and Adolescent Psychiatry 57(10supplement): 140	- Conference abstract
Irestig, R., Burstrom, K., Wessel, M. et al. (2010) How are homeless people treated in the healthcare system and other societal institutions? Study of their experiences and trust. Scandinavian journal of public health 38(3): 225-231	- Study conducted outside the UK and published before 2010
Jagpal, P., Saunders, K., Plahe, G. et al. (2020) Research priorities in healthcare of persons experiencing homelessness: Outcomes of a national multi-disciplinary stakeholder discussion in the United Kingdom. International Journal for Equity in Health 19(1): 86	- No qualitative data on phenomena of interest
Jardine, Lyn and Bilton, Kate (2006) Knowledge, understanding and views of homelessness amongst service providers (Research findings no 221).	- Incorrect study design
Jego, M., Grassineau, D., Balique, H. et al. (2016) Improving access and continuity of care for homeless people: how could general practitioners effectively contribute? Results from a mixed study. BMJ open 6(11)	- No qualitative data on phenomena of interest
Jenkins, M. and Parylo, C. (2011) Evaluation of health services received by homeless families in Leicester. Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association 84(1): 21-24	- Incorrect study design
Johnston, D.; McInerney, P.; Thurling, H. (2020) Experiences of the homeless accessing an inner-city pharmacy and medical student-run clinic in johannesburg. Health SA Gesondheid 25: 1-7	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Juandó-Prats, Clara (2017) Health Care Access and Utilization by Young Mothers Experiencing Homelessness: A Bourdieusian Analysis with an Arts-Based Approach. Health Care Access & Utilization by Young Mothers Experiencing Homelessness: A Bourdieusian Analysis with an Arts-Based Approach: 1-1	- No qualitative data on phenomena of interest
K, Martin Jared and R, Howe Tasha (2016) Attitudes toward mental health services among homeless and matched housed youth. Child and Youth Services 37(1): 49-64	- Incorrect study design
Kaplan, L. M., Sudore, R. L., Cuervo, I. A. et al. (2020) Barriers and Solutions to Advance Care Planning among Homeless-Experienced Older Adults. Journal of Palliative Medicine 23(10): 1300-1306	- No qualitative data on phenomena of interest
Karim, K., Tischler, V., Gregory, P. et al. (2006) Homeless children and parents: short-term mental health outcome. International Journal of Social Psychiatry 52(5): 447-458	- No qualitative data on phenomena of interest
Kennedy, A. C., Agbenyiga, D. L., Kasiborski, N. et al. (2010) Risk chains over the life course among homeless urban adolescent mothers: Altering their trajectories through formal support. Children and Youth Services Review 32(12): 1740-1749	- No qualitative data on phenomena of interest
Kerman, Nick, Manoni-Millar, Stéphanie, Cormier, Luc et al. (2020) "It's not just injecting drugs": Supervised consumption sites and the social determinants of health. Drug & Alcohol Dependence 213: N.PAG-N.PAG	- No qualitative data on phenomena of interest
Kertesz, S., Pollio, D., Johnson-Roe, K. et al. (2011) Crossing quality chasm: Primary care from the perspective of homeless patients and their caregivers. Journal of General Internal Medicine 26(suppl1): S122-S123	- Conference abstract
Kertesz, S., Steward, J., Johnson, K. et al. (2011) Crossing the primary care quality chasm for homeless patients: Understanding the perspectives of patients and their providers. Journal of Investigative Medicine 59(2): 534	- Conference abstract
Khan, Zana; Haine, Philip; Dorney-Smith, Samantha (2019) The GP role in improving outcomes for homeless	- No qualitative data on phenomena of interest

Study	Reason for exclusion
inpatients. Housing Care and Support 22(1): 15-26	
Kim, M. M., Swanson, J. W., Swartz, M. S. et al. (2007) Healthcare barriers among severely mentally ill homeless adults: Evidence from the five-site health and risk study. Administration and Policy in Mental Health and Mental Health Services Research 34(4): 363-375	- Incorrect population
King, Caroline, Fisher, Cameron, Johnson, Jacob et al. (2020) Community-derived recommendations for healthcare systems and medical students to support people who are houseless in Portland, Oregon: a mixed-methods study. BMC Public Health 20(1): 1-12	- No qualitative data on phenomena of interest
Klop, H. T., Van Dongen, S. I., De Veer, A. J. E. et al. (2018) The views of homeless people and healthcare professionals on palliative care and the possible use of a consultation function: A focus group study. Palliative Medicine 32(1supplement1): 125	- Conference abstract
Klop, Hanna T., de Veer, Anke J. E., van Dongen, Sophie I. et al. (2018) Palliative care for homeless people: a systematic review of the concerns, care needs and preferences, and the barriers and facilitators for providing palliative care. BMC Palliative Care 17(1): N.PAG-N.PAG	- Systematic review, included studies checked for relevance. No new studies added
Klop, Hanna T., Evenblij, Kirsten, Gootjes, Jaap R. G. et al. (2018) Care avoidance among homeless people and access to care: an interview study among spiritual caregivers, street pastors, homeless outreach workers and formerly homeless people. BMC Public Health 18(1): N.PAG-N.PAG	- Incorrect population
Ko, E. and Nelson-Becker, H. (2014) Does end-of-life decision making matter? Perspectives of older homeless adults. The American journal of hospice & palliative care 31(2): 183-188	- No qualitative data on phenomena of interest
Krausz, Reinhardt Michael, Clarkson, Adam F., Strehlau, Verena et al. (2013) Mental disorder, service use, and barriers to care among 500 homeless people in 3 different urban settings. Social Psychiatry & Psychiatric Epidemiology 48(8): 1235-1243	- Incorrect study design

Study	Reason for exclusion
Kryda, A. D. and Compton, M. T. (2009) Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically street homeless. Community Mental Health Journal 45(2): 144-150	- Study conducted outside the UK and published before 2010
Kurtz, S. P., Surratt, H. L., Kiley, M. C. et al. (2005) Barriers to health and social services for street-based sex workers. Journal of Health Care for the Poor & Underserved 16(2): 345-361	- Study conducted outside the UK and published before 2010
Kuyper, L., Kerr, T., Li, K. et al. (2006) Factors associated with buying and selling syringes among injection drug users in a setting of one of North America's largest syringe exchange programs. Substance Use and Misuse 41(67): 883-899	- Study conducted outside the UK and published before 2010
Larson, P. (2006) The complex self perceptions and relationships of patients who attended free clinics affected their attendance and ability to benefit from care. Evidence Based Nursing 9(2): 61-61	- Study conducted outside the UK and published before 2010
Latif, A., Mandane, B., Ali, A. et al. (2020) A qualitative exploration to understand access to pharmacy medication reviews: Views from marginalized patient groups. Pharmacy 8(2): 73	- Incorrect population
Leipersberger, T. (2007) An investigation of mental health care delivery from consumers' perspectives. Journal of Human Behavior in the Social Environment 15(1): 1-21	- Study conducted outside the UK and published before 2010
Lewinson, Terri and Collard, Carol S. (2012) Social service barriers experienced by low-income extended-stay hotel residents. Families in Society 93(2): 95-101	- No qualitative data on phenomena of interest
Lovisi, Giovanni Marcos (2006) Homelessness and mental illness: a literature review and a qualitative study of perceptions of the adequacy of care. The International journal of social psychiatry 52(5): 479-80	- Incorrect study design
Luck, J., Andersen, R., Wenzel, S. et al. (2002) Providers of primary care to homeless women in Los Angeles County. Journal of Ambulatory Care Management 25(2): 53-67	- Study conducted outside the UK and published before 2010
Maclure, K., Gibson Smith, K., Paudyal, V. et al. (2019)	- Conference abstract

Study	Reason for exclusion
Development of a tool to support community pharmacy engagement with patients who may be homeless. International Journal of Clinical Pharmacy 41(1): 326	
MacWilliams, J., Bramwell, M., Brown, S. et al. (2014) Reaching out to Ray: delivering palliative care services to a homeless person in Melbourne, Australia. International journal of palliative nursing 20(2): 83-88	- Incorrect study design
Mago, A., Brondani, M. A., MacEntee, M. I. et al. (2018) A Model Pathway to Oral Health Care for Homeless People. Journal (Canadian Dental Association) 84	- No qualitative data on phenomena of interest
Magwood, O., Leki, V. Y., Kpade, V. et al. (2019) Common trust and personal safety issues: A systematic review on the acceptability of health and social interventions for persons with lived experience of homelessness. PLoS ONE 14(12): e0226306	- Systematic review, included studies checked for relevance. No new studies added
Malden, Stephen, Jepson, Ruth, Laird, Yvonne et al. (2019) A theory based evaluation of an intervention to promote positive health behaviors and reduce social isolation in people experiencing homelessness. Journal of social distress and the homeless 28(2): 158-168	- No qualitative data on phenomena of interest
Mancini, N. L., Campbell, R., Yaphe, H. et al. (2020) 51 - Identifying Challenges and Solutions to Providing Diabetes Care for the Homeless. Canadian Journal of Diabetes 44(7supplement): 22	- Conference abstract
Martins, D. C. (2003) Health care experiences of homeless people. phd: 183 p-183 p	- Study conducted outside the UK and published before 2010
Martins, Diane Cocozza (2008) Experiences of homeless people in the health care delivery system: a descriptive phenomenological study. Public health nursing (Boston, Mass.) 25(5): 420-30	- Study conducted outside the UK and published before 2010
McBride, Rebecca G. (2012) Survival on the Streets: Experiences of the Homeless Population and Constructive Suggestions for Assistance. Journal of Multicultural Counseling & Development 40(1): 49-61	- No qualitative data on phenomena of interest
McCabe, S.; Macnee, C. L.; Anderson, M. K. (2001) Homeless	- Study conducted outside the UK and published before 2010

Study	Reason for exclusion
patients' experience of satisfaction with care. Archives of Psychiatric Nursing 15(2): 78-85	
McCann, E. and Brown, M. J. (2020) Homeless experiences and support needs of transgender people: A systematic review of the international evidence. Journal of nursing management	- Systematic review, included studies checked for relevance. No new studies added
McCoy, Karen (2000) Opening the door to health: access to primary healthcare services for single homeless people in Northern Ireland.: 48pbibliog	- Article unavailable
McGeough, C.; Walsh, A.; Clyne, B. (2020) Barriers and facilitators perceived by women while homeless and pregnant in accessing antenatal and or postnatal healthcare: A qualitative evidence synthesis. Health & social care in the community 28(5): 1380-1393	- Systematic review, included studies checked for relevance. No new studies added
McGrath, Liz and Pistrang, Nancy (2007) Policeman or friend? Dilemmas in working with homeless young people in the United Kingdom. Journal of Social Issues 63(3): 589-606	- No qualitative data on phenomena of interest
McGregor, F.; Shawe, J.; Robinson, A. (2016) Improving the sexual health of homeless young people resident in hostels. European Journal of Contraception and Reproductive Health Care 21(suppl1): 86-87	- Conference abstract
McKenzie, K., Murray, G., Wilson, H. et al. (2019) Homelessness-'It will crumble men': The views of staff and service users about facilitating the identification and support of people with an intellectual disability in homeless services. Health & social care in the community 27(4): e514-e521	- No qualitative data on phenomena of interest
McMaster, Rose, Lopez, Violeta, Kornhaber, Rachel et al. (2017) A Qualitative Study of a Maintenance Support Program for Women at Risk of Homelessness: Part 1: Personal Factors. Issues in Mental Health Nursing 38(6): 500-505	- No qualitative data on phenomena of interest
Meadows-Oliver, M. (2006) Homeless adolescent mothers: a metasynthesis of their life experiences. Journal of Pediatric Nursing 21(5): 340-349	- No qualitative data on phenomena of interest
Mellor, R. and Lovell, A. (2012) The lived experience of UK street-based	- No qualitative data on phenomena of interest

Study	Reason for exclusion
sex workers and the health consequences: an exploratory study. Health promotion international 27(3): 311-322	
Meschede, Tatjana (2010) Accessing housing: exploring the impact of medical and substance abuse services on housing attainment for chronically homeless street dwellers. Journal of Human Behavior in the Social Environment 20(2): 153-169	- No qualitative data on phenomena of interest
Meshbane, K. M.; Poquette, A.; Douglass, M. (2016) A preliminary assessment of knowledge, attitudes, and practice toward long acting reversible contraception among women experiencing homelessness. Journal of General Internal Medicine 31(2suppl1): 104	- Conference abstract
Metcalfe, S. E. and Sexton, E. H. (2014) An Academic-Community Partnership to Address the Flu Vaccination Rates of the Homeless. Public Health Nursing 31(2): 175-182	- No qualitative data on phenomena of interest
Miler, Joanna Astrid, Carver, Hannah, Foster, Rebecca et al. (2020) Provision of peer support at the intersection of homelessness and problem substance use services: a systematic 'state of the art' review. BMC public health 20(1): 641	- No qualitative data on phenomena of interest
Miller, A. B. and Keys, C. B. (2001) Understanding dignity in the lives of homeless persons. American journal of community psychology 29(2): 331-354	- No qualitative data on phenomena of interest
Miller, E.; Martineau, D.; Stewart, D. (2009) Personal health information system for homeless and marginalized youth: A feasibility study. Journal of Adolescent Health 44(2suppl1): S10-S11	- Conference abstract
Milligan, Renee, Wingrove, Barbara K., Richards, Leslie et al. (2002) Perceptions about prenatal care: views of urban vulnerable groups. BMC public health 2: 25	- Study conducted outside the UK and published before 2010
Moczygemba, L.; Marks, S.; Cox, L. (2013) Homeless care providers' perspectives about medication-related problems. Journal of the American Pharmacists Association 53(2): e40	- Conference abstract
Mollison, A. (2020) Who cares for the dying poor? Developing compassionate inner-city	- Conference abstract

Study	Reason for exclusion
communities. Progress in Palliative Care 28(2): 179	
Moore, Megan, Conrick, Kelsey M., Reddy, Ashok et al. (2019) From Their Perspective: The Connection between Life Stressors and Health Care Service Use Patterns of Homeless Frequent Users of the Emergency Department. Health & Social Work 44(2): 113-122	- No qualitative data on phenomena of interest
Moore-Nadler, M.; Clanton, C.; Roussel, L. (2020) Storytelling to Capture the Health Care Perspective of People Who Are Homeless. Qualitative health research 30(2): 182-195	- No qualitative data on phenomena of interest
Moravac, Catherine Claire (2018) Reflections of Homeless Women and Women with Mental Health Challenges on Breast and Cervical Cancer Screening Decisions: Power, Trust, and Communication with Care Providers. Frontiers in public health 6: 30	- No qualitative data on phenomena of interest
Morris, R. I. and Strong, L. (2004) The impact of homelessness on the health of families. Journal of School Nursing 20(4): 221-227	- Study conducted outside the UK and published before 2010
Moura de Oliveira, Deíse, Expedito, Adélia Contiliano, Aleixo, Milleny Tosatti et al. (2018) Needs, expectations and care production of people in street situation. Revista Brasileira de Enfermagem: 2689-2697	- No qualitative data on phenomena of interest
Muir-Cochrane, E., Fereday, J., Jureidini, J. et al. (2006) Self-management of medication for mental health problems by homeless young people. International Journal of Mental Health Nursing 15(3): 163-170	- Study conducted outside the UK and published before 2010
Mutere, Malaika, Nyamathi, Adeline, Christiani, Ashley et al. (2014) Homeless youth seeking health and life-meaning through popular culture and the arts. Child & Youth Services 35(3): 273-287	- No qualitative data on phenomena of interest
Neale, J. and Kennedy, C. (2002) Good practice towards homeless drug users: research evidence from Scotland. Health & social care in the community 10(3): 196-205	- No qualitative data on phenomena of interest
Nicholas, D. B., Newton, A. S., Calhoun, A. et al. (2016) The Experiences and Perceptions of Street-Involved Youth Regarding	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Emergency Department Services. Qualitative health research 26(6): 851-862	
Nickasch, Bonnie and Marnocha, Suzanne K. (2009) Healthcare experiences of the homeless. Journal of the American Academy of Nurse Practitioners 21(1): 39-46	- Study conducted outside the UK and published before 2010
Nuttall, Roger (2009) Holistic care of a drug-related wound: a case study from a clinic for homeless people. Nursing times 105(27): 18-21	- Incorrect study design
Nyamathi, Adeline, Hudson, Angela, Mutere, Malaika et al. (2007) Drug use and barriers to and facilitators of drug treatment for homeless youth. Patient preference and adherence 1: 1-8	- Study conducted outside the UK and published before 2010
O'Carroll, A., Irving, N., O'Neill, J. et al. (2017) A review of a GP registrar-run mobile health clinic for homeless people. Irish journal of medical science 186(3): 541-546	- No qualitative data on phenomena of interest
O'Carroll, A. and Wainwright, D. (2019) Making sense of street chaos: An ethnographic exploration of homeless people's health service utilization. International Journal for Equity in Health 18(1): 113	- No qualitative data on phenomena of interest
O'Doherty, L. and Ni Cheallaigh, C. (2017) Homeless patients' experiences in hospital. Irish Journal of Medical Science 186(6supplement1): 211	- Conference abstract
O'Donovan, J., Russell, K., Kuipers, P. et al. (2019) A Place to Call Home: Hearing the Perspectives of People Living with Homelessness and Mental Illness Through Service Evaluation. Community mental health journal 55(7): 1218-1225	- No qualitative data on phenomena of interest
Ogden, J. and Avades, T. (2011) Being homeless and the use and nonuse of services: A qualitative study. Journal of Community Psychology 39(4): 499-505	- No qualitative data on phenomena of interest
Oliver, Vanessa and Cheff, Rebecca (2012) Sexual Health: The Role of Sexual Health Services Among Homeless Young Women Living in Toronto, Canada. Health Promotion Practice 13(3): 370-377	- No qualitative data on phenomena of interest
Omerov, Pernilla, Craftman, Åsa G., Mattsson, Elisabet et al. (2020) Homeless persons' experiences of health- and social care: A systematic	- Systematic review, included studies checked for relevance. No new studies added

Study	Reason for exclusion
integrative review. Health & Social Care in the Community 28(1): 1-11	
Oosman, S., Weber, G., Ogunsonh, M. et al. (2019) Enhancing access to physical therapy services for people experiencing poverty and homelessness: The lighthouse pilot project. Physiotherapy Canada 71(2): 176-186	- No qualitative data on phenomena of interest
Ord, N. and Urata, R. (2020) Homeless to housed: How does stable housing affect healthcare utilization and perceptions in residents of the forget-me-not manor, a housing first program in Juneau Alaska. Journal of Investigative Medicine 68(1): A129-A130	- Conference abstract
Oudshoorn, Abram, Ward-Griffin, Catherine, Poland, Blake et al. (2013) Community Health Promotion With People Who Are Experiencing Homelessness. Journal of Community Health Nursing 30(1): 28-41	- No qualitative data on phenomena of interest
Padgett, D. K., Henwood, B., Abrams, C. et al. (2008) Engagement and retention in services among formerly homeless adults with co-occurring mental illness and substance abuse: voices from the margins. Psychiatric Rehabilitation Journal 31(3): 226-233	- Study conducted outside the UK and published before 2010
Paisi, M., Baines, R., Worle, C. et al. (2020) Evaluation of a community dental clinic providing care to people experiencing homelessness: A mixed methods approach. Health expectations : an international journal of public participation in health care and health policy 23(5): 1289-1299	- No qualitative data on phenomena of interest
Paisi, M., Kay, E., Plessas, A. et al. (2019) Barriers and enablers to accessing dental services for people experiencing homelessness: A systematic review. Community Dentistry and Oral Epidemiology	- Systematic review, included studies checked for relevance. No new studies added
Paisi, M., March-Mcdonald, J., Burns, L. et al. (2020) Perceived barriers and facilitators to accessing and utilising sexual and reproductive healthcare for people who experience homelessness: A systematic review. BMJ Sexual and Reproductive Health	- Systematic review, included studies checked for relevance. No new studies added
Paisi, Martha, Kay, Elizabeth, Burrows, Martin et al. (2019) 'Teeth Matter': engaging people experiencing homelessness with oral	- No qualitative data on phenomena of interest

Study	Reason for exclusion
health promotion efforts. British dental journal 227(3): 187-191	
Palepu, Anita, Hubley, Anita M., Russell, Lara B. et al. (2012) Quality of life themes in Canadian adults and street youth who are homeless or hard-to-house: a multi-site focus group study. Health and quality of life outcomes 10: 93	- No qualitative data on phenomena of interest
Paradis-Gagne, E. and Pariseau-Legault, P. (2020) Critical ethnography of outreach nurses-perceptions of the clinical issues associated with social disaffiliation and stigma. Journal of advanced nursing	- Duplicate
Paradis-Gagne, E., Pariseau-Legault, P., Villemure, M. et al. (2020) A Critical Ethnography of Outreach Nursing for People Experiencing Homelessness. Journal of community health nursing 37(4): 189-202	- No qualitative data on phenomena of interest
Paraskevopoulos, E. Z.; Dharamsi, S.; Paraskevopoulos, L. (2016) Exploring the health care experiences of women in vancouver's transitional shelters qualitative study. Canadian Family Physician 62(2supplement1): 2	- Conference abstract
Parsell, C.; Clarke, A.; Vorsina, M. (2020) Evidence for an integrated healthcare and psychosocial multidisciplinary model to address rough sleeping. Health & social care in the community 28(1): 34-41	- No qualitative data on phenomena of interest
Parsell, C., Ten Have, C., Denton, M. et al. (2018) Self-management of health care: multimethod study of using integrated health care and supportive housing to address systematic barriers for people experiencing homelessness. Australian health review : a publication of the Australian Hospital Association 42(3): 303-308	- No qualitative data on phenomena of interest
Paudyal, V., MacLure, K., MacKenzie, M. et al. (2016) Self care amongst the homeless. A qualitative study of associated barriers and facilitators. International Journal of Pharmacy Practice 24(supplement3): 40-41	- Conference abstract
Paudyal, V., Stewart, D., MacLure, K. et al. (2015) Perspectives of homeless patients on their prescribed medicines. International Journal of Pharmacy Practice 23(suppl2): 6-7	- Conference abstract

Study	Reason for exclusion
Paudyal, V., Stewart, D., MacLure, K. et al. (2016) Expectations, beliefs, behaviours and sources of information on prescribed medicines by homeless patients. International Journal of Clinical Pharmacy 38(6): 480	- Conference abstract
Paudyal, Vibhu, MacLure, Katie, Forbes-McKay, Katrina et al. (2020) 'If I die, I die, I don't care about my health': Perspectives on self-care of people experiencing homelessness. Health & Social Care in the Community 28(1): 160-172	- No qualitative data on phenomena of interest
Pauly, B. (2008) Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. International Journal of Drug Policy 19(3): 195-204	- Study conducted outside the UK and published before 2010
Pearson, Anita and George, Steve (1999) Type of accommodation and subjective health status in a population of homeless women in Southampton. HEALTH AND SOCIAL CARE IN THE COMMUNITY	- No qualitative data on phenomena of interest
Pedersen, M., Bring, C., Brunes, N. et al. (2018) Homeless people's experiences of medical respite care following acute hospitalisation in Denmark. Health & social care in the community 26(4): 538-546	- No qualitative data on phenomena of interest
Pendyal, A.; Rosenthal, M. S.; Keene, D. (2019) Challenges to self-management of heart failure among homeless individuals: A qualitative study. Circulation: Cardiovascular Quality and Outcomes 12(suppl1)	- Conference abstract
Perreault, M., Milton, D., Komaroff, J. et al. (2016) Resident perspectives on a Montreal peer-run housing project for opioid users. Journal of Substance Use 21(4): 355-360	- No qualitative data on phenomena of interest
Pham, T.; Doorley, S.; Ho, C. (2011) Dying on the streets. Journal of General Internal Medicine 26(suppl1): 27	- Conference abstract
Phillips, Darren and Kuyini, Ahmed Bawa (2018) Consumer participation at Specialist Homelessness Services: Do the homeless have a say in the services they receive?. International Social Work 61(6): 1095-1115	- No qualitative data on phenomena of interest
Phillips, S. L. (2003) An ethnography of homeless persons with serious mental illness. dnsc: 151 p-151 p	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Ploeg, J., Hayward, L., Woodward, C. et al. (2008) A case study of a Canadian homelessness intervention programme for elderly people. Health & Social Care in the Community 16(6): 593-605	- Study conducted outside the UK and published before 2010
Poulton, Brenda, McKenna, Hugh, Keeney, Sinead et al. (2006) The role of the public health nurse in meeting the primary health care needs of single homeless people: A case study report. Primary Health Care Research and Development 7(2): 135-146	- No qualitative data on phenomena of interest
Purkey, E. and MacKenzie, M. (2019) Experiences of palliative health care for homeless and vulnerably housed individuals. Journal of the American Board of Family Medicine 32(6): 858-867	- Duplicate
Quilgars, D. (2002) Women and homelessness in Europe: Pathways, services and experiences. Housing Studies 17(5): 798-800	- Incorrect study design
Quine, S., Kendig, H., Russell, C. et al. (2004) Health promotion for socially disadvantaged groups: the case of homeless older men in Australia. Health Promotion International 19(2): 157-165	- No qualitative data on phenomena of interest
Radcliffe, M. (2015) HIV and homelessness in central London: Reflections from a specialist homeless general practice. HIV Nursing 15(2): 33-37	- No qualitative data on phenomena of interest
Rajabiun, S., Mallinson, R. K., McCoy, K. et al. (2007) 'Getting me back on track': the role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. AIDS Patient Care & STDs 21: S-20	- Study conducted outside the UK and published before 2010
Recoche, K.; O'Connor, M.; Clerehan, R. (2018) Palliative Care for Underserved Populations in Australia: Homeless Persons A Discourse-Historical Approach. Journal of Pain and Symptom Management 56(6): e23	- Conference abstract
Reeve, Kesia; Casey, Rionach; Goudie, Rosalind (2006) Homeless women: still being failed yet striving to survive.	- No qualitative data on phenomena of interest
Regis, Craig, Gaeta, Jessie M., Mackin, Sarah et al. (2020) Community Care in Reach: Mobilizing Harm Reduction and	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Addiction Treatment Services for Vulnerable Populations. Frontiers in public health 8: 501	
Reid, Nadine, Khan, Bushra, Soklaridis, Sophie et al. (2020) Mechanisms of change and participant outcomes in a Recovery Education Centre for individuals transitioning from homelessness: a qualitative evaluation. BMC Public Health 20(1): 1-9	- No qualitative data on phenomena of interest
Reid, S.; Berman, H.; Forchuk, C. (2005) Living on the streets in Canada: a feminist narrative study of girls and young women. Issues in Comprehensive Pediatric Nursing 28(4): 237-256	- Study conducted outside the UK and published before 2010
Renedo, A. (2014) Care versus control: The identity dilemmas of uk homelessness professionals working in a contract culture. Journal of Community and Applied Social Psychology 24(3): 220-233	- No qualitative data on phenomena of interest
Rew, L. (2003) A theory of taking care of oneself grounded in experiences of homeless youth. Nursing Research 52(4): 234-241	- Duplicate
Rew, L.; Chambers, K. B.; Kulkarni, S. (2002) Planning a sexual health promotion intervention with homeless adolescents. Nursing Research 51(3): 168-174	- Study conducted outside the UK and published before 2010
Rice, Becky and et, al (2009) Reaching out: a consultation with street homeless people 10 years after the launch of the Rough Sleepers Unit.: 37p	- No qualitative data on phenomena of interest
Riley, R.; Johnson, T.; Pearson, L. (2001) An audit into homeless families in temporary accommodation. British journal of community nursing 6(1): 18-25	- Incorrect study design
Robards, F., Kang, M., Usherwood, T. et al. (2018) How Marginalized Young People Access, Engage With, and Navigate Health-Care Systems in the Digital Age: Systematic Review. Journal of Adolescent Health 62(4): 365-381	- Systematic review, included studies checked for relevance. No new studies added
Robards, Fiona, Kang, Melissa, Steinbeck, Katharine et al. (2019) Health care equity and access for marginalised young people: a longitudinal qualitative study exploring health system navigation in Australia. International Journal for	- Incorrect population

Study	Reason for exclusion
Equity in Health 18(1): N.PAG-N.PAG	
Rogers, Jim; George, Thomas; Roberts, Amanda (2020) Working with individuals who have experienced homelessness: Stresses and successes. Housing, Care & Support 23(2): 65-76	- No qualitative data on phenomena of interest
Roller, White Catherine and et, al. (2011) The relationship between homelessness and mental health among alumni of foster care: results from the Casey Young Adult Survey. Journal of Public Child Welfare 5(4): 369-389	- Incorrect study design
Romeo, June Hart (2005) Down and out in New York City: a participant-observation study of the poor and marginalized. Journal of cultural diversity 12(4): 152-60	- Study conducted outside the UK and published before 2010
Rosengard, C., Chambers, D. B., Tulsky, J. P. et al. (2001) Value on health, health concerns and practices of women who are homeless. Women and Health 34(2): 29-44	- Study conducted outside the UK and published before 2010
Ryan Greysen, S., Allen, R., Rosenthal, M. S. et al. (2013) Improving the quality of discharge care for the homeless: A patient-centered approach. Journal of Health Care for the Poor and Underserved 24(2): 444-455	- No qualitative data on phenomena of interest
Salem, Benissa E.; Kwon, Jordan; Ames, Masha (2018) On the Frontlines: Perspectives of Providers Working With Homeless Women. Western Journal of Nursing Research 40(5): 665-687	- No qualitative data on phenomena of interest
Salem, Benissa E., Nyamathi, Adeline, Idemundia, Faith et al. (2013) At a Crossroads: Reentry Challenges and Healthcare Needs Among Homeless Female Ex-Offenders. Journal of Forensic Nursing 9(1): 14-22	- No qualitative data on phenomena of interest
Salize, Hans J.; Werner, Amelie; Jacke, Christian O. (2013) Service provision for mentally disordered homeless people. Current opinion in psychiatry 26(4): 355-61	- Incorrect study design
Schaffer, M. A.; Mather, S.; Gustafson, V. (2000) Service learning: A strategy for conducting a health needs assessment of the homeless. Journal of Health Care for the Poor and Underserved 11(4): 385-399	- Study conducted outside the UK and published before 2010

Study	Reason for exclusion
Schmidt, R., Hrenchuk, C., Bopp, J. et al. (2015) Trajectories of women's homelessness in Canada's 3 northern territories. International journal of circumpolar health 74: 29778	- No qualitative data on phenomena of interest
Seiler, Ashley J. and Moss, Vicki A. (2012) The experiences of nurse practitioners providing health care to the homeless. Journal of the American Academy of Nurse Practitioners 24(5): 303-312	- No qualitative data on phenomena of interest
Shadel, W. G., Tucker, J. S., Mullins, L. et al. (2014) Providing smoking cessation programs to homeless youth: The perspective of service providers. Journal of Substance Abuse Treatment 47(4): 251-257	- No qualitative data on phenomena of interest
Shah, P.; Koch, T.; Singh, S. (2019) The attitudes of homeless women in London towards contraception. Primary health care research & development 20: e131	- No qualitative data on phenomena of interest
Sharma, T.; Carusone, S. C.; De Prinse, K. (2012) Assessing healthcare provider perceptions of barriers to medication reconciliation in homeless patients with HIV/AIDS at Casey House. Canadian Journal of Infectious Diseases and Medical Microbiology 23(supplsa): 67A-68A	- Conference abstract
Shatwell, Sylvia (2003) "We're just like other kids": The Homeless Families Project - a report into the needs of homeless children and families in Leeds.	- Article unavailable
Shawe, J., White, A., Ball, A. et al. (2014) Knowledge, attitudes and sexual health behaviour of residents attending a nurseled contraception and sexual health service within hostels for the homeless. European Journal of Contraception and Reproductive Health Care 19(suppl1): S142-S143	- Conference abstract
Shelton, J. (2015) Transgender youth homelessness: Understanding programmatic barriers through the lens of cisgenderism. Children and Youth Services Review 59: 10-18	- No qualitative data on phenomena of interest
Skott-Myhre, H. A.; Raby, R.; Nikolaou, J. (2008) Towards a delivery system of services for rural homeless youth: A literature review and case study. Child and Youth Care Forum 37(2): 87-102	- Incorrect study design

Study	Reason for exclusion
Sleath, B. L., Jackson, E., Thomas, K. C. et al. (2006) Literacy and perceived barriers to medication taking among homeless mothers and their children. American Journal of Health-System Pharmacy 63(4): 346-351	- Incorrect study design
Smith, Kathrine Gibson, Paudyal, Vibhu, MacLure, Katie et al. (2018) Relocating patients from a specialist homeless healthcare centre to general practices: a multi-perspective study. British Journal of General Practice 68(667): e105-e113	- No qualitative data on phenomena of interest
Solorio, M. Rosa, Milburn, Norweeta G., Andersen, Ronald M. et al. (2006) Emotional distress and mental health service use among urban homeless adolescents. The journal of behavioral health services & research 33(4): 381-93	- Study conducted outside the UK and published before 2010
Sommer, M., Gruer, C., Smith, R. C. et al. (2020) Menstruation and homelessness: Challenges faced living in shelters and on the street in New York City. Health and Place 66: 102431	- No qualitative data on phenomena of interest
St, Mungo'S (2016) Stop the scandal: can people living in homelessness accommodation access mental health services?.: 4	- Incorrect study design
St, Mungo'S (2016) Stop the scandal: the case for action on mental health and rough sleeping.: 36	- Incorrect study design
Stephens, Jo (2002) The mental health needs of homeless young people.	- No qualitative data on phenomena of interest
Stewart, H. C., Stevenson, T. N., Bruce, J. S. et al. (2015) Attitudes Toward Smoking Cessation Among Sheltered Homeless Parents. Journal of community health 40(6): 1140-1148	- No qualitative data on phenomena of interest
Stewart, Miriam; Reutter, Linda; Letourneau, Nicole (2007) Support intervention for homeless youths. CJNR: Canadian Journal of Nursing Research 39(3): 203-207	- No qualitative data on phenomena of interest
Stewart, S. A. (1999) The lived experience of dealing with health for adults who are homeless: 'I'm all I've got!'. phd: 217 p-217 p	- Study conducted outside the UK and published before 2010
Stormon, N., Pateman, K., Smith, P. et al. (2019) Evaluation of a community based dental clinic for youth experiencing homelessness in	- Incorrect study design

Study	Reason for exclusion
Brisbane. Health & social care in the community 27(1): 241-248	
Sturman, N. (2020) 'Lucky to be here in Australia': Understanding the challenges and opportunities for general practice to deliver compassionate and effective care to men experiencing homelessness. Australian Journal of Primary Health 26(4)	- Conference abstract
Sturman, Nancy and Matheson, Don (2020) 'Genuine doctor care': Perspectives on general practice and community-based care of Australian men experiencing homelessness. Health & Social Care in the Community 28(4): 1301-1309	- Duplicate
Sutherland, M. and Steeples, T. (2012) Addressing the health needs of young homeless people who have an intellectual disability - An Australian NGO's response. Journal of Intellectual Disability Research 56(78): 781	- Conference abstract
Sweat, J., Nyamathi, A., Christiani, A. et al. (2008) Risk behaviors and health care utilization among homeless youth: contextual and racial comparisons. Journal of HIV/AIDS Prevention in Children & Youth 9(2): 158-174	- Study conducted outside the UK and published before 2010
Swigart, V. and Kolb, R. (2004) Homeless persons' decisions to accept or reject public health disease-detection services. Public Health Nursing 21(2): 162-170	- Study conducted outside the UK and published before 2010
Tarzian, A. J.; Neal, M. T.; O'Neil, J. A. (2005) Attitudes, experiences, and beliefs affecting end-of-life decision-making among homeless individuals. Journal of Palliative Medicine 8(1): 36-48	- Study conducted outside the UK and published before 2010
Taylor, H. C., Stuttaford, M. C., Broad, B. et al. (2007) Listening to service users: young homeless people's experiences of a new mental health service. Journal of child health care : for professionals working with children in the hospital and community 11(3): 221-230	- No qualitative data on phenomena of interest
Thompson, Sanna J., McManus, Holly, Lantry, Janet et al. (2006) Insights from the street: Perceptions of services and providers by homeless young adults. Evaluation and Program Planning 29(1): 34-43	- Study conducted outside the UK and published before 2010

Study	Reason for exclusion
Tischler, V., Karim, K., Rustall, S. et al. (2004) A family support service for homeless children and parents: users' perspectives and characteristics. Health & Social Care in the Community 12(4): 327-335	- No qualitative data on phenomena of interest
Tischler, V.; Rademeyer, A.; Vostanis, P. (2007) Mothers experiencing homelessness: Mental health, support and social care needs. Health and Social Care in the Community 15(3): 246-253	- No qualitative data on phenomena of interest
Trickett, E. M. and Chung, D. (2007) Brickbats and bouquets: health services, community and police attitudes and the homeless experiences of women 45 years and over living in rural South Australia. Rural Social Work & Community Practice 12(2): 5-15	- Study conducted outside the UK and published before 2010
Vaclavik, J. M. (1999) Health, illness, and homeless women: A phenomenological study. phd: 86 p-86 p	- No qualitative data on phenomena of interest
Valaitis, Ruta K. (2011) Online communities of practice as a communication resource for community health nurses working with homeless persons. Journal of Advanced Nursing 67(6)	- No qualitative data on phenomena of interest
Varley, A. L., Montgomery, A. E., Steward, J. et al. (2020) Exploring Quality of Primary Care for Patients Who Experience Homelessness and the Clinicians Who Serve Them: What Are Their Aspirations?. Qualitative health research 30(6): 865-879	- Incorrect population
Vasiliou, Christina (2006) Making the link between mental health and youth homelessness: a pan-London study.	- No qualitative data on phenomena of interest
Vivat, B., Kennedy, P., Daley, J. et al. (2016) What do previously homeless people in London, UK, think about advance care planning (ACP) and end of life care (EOLC)? A qualitative investigation. Palliative Medicine 30(6): np224	- Conference abstract
Waldbrook, N. (2013) Formerly Homeless, Older Women's Experiences with Health, Housing, and Aging. Journal of Women and Aging 25(4): 337-357	- No qualitative data on phenomena of interest
Waldbrook, N. (2015) Exploring opportunities for healthy aging among older persons with a history of homelessness in Toronto, Canada.	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Social Science and Medicine 128: 126-133	
Waplington, J.; Morris, J.; Bradnock, G. (2000) The dental needs, demands and attitudes of a group of homeless people with mental health problems. Community dental health 17(3): 134-137	- Incorrect study design
Watson, D. P. (2012) From Structural Chaos to a Model of Consumer Support: Understanding the Roles of Structure and Agency in Mental Health Recovery for the Formerly Homeless. Journal of Forensic Psychology Practice 12(4): 325-348	- No qualitative data on phenomena of interest
Watson, D. P. (2010) The mental health of the older homeless population provider-perceived issues related to service provision. Journal of Applied Social Science 4(1): 27-43	- No qualitative data on phenomena of interest
Watson, Tyler, Schindel, Theresa J., Simpson, Scot H. et al. (2020) Medication adherence in patients with mental illness and recent homelessness: contributing factors and perceptions on mobile technology use. International Journal of Pharmacy Practice 28(4): 362-369	- No qualitative data on phenomena of interest
Weal, Rory and Orchard, Beatrice (2018) Dying on the streets: the case for moving quickly to end rough sleeping.: 20	- No qualitative data on phenomena of interest
Webb, W. (2016) When dying at home is not an option: An exploration of the perception of hostel staff regarding the provision of hostel-based palliative care to homeless people. Palliative Medicine 30(4): 23	- Conference abstract
Weber, Mary, Thompson, Lisa, Schmiege, Sarah J. et al. (2013) Perception of access to health care by homeless individuals seeking services at a day shelter. Archives of psychiatric nursing 27(4): 179-84	- Incorrect study design
Wen, C. K.; Hudak, P. L.; Hwang, S. W. (2007) Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. Journal of General Internal Medicine 22(7): 1011-1017	- Study conducted outside the UK and published before 2010
Weng, Suzie S. and Clark, Paul G. (2018) Working with homeless populations to increase access to services: A social service providers' perspective through the lens of stereotyping and stigma. Journal of	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Progressive Human Services 29(1): 81-101	
White, B. M.; Logan, A.; Magwood, G. S. (2016) Access to Diabetes Care for Populations Experiencing Homelessness: an Integrated Review. Current Diabetes Reports 16(11): 112	- Systematic review, included studies checked for relevance. No new studies added
White, B. M. and Newman, S. D. (2015) Access to primary care services among the homeless: a synthesis of the literature using the equity of access to medical care framework. Journal of primary care & community health 6(2): 77-87	- Incorrect study design
Whiteford, M. and Simpson, G. (2015) A codex of care: Assessing the Liverpool Hospital Admission and Discharge Protocol for Homeless People. International Journal of Care Coordination 18(23): 51-56	- No qualitative data on phenomena of interest
Whiteford, Martin and Simpson, Glenn (2016) “There is still a perception that homelessness is a housing problem”: devolution, homelessness and health in the UK. Housing, Care and Support 19(2): 33-44	- Incorrect study design
Whitley, Rob (2013) Fear and loathing in New England: examining the health-care perspectives of homeless people in rural areas. Anthropology & Medicine 20(3): 232-243	- No qualitative data on phenomena of interest
Williams, S. and Stickley, T. (2011) Stories from the streets: people's experiences of homelessness. Journal of Psychiatric & Mental Health Nursing (John Wiley & Sons, Inc.) 18(5): 432-439	- No qualitative data on phenomena of interest
Withy, K. M., Amoa, F., Andaya, J. M. et al. (2008) Health care needs of the homeless of O'ahu. Hawaii medical journal 67(8): 213-217	- Study conducted outside the UK and published before 2010
Wright, N. M. J.; Tompkins, C. N. E.; Jones, L. (2005) Exploring risk perception and behaviour of homeless injecting drug users diagnosed with hepatitis C. Health & Social Care in the Community 13(1): 75-83	- No qualitative data on phenomena of interest
Wusinich, C., Bond, L., Nathanson, A. et al. (2019) "If you're gonna help me, help me": Barriers to housing among unsheltered homeless adults. Evaluation and program planning 76: 101673	- No qualitative data on phenomena of interest

Study	Reason for exclusion
Yaphe, H., Campbell, R., Mancini, N. L. et al. (2020) 29 - Approaches to Enabling Care for People With Diabetes Experiencing Homelessness. Canadian Journal of Diabetes 44(7supplement): 15	- Conference abstract
Zur, J.; Linton, S.; Mead, H. (2016) Medical Respite and Linkages to Outpatient Health Care Providers among Individuals Experiencing Homelessness. Journal of community health nursing 33(2): 81-89	- No qualitative data on phenomena of interest

Excluded economic studies

No economic evidence was identified for this review. See Supplement 2 for the list of excluded studies across all reviews.

Appendix K Research recommendations

Research recommendations for review question: What works well and what could be improved about access to, engagement with and delivery of health and social care for people experiencing homelessness?

Research recommendation

What structural and systems factors help and hinder commissioning and delivery of wrap around health and social care support that is integrated with housing, for people experiencing homelessness?

Why this is important

The review of quantitative evidence demonstrated some positive outcomes of wrap around health and social care support, which is integrated with housing, as well as holistic assessments and multi-agency working. Although this was supported by the qualitative evidence the qualitative review also showed there were often barriers to achieving wrap around health and social care but specific insight was not provided. For example, there was a lack of data about the potential systems-level factors that helped or hindered effective governance, commissioning and delivery of wrap around integrated support for people experiencing homelessness.

Research is therefore needed to understand what structural and systems factors facilitate effective commissioning and delivery of wrap around health and social care support that is integrated with housing for people experiencing homelessness. The committee believe it will be important to focus in particular on governance arrangements, planning, commissioning and budgeting arrangements and the role of experts by experience in commissioning and planning.

The committee were also aware that there were sub groups of the homeless population for whom coordinated, wrap around health and social care, integrated with housing, is particularly lacking. These include people with the highest needs such as palliative and end of life care needs, including frailty and advanced ill health who are not receiving equitable joined up multidisciplinary person-centred care and support. These conditions require specific consideration from integrated systems approaches, to ensure the governance and commissioning of the right services. The committee were therefore keen for research to consider the structural and systems factors in health and social care that supports integrated, wrap around care for these groups.

Rationale for research recommendation

Table 55: Research recommendation rationale

Importance to the population	The review of evidence for the guideline identified the importance of wrap around health and social care support, integrated with housing as well as holistic assessments and multi-agency working. The proposed research will generate evidence to identify the system level factors for achieving this and overcoming common barriers. The evidence will ultimately be used to support the improvement of commissioning and design of wrap around services, bringing together the range of professions and agencies configured in a way to meet local needs. This will ensure that services meet the needs of local populations, ensuring the provision of integrated, wrap around support to address complex issues and improving individual experiences and outcomes including morbidity, mortality and quality of life.

Relevance to NICE guidance	The evidence reviews highlighted the importance of integrated health, social care and housing to achieve better outcomes for people who are homeless. However, the research also reflected relatively limited and inconsistent implementation of such services, and the committee discussed barriers to integrated working experienced by their own organisations, in particular the absence of adult social care. The expert witness testimony highlighted findings of Safeguarding Adults Reviews, which showed that gaps in provision contributed to negative outcomes that were related to a lack of integration. Identifying how to facilitate integration at the systems/ structural level and being able to make recommendations in future NICE guidance will improve the ability of commissioners and practitioners to deliver wrap around health and social care services that are integrated with housing, to meet the needs and improve health, social care and housing outcomes of people who are homeless.
Relevance to the NHS	The NHS in England is being re-structured towards population/ place based arrangements as a result of the White paper of February 2021, 'Integration and innovation: working together to improve health and social care for all'. This will see the establishment of Integrated Care System (ICS) NHS Bodies and Integrated Care System Partnership Bodies – who will include wider members, including adult social care and (potentially providers and people with lived experience). The ICS Partnership Bodies will be responsible for setting out health and care plans, to which the ICS NHS bodies must pay attention. Identifying the critical success factors for governance, commissioning and delivery of integrated health and social care services for people who are homeless will inform the development of these new structures.
National priorities	Understanding the critical success factors that deliver wrap around health and social care support for people who are homeless at the structural and system level is essential to deliver on national priorities including: The NHS Long Term Plan, which identified the importance of addressing health inequalities. Evidence has shown that health inequalities amongst the homelessness population are significant. The average age of death of someone who is homeless is 43 for women and 45 for men (Office for National Statistics, 2019). The government's Rough Sleeping Strategy of August 2018 committed to halving rough sleeping by 2022 and ending it by 2027, which included the request that NICE produce guidance to support targeted homelessness prevention, integrated care and recovery.
Current evidence base	The current evidence base highlights the importance of wrap around health and social care, integrated with housing and multi-agency working to meeting the health and social care needs of people who are homeless. However, there is little evidence of what enables and facilitates these arrangements – which inherently require co-operation and co-ordination between commissioners from the NHS, adult social care and local authority housing/ homelessness departments.
Equality considerations	Homeless people experience worse health outcomes than the mainstream population and within the wider homeless population, specific groups are over represented and would benefit from improved wrap around health and social care: • People with needs arising from long term conditions and frailty • People with palliative and end of life care needs

	• People with disabilities including learning disabilities • People with acquired brain injury Collection of disaggregated data based on equalities considerations would help understand needs of specific population groups. See Equality Impact Assessment for further detail about equalities considerations for this guideline: https://www.nice.org.uk/guidance/ng214/history

ICS: Integrated care systems; NHS: National Health Service; NICE: National Institute for Health and Care Excellence.

Modified PICo table

Table 56: Research recommendation modified PICo table

Population	People aged 16 or older who are experiencing homelessness. Sub groups of the homeless population including • People with palliative and end of life care needs, • People experiencing frailty and advanced ill health.
Phenomenon of Interest	Views and experiences of professionals and experts by experience about the system factors that enable the joint commissioning and governance of wrap around health and social care, which is integrated with housing. In particular: • The critical success factors (or enablers) that promote integrated commissioning and governance for wrap around health and social care • Examples of 'good' integrated commissioning. • System enablers specific to wrap around care for high needs groups such as people with palliative and end of life care needs. Views and experiences of professionals and experts by experience about what system factors that create barriers to joint commissioning and governance of wrap around health and social care, which is integrated with housing. In particular: • Barriers to integrated commissioning and governance and how to address these. • Barriers to integrated commissioning and governance which are specific to wrap around care for high needs groups such as people with palliative and end of life care needs. The views and experiences of professionals involved in commissioning, governance, planning and provision across the NHS, adult social care and housing will be included.
Context	Health and social care services that are integrated with housing for people experiencing homelessness. Research to be conducted in unitary and two tier authorities, urban and rural areas.
Study design	Qualitative, including interviews, focus groups and surveys with qualitative analyses of open ended responses.
Timeframe	In time for the next update of the NICE guideline on health and social care for people experiencing homelessness.

Additional information	-